

European guidelines for youth AIDS peer education

by Gary R Svenson and other collaborators



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European guidelines for youth AIDS peer education

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Preface

As Head of the Division of Social and Preventive Medicine at the Department of Community Medicine in Malmö, I am proud to have been the administrator of Europeer, the European joint action plan on AIDS peer education to reach young people in and outside the school system. The resulting guidelines in eight languages, the bibliography, and the interactive Internet network should prove to be an effective system for spreading information and expertise, and for sharing knowledge and experience between Europeans working in HIV prevention and health promotion.

The level of co-operation and goodwill from our Europeer partners and contributors has been extraordinary. I thank them for their efforts and generosity, and hope that our work will serve as an example of how well we Europeans can work together, and of how much we can accomplish.

As a researcher in social and preventive medicine, I continue to be concerned about the spread of HIV. An effective vaccine is yet to be developed and access to antiretroviral treatment remains a luxury available only in the wealthiest nations. As Executive Director of UNAIDS Peter Piot commented on UN World AIDS Day 1997, 'the more we know about the AIDS epidemic, the worse it appears to be'. In most parts of the world, the majority of new infections are among young people between the ages of 15 and 24.

AIDS peer education can be an effective approach to HIV prevention, and a way of empowering young people. However, we need to be cautious about our hopes and beliefs about this complex, dynamic method. We need evidence of AIDS peer education's effectiveness in a variety of populations. Moreover, we need a clearer understanding of its processes. I hope that the Europeer project is a step towards encouraging that commitment in all of us.

Lastly, I would like to thank Gary Svenson and the Europeer staff for their hard work on this elaborate task and to complement them on a job well done.

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Foreword

The aim of these Guidelines is to provide guidance on setting up, running and evaluating AIDS peer education projects for young people. They were written with the practitioner and policy maker in mind, but should be useful to young people or anyone else wishing to gain an understanding of the approach. The Guidelines are a product of the Europeer project, formally titled 'The European Joint Action Plan on AIDS Peer Education to reach Young People in and outside the School System'. The project is financially supported by the European Commission, the Swedish National Institute of Public Health and the Department of Community Medicine, Lund University.

In addition to the Guidelines, the project has produced an annotated bibliography on AIDS peer education and an interactive network site on the Internet (www.europeer.lu.se). This site includes downloadable and publishable versions of the Guidelines in French, English, Italian, German, Spanish, Portuguese, Greek and Swedish. In addition, the site offers downloads of the bibliography (mainly in English), AIDS peer education project locator maps of the European Union, a news page, a links page, and discussion forums for peer educators, practitioners, policy makers, researchers/evaluators and for general use.

Europeer developed out of a concern by its partners about the expanding use of AIDS peer education in Europe. Seeing a potential for the approach and agreeing to its health promotion philosophy, we felt that guidelines were needed. The growing use of the method had a momentum of its own, projects were working in isolation, there appeared to be little consensus on what it was or where it should be used, and there was an obvious lack of research on its effectiveness. The eventual partners and I had many discussions about the importance of this task whenever we met at European conferences and meetings. In 1996, I moved to a position at the Department of Community Medicine to continue researching in AIDS peer education, which gave me the opportunity to manage such a project. The partners, with their excellent ideas and suggestions, willingly gave me their support.

The methodology of Europeer is based on an exhaustive review of the AIDS peer education literature and qualitative interviews conducted with projects in 11 European Union member states. A total of nearly 400 literature items were collected, reviewed and entered into a database. Those items most relevant to AIDS peer education in Europe are provided in the Europeer bibliography. The projects interviewed were selected by the partners and contact persons in various countries. Priority was given to projects running successfully for some time and/or had carried out an evaluation. An attempt was made to capture the cultural diversity of Europe and include a range of target groups.

The interviews were conducted by myself, were tape recorded and field notes taken. If necessary, a translator was present. A total of 24 AIDS peer education projects were interviewed using individual or group methods. Interviewees consisted of 92 peer educators, 30 project co-ordinators and managers, 24 trainers, 13 project evaluators, 15 consultants, 30 intermediaries and 21 policy makers at local, regional and national levels. The interview questions are included as an appendix. The responses of the interviews are not provided in the Guidelines due to the lack of space, but were used to create the content.

Once the literature was reviewed and the interviews analysed, a draft of the Guidelines was written and distributed to expert practitioners, researchers, policy makers and young people in 14 EU member states. These individuals, and a representative of the WHO Regional Office for Europe, then gathered at a three-day European expert meeting on AIDS peer education for young people in Malmö, Sweden. Deliberating in plenary sessions and in four work groups, the participants came to a consensus on recommendations for the final Guidelines and their method of dissemination (the Internet). The four work groups were:

- 1 policy making and planning
- 2 initiating and setting up projects
- 3 training and implementation
- 4 evaluation.

The final step was to re-write the Guidelines and bibliography, taking into account the literature, the interviews, the needs of practitioners and policy makers, and the expert meeting. The re-write was monitored and approved by experts and partners from each group.

There are literally hundred of individuals and organisations who have contributed to Europeer – I thank them all. My deep appreciation goes to the project partners and the participants at the expert meeting for their hard work, wisdom, support and trust. Moreover, I am very grateful for the hospitality and openness shown by the young people and adults interviewed.

Several individuals and organisations need to be specially acknowledged for their extra efforts and generosity including: Advocates for Youth (Washington, DC.); Harry Black, Fife Healthcare (Scotland); the Center for Disease Control (Atlanta); Susan Charleston (London University); the ENHPS Secretariat (WHO Europe); Catharina Edlund (UNAIDS); Jo Frankham, Univ. of East Anglia (UK); the Health Education Authority (UK); Jeffrey Kelley (Univ. of Wisconsin); Laurel MacLaren (Washington, DC); Seicus (New York); and Patricia Light, UNICEF (Florence). My special thanks to Kent Johnsson, Ann-Christin Dufke and Anne-Marie Wangel for their hard work as Europeer staff.

Lastly, our grateful appreciation to D-G V of the European Commission, the Swedish National Institute of Public Health, the Malmö City Council, and Lund University for both their financial sponsorship and support for the project.

These Guidelines are dedicated to the future of European young people, especially my two children Emil and Stephanie.

Gary Svenson, Europeer Manager
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About AIDS peer education

The purpose of this booklet is to offer guidelines on the use of peer education for the prevention of HIV infection among young people in the European Union. This is no easy task, as the European Union is currently composed of 15 nations and many more sub-cultures. This distinction is important since peer education always has a cultural context. By the simplest of definitions, peer education is 'peer-to-peer communication' and thereby a social phenomena. In fact, as we will read further on in these guidelines, the approach relies on theories and assumptions concerning communication and social influence for its effect.

The social and scientific developments in the fight against AIDS have perhaps influenced the refinement and popularity of the approach more than any other factor. HIV prevention has required us to investigate and reflect on our sexual and drug use practices as never before. Moreover, the wide variation in these practices and their meanings according to cultures and sub-groups has been publicly acknowledged. Peer education's greatest potential lies in its ability to adapt prevention messages to local practices, values and needs. It is, however, a complex approach that is not applicable everywhere or undertaken by just anyone. After reading these guidelines, the practitioner should have a clearer understanding of what AIDS peer education is, its potential as well as limitations, and how to go about starting new projects.

What is AIDS peer education?

Definition

The English term 'peer education' is well-known internationally within AIDS education, but is difficult to translate into other languages primarily due to the word 'peer'. The word originated hundreds of years ago as a British term indicating membership in one of the five ranks of nobility. The modern use of the word, according to the Webster dictionary¹ is: 'one that is of equal standing with another; one belonging to the same societal group especially based on age, grade, or status'. Thus, the term 'peer education' would indicate 'peer-to-peer education' or those of the same societal group or social standing educating each other.

Historical background

Anyone who has studied some child psychology or observed the interactions of children and young people is aware that peer-to-peer education and social influence is occurring continuously. However, the first systematic use of the technique began perhaps in the early 1800's with the English 'monitor system'. School pupils were taught to teach to other classes on subjects they had already learned themselves. The primary motivation for developing the system was economic, since using pupils was less expensive than professional teachers.

Peer tutoring and teaching

In the 1960s, peer tutoring or teaching gained a rebirth in the US. The goal was to use pupils to help slightly younger pupils in classroom subjects, which was seen as psychologically beneficial for both the tutor and tutee. Educational and developmental psychologists, utilising the theories of Piaget, regarded peer interactions during learning as a means of triggering intellectual reconstruction in the child. They worked from the knowledge that children speak the same language, are often very direct with each other and are motivated to reconcile differences between themselves and other children. Children were more intimidated by adult-child communication than by informational exchange among themselves, which seemed to carry greater influence.

Two other important theoreticians from that time were Vygotsky and Sullivan². According to Vygotsky, whose theories were popular in both the Soviet Union and the US, children learn by way of internalising the thinking (cognitive) processes implicit in their interactions. Children introduce new patterns of thought through their interactions. After repeated exposure, individual thinking can be influenced. Through peer tutoring, children could thus learn strategies for solving particular tasks. Sullivan saw peer tutoring as a method for enabling children to learn information and develop improved thinking strategies by the process of sharing thoughts, compromising with each other and consequently remaining open to new ideas.

Several scientific studies were carried out that indicated benefits from peer tutoring, but surveys taken in the 1980s concluded that it was most appropriate in settings where there is a need to supplement teachers. Peer tutoring was also found to be useful in:

- contributing to creative learning
- helping overcome the motivational problems of underachieving pupils
- giving self-esteem and providing constructive social experiences.

Today, peer tutoring is an established approach used in primary and secondary schools as well as on college and university campuses. Research into the method continues.

Peer counselling and helping

The peer counselling approach grew out of peer tutoring and focused on helping young people deal with personal and social problems like drug abuse, rape and violence. Beginning in the 1970s and used primarily in North America, the method often focused on specific behaviour change and skill development. These programmes progressed from the educational focus of peer tutoring to working with the emotional and social influences on behaviour. Theoretically, the method drew on social learning theory and social inoculation theory (more on theories later). Young people were trained to counsel other young people similar to themselves. In some cases, the peer counsellors had previously gone through the process of dealing with the same problem themselves.

The method is currently used throughout North America and Europe. It is used in counselling young homosexual men and women during the 'coming out' process, in substance abuse counselling, in women's crisis centres, in suicide prevention, in safer sex and HIV counselling, and not least of all in supporting young people with HIV.

Peer education

Peer education is an approach whereby a minority of peer representatives from a group or population actively attempt to inform and influence the majority. Peer education projects have been set up at the grassroots level by non-government organisations (NGOs), community and spiritual organisations, youth organisations and educational institutions. Feasibility studies have been carried out by policy makers and researchers in their search for effective prevention methods. Subjects targeted include smoking, drug and alcohol use, violence, sexual health and HIV-STD risk behaviours.

It is in the area of HIV –and sexually transmitted disease (STD) prevention that the use of peer education has grown most rapidly. Since the early 1990s, its use has spread throughout the world and is today considered a very attractive approach. In the eyes of critics, the idealisation of peer education has led to its uncritical and over-enthusiastic adoption. This criticism is often based on the lack of scientific evidence for its effectiveness.

The question remains as to why peer education has expanded so rapidly despite scant evidence of its effectiveness. One senses a ground swell behind AIDS peer education's popularity, and there is no mistaking the enthusiasm among the young people and adults involved. It is a new approach that challenges the traditional 'expert' role and advocates the right of young people to have access to information about sexuality, HIV, STD, condoms, contraception and drugs.

Movements that advocate resistance to AIDS peer education are often driven by a reluctance to provide young people with encompassing information on sensitive subjects, especially through the use of interactive and role-playing techniques. Young people trained as peer educators become experts on these subjects relative to their peers, and then take action as agents of change. All this can not only unnerve traditionalists but can generate unease among adults concerning the accuracy of the information being taught, as well as its implicitly sexual nature.

Peer education within HIV prevention

At the beginning of the HIV pandemic there was a strong focus on using information campaigns to increase knowledge about the HIV virus: how it is transmitted and how to protect oneself. Medical experts took the initiative in informing the public and neutral medical terms such as 'bodily fluids', 'vaginal and anal intercourse', and 'risk group' were used. This language was often used to confirm existing prejudices about difference (ie foreigners), taboos (ie homosexuals), and immorality (ie drug use). Many people became captives to fear and blame. Those working in the fight against AIDS found themselves not only trying to slow the spread of the virus but working with issues of discrimination against HIV-positive people and other groups such as homosexuals.

As the pandemic continued into the late 1980s, an increasing number of scientific studies showed that increased levels of knowledge about HIV/AIDS did not lead to reductions in risk behaviours. By this time, many NGOs, community-based organisations (CBOs) and institutions at the local level had become firmly established in HIV prevention, supporting people with HIV, and fighting against discrimination. Concurrently, the health promotion approach was undergoing a re-birth, especially after the adoption of the Ottawa Charter in 1986.

In the early 1990s, the accumulated results of an increasing number of scientific studies began to show that social and normative influences, as well as partner-to-partner communication barriers, were determinants of sexual risk behaviours. This had usually been taken for granted by practitioners and volunteers working at the grassroots level. NGOs, CBOs, clinicians and sex educationalists were well-informed, experienced and often active in national or international networks where knowledge and problems were shared.

Practitioner and scientific journals now began calling for an alternative to top-down, expert-based information models. A commonly held view was that interventions needed to be tailored to each target group and that messages needed to be meaningful to people's everyday lives. Biomedical vocabulary had to be replaced with a more user-friendly, explicit language. Dynamic prevention models leading to an increased understanding of sexuality, gender-role, sexual orientation, relationships and drug abuse were called for.

Besides, how could an outside expert understand the implicit values, norms, and language of sexuality and drug use in a group they were not a part of? Citizen participation, community mobilisation and local empowerment was required to enable communities and groups to help themselves. Peer education was seen as one possible way of generating this process.

