Peer Health Education: Concepts and Content

By Luoluo Hong, Jason Robertson, Julie Catanzarite, and Lindsay Walker McCall

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Chapter 1
Campus Peer Health Education
By Luoluo Hong and Jason Robertson

Health Education: The Context for Peer Education

Regardless of the changes for higher education, as long as we believe that education has something to do with helping individuals achieve their maximum potential for self-development, the development of connection to others, and effective contribution to a lively democracy and its institutions, we cannot achieve the mission of higher education without dealing in some way with health. If we believe we can, we do so at the risk of ignoring major personal, environmental, and political dimensions of education (Burns 1990).

The health of college students is essential to their academic success during their undergraduate years. Health habits and lifestyle practices learned and adopted in college most likely will endure for a lifetime, and impact quality of life and longevity. Throughout the twentieth century, campus health services have played a major role in caring for students’ health and well-being. They have succeeded in providing quality care at an affordable cost. Professional health educators have been integral members of the health care team for college students for several decades. Now, peer health educators have joined that team.

The work of campus health educators, both peers and professionals, falls under the rubric of public health. Public health is the science and art of preventing disease, prolonging life, and promoting health through organized community efforts focused on the sanitation of the environment, control of communicable infections, education in personal hygiene, organization of medical services, and the development of the social system to ensure everyone a standard of living adequate for maintenance of health. Public health focuses primarily on the health of populations, communities, and organizations rather than on individuals, and is committed to social responsibility. Usually public health is concerned with a health problem, based on the assumption that the social, physical, and political environments play major roles in the amelioration of the problem (Modesto 1996).

Specifically, health education is an educational process concerned with providing a combination of approaches to lifestyle change that can assist individuals, families, and communities in making informed decisions on matters affecting restoration, achievement, and maintenance of health. It is a deliberately structured discipline or profession that provides learning opportunities about health through interactions between educators and learners using a variety of learning experiences. This process of learning can enable people to voluntarily change conditions or modify behavior. Health education is more than factual information. It includes those experiences that affect the way people think and feel about their health, and it motivates them to put information into practice (Modesto 1996).

In contrast, health enhancement refers to that dimension of health promotion pertaining to the aim of reaching higher levels of wellness beyond the mere absence of disease and infirmity. Health enhancement begins with people who are basically healthy, but is not limited to the well population. Everyone, including those with chronic health conditions, can improve their level of health.
Similarly, prevention refers to the process whereby specific action is taken to prevent or reduce the possibility of a health problem or condition development and to minimize any damage that may have resulted from a previous condition. There are three levels of prevention:

- **Primary:** stopping the health problem or condition before it occurs;
- **Secondary:** early detection and prompt treatment to deter further decay; and
- **Tertiary:** interventions to limit further disability and early death.

Finally, health promotion uses a combination of health education and specific interventions, such as anti-smoking campaigns, at the primary level of prevention designed to facilitate behavioral and environmental changes conducive to health enhancement. Health promotion aims at helping people change their lifestyle through public participation in a combination of efforts to enhance awareness, and create environments that support positive health practices that may result in reducing health risks in a population.

Health promotion involves three levels of attempts to improve and maintain health: disease prevention, health enhancement, and medical care. Tasks include needs assessment, problem identification, development of appropriate goals and objectives, creation of interventions, implementation of interventions, and the evaluation of outcomes or results. Benefits of health promotion may include changes in attitude, increased awareness and knowledge, lower risk for certain health problems, better health status, decreased morbidity and mortality, and improved quality of life.

**Defining Peer Education**

Peer education consists of instruction by or guidance from equals (Gould and Lomax 1993)—individuals who have some similarity with those they are teaching. Variables such as age, gender, race, religion, sexual orientation, socioeconomic status, and life experience or group affiliation may be used by target audiences to determine who is perceived as being “equal” or having similar lives. Thus, diversity in the student population requires a corresponding diversity of peer education staff. Ultimately, whether the audience perceives the educator as a peer or not is the determining factor in the effectiveness of the interventions (Gould and Lomax 1993). University campuses are not the only locations for peer education programs. Peer education models have been adapted in a variety of settings—schools, prisons, and churches—to impact a variety of human behaviors (health, crime, career, etc.). For example, many prisons have instituted peer education interventions in which inmates teach fellow inmates about HIV prevention and drug abuse.
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On university campuses peer education programs have taken many forms. Some are incorporated as part of residential living (e.g., resident assistants); academic advising programs frequently use peers; orientation programs may use ambassadors to provide new students with support and assistance; athletic departments may rely on mentoring programs to ensure retention of student-athletes. The vast majority of campus peer education programs are based in the student health center or health education department and used to provide health and wellness information to the student population.

Activities implemented by peer health educators vary from campus to campus and take place in one-on-one and group settings, ranging from individual consultations, small-group presentations/discussions, role plays, theater/skits, games, mass media campaigns, and campus-wide awareness weeks. Outreach educational programs are targeted to student living areas or for target student populations. Peers may also develop, produce, and disseminate public service announcements in video and other formats. Some peers serve on student health center advisory boards. Still others staff hotlines, resource centers, or outreach offices where students can access health information and participate in self-assessments. Additionally, peer educators on many campuses act in theater troupes (Gould and Lomax 1993; Sloane and Zimmer 1993).

Keeling and Engstrom (1993) have identified ten earmarks of what they call an enhanced peer education program. Such a program:

1. possesses an ability to sense, monitor, and react to change—a quality that makes programs durable, popular, and indispensable;
2. is frequently and carefully evaluated, in the context of an ongoing appraisal of campus needs in health education and health promotion;
3. has the ability to match the talents, skills, and preparation of peer educators to the most appropriate tasks, activities, and programs;
4. recruits people with specific talents that match the program’s needs;
5. recruits students who are broadly representative of the diversity of students on campus;
6. conducts highly targeted, carefully designed, frequently evaluated training activities, which are specifically tailored to the needs of each group of trainees;
7. exhibits an awareness of and responsiveness to the diversity of learning styles among students and their focus on visual learning;
8. displays a commitment to inclusive programming;
9. possesses flexibility; and
10. focuses on effective marketing for maximum visibility.

History of Peer Health Education

Peter Finn (1981,13) has noted that peer education takes place “constantly among youngsters and adults, regardless of instructional efforts to promote the use of more ‘reliable’ sources of information and advice.” He continues, “It is essential that we seek, through formal training, to put the inevitable peer education that will take place to positive use, rather than leave it to the vagaries of chance.”

It is not reported in the literature when and where the first college peer health educators emerged. One of the earliest recorded examples of a peer education intervention was at the University of Nebraska in Lincoln; student health aides were recruited in response to a 1957 epidemic of Asian flu (Helm, Knipmeyer, and Martin 1972). In rural New England, a small group of college students initiated their own campus reproductive-health peer education program in 1971. At that time, abortions and abortion counseling were illegal; contraceptives were not available on campus, and the nearest Planned Parenthood was forty miles away. The students traveled to Washington, DC, to receive training, then returned to campus to recruit and train other students to help
them. These students distributed a Canadian handbook on birth control, hosted peer education sessions about contraception, and assisted women in raising funds and identifying resources for safe abortions. Furious, college administrators threatened to suspend the academic privileges of the group’s leaders until the mother of one of the peer educators—an alumna—openly supported both the group’s efforts and her daughter’s participation. She reminded the administrators of a student from her graduating class of 1949 who died after an illegal abortion. By the 1973 commencement ceremonies, birth control services were available to students, and the peer education program was funded by the college (Zapka 1981).

The University of Massachusetts at Amherst pioneered campus-based peer education programs in 1970, providing a national model for substance abuse and sexuality peer education (Edelstein and Gonyer 1993). Now, over four decades later, the number of peer health education programs at colleges and universities across the US is burgeoning. Estimates are that nearly 80% of colleges and universities use some form of peer education or peer counseling to disseminate health information (Salovey and D’Andrea 1984). Several regional and national conferences now exist on peer health education, and the number of research articles investigating peer health education is gradually increasing.

Figure 1: Events that Shaped Campus-Based Peer Health Education. This diagram shows major moments in health that helped to inform and develop peer education programs.