As the majority of young people are in schools until they are 17–18 years old, the schools system had to be involved in HIV prevention, sex education and drug education. Conservative by nature, many school systems were and still are reluctant to such proposals. Few teachers were trained in these subjects, and the use of interactive techniques was a far cry from the traditional didactic teacher-pupil role. The subject matter was complicated, personal and even embarrassing to work with. The advocates of peer education, however, suggested that a possible solution to these problems was to let the pupils tackle the issues themselves.

Peer education was also seen as having the potential for reaching young people outside the schools setting. Europe also has an range of youth sub-groups who are outside the mainstream due to social circumstances, drug abuse, sexual orientation, poverty, lifestyle, and ethnic or religious background. Peer education appeared to be a convenient and effective method to reach them.

Today, AIDS peer education is a result of practical experience in HIV prevention, social science research, the changing nature of modern society and youth, and the health promotion movement. It is a movement in the sense that its supporters advocate change in current information hierarchies, increased youth participation, and the right of young people to have adequate information on health matters, including sexuality and drug use.

The term 'AIDS peer education' is currently used to describe a range of methods of educating young people about HIV, STD and other pertinent health subjects. It is in a state of flux and those involved in it seek to define it. These guidelines attempt to contribute to a definition by drawing on its historical context, examining its practical applications in Europe today, and sharing the knowledge and experience of experts and young people from 14 European countries.

Peer education in Europe today

When different people speak or write about 'AIDS peer education' they may not be discussing the same thing. This is especially apparent when reading the results of various research evaluations that compare the effects of various peer education projects or articles by practitioners who make generalised claims about the approach. In AIDS peer education, there can be a wide variation between the demographics and culture of each target group, including the setting and social-economic context, the training and amount of self-determination the peer educators receive, the content and steps of the implementation program, and the project aims and objectives.

As a first step toward bringing some order to this situation, a categorisation of European AIDS peer education is presented below. Each category is described in detail later in the guidelines. These categories are not analytical and are not offered as set of methods in themselves. They can be used in various combinations. They are based on the field interviews, the literature review, and the Europeer Expert Meeting.

AIDS peer education can be roughly divided into these four sub-approaches:

- 1 the pedagogical or educational approach
- 2 the outreach approach
- 3 the diffusional approach
- 4 the peer-facilitated community mobilisation approach.

Peer education and behavioural theories

Anyone carrying out an intervention has a theory about what they are doing, why they think it will work and what the outcome will be. However, there is a difference between an assumption and a theory. We make an assumption when we take for granted that an intervention is effective without having an understanding of its

mechanisms (processes) nor evidence of its effect. Scientific theories, on the other hand, summarise and integrate existing knowledge and guide us in understanding the mechanisms of behaviour change. Theories are tested and corrected scientifically and allow us to describe, explain and predict the processes and outcomes of interventions.

Behaviour change doesn't come all at once but through a series of steps. Perhaps most important for people working in the field is that theories can help identify expected mediators of behaviour change (i.e. knowledge, attitudes, social norms, etc.) and thereby contribute to clear project goals and objectives.

Theories eventually become outdated and can be more of a hindrance than a guide to developing effective interventions. Creativity and experimentation are to be encouraged, but we make a mistake when we assume something 'works' when we really do not know this for sure. Human beings are complex creatures, especially in terms of their sexuality, and working from the experimentation that lies behind tested theories can guide us towards our goals and in understanding what processes are occurring on the way to meeting it.

Lastly, there are a number of excellent behavioural theories that can be used for guiding peer education interventions. Since there is only space to present a few in these guidelines, we have chosen those most referred to in the international HIV-prevention literature³. The terms derived from them are widely used and have been integrated into other theories.

Health belief model

The Health belief model (HBM) was originally developed in the 1950s and has been reformed over the years⁴. It is based on various belief patterns in people that are used to predict their behaviour (a belief is a conviction that something is true or will happen). In short, the beliefs that are considered necessary for behaviour change are:

- that the person believes that they are susceptible to the health threat
- that the disease or state of non-health has a high degree of severity (pain, death, social consequences, etc.)
- that the benefits of a preventive behaviour (i.e. condom use) outweigh the cost and inconvenience of the behaviour
- the behaviour is possible for them to carry out
- that there is a 'cue to action' which prompts them to want to carry out the behaviour. Cues can come from the mass media or from the influence of others.

The key to the theory is the person's belief in the severity of the condition and their belief in their susceptibility. Too much of both can lead to fear, anxiety and denial. The model is logical but people can make rationalisations or create myths to escape the fear, anxiety and guilt, i.e. 'HIV only infects homosexuals and promiscuous people'. Measurements involving 'perceived risk' are based on this theory.

Social learning theory

Social learning theory contributes with the behavioural determinant of 'self-efficacy' and implies the ability of a person to take control over their own mental and environmental situation⁵. The concept of self-efficacy fits into the health promotion goal of enabling people to take control over and improve their own health. In Social Learning Theory, a person is not passively acted upon by their environment, but has a reciprocal two-way interaction with it.

According to the theory, a person can increase their self-efficacy by learning new knowledge and skills for handling situations. Learning can occur:

- 1 through direct experience
- 2 indirectly, by observing and modelling one's actions on others with whom one identifies
- 3 through training in situation skills and positive self-appraisal that leads in turn to confidence in being able to carry out a behaviour (i.e. negotiating condom use).

Self-efficacy is therefore a perception – an ability to see that one can succeed in carrying out certain actions in specific situations. This applies to peer education and interactive learning activities.

Theory of reasoned action

The theory of reasoned action has contributed with the inclusion of the behaviour determinants of 'perceived social norms' and 'intentions' in its model of behaviour⁶. In the model, a person's behaviour is influenced by the prevailing social norms towards a certain behaviour in a group or culture. This is called a 'perception' because it is difficult for a person to know what people are actually doing and thinking (especially when it comes to sex). If a person has the belief that his social environment has a positive opinion about a behaviour, then they are more likely to carry it out. This concept is obviously relevant when one considers the hypothesis that peers influence each other more than anyone outside the peer group.

The theory sees behaviour as a process, with a series of steps leading up to an 'intention' to carrying out an action. In the theory, behavioural intentions greatly dispose a person to actually carry out the action. Measures of intention have been found to correlate, to varying degrees, with actual behaviour. However, the use of intention as a determinant of actual behaviour is controversial. Nevertheless, it is sometimes used to measure impacts of interventions with young people who haven't had sex yet, and when there isn't time to conduct a long-term follow-up evaluation.

Theory of the diffusion of innovations

The theory uses a social influence model to explain behaviour change⁷. In practice, interventions are directed not only towards those witnessing an activity, but indirectly via the diffusion of innovation (change) through existing social networks in a target group or community. Innovations can be new information, attitudes, beliefs, and practices. The use of opinion leaders as 'change agents' is key to the theory, and these are defined as persons who are perceived by a social group as trustworthy, credible, innovative and who others turn to for advice. These individuals should have a wide social network so as to eventually influence a large number of people through a chain reaction of person-to-person exchanges and discussion. The theory has usefulness in guiding and explaining the expected impact of peer education interventions. Peer educators are usually assumed to be influencing not only those in direct contact with their activities (i.e. those in the classroom) but also, indirectly through an informal and diffusional effect, the target group outside the class. However, for the latter to be effective, the peer educators must be opinion leaders and the target group have discussions about the content of the activities.

Chapter 1

- 1 Merriam-Webster Collegiate Dictionary. 10th ed. Springfield, Mass: Merriam-Webster; 1994.
- 2 Damon W. Peer education: the untapped potential. *J of Applied Psychology* 1984; 5:331-343.
- 3 For current European theories read: Van Campenhoudt L, Cohen M, Guizzardi G, Hausser D. *Sexual interactions and HIV: new conceptual perspectives in European research*. London: Taylor & Francis; 1997.
- 4 Rosenstock IM. Historical origins of the health belief model. *Health Education Monographs* 1974; 2:328-335.
- 5 Suggested reading: Bandura A. Perceived self-efficacy in the exercise over the control of AIDS infection. *Evaluation and program Planning* 1990; 13:9-17.
- 6 Fishbein M. AIDS and behaviour change: an analysis based on the theory of reasoned action. *Interamerican Journal of Psychology* 1990; 24:37-56.
- 7 Rogers EM. *Diffusion of innovations*. New York, NY: Free press; 1983.

Policy making and AIDS peer education

About this chapter

AIDS peer education is an innovative approach to HIV prevention worthy of consideration by policy-makers. Policy makers have a key role to play in initiating and supporting peer education projects, since HIV transmission is related to risk behaviours and young people are difficult to reach through mainstream channels. Through the years of the HIV epidemic, policy-makers have shown concern for young people by making sure that sexuality, drug abuse and discrimination against people with HIV are on the agenda and that action is taken. This has required a difficult balancing act with a range of interest groups, but has led to major advances. Today, we know much more about how to continue the fight against AIDS effectively. Peer education is a result of the positive lessons learned all over the world and part of a growing trend in health promotion in which citizens and communities are being given opportunities to take control over their own health.

In essence, a policy decision involves a commitment between an organisation and other organisations, groups or individuals, to co-operate. With AIDS peer education, policy-makers need to know what it is, what direction it is taking, and whether or not it gives results. Peer education projects will be shaped, modified and maintained to varying degrees by policy making and administrative decisions.

Policy making and peer education

We have learned that just providing information about HIV and protection isn't enough. Prevention messages and implementations need to be adapted to specific cultures, sub-groups, lifestyles and age. Young people are different from adults on all these counts and to an ever increasing degree. The challenge for policy-makers and other prevention workers is to consider increasing youth participation as an effective approach to HIV prevention and health promotion in general by enabling young people to design and implement their own prevention efforts with adult support.

Several international health promotion agreements and charters that directly concern the question of citizen participation and empowerment have been written. AIDS peer education for young people fits into this context. The documents give an understanding of where health promotion is moving and can serve as guidelines.

International agreements in health promotion

Ottawa Charter

One of the most important international documents concerning health promotion is the Ottawa Charter (see appendix). A result of the first International Conference on Health Promotion in 1986, the Charter was a response to the growing expectations for a new public health movement around the world. In the Charter, health promotion is defined as 'the process of enabling people to increase control over, and to improve, their health'. The objectives for health promotion action given in the Charter are:

- 1 build healthy public policy
- 2 create supportive environments
- 3 strengthen community action
- 4 develop personal skills
- 5 reorient health services.

The Ottawa Charter acknowledges that people are themselves their main health resource. It also commits to helping people get healthy and maintaining their health through financial and other means. Moreover, the Charter recognises the voice of local community as essential in matters of health. The Charter was later integrated into the well-known World Health Organisation's (WHO) Health for All document.

Dublin Consensus Statement

In Dublin, 1995, the WHO Regional Office for Europe and the European Committee for Health Promotion Development composed a consensus statement on Health Promotion and Health Care System Reforms¹. The statement expanded on the Ottawa Charter and recognised five activities as those making the greatest contribution to promoting better health. These included:

- 1 strengthening the ability of communities to achieve better health – for example, helping them to set their own priorities and plan and implement effective strategies and
- 2 improving people's ability to look after their own health.

The first insight gained from these documents is this: health promotion and health care are moving towards enabling local communities to control their own health programmes, giving citizens a decisive voice, and improving health skills. Although young people are important members of the community, offering them these opportunities is, for some, a major and controversial step. This is especially the case with HIV prevention, since it involves the sensitive subjects of sexuality and drug use.

European young people today

We may need to reconsider our views of young people. Part of the reluctance to allow young people to participate in important debate has its roots in 19th century attitudes towards the young. Beliefs stemming from this period regard young people and children as too immature, irrational and unqualified to participate in serious decision-making. These opinions do not take stock of the fact that the current situation for young people and the future they are facing is different from that which faced their parents. HIV is very much a part of this new situation.

Changing this type of prejudiced attitude would involve convincing adults that young people's participation contributes to their personal development and involvement, the improvement of society, and would lead to the generation of more relevant and effective health promotion programmes. Because AIDS peer education actively involves young people in the debate surrounding HIV, sexuality, condoms, and drug abuse, this can mean a continuation of the advocacy policy-makers have been working with since the beginning of the HIV epidemic.

What European policy says about the matter

In Decision No. 647/96/EC of the European Parliament and the Council, AIDS is considered a 'major scourge' and the decision provides that it is important to 'promote the utilisation and proper use of condoms as a means of preventing the HIV virus and other STD'². The decision further states that 'the provision of information to children and young people must begin at an early age in the general context of information on hygiene and sexuality and health education'. These decisions are not an 'ideal' but reflect the reality that a majority of European young people have already experienced sexual intercourse by the age of 17.

The global view

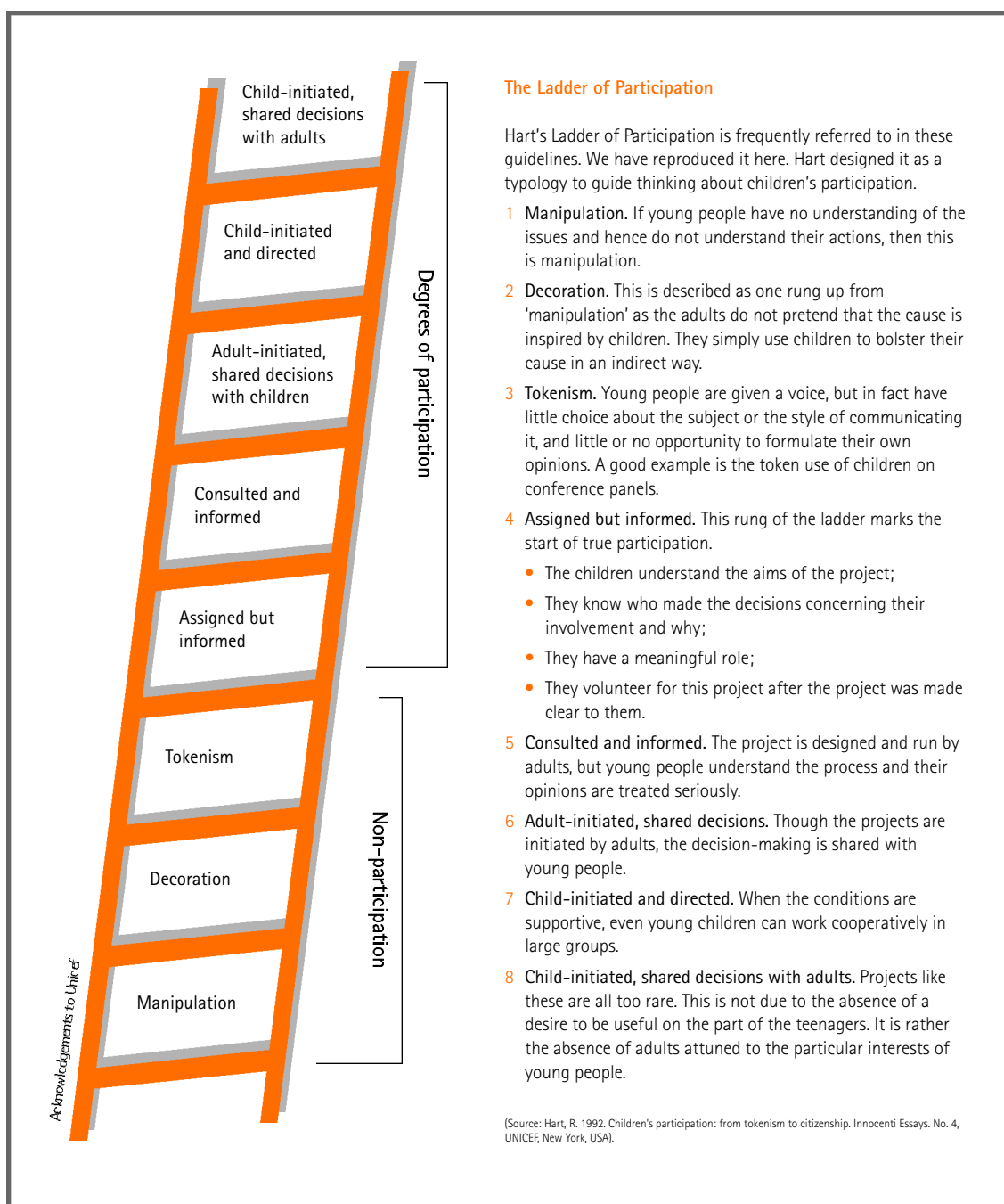
The United Nations became involved in the issue in 1989, when the General Assembly adopted the Convention on the Rights of the Child (CRC). This document is perhaps more idealistic, but is specific to children and young people and deals directly with their participation in the issues that affect them in the form of 'rights'. Article 12 of the CRC gives children the right to express their opinion and to have that opinion taken into account in issues that affect them. Article 13 gives children the right to obtain and make known information as well as to express their opinions, except when this violates the right of others. Articles 14 through 17 give children the freedom of thought and religion (Art. 14), the freedom of association (Art. 15), the right to privacy (Art.16), and the right of access to appropriate information (Art. 17).

Culture change and tokenism

The documents and agreements mentioned above reveal that we are in the challenging process of transferring the control of health promotion and education to local communities and their citizens, including young people. Adults will need to let go of some of the direct control they have over young people and endeavour to involve them in policy-making and prevention programmes. The end product of participation is not revolution or revolt, but a partnership between different age groups. This is a new role for young people and they will need to be guided into this new responsibility by adults.

However, we must be careful to avoid the dangers of what Hart has called 'manipulation' and 'tokenism', where young people become mere ornaments in a political process³. The aim of participation is not simply to give young people a voice, but to enable them to take responsibility for their own health. Peer education focuses directly on increasing youth participation and empowerment; to accomplish this task young people need support and guidance from adults.

We need to seriously consider the benefits of young people participating in health promotion programmes and in the decisions that affect them. This is important because young people are an essential asset to society – making a commitment to them is a commitment to the future⁴.



Why AIDS peer education?

Young people and adults

Young people are equally or even more concerned about HIV than adults. In a 1995 survey conducted by the European Commission⁵ based on 18,500 interviews in all EU member states, 80% of young people in the 15–24 age group indicated they wanted more information about HIV. Only 14% of young people believed they would 'never catch AIDS', compared to 25% of adults. Young people were found to be better informed than adults about HIV transmission and protection.

HIV and its spread is a collective concern involving everyone. Decision No. 747/96/EC by the European Parliament and Council reinforces the point: 'AIDS is a phenomenon that poses a dilemma not only for those parts of human relationships of most intimate concern to individuals, but also for modes of collective behaviour'

In most European societies young people and adults may live in almost separate worlds. Each may even wish to maintain this separateness and keep the other group distant. The thoughts, feelings, pressures and attitudes of young people surrounding this issue can be difficult for adults to understand and can even be kept secret from them. Young people usually discuss their experiences of sexual intimacy and drug use exclusively with their peers.

Young people as peer educators

What distinguishes peer education from youth participation in general is that in peer education young people are given the roles of peer 'expert' and 'change agent'. They are trained and educated in the health issues surrounding HIV/AIDS, STD, sexuality, safer sex, and drug abuse, and thereby become experts in these subjects relative to their peers. By taking action through various activities and discussions, they attempt to generate change in the knowledge, attitudes, norms, beliefs, and behaviour of their peers.

Partnership with adults

Peer education is an opportunity for expert adults to pass on their knowledge and experience to young people. It begins by focusing on young people's ideas about ways to tackle the problems, even if their thoughts may appear unprofessional or unconventional in relation to established professional views. This is done in such a way that young people are given a sense of ownership of the work being accomplished. Power is provided through a partnership with adults that includes openness and communication, mutual respect and trust.

Young people are rooted in communities via parents, schools, recreational centres, health care, community agencies and youth associations. The organisations and agencies in these community networks can serve as a base for AIDS peer education programmes.

Policy makers and planners should note that the four categories or sub-approaches of peer education presented in these guidelines are not specific or separate methods. They are descriptive and an attempt to sort what was found in the 11 different countries interviewed and in the international literature. In reality, peer education projects can effectively use a combination of pedagogical, diffusional, outreach and peer-facilitated community mobilisation approaches. What is most important is that peer education projects are adapted to the young people targeted, their physical, social and economical environment, their developmental stage (or age), and their own needs and issues.

Peer education in school settings

Peer education can be used in a variety of settings. In schools it can be used on its own or as a complement to other health promotion programmes. Policy-makers and local planners will need to convince school staff about the advantages of peer education projects that turn pupils into peer experts and agents of change, and eventually include staffing their running. Educators may see their role as providing knowledge and developing the thinking and reasoning skills of pupils using didactic techniques. The aim may be to keep pupils healthy enough, but this will not improve their ability to understand and improve their health. However, this view is changing, and schools are becoming increasingly involved in promoting pupil health.

Health promoting schools

The First International Conference of the European Network of Health Promoting Schools, sponsored by the European Commission, the Council of Europe and WHO-Europe, took place in Greece in May 1997. At the conference, a wide range of professionals from 43 countries discussed the issue of health promotion in schools. The official resolution of the conference was that 'Every child and young person in Europe has the right, and should have the opportunity, to be educated in a health promoting school' (see appendix 3).

These professionals created a resolution document urging all governments in Europe to adopt the concept of the 'Health Promoting School' and to create conditions for 10 different principals to put into practice. One of the principals, 'Empowerment and Action Competence', established that a health promoting school improves young people's ability to take action and generate change, and that pupils working together with teachers and others on health promotion can gain a sense of achievement and an ability to influence their lives and living conditions. Lastly, they recommended that this be achieved through policies and practices that give opportunities for young people to participate in critical decision making.

AIDS and embarrassment

School staff, parents and other gatekeepers can be especially shy about AIDS peer education. The subjects taken up are sensitive and perhaps embarrassing for some adults. The combination of subject matter, change in pupil roles, and interactive techniques may be unnerving to some. Another reason for opposition can be that it cuts into valuable curriculum time. However, peer education can be used in the context of subjects such as health, sex and drug education or conducted outside the curriculum or during other school events. There are many examples of peer education projects working in these ways throughout Europe.

Policy making can contribute by informing schools and educational systems about peer education and health promotion. School personnel can be trained in new methods such as peer education, and can collaborate with experienced personnel from other schools. Pilot projects and feasibility studies can be designed and sponsored. A great deal can be accomplished by facilitating intersectoral co-operation and collaboration at European, national, regional and local levels. This is especially the case with Ministries of Health, Education and Youth, where parallel systems reach from the national to the individual school level.

Peer education outside school settings

Peer education is especially valuable for those who want to reach young people outside the school setting. It can do this through:

- 1 formal structures such as sports clubs, penal institutions, boarding houses, or youth centres and
- 2 youth groups outside specific organisational frameworks.

Only the latter will be focused on here. This area includes a wide range of groups vulnerable to HIV, including migrants, ethnic youth, gay, lesbian and bi-sexual youth, intravenous drug users (IDUs), those engaged in prostitution, street youth and other socially disadvantaged groups.

Young people outside organisational frameworks usually have a sub-culture that lies far from the world of traditional experts and social marketing messages. It can be very difficult to gain access to these groups unless you are 'one of them'. In addition, these groups are wise to attempts by outsiders to send in proxies or to include them as tokens in decision-making.

Peer education can encourage these groups to create, initiate and own their own HIV initiatives. This is not simply a matter of prevention – it may provide a programme that contributes to increased self-esteem and social responsibility for the young people involved.

The community agencies, outreach programmes and NGOs in contact with these people often have a relationship of trust with them. These organisations can be encouraged to try peer education by spreading information about successful projects. In addition, the valuable experience and knowledge that already exists among ongoing peer education projects can be shared by networking between these and newly interested groups at European, national, regional, and local levels.

Project evaluation – a policy question

One of the main issues surrounding peer education is the lack of evaluation literature. This affects policy making because it makes decision making and prioritisation difficult. There are several factors contributing to this situation, including the 'gap' between practitioners and researchers, the wide variation in the use of the term peer education, and that AIDS peer education is a relatively new and innovative approach.

Practitioners vs. evaluators

Practitioners are those who work directly with young people, setting up and supporting peer education projects. They meet young people on a person-to-person basis and their knowledge is grounded in first-hand information about and experience of the lives of young people. They use their knowledge, experience and intuition to figure out what needs to be done and then do it. Practitioners may feel policed or supervised by outside evaluators, and may regard their involvement in programmes with suspicion. The theoretical methods evaluators use and the controlled conditions they employ may be seen as impractical.

Traditionally, evaluators and researchers remain objective by working from theory and scientific evidence. A hierarchical model of knowledge has developed which assumes that theory and research exist on a higher plane, and trickles down to practitioners. Difficulties in collaboration and the sharing of skills between practitioners and evaluators, and agencies and universities, contributes to the lack of evaluation literature⁶. Moreover long delays can take place between real world practice and the eventual reporting of research results. During the lapse, practitioners and the peer educators have learned from experience and moved on. This makes peer education a 'moving target'.

Policy making can encourage collaboration between universities, practitioners and citizens. Seminars, workshops, and training programmes on evaluation methods and reporting for practitioners can be arranged at national, regional and local levels. In the long term, this will contribute to individual project development and provide faster feedback on new and innovative approaches like peer education. The Evaluation chapter of these guidelines continues this discussion in greater depth and attempts to provide some practical solutions.

To ease their decision making, policy-makers can create networks where young people, practitioners, researchers, and themselves share experience and gain awareness of each other's perspectives.

Chapter 2

- 1 WHO Regional Office for Europe. *Health promotion and health care systems reforms - a consensus statement*. WHO Regional Office for Europe; 1995.
- 2 European Commission. Community action programme 'Europe against AIDS': Directorate general V, European Commission; 1996 Internal reference no.: CE-V/3-97-003-N/FR-C.
- 3 Hart R. Children's participation: from tokenism to citizenship. *Innocenti Essays*; No. 4; New York, NY: UNICEF; 1992.
- 4 Sustainable Agriculture Programme. *PLA Notes*, No. 25. London: International Institute for Environment and Development; 1996.
- 5 European Commission. *Europeans and AIDS: results of the Eurobarometers surveys 43.0 et 43.1*. Bruxelles: European Commission; 1996.
- 6 McCarett Hess P, Mullen EJ, editors. *Practitioner-researcher partnerships: building knowledge from, in and for practice*. Washington, DC: NASW Press; 1995.

Initiating and setting up peer education projects

About this chapter

This chapter presents guidelines about initiating and setting up peer education projects with young people. The future course of the project will be influenced by how successfully the initial planning is carried out. Perhaps the most challenging aspect of this phase is the 'people work' it involves. Setting up a project means joining the on-going dynamics of a group or community and finding the right role to play.

Handle with care!

Peer education can bring the very positive rewards of working closely with young people. First of all, however, it is important to look at three ethical issues concerning adult responsibilities. These can be regarded as 'handle with care' notices.

- 1 Make sure the young people you are targeting are really interested in an AIDS peer education project. Explain the concept of peer education clearly. They may prefer receiving information from professionals or other adults, or would rather have information on another topic altogether.
- 2 In their new role as experts and agents of change in sensitive subjects, peer educators will expose themselves to the opinions of others. They will be asked personal and complicated questions from friends and peers and given the responsibility of answering with accurate, up-to-date information or providing professional referrals. In addition, they will be given the responsibility of maintaining confidentiality about what they hear and pressure to 'practice what they preach' – no easy task.
- 3 A mistake or oversight can cause social and emotional harm. Adults have a responsibility to see that a 'no-harm' ethic is employed and maintained throughout the course of the project. This is applied through adequate support, clear and accurate information, and a project conclusion that doesn't abandon its young people. In addition, there will need to be clear ground rules on confidentiality, care in selecting trustworthy trainers, supervisors and co-ordinator, and adequate man-hours for adults to be responsive to the needs of peer educators.

Project processes

Setting up and implementing a peer education project will involve working with several parallel activities at the same time. These activities are:

- 1 procuring and maintaining funding,
- 2 building and maintaining a project 'coalition'
- 3 working with young people
- 4 the logistics of training, implementation and support, and
- 5 designing and carrying out an evaluation.

Though every peer education project is unique and follows its own course of development, the 'European interviews' that were the sources for these guidelines, and the associated literature, do offer general advice.