The Women’s Health Movement (1960s) fostered greater emphasis on self-care and self-empowerment of the patient. Priority was placed on disseminating accurate information regarding birth control to women of all walks of life. Women demanded that patient and provider be regarded as more equal partners in health care. There was a demand to demystify medicine and a similar move to make health care more accessible to the layperson, thus debunking the monopoly of the professional health care provider as a purveyor of health information. Alternative modalities of treatment began to gain popularity.

When the Public Health Movement (1970s) resurfaced, large-scale epidemiological studies revealed that many instances of morbidity and mortality in the US were due to controllable lifestyle factors (rather than genetic traits or unavoidable infectious agents). Educational strategies could be used to change these behavioral factors. At the same time, university campuses saw an upsurge in enrollment, requiring additional resources and services.

The HIV/AIDS Epidemic (1980s) signified the emergence of a fatal disease for which there is no cure, and shifted emphasis from treatment (medical model) to prevention (public health/community health model). Educational campaigns using gay men to reach their peers were launched in cities such as San Francisco and New York; these programs were successful in curbing the rate of HIV infection among gay men, thus demonstrating the effectiveness of peer education.

Structure of Peer Education Organizations. While most peer health educators are supervised by a student health center or health education unit, occasionally some have been advised by an academic unit (Medical School, Nursing School, Allied Health & Life Sciences, College of Education, Department of Kinesiology, etc.) or some other student affairs/services department (e.g., residential life, dean of students, counseling center, campus activities, student health services, and health promotion).

Depending on the campus’s financial and staffing resources, peer health educators may be unpaid volunteers; receive course credit (1–6 hours) for their training, service, or both; or are paid as student employees (work-study,
financial aid, etc.). The selection process for peer educators varies by school and by organization, as well. Some organizations may have no membership requirement (i.e., open membership). Many institute an application/screening process to ensure quality among their candidates. At some institutions, targeted recruitment for members (e.g., student-athletes, Greek leaders, minority students, non-traditional students) takes place (Gould and Lomax 1993).

Training received by peer health educators also differs across campuses and may take the form of weekend retreats; weekly/biweekly in-service meetings; non-credit course(s); for-credit course(s); attendance at local, regional, and national conferences; or a combination of the above (Gould and Lomax 1993).

Motivations of Peer Educators. Klein, Sondag, and Drolet (1994) examined the factors that motivate individuals to volunteer for a peer health education program. Based on data from five focus groups with nineteen subjects ranging in age from 17 to 34 years (four men, fifteen women), the researchers identified numerous reasons students became volunteer peer educators, many of which overlapped.

Many of the peer educators attributed their motivation to join to family experiences, some positive but many negative (e.g., father was alcoholic, mother was manic-depressive). Some respondents indicated that the experiences of friends (e.g., unplanned pregnancy, date rape) provided the impetus for volunteering. Still other subjects reported that personal circumstances, such as past risk-taking or strong religious values prompted them to serve as peer educators. Some respondents were motivated to become volunteers after observing other peer educators during presentations. Some subjects joined peer health education programs out of a desire to help or serve others—to improve the health of their peers. Finally, a group of respondents became volunteers to gain job or public speaking experience, to simply meet people with similar interests, or to gain health information for personal benefit.

Pros and Cons of Peer Health Education. Here are some of the common arguments about the advantages and strengths of peer health education:

- In times of shrinking health care costs from which colleges are not immune, peer educators are cost-effective and cost-efficient (Gould and Lomax 1993; Sawyer, Pinciaro, and Bedwell 1997; Sloane and Zimmer 1993).
- Peers are the best venues for conveying health information of a sensitive or value-laden nature (especially sexual health, and alcohol and other drugs); they can be regarded as non-threatening authorities who “speak their language.” Students are most likely to open up to a peer educator (Sawyer, Pinciaro, and Bedwell 1997; Sloane and Zimmer 1993; Wessel 1993).
- Students (particularly traditional-aged) are most likely to turn to their peers for health-related information; peers are readily accessible in terms of location and time—they live with the students (Sloane and Zimmer 1993).
- Peers (especially leaders of social groups) can effectively model healthful attitudes and behaviors and are credible role models (Sloane and Zimmer 1993).
- Some health information may be easier for a student to grasp if it is explained by a peer (Damon 1984).
- Peer education, through the leadership and service opportunities it provides, trains future professionals in health and human services (Klein, Sondag, and Drolet 1994; Drellishak 1997).

Several drawbacks and weaknesses of peer health education have also been pointed out:

- Evaluation efforts have been skimpy at best (Fennell 1993; Haines 1993; Keeling and Engstrom 1993).
- The input by professional staff to train, supervise, and motivate peers far exceeds output of peers (Haines 1993; Lindsey 1997).
- The quality of programs (e.g., informational accuracy) provided is not as good as those provided by professionals, and students are less likely to perceive peers as credible sources of information.
The greatest gain and impact is accrued by the peer educators themselves; the impact on others is questionable, short-term, and minimal at best (Kelley 1993).

- Use of peer health educators may reduce the commitment of a university to invest more resources into health education efforts and staffing (Wessel 1993; Lindsey 1997).
- Many advisors also agreed that the majority of campus peer education programs fail to recruit or retain student staff from a diverse range of backgrounds reflective of the campus population; for example, the majority of peer educators at many large, public university campuses are white females of traditional college age (18–23 years).

**Evaluation of Peer Education Programs.** Peer health education bears particular quality assurance issues that can be measured by both process and outcome evaluation techniques. **Process evaluation**, some types of which are frequently referred to as quality assurance review, is the most commonly used method by those campus peer health education programs that do conduct evaluation. This type of evaluation requires that standards of performance be identified and applied before the effects of programs are measured. The evaluation process then documents what is occurring in any given program or workshop and analyzes its structural elements (Green and Lewis 1986). In most college health services, process evaluations constitute the “customer satisfaction” aspect of assessment.

**Outcome evaluation** measures how effective an intervention is in producing changes in knowledge, attitudes, beliefs, and behavior (Green and Lewis 1986). Because it requires the identification of clear and accurate outcome measures, this is the most challenging form of evaluation for health educators (Croll, Jurs, and Kennedy 1993). Only four such studies exist in the literature. Furthermore, researchers have long argued about whether or not the short-term, one-shot program interventions typical of health education have any long-term impact in changing behavior.

Sawyer, Pinciaro, and Bedwell (1997) conducted a study documenting the effects on behavior change of a long-term intervention. They examined the effect that year-long service in a peer sexuality education program had on sixty-five peer educators from ten universities in the US. While quantitative analysis comparing pre- and post-test results on three instruments (Rosenberg Self-Esteem Scale, Personal Development Inventory, and Safe Sex Behavior Questionnaire) yielded a positive change that was statistically insignificant, qualitative data described increased levels of self-reported self-esteem, confidence in public speaking, and practice of safer-sex behaviors among study participants. In addition, 20% of respondents changed their future career interests to health education or public health as a result of their service as a peer educator.

**Peer Education: A Contrast in Paradigms**

There exist two predominant models of peer health education; they differ both in their administrative characteristics and in their educational goals. The **traditional health education model** has been in existence on many college campuses since the 1960s and is the model adopted by most peer health education programs. The community action model (also known as the **system leadership model** or **service-learning model**) is a relatively new way of conceptualizing campus peer health education programs.

Based on her extensive work with peer educators, Pat Fabiano (1994), a health educator at Western Washington State University, has compared the two peer health education models, examining differences in philosophy, training, recruitment, activities, and goals.

**Philosophy.** In the traditional model, individuals are largely responsible for their health by virtue of the choices they make, i.e., personal decisions regarding lifestyle and behavior. People can reduce their health risks and improve their health status largely through personal decision to change. Health-enhancing behavior can be
increased by providing students with sufficient information about risk, teaching new skills, and increasing their sense of self-esteem.

In contrast, the community action model regards health as a process that occurs within the dynamic interaction between the individual and the environment in which he or she lives. Health is neither achieved nor compromised in isolation. An individual’s health and the health of his or her environment and society are inextricably interrelated. Health decisions, therefore, are made and sustained within the whole context of a person’s life. The basis of “health” is more than a medical issue. Rather, it is an issue of sufficient food, shelter, safety, affiliation, work, and community. The focus of health education must encompass and exceed working with individuals one by one to make changes in the way they live. It must also include working with social, cultural, and political systems to enhance the capacities of communities to help the individuals who live in them solve problems and make healthier choices.