Procuring funding

Like most public enterprises, AIDS peer education projects will require funding. Funding can be found in grants, allotments and subsidies or through utilising current recourses. The various policy-making levels, private sponsors or research foundations can also be potential sources of funding.

Financial sources need not be limited to those sponsoring HIV and drug prevention. AIDS peer education is an aspect of the expanding health promotion approach and potential sources of sponsorship lie in the public health and educational systems. It is not unusual for funding to be specially earmarked for vulnerable groups such as migrants, ethnic youth, IDU's, and the underprivileged.

Whatever the source of the financing, the organisation responsible for allocation will need to be convinced of the project's worthiness.

Building the project coalition

Peer education projects are people-intensive. Working with young people, especially those who have not reached the age of majority, will mean involving gatekeepers and intermediaries such as parents, teachers, and youth workers. Since intermediaries belong to community organisations this will entail collaboration between the initiating agency and the organisations involved. Gatekeepers such as parents are often represented in associations and the project will need their co-operation. We recommend creating a project coalition with these organisations and groups. The nature of this coalition will vary considerably depending on the target group and the peer education approach used. In outreach programmes, the coalition may include pub or café owners, youth and outreach workers, and so on.

The coalition is formed in the earliest planning stages and maintained through co-operation, communication and compromise. Convincing these individuals and organisations of the advantages of youth participation and AIDS peer education will be a major step. Their support, contribution and involvement will need to be actively maintained.

Working with young people

The main focus throughout the project will be the group of young people targeted and the peer educators. Young people usually know little about peer education, what it involves or what it is like to be part of it. They will need to be approached, informed, have their opinions heard, and eventually given a sense of project ownership. This relationship will need to be maintained throughout the project.

Once the peer educators are recruited they will need to be trained, enabled and supported in their work. Chapter 4 covers this process in greater detail. Moreover, the project will not always be composed of the same peer educators. Peer educators will drop out, get older and move on, and new ones will be recruited. Adults involved in the project may also move on. The hosting agency will need to take responsibility for the continuity of the project and stay in touch with the changing nature of young people.

Logistics

Practical arrangements will need to be made to ensure the project's success. These include co-ordinating peer educator training and support, arranging facilities and materials, setting up activities and meetings, writing reports, and so on. This logistical work is people-intensive, as it involves the peer educators, the coalition partners and intermediaries. Continuous support for peer educators must be provided on an as-needed basis.

Designing an evaluation

The aim of evaluation is to assess what the project achieved, how it was achieved, and to provide information for future practice. For an evaluation to be successful, it will need to be designed at the earliest stages of the project and continued as a parallel process until the project's completion or a pre-determined date.

The above processes sound like a great deal to plan for, but this is true for most prevention projects. What distinguishes work in peer education is the active participation of young people and an empowering and supportive role for the adults involved. How much actual work there will be depends on the size of the project. Having an active coalition means that the work can be spread out over various agencies or integrated into already ongoing activities, such as school classes. The peer educators will eventually be able to do a great deal themselves. Outside trainers, evaluators and educators can be used on an as-needed basis. Nevertheless, a co-ordinator will be needed to oversee all activities.

Planning

Planning a peer education project will involve the steps given below, though not necessarily in the same order:

- 1 Assessing a group of young people for peer education
- 2 Designing projects
 - a Defining tentative aims and objectives
 - b Developing a project model
 - c Preparing an evaluation
- 3 Initiating a project
 - a Building a project coalition
 - b Developing an action plan
 - c Recruiting peer educators
 - d Preparing for training
 - e Preparing support
 - f The project co-ordinator

1 Assessing a group of young people

Peer education has proved to be useful in reaching mainstream and marginalised young people both in and outside the school system. Projects can be started using new funding or be integrated into existing programmes.

HIV prevention is a necessary investment concerning all young people and our future. However, some groups are more vulnerable than others due to risk behaviours or because they remain outside mainstream prevention efforts. The nature of these groups varies considerably from region to region in Europe. Since the HIV epidemic is actually a conglomeration of smaller epidemics with roots in local practices and social, economic and environmental conditions, peer education has the advantage of being able to focus on small and culturally unique groups of young people. However, it is only one of several approaches that may be used.

Success in approaching any group of young people will depend on intermediaries whom the young people like and trust. These intermediaries can serve as contacts and eventually as key members of a project

coalition. Projects that will involve youth in institutions such as schools, penal institutions, or recreation centres will need to gain formal approval. Gain the views, opinions, advice and support of these individuals and organisations from the very first contact.

Once in contact with the young people, make an inventory of their views on the HIV issue. One can meet with them in small groups, in assemblies, by using focus group discussions or other formal techniques. Another tactic is to meet and discuss the issue with opinion leaders and formal leaders from various youth clubs and associations. In the meetings, the young people may make requests for actions or objects that you are unable to provide: for example, easy access to condoms or syringe exchanges. In underprivileged groups there may be requests for financial aid.

This is an uncomfortable position. The young people will often want to know where you stand on these issues. You will need to explain that you and your agency are there to enable and support them in doing something positive about HIV. Your trustworthiness, credibility and empathy will be crucial. You may find out that peer education is unwelcome and unlikely to work. There is no use in pushing the project or being insincere about where you stand on issues. Co-operation between young people and adults is so close in peer education that a hidden attitude will sooner or later reveal itself.

Lastly, depending on their age, young people may not fully understand their own attitudes towards HIV, sexuality or drug use. A good starting point is to ask their opinions about what information they have received in the past and whether they still feel unclear about certain issues. This will hopefully lead to a discussion or debate. As mentioned earlier, 80 per cent of European young people want more information about HIV and how to protect themselves.

2 Designing projects

a Defining tentative aims and objectives

Those involved in an AIDS peer education project should aim to accomplish certain goals. These could include:

- piloting its feasibility in a specific target group
- measuring its effectiveness or processes
- increasing young people's self-esteem or life-skills
- slowing the spread of HIV.

'Objectives' express in detail the results the project hopes to achieve. Typical examples are:

- positive changes in HIV knowledge, attitudes, beliefs and behaviours
- increases in specific skills such as condom use and negotiation
- the proper cleaning of injection equipment.

Objectives can be given in a logical step-by-step approach leading to the achievement of project aims. The best way to understand objectives is to see them as 'concrete' and measurable goals that can be reached, for example, through the use of a marker or an evaluation. Creating objectives is an excellent exercise for thinking out exactly what one is trying to accomplish and if it is feasible.

b Developing a project model

The project model is a specific description of the project that includes the content, the approach used and how the project will go about accomplishing its aims and objectives. Models are dynamic and take into account the various processes discussed above. It begins with the true nature of the target group, suggests implementations, and describes the roles of the co-ordinating agency, the coalition partners, the peer educators, the intermediaries, and the community. The project will develop in successive steps over a period of time as the peer educators gain increasing competence, influence and control. A theoretical or logical

explanation of why it can succeed and how it will unfold should be included. If there is an evaluation it will need be built into the model.

The first draft of the model is the starting point for explaining and negotiating the future project with the young people and potential coalition members. This process of collaboration on the project model facilitates youth participation, empowerment and sense of project ownership. Involving young people in this way together with the input from potential coalition members can lead to the creation of a sturdy project model better adapted to real-world conditions.

In the introduction, we offered four descriptive categories or sub-approaches to AIDS peer education that were created out of the European interviews, the international literature on peer education and the Europeer Expert Meeting. We present them here in greater detail as an aid in designing models.

The sub-approaches are:

- 1 the pedagogical or educational approach
- 2 the outreach approach
- 3 the diffusional approach
- 4 the peer-facilitated community mobilisation approach

Pedagogical approach

This approach is characterised by the presentation of information in a formal setting. A typical project involves peer educators giving 1–2 hour presentations in a lecture setting using didactic and interactive techniques with or without an adult present. The peer educators are the same age or older than those participating but do not necessarily belong to the same social group or have the same experiences.

The activities or session could be done by adults but the assumption is that the peer educators will use an implicit and explicit language more adapted to young people and that questions will be more direct. Activities used in this approach range from using adult-created 'scripts' to content completely determined by the peer educators themselves.

The approach relies on the transferring of accurate information, increases in self-efficacy and negotiating skills if interactive games are used, and the working out of young people's 'myths' and misinformation about HIV, STD, drugs, etc. Diffusion of the information through social networks outside the formal setting is rarely expected. The approach is often used as a complement to other interventions, such as sex education.

Outreach approach

In this approach, the peer educators rarely belong to the social group receiving the peer education but share characteristics with them, such as age, ethnic group, language, sexual orientation, problem (i.e. drug abuse), and so on. Its use is based on the same assumptions as the pedagogical approach concerning explicit and implicit language. Because the peer educators share characteristics and lifestyle with the target group, it can identify with them more easily and this can be an advantage over using an adult outreach worker. When used with marginalised or non-mainstream youth this can be very important. Examples are peer educators going into ethnic neighbourhoods to give lectures or presentations in formal settings (i.e. youth centres) or talking informally to other young people in pubs (i.e. gay pubs), discos or on the street. It is an outreach approach in the sense that there is an attempt to reach young people who do not share or understand the values of mainstream prevention messages, or require special efforts due to their vulnerability to HIV.

Diffusional approach

This approach uses peer educators who belong socially to the target group. It relies on informal peer-to-peer communication and social influences that occur outside the formal setting to create the right conditions for dialogue. It attempts to use existing social networks and communication channels to diffuse change or innovation through the group. This includes spontaneous discussions between young people and activities peer educators carry out in informal settings. Possible activities include plays and sketches, condom distribution, radio programs, World AIDS Day events, film and music sessions, information kiosks, or being active as a group during local events such as festivals.

What distinguishes this approach from the pedagogical and outreach approaches is that it focuses directly on influencing the opinions, beliefs and perceived social norms connected with risk behaviours and lifestyle. For maximum effect, activities should be witnessed by the target group and this in turn should create a focus for discussion. The use of natural opinion leaders with large social networks can qualitatively and quantitatively amplify the effect. If the target group is large or diverse, the use of peer educators representing various subgroups can be useful. A sense of ownership by the target group and identifiable peer educators will contribute to the strength of the project.

Peer-facilitated community mobilisation

This approach uses the local community as its base and involves a strong coalition of community organisations, opinion leaders, professionals and young people. Here, the term 'community' covers geographical communities, ethnic communities, school communities, religious communities, gay communities, and so on. The approach is near to the health promotion ideal of mobilising the local community in addressing health problems via the involvement and endorsement of as many sectors as possible. In some communities, an AIDS peer education project is only possible if the entire community supports it due to the sensitivity of the subject.

In this approach, the young peer educators are typically responsible for developing and implementing the interventions. They represent the community rather than a single project or agency. Projects usually begin as pilot studies and eventually diffuse to new settings. Young people such as college students and youth involved in associations can eventually take over responsibility for the project.

Projects often use a combination of pedagogical, outreach and diffusional methods.

c Preparing an evaluation

As previously mentioned, evaluation is 'the process of systematically assessing what the project has achieved, how it was achieved, and how it can inform future peer education practice'. Policy makers and financial sponsors often require project evaluations. An outside consultant may or may not be necessary.

In Chapter 5, evaluation issues and three approaches are covered: the reflective practitioner model, the objectives-based model, and the comparative or experimental model. In short, the reflective practitioner approach provides those involved in the project with a systematic method of learning from experience. An objectives evaluation involves data collection at various stages of the project using quantitative or qualitative methods, such as questionnaires or interviews. In comparative evaluations, one compares attitudes and knowledge in the group of young people targeted compared to those of a similar group or groups not exposed to the project.

3 Initiating a project

a Building a project coalition

The building of a project coalition is basic to every project and how one goes about building one depends on the nature of the initiating agency, the setting, the target group and the model being used.

The coalition work begins the moment the project idea is first presented to a future collaborator. Eventually, there may be several collaborators in the project and the co-ordinator will need to maintain their interest, involvement and co-operation.

The Brazilian educationalist Paulo Freire describes the proper approach to initiating community projects by an outside professional in his distinction between 'cultural invasion' and 'cultural synthesis'. In cultural invasion the outside agent draws from and imposes his own values and ideology. His starting point is his own world and he or she enters to 'invade'. In cultural synthesis as Freire explains it, 'They come not to teach or to transmit or to give anything, but to learn with the people, about the people's world.'

b Developing an action plan

Once the above steps have been completed and funding secured, draw up an action plan. An action plan is simply a practical method of working out a design for going about the project. It includes the project's goals and objectives, a communication strategy for keeping everyone involved, an implementation strategy, realistic and achievable target dates (time-table), and a description of the roles of those involved. Action plans are not static but take into account processes discussed earlier and the dimension of time. If it is a new project and young people are not yet completely involved, the action plan should be seen as tentative. Once the peer educators are recruited they need to be given the opportunity to amend it.

One of the first issues to be dealt with is the degree of peer educator decision making and control. This can range from having peer educators read scripts at pre-arranged presentations to allowing them to influence the training, the implementations and the evaluation. Naturally, the decision of how much control and participation to allow will depend on their age and maturity. Adult control may be necessary in the early stages of the project and then gradually left over to the peer educators. However, it is only in rare exceptions that peer education can be delegated completely to young people without adult support.

With peer education projects it is especially important that the action plan is flexible and takes into account variability in activities. At the start of the project, a great deal of time will be spent on assessing the young people, involving them, and building up the coalition. Then comes the work of building up the project into something concrete, training the peer educators and getting them started. In the implementation phase, most of the work will be more routine and go to supporting the peer educators and the coalition. If there is an evaluation it will need to be scheduled and set into the action plan.

The need for flexibility arises out of working with dynamic young people who have a wide range of interests and may drop out. Also, gatekeepers and intermediaries may have second thoughts and policy-makers may have new priorities.

Generally speaking, we would advise those initiating peer education projects for the first time to begin on a small scale and not to push too hard toward achieving quick results. Peer education should be viewed as a process requiring periodical re-assessment, re-thinking and re-planning.

c Recruiting peer educators

Recruiting peer educators is perhaps the most difficult step for those initiating projects. There are three main factors to think about when recruiting young people as peer educators:

- 1 they must be acceptable to the target group
- 2 their personality must be conducive to training and the work they will be doing
- 3 they must have the proper motivation or incentives to become and stay involved.

Acceptable to the group

The 'ideal' peer educator is a young person who is liked by his peers, has a wide social network, is trustworthy, credible, and someone other young people turn naturally to for advice. They should be innovative in the sense that they are used to bringing new ideas and practices into the peer group, but at the same time not so 'radical' or outside the group that other young people won't listen to them. This type of person is usually called a 'natural opinion leader'.

The importance of using natural opinion leaders depends upon the approach used. If the project relies on social diffusion for its effect, opinion leaders are more likely to diffuse information and change than other members of the target group.

Personal characteristics

Besides being opinion leaders, there is no real agreement in Europe on the personality attributes most conducive to being a peer educator. However, during the interviews, the following characteristics were often repeated:

- communication abilities and assertiveness
- an innovative mind and an openness toward change

- an ability to work in groups and as a team member
- a respect for other people and for confidentiality
- an interest in the topic of the project or in specific types of interventions (i.e. video production, drama, etc.).

What the target group thinks and feels about their peer educators is a crucial factor – this should be the focus during recruitment. Since proper peer education has a strong focus on peer educator self-development, many of these characteristics can be developed. If those recruited feel they do not fit into the project or lose interest, they should be allowed to drop out without a sense of guilt or shame.

Motivation and incentives

Experience has shown that peer educators who stay with projects often joined for altruistic reasons and want to inform their peers about HIV and other health issues. Peer education can offer the opportunity to develop social skills or specific skills in subjects such as media, public speaking and drama. Once a project is running, the friendships among the peer educators and their social activities will be important incentives. In some projects, being a peer educator brings increased popularity and status.

Other incentives can be provided. Pupils can be offered course credit for their involvement, youth clubs can offer free admission, the project can provide field trips and outings, etc. Community sponsors can be very helpful in this regard.

The characteristics of the adults working in the project are very important. In the well-functioning projects interviewed, these adults were seen by the peer educators as trustworthy, credible, 'one of them', and someone they could turn to for help and advice. In addition, the way in which the peer educators are treated and co-operated with by the intermediaries is important.

Experience has shown that some who dropped out of projects had expected a passive role, were expecting only fun, or wanted to get out of other activities (for example, classes). Make clear when recruiting peer educators what the project will require of them. Being a peer educator involves a commitment, since the roll requires time for training, supervision sessions and activities.

At initial recruitment, most projects attempt to begin with equal proportions of boys and girls, but the general trend is for more boys to drop out. The primary reason is that girls are simply more mature than same-age boys and it can be easier for girls to discuss issues like relationships, emotions, love, sex and HIV. Extra effort will be needed to gain boys' interest and find a role for them in the project.

The success of a peer education project will usually depend upon creating a fun and easy-going atmosphere, providing the opportunity for self-development, utilising interesting and fun learning techniques, and providing empathic support from the adults.

Using payment as an incentive

The use of money as an incentive is controversial among those working in peer education. Some believe that 'true' peer education is grassroots volunteerism and should not involve monetary reimbursement. The other argument is that the peer educators are doing the agency a service and should consequently be reimbursed. Both arguments usually have the best welfare of the peer educators in mind.

Of the project co-ordinators interviewed, those that offered payment did so because the peer educators were:

- presenting an adult created package to groups (i.e. classes) for a limited number of times or
- were doing presentations among youth groups outside their own neighbourhood and these projects used strict pedagogical and outreach approaches that could be done by professionals. The co-ordinators and managers of these projects felt it would be exploitation not to offer some compensation. It was clear from the interviews with the peer educators that payment was not the only motivation for them to carry out the presentations.

Because peer education in these circumstances is hard work, requires time and commitment, and involves a presentation based on materials created by adults, it can hardly be morally wrong to give peer educators compensation. However, if such an approach becomes systematically used and distorts young people's motives and goodwill then one must address the question of exploitation.

Using paid peer educators in community-based or diffusional projects is not recommended, since one defeats from the start the principle of 'empowerment'. Moreover, these approaches rely for their impact on inducing diffusional changes in norms and lifestyle via informal networks and paid peer educators would have less effect.

d Preparing for training

Peer educator training is discussed in detail in the next chapter and will only be covered briefly here for planning purposes. Project training usually begins with an intensive training session such as a residential weekend. This is followed up by shorter training sessions in specific subjects and skills, support and self-development sessions with supervisors, and social activities. The aim of these various training elements is both to develop the peer educators and to support them in bonding as a group.

The peer educators will find each other to be a very important support group both emotionally and in the development of their skills through exchange. The continued involvement of adults will be important so that these relationships do not develop into conflict but into increased social skills. Therefore, the guidelines recommend that the training programme begins with a weekend residential. Further, we recommend the use of trainers skilled in carrying out these types of workshops and working with young people in the areas of sexuality and drug abuse.

In general, the content of peer educator training programmes can be divided into the following categories.

Knowledge

The knowledge component needs to be presented in a way that leads to a personal understanding of the topic (e.g. HIV/AIDS and sexuality). The peer educators will eventually be asked questions and involved in discussions where question-answer formats may not be the rule. Moreover, they will need sufficient understanding to correct myths, misinformation, and the logic behind them. After the basic training the peer educators will need to be regularly updated and given the opportunity to have their questions answered by experts (ie physicians) whenever necessary.

Communication skills

This involves a combination of specific skills training, assertiveness training, the opportunity for practice and feedback, and increased self-esteem. They should become familiar as well as comfortable with the language of HIV, STD, sexuality and drug use. If the peer educators are to give presentations before groups they need to be taught how to lead group discussions and to handle overtly personal questions, teasing and disorder.

Self-development

This training should offer a greater understanding of sexuality, gender, relationships, sexual orientation, drug use and HIV/AIDS on a personal level. In addition, an understanding and appreciation of human difference, including the dynamics of prejudice and discrimination, should be included. Eventually, young people's greater understanding of themselves and interpersonal relationships as well as improved social skills should be the aim.

e Preparing support

Support is provided in supervision sessions and on a 'as-needed' basis by project staff and intermediaries. It should be emphasised that there are limitations to what the young people in the project are independently capable of doing, and that this is age-dependent. Despite their enthusiasm, they should not be overloaded with adult responsibilities and roles.

Briefly, the required support can be summarised as follows. It should include:

- regular supervision sessions, the frequency of which depending on age and maturity. In these sessions, the peer educators can receive support in working out and planning their implementations, in further training and self-development, and in resolving conflicts and differences of opinion

- technical support in the form of information, skills training, answers to questions, help in setting up presentations and activities, and funding for implementations and equipment
- social and community support in maintaining links and liaisons with project collaborators and other peer education projects, help in carrying out negotiations with adults, and support in resolving problems between the peer educators and the intermediaries, gatekeepers and parents
- personal assistance in the form of emotional support on an 'as-needed' basis for both project activities and personal growth, the maintenance of a positive atmosphere in the peer educator group, and support in times of personal and group crisis.

f The project co-ordinator

The co-ordinator will not only co-ordinate the project action plan but set the project style. The co-ordinator's contacts will include policy-makers, administrators, intermediaries, medical and social science professionals, parents, the peer educators and the targeted young people. During the planning stage, it is important that attention is given to hiring or appointing the appropriate person. This person should be well trained or experienced in these areas, knowledgeable in the subject matter, flexible, open, and well supported by his or her agency. Since the co-ordinator will often work in the field, it is important that special care is taken that they don't become isolated or develop conflicts of interests.

Further, the co-ordinator oversees the training of the peer educators and maintains supportive contact with them afterwards. He or she needs to be experienced with young people, enjoy working with them, understand their spirit, and have a sense of responsibility for their care and development. The role of the project co-ordinator in peer education is often ignored in the literature but they are key to project success and peer educator well-being. Not everyone is able to do this.

Training and implementation

About this chapter

Assessing, planning and initiation has been completed – now it is time to start the project work in earnest. This chapter will present general guidelines relevant to a range of AIDS peer education approaches.

Peer educator self-determination and empowerment

The peer educators should be allowed to influence the content and course of the project from the recruitment stage onwards. 'Self-determination' does not, in this context, mean total peer educator control – it describes the degree of empowerment¹ given by the adult practitioners in the project. The process should increase the peer educators' decision-making skills, self-esteem, motivation and command of their project responsibilities. This approach requires the practitioner to view every young person as unique, with valid experience regardless of their age. From then on, the practitioner builds a relationship with the peer educators and acts as teacher, coach, mentor, and someone to turn to.

Young people of all ages have valid experience to share, but may not be aware of what they know or what they need to know. Working with peer educators will mean validating their experience and engendering the desire and motivation to learn in them. This is done by creating a supportive atmosphere that encourages inquiry, discussion and self-reflection. Practitioners should resist providing solutions. Instead, they should point to a variety of possible solutions in a way that allows the peer educators to choose on their own.

The empowering process of inquiry, learning, discussion and pursuing objectives as a member of a team strengthens the peer educators abilities as critical thinkers and their confidence in being able to bring about constructive change. For the target group, it may be a step toward slowing the spread of HIV through a grassroots approach, giving information in a way that is adapted to suit their values, needs and lifestyle.

Training

The essence of peer education training is to equip young people with the knowledge, understanding, skills, and motivation to carry out prevention activities. The practitioners and trainers should meet with the peer educators recruited before the training begins, to allow them to give their input to the programme and gain a sense of ownership from the earliest stage. This meeting would include a presentation of the project outline, its goals, and an explanation of peer education. It could also include a presentation on HIV and prevention, demonstrations of interactive games and exercises, group discussions, and brainstorming. The amount of time and commitment that the project requires should be made clear to the peer educators during the meeting. If the project is the first of its kind in the area, peer educators from other similar projects can be invited in to talk.

As this section will present only a general outline of peer education training, the reader should make use of published training manuals. These can be found in the Europeer bibliography or by contacting with established projects. Most training manuals are in English and may require translation and cultural adaptation.

To summarise, training programmes should include the following elements:

- 1 the preparatory meeting and a training residential
- 2 the imparting of formal knowledge on HIV and related subjects
- 3 a focus on personal development and cultural issues
- 4 skills training
- 5 continuing support, supplementary training and assistance.

1 The training programme

We recommend that training begins with a residential weekend to allow the peer educators to get to know each other and to start working with project staff. The weekend shouldn't be over-structured, but provide time and an appropriate environment for the sharing of experiences and discussion. Previous European projects and training manuals often included the following in their residential training:

- warm-up and ice-breaking exercises
- brainstorming and group discussion
- role-play and interactive games
- lectures and presentations
- question-and-answer sessions that focused on young people's way of thinking.

The core of the training was usually based on interactive learning exercises, with ample time for feedback and discussion.

2 Knowledge component

The length and intensity of the knowledge component depends on the aims and approach of the project. General health promotion projects can cover a range of topics other than HIV, including alcohol and tobacco use, safe driving, nutrition, and the prevention of other diseases. In these types of projects, the young people being trained are sometimes referred to as 'health promoters' rather than peer educators.

Sexual education projects cover topics such as sexuality, sexual relationships, safer sex, reproduction, contraceptives, gender roles, the spectrum of sexuality, sexual development, and so forth. HIV-related drug projects include information about various drugs and drug use.

As well as information about HIV, training programmes should include information about the various sexually transmitted diseases (STD), their prevalence, symptoms, risks, and treatment.

Be careful not to drift from the problems and concerns that young people experience. Begin from their age-related experience and what they already know, though repetition may be necessary to allow for proper understanding and to dispel myths or misinformation. Lastly, take care not to overload them with information, creating expectations of expertise beyond their present capacity.

It is recommended that the HIV/AIDS knowledge component covers the topics given below:

- the history of the epidemic
- the epidemiology of the infection, locally and global
- the virological aspects including modes of transmission
- behaviours leading to transmission and their risks
- knowledge and understanding of the clinical development of HIV to AIDS and treatment
- HIV testing and its issues
- philosophy of how to care for someone with HIV/AIDS
- social issues raised by HIV
- legal and legislative issues
- methods of protection
- basic sexuality, depending on age and earlier sexual education
- various drugs and drug use.

Because the peer educators will provide information and answer questions from their peers, they will need to have correct knowledge and be secure in their role as peer experts. The use of interactive games, role-play and feedback sessions can help them sharpen their skills in 'talking on their feet'.

3 Personal development and cultural issues

HIV/AIDS and the topics related to its transmission are closely associated with personal and cultural values. The issues surrounding HIV can touch upon the deepest of human concerns. This is well illustrated in the irrational fear of and discrimination shown towards people with HIV. Moreover, topics related to sexual risks touch upon personal and cultural issues surrounding relationships, sexuality, religious faith, gender roles, the spectrum of sexuality, and family.

In this component, the training takes up and explores these issues. There will be wide variations in the attitudes and beliefs held by people in any target group, and it is therefore important that the peer educators gain knowledge and an appreciation of differences in values, lifestyle and beliefs. In the projects examined, it was not unusual to find peer educators with opposing views on sexuality working harmoniously together.

This appreciation of difference can be gained through discussions and interactive exercises, where the peer educators learn from each other's experience. However, there should be a ground rule that no-one ought to feel compelled to share their thoughts or participate in exercises if they don't wish to. This is both ethically correct and an exercise in accepting difference. A second ground rule is confidentiality concerning conversations during the training. This applies equally well to the private conversations the peer educators will have with other young people in their later work except when support and expertise is needed from the project group. They will need to learn this ethic and continue to keep quiet about what they have heard even after they leave the project.

The goal of this training component is to provide the peer educators with a greater understanding of themselves, their work, and of others. It is done in an empowering way that strengthens and motivates them in their role as peer educators. A list of topics that can be included is given below.

Health and prevention

The topic is often covered in general health promotion projects and provides an understanding of physical, psychological and social well being and how to maintain it. It gives a general understanding of personal health, and of methods of teaching others about it.