Training. Training curriculum is largely health-content-oriented in the traditional model. The content may either be general health issues (wellness, health risks, health objectives) or specific topic-based issues (HIV/AIDS, alcohol and other drugs, etc.). Training may also include (1) process skills necessary for peers to present effective programs (e.g., presentation skills, active listening, role playing) and (2) value clarification for peers to assess their attitudes and beliefs before presenting programs.

In the community action model, preparation includes traditional health content areas and exceeds them. Students are trained to become aware of interconnectedness of “personal health problems” and “public health issues.” All specific health content topics are presented from a systems model emphasizing the interdependence of individuals and the environments in which they live. Students are challenged to see health issues in the context of society and culture.

Recruitment. In the traditional model, a small number of highly qualified students are selected through an application and interview process. Students are trained to “do programs” and provide service largely confined to the campus community. In programs guided by the community action model, large numbers of students are recruited and registered for peer education training courses. The goal is to train sufficiently large numbers of students on a campus to approach a “critical mass,” empowered to speak from experience about the reality of making and sustaining healthy lifestyles. Students who come into the program who are themselves “wounded” or recovering from specific health concerns are seen as resources. Supervision shifts to a model of mentoring.

Activities. Information and skills-based programs are usually offered within the context of the college campus (e.g., residence halls, health fairs, displays in the student health center, targeted classrooms) in traditional peer education models. Programs may include planning and implementing health promotion campaigns, such as those for National Collegiate Alcohol Awareness Week, National Condom Week, Sexual Assault Awareness Month, and World AIDS Day.

However, in the community action model, students are offered a variety of service levels for participation. Some students present traditional health information and skills-building programs in the college residence halls or in classrooms. Other students are encouraged to apply what they have learned in community service sites where they gain hands-on experience regarding the complexity and interconnectedness of solving personal and public health problems. A third group of students takes its place as “health opinion leaders,” willing to assert its opinions regarding thorny health issues at the natural teachable moments in normal social life and interaction. Health opinion leaders are the keystone of the social action approach. Their work redefines the context of “program” to everyday natural interactions students have with each other.

Goals. Programs under the traditional model aim to increase the health literacy of the students and to decrease students’ risk for illness and injury while they are in college and in the future. Goals may also include providing peer health educators with valuable, hands-on, paraprofessional experience in a health-related field. In contrast, the focus of community action-based programs and curricula is to facilitate students’ understanding of the connections between their personal health and the health of their communities (Fabiano 1994).
Figure 2: Comparison of Traditional Health Education and Community Action Models

Adapted from Montana State University, Peer Health Education Program. Program presented at 1994 American College Health Association Annual Meeting, Atlanta, GA.

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<thead>
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<th>Traditional Health Education Model</th>
<th>Community Action Model</th>
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<tr>
<td><strong>1. Health Educators</strong></td>
<td><strong>1. Health Leaders</strong></td>
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<tr>
<td>Focus on education of individuals by providing</td>
<td>Focus on changing campus environment through organizational development.</td>
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<td>information.</td>
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<td><strong>2. Centralized</strong></td>
<td><strong>2. Decentralized</strong></td>
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<tr>
<td>Program based in and operates out of a student health</td>
<td>Programs, staff, and leaders are spread throughout the campus community.</td>
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<tr>
<td>center.</td>
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<td><strong>3. Content Focused</strong></td>
<td><strong>3. Process Focused</strong></td>
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<tr>
<td>Ninety percent of program energies are devoted to</td>
<td>Ninety percent of energies are devoted to developing and changing campus organization.</td>
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<td>providing information.</td>
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<td><strong>4. Steep Organizational Hierarchy</strong></td>
<td><strong>4. Circular Organizational Structure</strong></td>
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<tr>
<td>Proper information goes from health educator to</td>
<td>Large numbers of students and staff with accountability to each and mentors, rather than a director. Wheel shaped.</td>
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<td>specialized staff to student presenters. Pyramid</td>
<td></td>
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<td>shaped.</td>
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<td><strong>5. Individual Change Model</strong></td>
<td><strong>5. Social Change Model</strong></td>
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<tr>
<td>Efforts devoted to influencing the campus by affecting</td>
<td>Efforts devoted to influencing the campus through reshaping social and organizational norms.</td>
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<td>the beliefs and behaviors of individual students.</td>
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<td><strong>6. Deficit Reduction</strong></td>
<td><strong>6. Asset Building</strong></td>
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<tr>
<td>View students as lacking knowledge, skills, or</td>
<td>View students and the campus as resource rich. Students are encouraged to jump in and learn while contributing.</td>
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<td>attributes. Peer educators need to attend training</td>
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<td>before contributing.</td>
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<td><strong>7. Students as Prevention Receptacles</strong></td>
<td><strong>7. Students as Prevention Partners</strong></td>
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<tr>
<td>Staff-driven programs reach the student body through</td>
<td>Staff and students interact as partners in the process of reshaping campus culture.</td>
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<td>student programs.</td>
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<td><strong>8. Inadequate Support</strong></td>
<td><strong>8. Priority Support</strong></td>
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<tr>
<td>Program does not receive necessary administrative and</td>
<td>Central to the campus mission, program receives noticeable financial and administrative support from many sources.</td>
</tr>
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<td>financial resources. Support from one source.</td>
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<tr>
<td>Works within the current system to impact students</td>
<td>Challenges current system through organizational change and political activism.</td>
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<tr>
<td>without challenging the system.</td>
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<td><strong>10. Sole Source</strong></td>
<td><strong>10. Multiple Resources</strong></td>
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<tr>
<td>Health educators function as gatekeepers of campus</td>
<td>Health educators work themselves out of jobs by empowering others and the system.</td>
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<tr>
<td>health information.</td>
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Suggestions for Further Reading


Questions to Consider

1. How do you see yourself fitting into the peer education program?
2. Why is a peer education program important on the campus?
3. In what ways do you view peer education as being beneficial to you? To your peers?
4. How does peer education fit into the community action model?
5. What events have influenced peer education today? (e.g., Women’s movement)

References


Individual Level Theories and Models

Stimulus Response Theory (Skinner 1953). Learning results from temporally associated consequences that either increase or decrease the likelihood that a particular behavior will occur. Consequences of behavior can either be reinforcement or punishment. **Reinforcement** is any event following a behavior that increases the probability of that same behavior being repeated in the future. Behavior is most likely to recur if (1) reinforcement is frequent, and (2) reinforcement is immediate. **Punishment** is any event following a behavior that decreases the probability of that same behavior’s reoccurrence. Both reinforcement and punishment can be either positive (adding stimuli to an event) or negative (removing stimuli from an event).

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Consequences</th>
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<tbody>
<tr>
<td>Increase in frequency</td>
<td>Positive reinforcement</td>
</tr>
<tr>
<td>Decrease in frequency</td>
<td>Positive Punishment</td>
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While reinforcement is an integral part of learning, various cognitive constructs (synthesized thoughts or key concepts) also play a role. Behavior becomes a function of the subjective value of an outcome and the subjective probability (or expectation) that a particular action will achieve that outcome; such formulations are known as value-expectancy theories.

Frequently used constructs of social cognitive theory include:

1. **Reinforcement.** Responses to behavior that increase the chances of its recurrence. Responses can occur (1) directly, (b) vicariously, or (c) through self-management.
2. **Behavioral Capability.** Knowledge and skills necessary to perform a behavior.
3. **Outcome Expectations.** Beliefs that the likely outcomes of certain behaviors will be positive rather than negative.
4. **Expectancies.** The values that individuals place on an expected outcome; if a person values an expected outcome, s/he is more likely to perform the necessary behavior to yield that outcome.
5. **Self-Control or Self-Regulation.** Gaining control over one’s own behavior through monitoring and adjusting it.
6. **Self-Efficacy or Efficacy Expectations.** Refers to the internal state that an individual experiences as “competence” to perform a certain desired task or function. This state is situational. Individuals
become self-efficacious in four ways: (a) through performance attainments (personal mastery of a task); (b) through vicarious experience (observing the performance of others); (c) as a result of verbal persuasion (receiving encouragement from others); and (d) through emotional arousal (interpreting one’s emotional state).