Values

Young people are in a period of their lives when they are gaining experience and developing ideas about sexuality and relationships. Attitudes and beliefs surrounding sexuality, relationships and drug use need close reflection. The trainer should respect the fact that a proportion of the peer educators (and the target group) may never have had sex before nor wish to for some time.

People with HIV have suffered varying degrees of discrimination in nearly all societies, and this fact should be examined closely.

In short, the peer educators should first learn to separate their ingrained beliefs from valid information and facts in order to teach others.

Gender

The issue of gender and of gender roles should be explored in both a personal and cultural context. Through information and exercises, an increased understanding of one's own gender and that of others should be gained. Myths and misinformation concerning differences in gender sexuality and identity are often the source of communication barriers, leading in turn to unprotected sex.

Sexuality

This complex topic is worthy of a chapter of its own, but, owing to space limitations, we must refer the reader to local literature and expertise for more detailed information. A variety of training manuals on sex education are available, though they may require language and cultural translation.

The content of this training will vary considerably according to local culture, religious beliefs, legislation, the opinions of the coalition, and the age of the peer educators. Topics covered in sex education can include sexual relations, reproduction, contraception, gender roles and identities, the spectrum of sexuality, sexual dysfunction, prostitution, and so on.

The aim of comprehensive programmes is to develop the necessary knowledge, understanding and skills that lead to healthy decision-making and life-styles. This includes increased understanding and security about their own sexuality. Since the peer educators will be working with their peers, they will need to become accustomed to the language of sexuality, including street language and the misconceptions behind it. The ground rules concerning participation in discussions, self-disclosure and confidentiality apply especially to this topic.

HIV positive people

The peer educators should gain an understanding of the situation of HIV-positive people and of the prejudice and discrimination they can experience. Peer educators need to regard HIV-positive people or those with AIDS as real people, not stereotypes. The aim is to replace fear, uncertainty, prejudice and myths with valid information and awareness.

Drugs and drug use

The issues surrounding drugs and drug use face many young people on a daily basis. Drug use contributes to the HIV epidemic, and in some European countries the sharing of HIV-contaminated syringes is the major route of HIV transmission. The topic is therefore an important part of the training.

Sexual orientation

This component attempts to create an awareness of the spectrum of sexuality, including homosexuality, lesbianism, and bi-sexuality. The subject should be integrated into the proceeding components and also presented on its own. Myths, prejudices and misinformation are brought into the open and corrected.

Decision-making and risks

The peer educators should understand exactly how they and others make decisions that can lead to risk-taking and unhealthy behaviour. The training examines the personal decision-making process and develops an increased awareness of how peer pressure, social norms and the mass media influence decisions. Risk-taking decisions are often spontaneous and based on complex motives. Risk-taking in general can be a natural tendency among young people. Therefore, they need to gain the self-confidence and skills to translate healthy intentions into real world practice. Acting out real-life scenarios where tough decisions have to be made, and then reflecting on the process in group discussions, is one useful training method.

4 Skills development

It is important that peer educators learn their own training skills, along with personal development. Exactly what skills will need to be developed depends on the project model and action plan. The use of drama

techniques, the presentation of lecture packages, talking informally to other young people about HIV, and the use of various media are examples of useful training skills. In some projects with older young people, the peer educators initially develop increasing self-confidence, then concentrate on the developing their own creative activities.

HIV and risk behaviour

This covers specific skills in avoiding HIV infection. The training can cover decision-making and negotiating safer sex, proficiency in condom use, and the safe use of syringes. The peer educators should become familiar with the various models of condoms available, and their specific uses. Training in condom use should not just be technical and didactic, but instead encourage personal and effective responses. This allows the peer educators get over their embarrassment, and helps predict the responses of those they will be instructing themselves.

Communication skills

The peer educators will eventually need to learn how to communicate messages to other young people, to perform in front of groups, and to work with groups. This can require the ability to handle teasing, disorder, and intimate questions. Peer educators learn these skills through coaching from adults and feedback from the other peer educators. The project can invite specialists on drama, speech, media, and sex education to contribute to the training.

5 Support and sources of assistance

After the initial training, the peer educators will embark on a new learning experience and need support and assistance in developing activities and carrying them out. We recommend the use of small supervision groups that meet on a regular basis. These are facilitated by adults experienced in peer education or who are specially trained in this role (for example, school staff). Peer educator self-development and relationships within the project and with intermediaries need special attention.

Other forms of assistance can be made available. Where to find the kinds of expertise that, for example, local trainers, intermediaries and medical professionals can offer, should be clearly explained to the peer educators. Support can also include supplementary training, use of localities, and local sponsorship.

Implementation

In this phase, the knowledge, skills and insights gained by the peer educators during training are transformed into activities. Exercises completed during their own training may be re-used or new and unique activities developed. Throughout the process, the peer educators will act as change agents during their informal contacts with friends and peers.

What was planned during the beginning of the project might end up being unfeasible, and expectations will have to change. This is part of the on-going adaptation process. However, implementations should never lose sight of HIV-prevention aims. Flexibility and negotiation are key and the project should evolve rather than be forced.

Implementation sub-approaches

Presented below are examples for carrying out various implementation programmes using the four descriptive sub-approaches presented earlier. Otherwise, we refer the reader to local experience and the published literature.

Pedagogical approach

This approach may be used on its own or to complement other programmes (i.e. sex education). It usually takes place in a formal setting, using a combination of didactic presentations, videos, slide shows, question-

and-answer sessions, interactive games and role-play. Interaction or discussions between the participants and an easy-going atmosphere can contribute to learning and the formation of new attitudes. Some projects offer pedagogical sessions as packages that the peer educators have learned and amended.

The possibility for participants to write anonymous questions before a session is a good method to draw out honest concerns and allow the peer educators to prepare. These can be left in question boxes and discussed by the peer educators in front of the group.

Depending on the age of the peer educators and the project programme, the presentations can include a combination of activities and games which the peer educators have been specifically trained to carry out, activities the peer educators have developed themselves, and free time for questions and discussion.

Some projects may offer one or two short sessions to groups and others multi-session programmes. One can expect little or no long-term behaviour change from one or two short sessions. Depending on discipline problems and local laws, an adult may or may not be present in the room. Generally speaking, and assuming order in the group, peer educators have found that the atmosphere is more open and frank if there are no adults present.

Outreach approach

The implementation possibilities with this approach vary widely depending on the target group and setting. They can range from lecture and theatre presentations at community youth centres to initiating discussions in cafés, pubs, or on the street. What is most important is that the peer educators are identifiable, that the group is prepared for their arrival and that each is accepted as 'one of us.' This requires publicity and co-ordination with intermediaries during the setting-up phase.

Other typical examples are condom distribution, support groups for young people with HIV, street theatre, distributing printed information, posters, and entertainment events. The objective is usually to raise a target group's awareness about HIV and risk behaviours, complement other programmes, provide information otherwise unavailable due to language or religion, provide information adapted to the norms of marginalised groups, and encourage safer sex and safe use of syringes.

Diffusional approach

The diffusional approach relies on spreading information and new attitudes or practices through a social group using existing communication networks. This can be verbal, non-verbal or through reports about personal behaviours and practice. The use of natural opinion leaders as credible, trustworthy sources are important in the approach. Since there are variations in the values and norms in all target groups various subgroups should be included in the project. Once the project is established, popular and 'owned' by the young people targeted, it might be possible to create opinion leaders out of new peer educators.

The approach relies on the peer educators' live activities and the discussions that result from them in the target group. The term 'live activities' also includes the informal and spontaneous face-to-face conversations between the peer educators and the target group members. Generally speaking, teenagers may infrequently have long serious discussions about HIV, sex and sexual behaviours. The topics may come-up during short discussions, as joking or as comments. These are not always meaningless exchanges but can involve a coded sharing of attitudes and beliefs or be used as a means to test new opinions with peers.

There is almost an unlimited range of activities that can generated through the inspiration and energy of the young peer educators. Besides informal discussions, activities could include:

- plays and presentations
- posters and leaflets
- condom distribution
- films and videos
- live music
- festivals
- radio and TV programs
- articles and newsletters

- information kiosks
- booklets
- project T-shirts and buttons
- World AIDS Day activities, and so on.

Peer-facilitated community mobilisation approach

This type of project is endorsed by the community and involves mobilising people of all ages in addressing the spread of HIV. The peer educators are usually supported by various youth groups and the project is an alliance between local institutions, policy makers and grassroots associations.

Actual implementations can include any or all of the activities and sub-approaches mentioned earlier. Young people, the community and its institutions have a common aim and the peer educators design and carry out the implementations. If the young people are old enough, this may result in a new youth organisation or the integration of the project into existing youth association networks.

For teenage peer educators, such an approach requires solid support from a community's adults and a healthy alliance between local agencies, institutions, parents and policy makers. The approach requires successful co-ordination of the alliance to keep it together and involved. This is done through personal contacts, meetings, seminars, training programs for intermediaries and even recreational activities.

Peer educators activities include the full range of pedagogical, diffusional and outreach approaches as well as participation in community festivals, fairs and other events. Projects for teenagers often begin at a single agency or health centre and then expand to included other youth in the community.

Project maintenance and peer educator support

Project maintenance

The enthusiasm of the peer educators will grow as they put their new skills and experience into action. In addition, the target group and the intermediaries will adapt to having peer education in their midst. For project staff, this means working with the peer educators and continuing to attune adults to the particular interests of young people and the project's prevention aim. Critical opinions and resistance may be expressed as part of the adaptation process.

Rather than seeing eventual changes to the programme as blunders or sources of conflict, they should be seen as opportunities for improvement. Though advocacy for young people and effective HIV prevention are both elements of AIDS peer education, the project may need to negotiate in order to survive and to meet aims of long-term behaviour change and increased youth participation in the community. The top rung of Hart's Ladder of Participation (Chart page 16) is not control by children but a partnership where activities are initiated by children (and young people) and decisions shared with adults.

Below is a short review of guidelines for project maintenance presented according to the five project processes given earlier.

Funding

The project will be able to take care of its budget without our advice. However, local financial support and contributions are empowering for peer educators because they express approval and commitment on the part of the sponsor.

Involving people and organisations

Throughout the project, the co-ordinator and manager will need to keep the coalition interested and motivated through providing updates, asking their opinions, regular meetings, negotiations, and personal contact. The same is true for intermediaries, gatekeepers, parents, sponsors and policy makers. Our advice is to keep all of these groups informed and involved even when it takes valuable time. Their input and feedback can be invaluable.

Youth participation and empowerment

Throughout the guidelines we have attempted to describe and elucidate the process of working with young people in AIDS peer education. The target group will always remain the primary focus, since it is here that the peer educators are recruited and return as experts and change agents.

Adults in the project begin from the perspective of young people, and then guide and channel the peer educators' motivation and growth into maturity, improved life-skills and social involvement. This requires an open and reflective dialogue with young people even when it means listening to their criticism. Patience is required because they are young and as volunteers can drop-out as they wish. Time and effort will be needed to keep them involved and motivated.

In successfully co-ordinated projects, the peer education process can directly or indirectly lead to increased youth participation in local health promotion issues. By observing the co-operation and shared responsibility between adults and young people in the project they may be empowered to do something about the health problems concerning them. HIV may shift from being 'someone else's' problem to being one of their own.

Logistics

Logistics will take a good proportion of the co-ordination time. Localities have to be arranged for the peer educators' activities, supervision meetings, supplementary training sessions, social activities and storage. If there is not space at the co-ordinating agency, localities can be borrowed from collaborators and in the community. Scheduling includes the project's internal activities and making arrangements with intermediaries for various peer educator activities.

The peer educators will need materials such as supplies of condoms, overheads or slides, posters, printed matter, or even costumes for drama presentations. The peer educators may need help in locating and purchasing these materials.

Depending on their age, the peer educators will eventually be able to take over some of these responsibilities. They can also be shared with the small group supervisors and with intermediaries.

Evaluation

An evaluation informs future practice and provides feedback to those working in the project as well as to sponsors and policy makers. An evaluation will need to be carried out with vigilance.

The amount of scheduling and time the evaluation will require is dependent upon the design used and examples are covered in the next chapter. If an external consultant conducts the evaluation, this person should be integrated into the project. This meeting of the world views of the practitioner and the evaluator is discussed in the next chapter as well.

Peer educator support

In review, the aims of adult peer educator support and supervision are the following:

- to provide information up-dates and access to professional information and advice
- to provide continuing self-development training
- to allow group brainstorming sessions where new implementations can be generated
- to keep the peer educators focused and their feet on the ground when overwhelmed by their own enthusiasm.
- to provide technical support in creating new implementations, i.e. posters, dramas, presentations, etc.
- to make sure the group dynamic are functioning well and help solve problems as they arise
- to provide feedback and encouragement on the work being done and emotional support when it doesn't
- to intervene when there are problems between the peer educators, intermediaries or gatekeepers
- to provide a social program that keeps the group together.

The support and encouragement of other young people is crucial for the peer educators. This includes the project team they work with, the supervision groups and the peer education group as a whole. Networking and exchange with similar peer education projects can be very encouraging and fun as well as facilitate the

exchange of ideas and experience. The opinions of friends and peers can be decisive. For this reason, the project needs to maintain a positive profile and an admirable reputation.

Chapter 4

- 1 Rappaport J. Terms of empowerment/Exemplars of prevention. *Am J of Community Psychology* 1987; 15(2):121-143.

Evaluating peer education projects

About this chapter

This final chapter will present a short overview of the important process of evaluating AIDS peer education projects. Evaluations provide valuable feedback for project participants and stakeholders such as policy makers and sponsors. Moreover, evaluations can inform future practice. This is especially important in the case of AIDS peer education because its use is expanding rapidly, it is breaking new ground and uses innovative techniques.

There are many methods of knowing about the world including intuition, observation and reflection. One method is not necessarily better than another. Conducting an evaluation means carrying out a selective and systematic inquiry about a phenomenon – in this case, an AIDS peer education project. The goal of the enquiry is increased understanding and knowledge. However, while the practitioner may wish to gain direct understanding and knowledge of their particular project and the target group, the scientist is often interested in gaining an understanding that allows deduction and enables prediction through theories. Evaluations are often carried out by outside professionals trained in evaluation methodology rather than practitioners and tensions can develop between them.

AIDS peer education can be a complicated approach to evaluate because it involves a variety of participants and settings, uses social influences and diffusion for its effect, and contains any of a number of specific implementation activities. Moreover, the characteristics and activities of a project can change over time, making it a 'moving target' for evaluators.

Three models of evaluation are presented in this chapter. These are the reflective practitioner model, the objectives-based model and the comparative (experimental) model. All three are systematic approaches to evaluation. The reflective practitioner model is largely descriptive and focuses on reflection-in-action, problem solving, and actively moving the project forward. The objectives-based model is more scientific in nature in that it involves specifying measurable aims and objectives for the project, using indicators or mediating variables often taken from theory, and carrying out measurements (ie pre-test/post-test designs). The comparative model involves an experimental design where the effect of a project intervention is compared to one or more similar 'control groups' that do not receive the intervention. This is done to single out the effect of the project on the target group from other 'confounding' influences and to search for causality.

Equity and empowerment

Health promotion advocates increased citizen participation, community empowerment, intersectoral collaboration and equity in prevention programmes and health care. This would involve increased involvement by the community, project participants and young people in the evaluation process. Their involvement can not only improve the quality of the evaluation but contribute to a sense of ownership of the project and its results. A step in this direction would be to train practitioners in evaluation methods, gain evaluation partners or develop more user-friendly methods.

Once the results have been analysed they can be disseminated in a language that project participants, policy makers and young people understand. Knowledge fed back into the community in this way informs decision making and can promote the health of young people.

Young people are a valuable resource for refining evaluations so that they address the true HIV issues and problems. For instance, the language of evaluation questionnaires can be adjusted by young people so that they are easily understood and correctly reflect their meanings and everyday language.

Systematic evaluation

An evaluation involves examining systematically and critically a project's processes and outcomes. The actual question to be addressed in the evaluation can be set by project participants or someone outside the project, (for example, sponsors or administrators). Researchers may be interested in gaining scientific knowledge through the evaluation.

The evaluation question needs to be well-formulated and address specific problems. It needs to be put into a context that takes into account the needs of the project, stakeholders and the constraints of cost and time. Otherwise, there is a risk that the evaluation becomes lost in its search for project understanding. As an aid in framing the evaluation, it can be useful to understand what researchers call 'standards of acceptability'. These provide a context by comparing the project to various standards.

'Arbitrary standards' are set by sponsors or administrators. They can range from a requirement that the project reaches a certain percentage of a target group to evidence of reductions in risk behaviours. Using a 'historical standard' would involve comparing the current condition of the project or target group to that of a previous period (for example, measuring reduced peer educator drop-out, or increases in positive attitudes towards the project). One can also compare project results to those of other projects carried out in a similar group of young people – this is referred to as the 'normative standard'. 'Scientific standards' are based on the use of rigorous evaluation methodologies in order to contribute data to an existing body of knowledge and to test or develop theories.

Regardless of the evaluation question being addressed the evaluation needs to take into account the environmental and social context of the project, the content and process of implementations, and the immediate and long-term effects. There exists a wide range of literature on evaluation in nearly all languages and the reader is encouraged to examine them. The WHO Regional Office for Europe has recently produced a easy to use booklet, 'Guidance for Practitioners on Evaluation of Health Promotion Initiatives', written by Jane Springett on behalf of the WHO-Euro Working Group on Evaluation of Health Promotion Initiatives¹.

Quantitative vs. qualitative methods

The debate concerning qualitative versus quantitative methods is often heard in professional and research communities. Quantitative methods have their roots in the positivist scientific tradition that assumes that objective accounts can be made of the world. The method is able to describe general patterns of reality and to discover causal relationships between occurrences. The method is often used for assessing the achievement of project objectives as 'outcomes'. The use of questionnaire surveys is a commonly used technique.

Qualitative methods attempt to provide systematic in-depth information about project dynamics and the group of young people's targeted. People's subjective accounts and their interpretations of phenomena are considered important. These are usually elucidated using individual and group interviews carried out by trained professionals. Qualitative methods can be useful for understanding the complicated dynamics of peer education and gaining young people's subjective accounts on sexuality, drug use and risk behaviours. Qualitative and quantitative approaches are both valuable in AIDS peer education and can be used in combination as a 'triangulation' of methods.

Formative and summative evaluations

Basically, there are two purposes for an evaluation. They can be ongoing and feed knowledge directly into the project with the aim of improving it (formative) or used to measure the effect of the project activities on the target group (summative). Formative evaluations use both quantitative and qualitative methods. For instance, surveys can be used to identify the important determinants of risk behaviours in a group of young people, and qualitative interviews used to understand the interpersonal dynamics between the peer educators and other young people. The resulting findings are used to improve the project and guide it along the most effective course.

Summative evaluations measure the impact of the project and its activities on the target group. If project objectives are clearly defined one can use a summative evaluation to measure to what degree they have been met. Measurements could range from the finding the percentage of the target group reached to measures of behaviour change. In a so-called pre-test/post-test design, measurements are made in the target group before the project begins and then repeated after the project has been running for some time to see if there is any difference. However, if changes are found, it is very difficult to know or prove that the project activities and not some other external event caused the change. To do so requires an experimental or comparative design. This is covered later in the chapter.

Processes

A word about processes. AIDS peer education projects involve complicated processes and a key aim of an evaluation is to gain an understanding of them. This is valuable for identifying successful or unsuccessful elements and describing to others how the project was carried out. For example, feasibility studies often investigate processes using qualitative methods in order to find the best approach for conducting peer education in a particular setting or group. Process evaluations provide a clear, descriptive picture of the quality of the project and its elements, the dynamics involved, and how this relates to project outcomes. Ongoing process evaluations allow judgements to be made about how well the project is working, and to make midstream adjustments.

Methods used to conduct process evaluations include:

- field diaries
- periodic surveys
- appraisals of activities
- observations
- one-to-one interviews
- and focus group discussions.

Models of systematic evaluation

a Reflective practitioner model

Practitioners in AIDS peer education work with young people on a person-to-person basis and attempt to understand young people's opinions, life-styles and problems. In many regards they are the mediators between the world of young people and the complicated and often political world of adults and organisations. Moreover, practitioners in HIV-prevention hold valuable knowledge of the consequences of HIV and of surrounding issues such as sex education, drug education, and discrimination.

Working at the interface of youth and adults, individuals and organisations, innovation and tradition is a balancing act that calls for sensitivity and professionalism. It is a world of multiple roles and reflection in action. Skills develop through training, experience, the literature and the self-reflection that comes from working in the uncertainties of the practice situations. In the end, a practice wisdom develops from this work in the world. In AIDS peer education this involves working with change as well as seeking to create it.

Everyone has a theory about what they do, why they think it will work and what the outcome will be. Without the feedback of an evaluation it is easy to be enchanted by one's own assumptions and beliefs. However, practitioners are often educated in a tradition where practice is separated from research and its methodologies. This means outside consultants may have to be used.

Without the necessity of an evaluation consultant the practitioner can use the reflective practitioner approach to systematically evaluate the project². This model involves continuously monitoring and guiding the project towards its goals and objectives. This includes reflection on the progress of the project in relation to its past and anticipating its future course. In addition, the practitioner 're-frames' his or her perspective on the project through continuous dialogue with the young people targeted, the peer educators, intermediaries, the coalition, and the community. This is both a systematic situation assessment of the project and a learning process.

Moreover, valuable knowledge and perspectives can be gained by networking with colleagues in other peer education projects, reading the peer education literature and examining results from similar projects. A familiarity with social and behaviour change theories can help to explain phenomena, guide the change process, and provide an objectivity that is weighed against intuition, personal ideologies and commitments.

In practice, the practitioner can document project activities, processes and achievements. Keeping logs is useful. In this way the practitioner can monitor and evaluate the work that has been completed and the outcomes. This type of documentation is largely descriptive but is useful for guiding the project forward and remaining aware of changing contexts.

b Objectives-based model

Background

Let us begin from the setting up stage of the project. One needs to be specific in defining the young people that will be used to measure the effect of the project – the so-called target group. This is easiest in situations where the group is already well-defined or 'captive' such as in schools, but difficult with populations such as street youth. Even with well-defined groups one needs to think of reaching those young people most vulnerable to HIV due to high risk behaviours. Even if project messages reach beyond it, the target group remains the focus of the evaluation.

The next step is to decide what to measure. These are the objectives defined after an assessment has been made of the young people who will receive the project (Chapter 3). Project objectives are clearly formulated and do not focus on the project itself but on what one expects to happen to the target group as a consequence of the project activities. They can be formulated in terms of measuring achievements such as degree of the target group reached, positive changes in mediating variables (see below) or reductions in specific risk behaviours.

Evaluating the degree that the project activities reached the target group and attitudes towards the project based on characteristics such as age, sex, or degree of risk behaviour is important. For instance, the project may have a number of enthusiastic peer educators, but are they actually reaching other young people? Moreover, one needs to know if the project is reaching those people most vulnerable to HIV due to high risk behaviours.

The ultimate aim of the project will be to slow the spread of HIV among young people. This is, however, extremely difficult to prove without robust, long-term scientific evaluations. Instead, one can use specific and well-defined project objectives that are steps towards this aim. One makes an assumption in doing this since it is not known whether or not meeting the objectives will lead to reductions in HIV transmission. We do know that certain behaviours increase the risk of transmission, i.e. unprotected intercourse and sharing of HIV contaminated syringes. As to condom use, they need to be used quite consistently to reduce transmission rates in a group or population.

Direct changes in risk behaviour occurs rarely in people as an immediate result of a project but through a series of stages. Behavioural theories and models can be very useful for understanding this process. One example of several that may be applied is Prochaska and DiClemente's 'stages of change model'. In this model an individual goes through the following steps: pre-contemplation, contemplation, preparing to change, making the change, and maintenance.

'Mediating variables' are factors or conditions assumed by theory to influence people towards behaviour change. A mediating variable confirmed by research to bring about behaviour change in one group may not necessary do so in another. If possible, the influence of these variables on risk behaviour should be measured in each target group using questionnaire surveys or interviews.

Below are some examples of a few mediating and outcome variables that can be used (see the literature for further explanation and how they are measured):

- level of knowledge on HIV and protection
- attitudes – perceptions about personal susceptibility, condom use, abstention from sex, etc
- skills – ability to negotiate condom use and to refuse sexual intercourse or drug use
- behaviour – degree of activity in various risk behaviours
- self-efficacy – degree of confidence in being able to not to engage in risk behaviours that is based on perceptions of personal skills, knowledge and decision making
- social norms – perceptions of how peers behave in regard to risk behaviour and condom use.

Conducting objectives-based evaluations

An objectives evaluation involves measuring the target group before the project begins (pre-test) and again after it has been running for a pre-determined period (post-test). One can conduct a series of measurement during the life of the project. Objective evaluations can provide valuable information about project progress.

The procedure for collecting data should be incorporated into the action plan. This includes the question or problem to be addressed in the evaluation, the method or methods used, the procedure for carrying it out, who will conduct it, and when or how often it will be done. If statistical methods are to be used in the evaluation, (for example a questionnaire survey), then a statistician should first be consulted. Otherwise, there is a risk that later the data will not be analysable. This would be disappointing, a waste of time and expense, and young people shouldn't be put through unnecessary investigation.

From the start of the project, the data will need to be collected in a way that allows analysis. Once the data is gathered it will need to be analysed using statistical or interview analysis. This can be a complicated and time consuming task requiring expertise.

The most common method used to carry out an objectives evaluation is to distribute anonymous questionnaires to a target group. For the returned questionnaires to be representative they will need to be distributed to everyone in the group or through using a randomly selected sample of individuals. If a random sample is used, statistical expertise should be consulted in deciding how to go about it.

Questionnaires can be descriptive in that they ask straightforward questions about who people are, to what degree they engage in risk behaviours, what their attitudes are about various issues, what their opinions are about the project and what they have gained from it. Analytical questionnaires attempt to measure demographics, mediating variables, risk behaviours and details of contact with the project, then search for relationships between them to gain understanding.

A high response rate to the survey questionnaires is very important. If only 50% return the questionnaires then one never knows how the project affected the other half or who they are. There may be a bias in the non-respondents that is related to risk behaviour or the project. In addition, questionnaires need to be carefully formulated and understood by the young people filling them out. One needs to be sure that the questions are actually measuring what was intended as well. Therefore, the questionnaires should be piloted in a sample of the target group who are interviewed or debriefed afterwards.

Peer educator activities can involve a wide range of informal and formal influences that are difficult to capture using only questionnaires. Moreover, it is difficult to translate people's subjective thinking and feelings into quantitative variables that can be measured. A combination of quantitative and qualitative methods can provide a wealth of information if time and costs allow it.

The advantages of the objectives-based model are they are pragmatic, produce tangible evidence, enable progress to be seen and are more easily understood by funders and administrators. The disadvantages are that they are inflexible compared to the reflective practitioner model, provide little information on which action caused which effect (weak on causation), require time and special training, and may not be relevant to some kinds of peer education.

c. Comparative model

Let us suppose that significant increases in condom use were measured in a target group using pre-test/post-test surveys. This may feel like good news and one might assume that the project had a positive effect on the target group. On the other hand, maybe the change in behaviour was due to some other outside influence. Perhaps the young people became more mature or they were influenced by someone in the group become HIV-infected. Another possibility is that having the young people fill in the first questionnaire influenced them by focusing them on what they were supposed to learn or how to change. The above objectives-based model may be satisfactory in drawing information that will contribute to the project but gives no evidence that it worked.

To answer that question it is necessary to design the evaluation and the data analysis in such a way as to isolate the particular effect of the project interventions and control for the influence of other non-project variables. One way to do so is to use a very similar group of young people that do not experience the project and to measure them with the same survey at the same time points. These groups must be randomly assigned to either receiving the project (the so-called 'experimental group') or acting as the 'control group'. For example, it may be possible to use several similar sites for a project, then randomly assign two or more to either the experimental or control groups.