7. **Reciprocal determinism.** Behavior changes result from an interaction between the person and the environment; change is bidirectional.

8. **Locus of control.** Refers to a person’s belief about whether or not his or her own actions lead to certain reinforcements.

9. **Emotional coping response.** For people to learn, they must be able to deal with the sources of anxiety that surround a behavior.

*Theory of Reasoned Action (Fishbein and Ajzen 1975)*

An individual’s intention to perform a given behavior is a function of his/her intention to perform the behavior, his/her attitude toward performing the behavior, and normative beliefs about what relevant others (individual or groups) think s/he should do, weighted by motivation to comply with those others. These normative beliefs are frequently referred to as the **subjective norm**.

*Theory of Planned Behavior (Ajzen 1988)*

Like Theory of Reasoned Action, this theory includes attitudes toward the behavior and subjective norm as determinants of behavior and adds the concept of perceived **behavior control**—the perceived ease or difficulty of performing the behavior, based on experiences as well as anticipated impediments and obstacles. In general, the more favorable the attitude and subjective norm with respect to a behavior and the greater the perceived behavior control, the stronger should be the individual’s intention to perform the desired health behavior.

*Theory of Freeing (Freire 1973)*

This theory is aimed at empowering education, where **empowerment** refers to the process by which individuals, organizations, and communities acquire the ability to control their own lives and effect change. An underlying concept of this theory is that **critical consciousness** is determined by the reciprocal interaction with one’s culture. Oppressed people are “of the world”; that is, their consciousness is a product of the culture, and they are unable to perceive, respond, and act with power to change concrete reality. Free people are “in the world”; their consciousness is a creator of culture. Interactive, iterative education based on dialogue between teachers and participants is the key to becoming critically conscious.

There are three stages in this theory. **Stage 1** is the listening stage, in which members of the target population have an opportunity to share thoughts, identify problems and needs, and establish their own priorities. **Stage 2** entails dialogue revolving around a code—any concrete, tangible physical representation of an identified community issue. Group facilitators help move the target population from a personal to a social analysis and action level with five statements: (1) Describe what you see and feel; (2) As a group, define the many levels of the problem; (3) Share similar experiences from your lives; (4) Question why this problem exists; and (5) Develop action plans to address the problem. **Stage 3** is the collective action stage, in which members of the target population try out the plans outlined in Stage 2, reflect on their experiences, and refine the plan.

*Health Belief Model, or HBM (Rosenstock et al. 1988)*

This model hypothesizes that health-related actions depend upon the simultaneous occurrence of three classes of factors:

1. The existence of sufficient motivation (or health concern) to make health issues salient or relevant.
2. The individual perception that one is susceptible (vulnerable) to a serious health problem (perceived susceptibility) or to the sequelae of that illness or condition (perceived seriousness, or severity). This is often perceived as perceived threat. Factors that modify perceived threat include:
   a. Demographic variables (sex, age, race, ethnicity, and social class);
   b. Sociopsychological variables (personality, and peer and reference group pressure;
   c. Structural variables (knowledge about and prior contact with the disease); and
   d. Cues to action (mass media campaigns, advice from others, reminder postcards from health care provider, and illness of family member or friend).

3. The belief that following a particular preventive behavior would be beneficial in reducing the perceived threat (perceived benefits), and at a subjectively acceptable cost. Cost refers to the perceived barriers—both financial and otherwise—that must be overcome in order to implement a particular health recommendation. When perceived benefits exceed perceived barriers, the likelihood of taking recommended preventive health action is increased.

**Transtheoretical Model, or Stages of Change (Prochaska 1979)**

This model describes the cyclical change pattern that the majority of individuals experience as they attempt to alter their health behavior over time. Movement through these stages is not linear; rather, most people will relapse and return to the precontemplation or contemplation stage before eventually succeeding in maintaining the desired behavior.

<table>
<thead>
<tr>
<th>STAGE</th>
<th>TIMEFRAME</th>
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</thead>
<tbody>
<tr>
<td>Precontemplation</td>
<td>Not seriously thinking about changing their behavior during the next six months; unaware or underaware of their health status.</td>
</tr>
<tr>
<td>Contemplation</td>
<td>Aware that a health problem exists, seriously thinking about change in the next six months, but have not yet made a commitment to take action.</td>
</tr>
<tr>
<td>Preparation</td>
<td>Intending to take action within the next month, actively planning change, taking some small steps toward action.</td>
</tr>
<tr>
<td>Action</td>
<td>Overtly making changes in behavior, experiences, or environment to overcome health problem.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Taking steps to sustain change and resist temptation to relapse.</td>
</tr>
</tbody>
</table>

**Relapse Prevention Model (Marlatt 1982)**

This refers to a self-control program designed to teach individuals who are trying to change behavior how to anticipate and cope with relapse. Relapse is triggered by high-risk situations (intrapersonal or interpersonal)—situations that threaten the individual’s sense of control. Individuals who possess the coping skills to deal with
high-risk situations have a much greater chance of preventing relapse than those do not. A complete application of the relapse prevention model includes both specific and global strategies for self-control. **Specific** intervention procedures help the individual anticipate and cope with the relapse episode itself, while **global** intervention procedures are designed to modify the early antecedents of relapse, including restructuring of the individual's lifestyle.

**Social Level Theories and Models**

**Diffusion Theory (Rogers 1983)**

This socioanthropological model of cultural change explains the diffusion of new ideas, techniques, behaviors, and programs within a target population. When people become “consumers” of an innovation, they are referred to as adopters; adopters can be categorized by when they adopt the innovation, and the rate at which people become adopters is represented by the bell-shaped curve. **Innovators** (less than 3% of the population) are the first to adopt the innovation. **Early adopters** (14%) are very interested in the innovation but do not want to be the first involved; they are typically respected and regarded as opinion leaders in their social networks. The early majority (34%) is composed of people who may be interested in the innovation but require external motivation to get involved. People who are skeptical and will not adopt the innovation until most people in the social system have done so represent the late majority (34%). The **laggards** (16%) will be the last group to adopt an innovation, if at all.

**Leadership-Focused Model (Academy for Educational Development 1996)**

This model combines aspects of diffusion theory and community organizing theory. Naturally emerging leaders—not just formal leaders—within a community are encouraged to exhibit and communicate an innovation to their peers. Because these innovations may be different from the community's established behaviors or social norms, this model focuses on how risk-reduction strategies become the norm within a social structure. Key steps in implementing this model include locating relevant leaders, enlisting their support, motivating them to take on the work and risk of advocating for an innovation, and preparing them for this task (education, support, materials). The effectiveness of the leadership-focused model depends on the level of resistance to change among powerful segments of the community, the lifespan of the social network involved, and the duration of influence of the leaders who are communicating the innovation.

**Social Network Theory (Academy for Educational Development 1996)**

This describes relationships or interactions between two or more people. Networks are matrices linked by family relationships, friendships, or commercial relationships—referred to as ties—that generate a special or unique feeling: need, concern, loyalty, frustration, power, affection, obligation, etc. Researchers characterize social networks either in terms of the individual and his/her relationship to others, or in terms of any set of linkages among people in a given group or network. Additionally, an individual may serve as a link between two seemingly unconnected networks. From a health-promotion perspective, when people are “networking,” they are looking for relationships that are useful in helping them with their concerns, such as problem solving, program development, and resource identification.

**Social Movement/Community Mobilization Theory (Goldstein 1992)**

This is a description of how a community's culture, institutions, experiences, or characteristics can be changed to improve the health of that community by members of that community. Existing or emerging local leaders usually initiate and maintain social movements, but they can also occur as the result of outside interventions.
Social movements represent loosely organized collections of social activities, either in protest or for promotion, that exhibit some continuity over time and are based on a core of moral ideas. Local popular involvement and mobilization in the civil rights movement, the women’s movement, and the gay rights movement have given rise to more formal, national collectives that lend visibility and provide leadership to the values they advocate.

*Misperceived Norms Model (Perkins and Berkowitz 1986)*

This model posits that health promotion interventions focusing exclusively on health problems and draw attention to their negative consequences may inadvertently create a perception that the campus population is less healthy than it really is. Perkins and Berkowitz (1986) cite statistics from studies of alcohol abuse and cigarette use that find that substantial numbers of students who hold moderate views about drinking and smoking incorrectly perceive their peers as being more permissive. Students who experience themselves as deviating from this false norm increase their consumption of alcohol or cigarettes over time in order to more closely conform to their peers’ purported behavior. Research shows that student leaders, staff, faculty, and administrators are all prone to these kinds of misperceptions. Therefore, efforts to correct misperceptions and focus on healthful, positive behaviors can serve as a method of alleviating perceived peer pressure to use alcohol and other drugs, or of delaying the onset of use.

**Social Marketing**

*Social Marketing* is the adaptation of commercial marketing technologies to programs designed to influence the voluntary behavior of target audiences in order to improve their personal welfare and that of the society of which they are a part. “Social marketing brings to the challenge of [prevention] three important features: a focus on understanding how and why individuals behave as they do; creation of beneficial exchange relationships to influence those behaviors; and a tool for strategic program management”, (CDC 1995).

Social marketing can be divided into a series of sequenced steps, each reinforcing and expanding the other. Information gathered during one step can influence a previous step. For example, data gathered as you segment audiences may cause you to revisit your definition of the problem, or you may change your marketplace assessment as you determine gaps.

**Step 1: Define the Problem.** At the heart of any health problem, you will always find human behavior. Epidemiology helps pinpoint who’s at risk and what they do that puts them at risk. But it isn’t the whole story. Epidemiology doesn’t give program planners the necessary insight into a target audience’s perspectives on behaviors, especially the causes or “determinants” of behaviors: external factors like low income and isolation from services, and internal factors like perceptions of self-efficacy (the individual’s belief that he or she can do the desired behavior), social norms, barriers to performing lifesaving behaviors, and benefits of adopting lifesaving behaviors. This information is critical to understanding how an audience sees and reacts to a specific behavior you want to promote. To get it, you need behavioral science for insights into the target audience’s current knowledge, skills, attitudes, beliefs and behaviors, and marketing data about consumers’ buying behaviors and the external and internal forces that prompt them.

**Step 2: Assess the Marketplace.** This stage is commonly called needs assessment. It includes “environmental scanning” to get a picture of the community in which you will be working: its politics, its consumers and their habits (what they buy, what they do for fun, etc.), what its media have reported on, and other characteristics. During this step, program planners should:

- identify and consult with relevant community groups;
- analyze what they know about the audience and what they need to know to design an audience-centered prevention program;
• assess local health promotion and disease prevention programs—Who do programs serve? What are their services? What are the gaps in service? What resources are available to address those gaps?

Step 3: Segment Audiences. Demographics are an obvious way to define groups—for example, along racial/ethnic lines, by sexual activity, by gender, or by age. But demographics don't provide the whole picture of a given audience. Within a community, within age groups, within sexes, within socioeconomic rungs, different people share different values, are affected by different pressures, and receive information through different channels. Social marketing defines groups according to these various lifestyle factors, and spotlights likenesses and dissimilarities within and across groups. For example, even across race, ethnicity, sexual orientation, and socioeconomic status, research shows that young adults aged 18–25 are more alike than they are dissimilar. It makes sense to create messages that capitalize on that similarity.

But even people who share lifestyle factors may be at different levels of readiness for new behaviors. In a single peer group, one college student might be committed to abstaining from sex, another might be sexually active but willing to try condoms, and another might reject the idea that he or she is at risk for sexually transmitted infections, including HIV infection. Behavior science helps program planners determine which perceptions, attitudes, and beliefs are important to specific audiences.

Step 4: Plan a Program with Specific Behavioral Goals. Armed with extensive audience research, social marketers define audience segments and set measurable, realistic, and prioritized goals for each segment. Proposed interventions aim to influence specific beliefs, develop specific skills, enhance specific knowledge, and change or maintain specific behaviors.

The program plan should outline specific strategies and methods for delivering messages and an evaluation plan that includes both process and outcome measures to monitor the impact of your messages.


Step 6: Determine the Marketing Mix. A program’s marketing mix—or the “four Ps” of product, price, promotion, and place—is central to its success. These four elements balance the audience’s perceptions and feelings about a given health behavior to create optimum appeal. This is where formative research with the target audience is invaluable, because that research reveals what the audience believes about your product, what they are willing to do (or not do) to get your product, how you can best position the product to appeal to them, where and how they can get the product, and so forth.

Product. In commercial marketing, “product” usually means a thing to sell to consumers—an item, a service, sometimes an idea. In social marketing, the product is typically the desired attitude or behavior that will be exchanged for another attitude or behavior. To be successful, a product must offer a benefit people want. For example, extra-strength deodorant “offers” better body odor. What does safer sex or low-risk drinking “offer” that people want—and want enough to exchange unsafe sex or high-risk drinking for?

Price. The old saying, “Everything has its price,” couldn’t be more true in social marketing. But the price usually isn’t merely the actual monetary cost. In this context, the “price” is the monetary, physical, and/or emotional cost to the consumer to buy or use the product. The highest costs are often social, psychological, or emotional. For example, research with people at high risk for HIV infection often reveals that they fear losing their partner if they insist on using condoms—a high, and seemingly unaffordable, cost to them.

Prevention program planners must understand and appreciate the costs their targeted audiences will pay in exchanging behaviors. At the very least, it is essential to know that changing behavior is
seldom, if ever, easy. And difficulties are increased monumentally when people’s self-esteem, safety, comfort, and other central ego supports are involved. This is compounded when they don’t get immediate benefits that they care about after paying what to them may be very high costs.

Appreciating how students perceive costs helps you identify a desired behavior that has benefits that make the costs worth it. Only then can you position the desired behavior and its benefits and realistically ask people to change.

It’s important to remember that messages may not center on lowering the cost, but on increasing the value of the product. For example, your audience might appreciate the benefits of latex condom use (protection from HIV and other STDs, peace of mind, greater staying power, etc.), making the costs of using condoms (less skin-to-skin contact, loss of sensation, or perceived lack of spontaneity, etc.) seem reasonable and affordable. Or they might value the benefits of complete abstinence (no need to worry about infections or pregnancy, feeling good about being an individual and not going along with the crowd, knowing your partner cares for you and not just for sex), making the costs of abstaining (such as being perceived as a prude, not being like your peers, foregoing pleasure, losing love) seem less consequential.

Promotion. Promotion is about messages and the channels that deliver them. A comprehensive promotion plan takes into consideration the full range of communication tools—such as social advertising, public and media relations, media advocacy, entertainment media, personal selling, community-based programs, direct marketing, special events, and live entertainment. Messages should be clear, break through the clutter of other messages, and be memorable, persuasive, accurate, and widely recognized. Promotion is designed to prompt a decision to practice the target behavior. That decision is then acted on in various places.

Again, the student’s needs, lifestyle, and other factors must take precedence. Just because administrators, program planners, or others may be personally influenced by editorial coverage in newspapers and magazines doesn’t mean that students will be. The targeted audience may not regularly read newspapers or magazines. Or if they do, they may not find these sources of information to be credible.

Place. In commercial marketing, “place” refers to the location a product is offered. The optimal place is the most convenient outlet to consumers that is also the outlet that offers the most emotional benefits. For example, a product (e.g., perfume) with a high price ($65 an ounce) could be placed in a variety of retail locations ranging from discount stores to department stores. Discount stores would likely be the most convenient place for potential consumers, but would they offer consumers an emotional benefit? Consumer research would probably show that people would not expect to purchase expensive perfume in those locations and would not want to think of themselves as discount shoppers for this item. On the other hand, large department stores might be less convenient to get to, but shoppers would be more likely to expect to purchase a high-ticket item in them, and consumers would feel good buying in such stores.

In social marketing, when the product is usually a behavior, the analysis of convenience and emotional benefits is equally important, but the goals are different. Analyzing place is really analyzing the locational constraints on behavior. It takes into account that people may have made a previous decision—for example, to say no to sex or to always practice safer sex—and then examines how a particular place, such as a bar, might affect that previously made decision. The analysis asks, “What can I do to make the place where people act on their decisions more likely to prompt the target behavior?”