The meaningfulness of the data gathered with this design depends on the similarity between the two groups. In essence, the control group stands for the experimental group as it would have been if unaffected by the peer education project. However, there can still be innate differences between the two groups that are the real reasons behind the change rather than the project. There is also the risk that the effect of the project on the first group 'spills over' to the second through social contacts and indirectly influences that group as well.

One solution is to add more groups to the randomly assigned experimental and control categories. The more groups used and the more random their assignment to one of the categories, the stronger the evidence that the project may be responsible for the change. This is the so-called randomised controlled trial. This method, together with at least a pre-test/post-test measurement of both experimental and control group(s), is considered the 'gold standard' in intervention research.

It may not be necessary to use a sophisticated and costly method such as a randomised controlled trial to make a comparative evaluation. There are several variations on these designs which do not meet all the requirements of a true experimental design. These so-called quasi-experimental designs are weaker in that they do not control as strongly for the effect of non-project influences on the target group. For instance, one can still use a pre-test/post-test design but not assign the groups randomly. The two groups should be matched as closely as possible for characteristics and settings.

Other possibilities include designs where the experimental group serves as its own control and where the same 'cohorts' or groups of young people continue to be measured over a period of time.

Comparative models are good at identifying causes of particular effects (causality) of the project, can be useful in developing theoretical models and are seen as most credible by funders. The disadvantages are that they are costly, cumbersome, can contain the development of a project, and provide little information on unanticipated consequences.

Project flexibility and project evaluation may have to be weighed up against each other. This is a dilemma and a decision will have to be made before the project begins.

Evaluation ethics

Asking questions of young people or pupils about their attitudes or activities, especially about sexuality and drug use, can be sensitive. The evaluation design, content, procedure and method of reporting may need to be negotiated with research ethics boards, parents, school staff and other authorities. Complete anonymity to protect the confidentiality and integrity of respondents should be guaranteed and provided. This can encourage honest responses as well.

Evaluations need to practice a no-harm ethic and results should be reported objectively, accurately and honestly. The potential cost of the inquiry to the individual has to be weighed against the potential gain from the evaluation. Subjects should be clearly informed about how the information will be used and reported before they are asked to submit to an evaluation.

Summary

After reading the above chapter it may appear difficult to ever learn what effect a peer education project has had on a group of young people. This is common when working outside laboratory conditions. Evaluations do not necessarily need to search for the 'truth' of a project and explain everything. The type of evaluation carried out will depend upon what one needs to know and who needs to know it. We refer the reader to the previous section about standards of acceptability. Most important is that evaluations aid in refining our skills, provide feedback to colleagues and community, and bring us a step closer to effective HIV prevention for young people. This is an issue for policy makers, practitioners, communities, scientists and young people.

Chapter 5

1 Available at the WHO Regional Office for Europe, Scherfigsuej 8, DK-2100 Copenhagen, Denmark.

2 Schön D. Educating the reflective practitioner. San Francisco: Jossey-Bass, Inc; 1987.

Appendix 1

Field interview questions

European field interview questions

The following questions were addressed to the project staff and peer educators. Questions used with policy makers, intermediaries and special consultants are not given here since they were uniquely design for each project setting and approach.

Project Staff and Co-ordinators

Project background

- Please describe the group targeted by your project.
- What are your project's goals and objectives?
- Please describe the project's working model and how you put it into practice.
- What is the theoretical or practical basis of your project/project model?
- What other programs/interventions are being targeted towards this group?
- What kind of results or impact do you expect from your project?
- How will you know?
- Where does the project's funding come from and what's the process of obtaining it?

Project details

- How and when was the project begun and what are your plans for its future?
- Please describe the process of peer educator recruitment.
- Please describe the training they receive.
- How is peer educator retention?
- What do you believe motivates the peer educators to implement and stay involved in the project?
- Please describe the degree of peer educator self-determination and involvement in project and activity decision making.
- Please describe the individuals involved in the project and their roles.
- Please describe any community involvement.
- How cohesive is the project?
- How sturdy is the project and will it continue?

Evaluation

- Please describe any evaluations (formative, process or impact) that have been or are being conducted.
- What are the results, how are they being used and by whom?

Peer Educators

- How did you become a peer educator?
- What were your reasons for deciding to join the project?
- Please describe the training you received.
- What are your own personal goals in your peer education work?
 - The 'problem' as they see it (i.e. risk behaviours).
 - What do they do to tackle the problem?
 - Do they feel they have the necessary skills and knowledge to do so?
- What have you done/do as a peer educator?
- What kind of support do you receive in your work?
 - Supervision?
 - Emotional support?
 - Answers to your questions?
- How do your peers respond to your involvement as a peer educator?
 - Private life friends (even parents).
 - Public peers and school mates.
- How has this work affected you? Have you changed in any way?
- What is the quality of the communication between you and:
 - the other peer educators?
 - the intermediaries?
 - the project leaders (adults)?
- What kind of influence do you have on project self decision-making?
- What would you like to change about the project and project roles to make it work even better?
- What does HIV mean to you?

Appendix 2

Projects interviewed for these guidelines

The projects listed below were interviewed by the author between April and September 1997. Unless otherwise indicated, the interviewees included peer educators, project staff, intermediaries and external consultants such as evaluators. The level of the policy makers interviewed in each country is noted.

Austria

- 'Peers education/Kondomautomatenprojekt II', Steirische AIDS Hilfe, Graz
- 'HIV Peer education an der Universität Graz', Universitätsklinikum Graz, Graz

National policy makers were interviewed.

France

- 'Formation par les pairs', Prévention de la Mutualité de Bourgogne Et ARCAT-Sida Paris (co-ordinator, trainer and evaluator were interviewed).
- '3000 scénarios contre un virus', CRIPS-Ile-de-France, Paris (co-ordinator and evaluator interviewed)

National and regional policy makers were interviewed.

Germany

- 'InTeam', Senatsverwaltung für Gesundheitsförderung und AIDS-Prävention für junge Menschen and Freie Universität Berlin, Berlin

National policy makers were interviewed.

Greece

- 'AIDS prevention in secondary schools by peer education method', Dept of Public and Administrative Health, National School of Public Health, Athens

National policy makers were interviewed.

Ireland

- Pilot programmes co-ordinated by the National Youth Federation. National Youth Federation; Health Promotion Unit, Dept of Health (co-ordinator and trainer were interviewed.)
- Peer education project at Youthreach Transition Centre, Dublin.

National policy makers were interviewed.

Italy

- 'Imola Schools Project', Dept of Child Health, Imola (co-ordinator and evaluator interviewed)
- School project at Istituto Tecnico Commerciale Statale 'Rino Molari', Sant'Arcangelo di Romagna.
- 'Radazione Studenti On-line', Ministry of Public Instruction, Rome.

National, regional and local policy makers were interviewed.

Portugal

- PROJAS- 'Projecto Jovens Animadores de Saúde', Centro de Saúde da Moita, Moita
- Escola secundária de Alfragide peer education project, Ministry of Education, Lisbon.
- Escola secundária de Alvide peer education project, Ministry of Education, Cascais.
- AJPAS – 'Associação de Jovens Promotores da Amadora Saudável', Amadora
- 'Youth Health Promoters Project', Instituto Português da Juventude (Portuguese Youth Institute), Lisbon (co-ordinator and intermediaries interviewed).

National and regional policy makers were interviewed.

Spain

- Youth associations project at Consejo de la juventud de la comunidad de Madrid, Madrid.

National policy makers were interviewed.

Sweden

- 'Projekt 6 (sex)', Lund University, Lund.

National and local policy makers were interviewed.

The Netherlands

- 'SeXplain', Municipal Health Services, Dept. of Infectious Diseases, Rotterdam.

Local policy makers were interviewed.

United Kingdom

- 'The Pupil-led Sex Education Project', University of London, IBIS Trust and University College London, London (peer educators not interviewed.)
- South Camden sex education project for young Muslim women. IBIS Trust, Chesham, Buckinghamshire.
- 'A Pause', Dept of Child Health, University of Exeter, Exeter (project co-ordinator was interviewed).
- 'Norwich HIV/AIDS Peer Education Project', East Norfolk Health Authority, Norwich (co-ordinator and trainer were interviewed).

Scotland

- 'Peer Education Project', Fife Healthcare NHS Trust Health Promotion, Leve, Fife

National and regional policy makers were interviewed.

Appendix 3

Charter and resolution

Charter from the First International Conference on Health Promotion Ottawa, Canada, 17–21 November 1986

Health Promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health Promotion Action Means

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy-makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy-makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike is the need to encourage reciprocal maintenance – to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment – particularly in areas of technology, work, energy production and urbanization – is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services, which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource, to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and wellbeing;
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognize health and its maintenance as a major social investment and challenge; and
- to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, health for all by the year 2000 will become a reality.

Resolution of the First Conference of the European Network of Health Promoting Schools

'The Health Promoting School – an investment in education, health and democracy'
Thessaloniki-Halkidiki, Greece, 1–5 May 1997

Every child and young person in Europe has the right, and should have the opportunity, to be educated in a health promoting school

Evidence shows us that the determinants of both education and health are indivisibly linked. There is a dynamic at work which cannot be ignored if we are to protect, sustain and enhance the education and health of our young people. The European Network of Health Promoting Schools has indicated that the successful implementation of health promoting school policies, principles and methods, can contribute significantly to the educational experience of all young people living and learning within them. The health promoting school has been shown to be an investment in both education and in health. Moreover the Network has a major positive impact upon all those who teach, administer, maintain and support the schools and their community.

Schools are the prime force in creating a generation with raised expectations and high educational achievements. Health promoting schools will have a substantial impact in reducing inequities in society, thereby contributing to the health and wealth of the population at large.

The health promoting school is based upon a social model of health. This emphasizes the entire organization of the school as well as focusing upon the individual. At the heart of the model is the young person, who is viewed as a whole individual within a dynamic environment. Such an approach creates a highly supportive social setting which influences the visions, perceptions and actions of all who live, work, play and learn in the school. This generates a positive climate which influences the way relationships are formed, the decisions of young people are made, and their values and attitudes are developed.

This Conference resolution, which advocates government action for full implementation of the health promoting school concept throughout Europe, has been agreed, at the First Conference of the European Network of Health Promoting Schools. The resolution is designed to encourage the formulation of policy, including legislation, and indicate what needs to be put in place by way of enabling mechanisms. The resolution defines the principles and actions necessary to realize the full potential of the health promoting school.

This Conference, which reflects the views of a wide range of professionals from 43 countries, urges the governments of all European countries to adopt the concept of the "Health Promoting School" and calls upon them to create the conditions for the following principles to be put into practice.

1 *Democracy*

The health promoting school is founded on democratic principles conducive to the promotion of learning, personal and social development, and health.

2 *Equity*

The health promoting school ensures that the principle of equity is enshrined within the educational experience. This guarantees that schools are free from oppression, fear and ridicule. The health promoting school provides equal access for all to the full range of educational opportunities. The aim of the health promoting school is to foster the emotional and social development of every individual, enabling each to attain his or her full potential free from discrimination.

3 *Empowerment and action competence*

The health promoting school improves young people's abilities to take action and generate change. It provides a setting within which they, working together with their teachers and others, can gain a sense of achievement. Young people's empowerment, linked to their visions and ideas, enables them to influence their lives and living conditions. This is achieved through quality educational policies and practices, which provide opportunities for participation in critical decision making.

4 *School environment*

The health promoting school places emphasis on the school environment, both physical and social, as a crucial factor in promoting and sustaining health. The environment becomes an invaluable resource for effective health promotion, through the nurturing of policies which promote well-being. This includes the formulation and monitoring of health and safety measures, and the introduction of appropriate management structures.

5 *Curriculum*

The health promoting school's curriculum provides opportunities for young people to gain knowledge and insight, and to acquire essential life skills. The curriculum must be relevant to the needs of young people, both now and in the future, as well as stimulating their creativity, encouraging them to learn and providing them with necessary learning skills. The curriculum of a health promoting school also is an inspiration to teachers and others working in the school. It also acts as a stimulus for their own personal and professional development.

6 *Teacher training*

The training of teachers is an investment in health as well as education. Legislation, together with appropriate incentives, must guide the structures of teacher training, both initial and in-service, using the conceptual framework of the health promoting school.

7 *Measuring success*

Health promoting schools assess the effectiveness of their actions upon the school and the community. Measuring success is viewed as a means of support and empowerment, and a process through which health promoting school principles can be applied to their most effective ends.

8 *Collaboration*

Shared responsibility and close collaboration between Ministries, and in particular the Ministry of Education and the Ministry of Health, is a central requirement in the strategic planning for the health promoting school. The partnership demonstrated at national level is mirrored at regional and local levels. Roles, responsibilities and lines of accountability must be established and clarified for all parties.

9 *Communities*

Parents and the school community have a vital role to play in leading, supporting and re-enforcing the concept of school health promotion. Working in partnership, schools, parents, NGO's and the local community, represent a powerful force for positive change. Similarly, young people themselves are more likely to become active citizens in their local communities. Jointly, the school and its community will have a positive impact in creating a social and physical environment conducive to better health.

10 *Sustainability*

All levels of government must commit resources to health promotion in schools. This investment will contribute to the long-term, sustainable development of the wider community. In return, communities will increasingly become a resource for their schools.

Investing in the Future

These principles are enshrined within the concept and practice of the health promoting school. They provide the basis for investing in education, health and democracy for generations to come.

The Conference invites the European Commission, the Council of Europe and the WHO Regional Office for Europe to continue their support and leadership for this important work. The Conference asks all three organizations to act on this resolution.

Every child should now have the right to benefit from the health promoting school initiative.

'It has taken a long time, but we now have a document that looks at the key issues in peer education, which have been argued and debated within and between the countries of Europe. The author has collected data from an extensive investigation of research and practice and has provoked thought in a number of areas. It is a testimony to the growing "expertise" across Europe, that this invaluable resource has been written. Someone said that peer education is not just a science, but a beautiful way of working with people. These guidelines show this and more. There is something in it for everyone!'

William Miller, Senior Health Promotion Officer
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