A key question to ask in thinking about place is: What has the audience told us about this? Where do the consumers spend the majority of their time? Or, what various “lifepoints”—buildings, streets, stores, restaurants, libraries, classrooms, etc.—do they cross daily? Do you know how these
locations affect their behavior? Sometimes, there is relatively little that can be done to make a place more likely to elicit the desired behavior, but other times your creative analysis of place will pinpoint some avenues for change.

**Step 7: Deliver the Program.** Put the program to work with the target audience. Distribute materials and messages, and generate support. Ensure all linked organizations and campus departments—academic units, student services, student government, student organizations, etc.—work together to reinforce the program and its behavioral goals.

**Step 8: Evaluate and Alter As Needed.** Monitor the program. Change strategies, messages, materials, and channels as necessary to meet evolving needs. Social marketing programs are not unchanging, static programs. They change as audiences change—constantly!

Evaluate the total program. Use both process criteria and outcome criteria. How many people did you reach? Whom did you reach? When? Where? How often? Who responded? How? What changes occurred? Based on what you learn, ask: “What do we need to change to move closer to our program goals?”

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**Figure 5: Comparison of Individual and Social Level Prevention Strategies.**

<table>
<thead>
<tr>
<th>Individual Wellness (Individual-Level Approaches)</th>
<th>Community Well-Being (Social-Level Approaches)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health is viewed as the result of personal decisions regarding lifestyle and behavior.</td>
<td>Health is viewed as an on-going process that results from interaction between an individual and the environment and culture in which s/he lives.</td>
</tr>
<tr>
<td>People reduce health risks and improve health status via personal decisions to change.</td>
<td>Health decisions are made within the whole context of a person's life.</td>
</tr>
<tr>
<td>Health-enhancing behavior increased by providing information about risk, teaching new skills, and increasing self-esteem.</td>
<td>Health-enhancing behavior increased by working with social, cultural, economic, and political systems to enhance the abilities of communities to help individuals who live in them solve problems and make healthier choices.</td>
</tr>
<tr>
<td>Focus on changing individual attitudes, beliefs, and values.</td>
<td>Focus on policy development and changing cultural and peer group norms.</td>
</tr>
<tr>
<td>Focus on the relationship between the individual and health problems.</td>
<td>Focus on individuals gaining power by acting collectively.</td>
</tr>
<tr>
<td>Short-term in scope.</td>
<td>Long-term in scope.</td>
</tr>
<tr>
<td>Individual is the audience.</td>
<td>Individual is the advocate.</td>
</tr>
<tr>
<td>Professionals and “experts” make the decisions.</td>
<td>Professionals help create avenues for students to develop and express their power.</td>
</tr>
</tbody>
</table>

Questions to Consider

1. Why is it important for peer educators to understand behavior change theory?
2. Name two theories you find most interesting? How can you see these being useful?
3. Why is it important to use theory to inform the work you do as a peer educator?
4. Think of a health issue affecting college students. Create a brief social marketing plan.

References


Chapter 3
Planning Effective Educational Programs

By Luoluo Hong and Julie Catanzarite

The PRECEDE Model for Health Education Planning

Green et al. (1980) offered the following model for planning health education interventions. This model is frequently followed by professional health educators, and serves as a basis for peer health educators.

**Step 1: Social Diagnosis.** Assess the quality of life in the target population, as well as the major problems that concern that group. Individuals are more motivated to change if the issue is relevant to them. Subjectively define problems of individuals or communities. Social indicators: illegitimacy, population, welfare, unemployment, absenteeism, alienation, hostility, discrimination, votes, riots, crime, crowding, etc.

**Step 2: Epidemiological Diagnosis.** Identify the major causes of morbidity and mortality in this population. Allocate scarce resources to more serious health problems. Account for nonhealth factors, e.g., natural disasters, weather. Vital indicators: morbidity, mortality, fertility, disability, etc. Dimensions: incidence, prevalence, distribution, intensity, duration, etc.

**Step 3: Behavioral Diagnosis.** Identify the specific behaviors related to major health problems. Prioritize these behaviors. Account for nonbehavioral causes, e.g., genetic, environmental, economic. Behavioral indicators: utilization, preventive actions, consumption patterns, compliance, self-care, etc. Dimensions: earliness, frequency, quality, range, persistence, etc.

**Step 4: Educational Diagnosis.** Describe the following three factors: (1) “predisposing factors,” which increase or decrease the motivation for change, including cognitive variables such as attitudes, beliefs, knowledge, perceptions, and values; (2) “enabling factors,” the barriers to change created by societal forces and systems, including availability of resources, accessibility, referrals, and skills; and (3) “reinforcing factors,” social feedback that encourages or discourages behavior change, including attitudes and behavior of health and other personnel, peers, parents, employers, etc. Decide which factors will be the focus of the intervention.

For example, an educational diagnosis applied to campus alcohol abuse might yield the following predisposing, enabling, and reinforcing factors:

**Predisposing factors:**
- Myths and misconceptions about the effects/physiology of alcohol abuse;
- Binge drinking;
- Drinking as a rite of passage (Butler 1993);
- Drinking as a form of “liquid bonding” (Kuh and Arnold 1993);
- Drinking as a recreational activity unto itself;
- Drinking as a “social lubricant”;
- Drinking as a coping strategy; and
- Sexual victimization (acquaintance rape, childhood sexual assault, sexual harassment, etc.)
**Enabling factors:**

- Lack of university-wide coordination of prevention efforts;
- Failure of teachers, physicians, law enforcement, etc. to refer students for intervention after alcohol-related incidents;
- Lack of skills in appropriate intervention by peers;
- Lack of political support and understanding of the problem;
- Paucity of financial resources allocated for alcohol abuse prevention, relative to other investments;
- Media advertising (radio, television, campus newspaper, local bars);
- Issue of confidentiality for treatment services;
- Presence of hard-to-reach populations (e.g., men, Greeks, etc.); and
- Competition from promotional efforts of alcohol distributors.

**Reinforcing factors:**

- Peer pressure and false perception that everyone drinks;
- Parents and other mentors sanction drinking;
- Alcohol allowed at many community events, including athletics, social, theater, music, and academic;
- Campus leaders are limited in their knowledge of alcohol use/abuse and their impact on academic performance quality of life;
- Campus/opinion leaders oftentimes model alcohol abuse;
- Medical professionals do not recognize seriousness of alcohol-related incidents;
- Legal loopholes in the State underage drinking statutes; and
- Problem of law enforcement (inconsistencies in application of law).

**Step 5: Administrative Diagnosis.** Assess resources, time constraints, and abilities. Only intervention components with highest priority can be implemented with limited resources. Components of a health education program should include: (1) direct communication to the public, patients, etc.; (2) training for community organizations; and (3) indirect communication in the form of staff development, training, supervision, consultation, and feedback.

**Step 6: Evaluation.** Assess intervention impact and effectiveness on a continuous and ongoing basis.

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**Behind the Scenes: Eight Steps to a Successful Program**

**Step 1: Receive Your Assignment.** You and your co-facilitator(s) will receive a program assignment from your advisor or the health education department administrator, depending on who schedules the programs. You should generally have 2–3 weeks’ notice. This assignment should include the following information:

- time, date, and location of the workshop
- organization or residence hall requesting the workshop
- number of people expected to attend
- demographic profile (sex, age, etc.)
- special topic requests (if any)
- name and phone number of contact person

**Step Content**

<table>
<thead>
<tr>
<th>Step</th>
<th>Content</th>
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<tbody>
<tr>
<td>1</td>
<td>Receive your assignment</td>
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<tr>
<td>2</td>
<td>Confirm your assignment</td>
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<tr>
<td>3</td>
<td>Develop an outline</td>
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<td>4</td>
<td>Prepare and practice</td>
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<tr>
<td>5</td>
<td>Reconfirm and practice</td>
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<tr>
<td>6</td>
<td>Set up</td>
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<tr>
<td>7</td>
<td>Evaluate the workshop</td>
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<tr>
<td>8</td>
<td>Debrief with your co-facilitators</td>
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</table>

**Figure 6:** The eight steps to a successful program. A quick reference to getting ready for a program.
Step 2: Confirm the Assignment. This is very important from both a public relations perspective and a logistical one. Designate one co-facilitator to verify the above information with the contact person as soon as you receive an assignment. Discuss refreshments (what and when) and advertising (content, who is responsible). Also consider what resources the audience might be able to use prior to the event. Send any questions, surveys, or articles to the contact person to help frontload participants. Always research your audience as thoroughly as possible. Be sure to ask important questions such as:

- What motivated the contact person to make this request? Did an incident occur recently? Is she concerned about an individual in the hall or group?
- Who is being invited and what are the circumstances? Is attendance mandatory or voluntary? Are audience members close friends or casual acquaintances?

The answers to these questions can have ramifications on how you plan and deliver your program.

Step 3: Develop an Outline. Always do this, even if you’ve already done a similar program on the same content area. A well-written, thorough outline is the single most important thing you can do to have a successful program. It can also serve as a valuable tool in your preparation and planning. In addition, many peer education organizations maintain a notebook of outlines from past workshops to assist new members in program development.

Clearly delineate on the outline who is responsible for each item. Record the approximate time allotted for each section; a timekeeper may be assigned. Most importantly, make decisions about which material is absolutely essential to cover, and indicate which material can be discarded in the event that discussion runs over or you run out of time. Conversely, be familiar enough with your content information to expand on areas the audience may express particular interest in. Make sure each co-facilitator has his/her own copy.

In general, for a one-hour workshop, plan programming and activities for forty-five minutes; this builds in an automatic fifteen-minute time cushion for questions and answers, discussion, or unexpected delays. Whichever format you select, all peer education programs should have the following structure:

I. Introduction. Establishing credibility and legitimacy early in the program is important, as is establishing a nonjudgmental, comfortable tone.

A. Introduce yourself. Say more than just a name or major; perhaps share why you became a peer educator, your favorite health fact, etc. This is an opportunity for the audience to start getting to know you and for you to establish rapport and trust.

B. Briefly discuss the purpose of your peer education organization. This means you need to be familiar with the history, mission, and activities of your organization.

C. Talk about the Student Health Center. Describe all three units: Medical Clinic, Mental Health Service, and Wellness Education Department. Be sure to have pamphlets available; provide appropriate phone numbers.

D. Outline the agenda for the program. A useful strategy is to highlight the two or three main points of your program. Negotiate with the audience: Does this meet their needs? What are their expectations? Are there any questions to begin with?

E. Establish ground rules. Examples of relevant ground rules might be confidentiality, respectful listening, negotiation of terms/language that are acceptable to the audience, etc. Post or write these ground rules on a board or easel if possible.

II. Mini-Lecture. Improving health and wellness typically involves a combination of increasing knowledge, assessing values, and changing behavior. Some information is best understood when delivered in a straightforward manner using layperson’s terms. This is an opportunity to include
basic information regarding statistics, definitions, etc. Try to limit this section to no longer than 10–15 minutes.

III. **Discussion or Interactive Activity/Game.** Students learn best when they are required to share their viewpoints and ideas about the particular topic. Don't be afraid to “give up control” and let the audience do some self-exploration.

A. Discussion topics should focus on an issue that is open-ended, generates a lot of emotions, lends itself to multiple perspectives (i.e., not a “black or white” issue), or is perhaps even controversial. To enhance audience participation, try to maintain the role of a moderator (by restating audience views, asking questions to clarify), and refrain from sharing your views until the end. Also, don't be afraid of silences; those are crucial for thinking! (Try the five-count: one one-thousand, two one-thousand, etc., before jumping in.)

B. For interactive activities and games, use those you’ve picked up during your training, but also feel free to design something on your own. Possibilities include quizzes, game shows, values clarification exercises, board games, brainstorms, etc. Be sure that humor associated with the activity doesn't contradict your message or hurt people inadvertently. Sarcasm should be avoided.

IV. **Closure.** Some programs may have aroused strong emotions for students. The program may have been thought-provoking. Challenge students to continue learning with each other, perhaps by asking what they intend to do after attending this program.

A. Summarize your two or three key points.

B. Provide the appropriate on- and off-campus resources for referral.

C. Answer questions. If you don't know the answer to a question, don't be afraid to say so. Offer to follow up; arrange for a way to get in touch with the student.

D. Thank the group for attending and participating.

E. Distribute and collect evaluations.

What follows are two examples of program outlines. The mistake that most peer educators make is to write an outline that is too sparse. Remember, for the outline to be helpful, it must be dense with information. Err on the side of putting too much in the outline rather than too little. A guideline for developing an outline is to ask yourself, “Could another peer educator reproduce my workshop just from reading my outline?” If not, then you’ve probably done an insufficient job on the outline. However, remember that you will not be referring to the outline directly during the workshop. Doing so erodes your credibility and makes you appear as though you have not practiced. If you wish to have notes to refer to during the workshop, jot them down on index cards no larger than 3” x 5” in size.

**Sample Outline #1 for Educational Program**

**Topic or Title:** *Sex in the Age of AIDS*

I. **Introduction**

A. Each group member introduce him- or herself

B. Talk about Sexual Health Advocates (peer education organization)

C. Discuss the Student Health Center, Counseling Center, Wellness/Health Promotion Office

D. Set up ground rules:
1. Humor okay
2. Please ask questions
3. Respect audience members’ confidentiality (this is a potentially touchy subject)

II. Brief Lecture on HIV/AIDS
   A. History
   B. Statistics
      1. As of 2008, one in 1,500 college students are HIV-positive
      2. Half of all HIV infections are among people under the age of 30
      3. In terms of geographical areas, the region with the highest rates of persons living with AIDS are in the south (40%), followed by the west (20%), northeast (29%), and midwest (11%) (CDC 2007).
      4. AIDS isn’t a gay disease: over 75% of AIDS cases worldwide are among heterosexuals
      5. Women are four times more likely to contract HIV from their male partner than vice-versa
   C. Modes of Transmission
      1. Blood (sharing unclean needles for steroids, illegal drugs, ear piercing, etc.)
      2. Semen (unprotected vaginal or anal intercourse, oral sex on a man
      3. Vaginal secretions (unprotected vaginal intercourse, oral sex on a woman)
      4. Mother-to-child
      5. Not transmitted through tears, kissing, toilet seats, mosquito bites
   D. Risk Reduction
      1. Discuss how to reduce risks
      2. Abstinence
      3. Safer sex
   E. Importance of honest communication

III. Interactive Activity: Condom Cards (To teach about safer sex)
   A. Distribute condoms cards randomly to members of the audience; each lists a step in putting on a condom:
      1. Lots of hugging, touching, and kissing
      2. Talking about sex
      3. Clothes drop to the floor
      4. Couples becomes aroused
      5. Erection
      6. Condom package is ripped open (slowly, of course, so the condom won’t be ripped)
      7. Pinch the tip of the condom to leave room for what “comes” later
      8. Partner places condom over the tip of the erect penis
      9. Condom rolled down over the penis
     10. Partner smooths out any air bubbles in the condom
     11. Partner puts on lots of water-based lubricant all over the condom
     12. Insert spermicide containing Nonoxynol-9 into vagina or anus
     13. Intercourse
     14. Orgasm
     15. Man holds onto the base of the condom as penis is slowly withdrawn
     16. Throw out the condom
     17. Savor the moments of the afterglow of love
18. Fall asleep

B. Have volunteers from audience line up in to correct order for correctly putting on a condom; other audience members can assist by “editing” the volunteers’ work; demonstrate the steps with penis model as audience members read the cards out loud

C. Discuss: what are some barriers to condom use? how can we overcome them?
   1. Embarrassment
   2. Don’t have a condom
   3. Partner gets offended
   4. Doesn’t feel as good
   5. Ruins the moment
   6. Others?

IV. Conclusion
   A. Emphasize importance of abstinence as only 100% method of protection
   B. Emphasize importance of using condoms with spermicide to reduce risk of HIV infection if the choice is to be sexually active
   C. Talk about HIV antibody testing sites for students
   D. Answer any questions
   E. Distribute evaluation forms
   F. Pass out brochures

Sample Outline #2 for Educational Program

**Topic or Title:** Sexual Assault Prevention for Men

I. Introduction
   A. Each facilitator introduces himself
   B. History and purpose of Men Against Violence
   C. Describe services at your Student Health Center
   D. Set up ground rules
      1. Confidentiality—what’s said in this room stays in this room
      2. Active participation enhances your learning
      3. Please respect each other’s opinions
      4. Informal atmosphere—please ask questions

II. Discussion: Fact or Fiction? (Note that all statements are fiction!)
   A. If she really didn’t want it, she would have fought back harder. (The “You Can’t Thread a Moving Needle” Theory)
   B. When she says “no,” she really means “yes” but is playing hard to get. (The “No Means I Want to be Seduced” Theory)
   C. The majority of women secretly fantasize about being raped. (The “She Really Wanted It” Theory)
   D. Most women who accuse a man of rape are doing it to “get back at him” if he doesn’t call or go out with her. (The Vindictive Woman Theory)
E. It’s highly unlikely that a woman who has had a lot of sex partners could be raped. (The Virgin-Whore Theory)

F. It’s not fair for a woman to sexually tease a man, for example, give him a blow job, and then expect him to stop when it comes to intercourse. (The Blue Balls Theory, or the Point of No Return)

G. Men who rape are generally those who do not have ready access to a steady sexual partner.

III. Legal Definitions of Rape, Aggravated Rape, Forcible Rape, Simple Rape, and Sexual Battery in State of Louisiana.

A. Rape is the act of anal or vaginal sexual intercourse with a male or female person committed without the person's lawful consent. Emission is not necessary and any sexual penetration, vaginal or anal, however slight is sufficient to complete the crime (La. R.S. 14:41).

B. Aggravated rape is rape committed under any one or more of the following circumstances: (1) the victim is overcome by use of force or threat of force or bodily harm; (2) the offender is armed with a dangerous weapon; (3) the victim is under the age of twelve; or (4) two or more offenders participate in the act (La. R.S. 14:42).

C. Forcible rape is rape committed in which the victim is prevented from resisting by force or threats of physical violence under circumstances where the victim reasonably believes that such resistance would not prevent the rape (La. R.S. 14:42.1).

D. Simple rape occurs when a victim who is not the spouse of the offender is incapable of resisting or understanding the nature of the act due to any one or more of the following circumstances: (1) diminished mental capacity produced by an intoxicating, narcotic or anesthetic agent; (2) in a stupor or is unconscious; (3) temporary or permanent unsoundness of mind and the offender knew or should have known about the victim’s incapacity; or (4) false belief that the offender is a spouse, and this belief is intentionally induced by any artifice, pretense or concealment practiced by the offender (La. R.S. 14:43).

E. Sexual battery is the touching of the anus or genitals of the victim by the offender using any object or any body part of the offender, or the touching of the anus or genitals of the offender by the victim using any object or any body part of the victim, where the offender acts without the consent of the victim, or where the victim is not yet 15 years old and at least three years younger than the offender (La. R.S. 14:43.1).

NOTE: These are specific to the State of Louisiana. Peer Educators would need to research their state law and add that information here.

IV. Solutions: How Men Can Prevent Rape

A. No man ever thinks to himself, “I’m a rapist.” It’s not enough to be “against rape.” Take an active stand.

B. Never assume; learn to ask straightforward but respectful questions about intent, sexual boundaries, and desire, e.g., “Do you want to have sex with me now?” Forget about being embarrassed or offensive. If you think you’re ready to have sex, then you should be comfortable dealing with open, honest communication—even if it means you get rejected.

C. Refrain from coercive, pressuring techniques; if she wants to play mind games, too bad for her. You can always find a mature woman who does know her mind. No sex is worth an accusation of sexual assault.

D. Realize that men and women interpret non-verbal signals, dress, and behavior in different ways. Men, in general, tend to interpret cues as signs of sexual interest when women see them as
merely being friendly or flirtatious (e.g., going up to a guy’s room, revealing clothing, etc.).

Take everything except a verbal, audible, and sober “yes” from your partner as a “no.”

E. Don’t use her alcohol consumption or yours as justification for why you ended up having sex. We’re not saying you can’t drink; just realize that you are always responsible for your actions. It’s best to not mix drinking and sexual activity.

F. It’s true; many college women are confused about their sexuality: do they want it or not? But it’s not your job to make the decision for them.

G. Realize that the way men are brought up has a lot to do with how men think about sexual relationships and about women. We understand the pressure you are under to prove your masculinity. Remember that true masculinity arises from being the best that you can be; don’t use women to prove your masculinity.

H. Greek men and student-athletes are not ordinary men; they consciously choose to hold themselves to higher standards. Make sure that you remember the values you chose to follow.

Step 4: Prepare and Practice. There are a variety of formats that a peer education program can take. Peer educator teams can range from two to six individuals, and activities can include interactive games, video viewing, discussion, debate, role playing, and theater presentations. The key to a successful peer education program is selecting a format and style that feels comfortable and natural to you and your co-facilitator(s). In addition, deliberately select co-facilitators who have different strengths and experiences from yours to enhance the effectiveness of your peer education team, as well as increase the likelihood that your audience will relate and respond to you.

Co-facilitators should always meet and discuss who is responsible for content areas, activities, etc. Discuss any possible concerns or potential obstacles with your advisor. Decide what handouts and props you will use, and designate a co-facilitator who will be responsible for picking them up. If possible, visit the location at which you will be giving the workshop to familiarize yourself with the lighting, space, acoustics, microphone, AV equipment, etc., as necessary.

If you require any equipment that is not available, make arrangements with your advisor or the program contact person as soon as possible. You need to know early what you will have available so that you can make adjustments to your program accordingly. With the burgeoning technology available to college students, be sure that your workshop environment will be able to accommodate your audiovisual needs. For example, it probably won’t be feasible to plan a PowerPoint presentation using your laptop computer for a residence hall program, as you will be unable to attain the appropriate data projector.

Remember, preparation is the key to a successful, effective program. Run through the entire program at least twice; don’t just “talk through” the outline. That way, you’ll have a better sense of the flow and timing, and have an opportunity to work out kinks. Audiences can detect if you are unfamiliar with your topic, or if you did not care enough to practice, thus eroding your credibility. The one mistake made most often by peer educators is to assume that they know the material or that “everything will fall into place when we do it.” Don’t just write out the scripts for role plays and skits: actually rehearse them. Similarly, rehearse any new game or activity. If you will be using audiovisual equipment, practice their handling and operation prior to the workshop so you don’t appear incompetent.

Practice speaking in front of a mirror or in front of friends. Look for and minimize distracting facial expressions, unnecessary body movements, or poor posture. Listen for and get rid of monotonic delivery, mumbling, and speech fillers such as “and, uh,” and “you know.” It’s always illuminating to videotape yourself and watch!

Step 5: Reconfirm the Assignment. The day before the workshop, confirm with the contact person once again. At least one day before the workshop, a co-facilitator should pick up the pamphlets, evaluation forms, supplies,
visual aids, videos, equipment, etc. needed for the workshop from your health promotion/health education office.

**Step 6: Set Up.** Arrive a half hour before the workshop to set up the room. Discuss any final glitches that may need to be ironed out. Be sure to pay attention to such things as noise level, lighting, room temperature, and visibility of visual aids.

**Step 7: Evaluate the Workshop.** After the workshop, be sure to distribute and collect evaluations from the audience. Time for this activity should be allocated in your outline. These evaluations are to be submitted to the advisor for reviews. Plan to remain an extra 10–15 minutes to answer questions or to make referrals.

There is no need to be afraid of the evaluation process. This is an opportunity to learn your strengths, as well as receive feedback about areas that you can improve. In addition, evaluations help ensure quality in peer education programs, and are the building blocks for expanding and improving your services.

**Step 8: Debrief with Your Co-Facilitators.** You should never plan anything to take place immediately after your scheduled workshop time. Co-facilitators should always meet for an additional 10–15 minutes immediately after the program to discuss the strengths and challenges during the workshop. An understanding of what worked well, what didn’t work and why, will enhance skills for future workshops. Each facilitator should complete a written evaluation of his or her own performance to be submitted to the advisor. If necessary, schedule an appointment with the advisor to discuss any problems encountered, receive feedback, and incorporate suggestions.

### Questions to Consider

1. Choose a topic, other than alcohol, and determine its predisposing, enabling, and reinforcing factors.
2. Using the eight steps of a successful program, as well as the topic used in question one, create an outline for a successful program.

### References

