

Evaluating Youth Sexual Health Peer Education Programs: *Challenges and Suggestions for Effective Evaluation Practices*

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Abstract

Although peer sexual health education is a common form of sexual health promotion for youth, systematic reviews of these programs are relatively rare. In this study we interviewed youth peer educators to inquire about their experience of program evaluation and their perception of what is needed to develop effective evaluation practices. Data were collected from eighteen participants in semi-structured qualitative interviews of youth (aged 16-28 years) sexual health peer educators in Ontario, Canada. Community-based research principles were employed throughout the project with youth involved in all stages of the research. Analysis of the data revealed four key themes relating to youth sexual health peer education evaluation: i) varied program goals; ii) benefits to peer educators; iii) diverse evaluation methods; and iv) challenges in conducting evaluation. We discuss the relevance of our findings for evaluation practices of peer sexual health education programs.

Keywords: sexual health, peer education, evaluation, youth

1. Introduction

In this paper we report on the findings of a study designed to inquire about the evaluation practices used in youth sexual health peer education programs. Across Canada, and globally, peer education or peer-to-peer programming is frequently employed in sexual health promotion for youth (Adamchak, 2006; Figueroa et al., 2008; Gao, Lu, Shi, Sun, & Cai, 2001; Jones, Myrah, & Tigar, 2004).

Although peer sexual health education is a common form of sexual health promotion for youth, systematic reviews of these programs are relatively rare (Cartagena, Veugelers, Kipp, Magigav, & Laing, 2008; Peñã, et al., 2007). In studies comparing peer-led interventions to non peer-led interventions, or no intervention at all, the results of evaluations have been equivocal. Some studies have found peer education to be effective in promoting sexual health among youth; in other studies the results are less favorable (Harden, Oakley, & Oliver, 2001). The conflicting data on the efficacy of peer youth sexual health education signals a need for more attention to program evaluation. To address this need, we interviewed youth sexual health peer educators involved in community-based organizations. We wanted to know about their experience of program evaluation and their perception of what is needed to develop effective evaluation practices.

Peer education, in the context of youth sexual health education, involves teaching or knowledge exchange of

health information, values and behaviours by individuals of a similar age or social group (Sciacca, 1987). Youth sexual health peer education programmes cover a wide range of topics such as the risk of sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV); safer sex practices and the use of condoms; birth control; violence and healthy relationships, often within an anti-oppression framework (Bluhm, Volik & Morgan 2003; Hampton, Jeffery, Fahlman, & Goertzen, 2005). The aim of many sexual health peer education programs is to help youth make informed decisions while providing them with support and accurate information. However, the knowledge being disseminated by peer-led programs often goes beyond factual information: youth peer leaders may also draw from their personal experiences and provide valuable counsel to youth from the point of view of someone who has experienced similar situations. In general, what constitutes peer education can range from informal conversations with youth to formal referrals to service providers (Bluhm, et al., 2003). Workshops, posters, pamphlets, theater, art and social media are just some of the many methods used by peer educators. The methods of peer education are extensive and constantly expanding (Gange, Kanepaja-Vanaga, & Upenieks, 2003).

Peer education has a number of advantages as a practice for youth sexual health education. Peer educators often share the challenges, interests and experiences of the youth they are trying to reach and can communicate in a youth-friendly style (Stakic, Zielony, Bodiroza, & Kimzeke, 2003). Many youth are more likely to ask questions about sexual health from peers who they perceive as having a better understanding of their situation than authority figures such as teachers or service providers (DiClemente, 1993; Bluhm, et al., 2003). Peer education also has value for the peer educators themselves. Skills in communication and organization, increased knowledge about sexual health and teaching experience are just some of the benefits that can increase peer educators' job opportunities and eligibility for higher education (Gasa, 2007; Adamchak, 2006; National 4-H Council, 1999; Svenson, Burke, & Johnson, 2007).

Peer education also has limitations. Peer educators do not have the same training and experience as professional health educators so their ability to provide quality education may be compromised (Walker, 1999). The assumption that peer educators can affect behavioral change has also been questioned due to concerns about inadequate evidence (West & Michell, 1999). Despite its popularity, data on the effectiveness of peer sexual health education are rare. This may be due to a number of factors: the diverse range of programs unsuited to standard evaluation tools; the difficulty in making comparisons programs that vary in format, and the lack of human resources to implement evaluation protocols (Sriranganathan et al., 2012). The goal of our study was to speak with peer sexual health educators to get a better sense of the current program evaluation practices, to identify the barriers to effective program evaluation and to determine what is needed for improvement.

This research was a partnership between the University of Toronto, York University and two community groups: Planned Parenthood Toronto (PPT) and LetsStopAIDS. Planned Parenthood Toronto (PPT) is an accredited community health centre that offers sexual health clinical services to a clientele composed predominantly of youth aged 13-29. In addition to clinical services, PPT is very active in health promotion, particularly through peer-to-peer education. LetsStopAIDS is a youth-run charitable organization mandated to deliver youth sexual health peer education. The project was initiated by LetsStopAIDS who identified a need for increased capacity to evaluate their peer education programs and contacted potential partners to collaborate on this study.

2. Methods

This study used a community-based research approach that involved youth in all stages of the research. A Community Advisory Board (CAB) of 12 members consisting of peer sexual health education program directors, peer educators and other stakeholders from across Ontario, Canada, was formed to assist with recruitment of study participants, provide input into the development of the research tools and to advise and participate in the interpretation and dissemination of results.

2.1 Participants

Purposive sampling was used to recruit youth sexual health peer educators aged 16-28 from across Ontario to participate in interviews to discuss peer education programs and evaluation. We contacted organizations that deliver a diversity of youth sexual health programs and disseminated recruitment flyers through electronic networks of youth sexual health peer educators. Youth sexual health peer educators were defined as youth who provide sexual health education services to other youth either through the direct delivery of peer education programs or through active participation in program development. Eighteen youth agreed to be interviewed.

2.2 Involvement of Youth Researchers

Three experienced peer sexual health educators were hired as youth researchers and trained to develop literature

reviews on peer sexual health education, conduct interviews with youth peer educators, analyze the interview data using qualitative data analysis software, write abstracts, present at conferences and participate in manuscript development. The youth researchers were recruited from our community partners and their networks. Youth research training sessions were conducted by the research team and a Master's student who provided on-going support and supervision. Three additional youth were also trained in data transcription. Our goal in training youth researchers was to build youth capacity, support meaningful youth participation in research and ensure that the perspective of youth was incorporated into all aspects of the study. Details of the process used to engage youth researchers is described elsewhere (Jaworsky et al., 2009).

2.3 Data Collection and Analysis

The youth researchers conducted 17 semi-structured interviews in person or by telephone. One interview involved two interviewees from the same organization, for a total of 18 interview participants. Telephone consent was obtained from each participant. Participants were asked to describe their work as a peer sexual health educator, provide their definition of sexual health and peer education, reflect on the benefits and challenges of being a peer educator, discuss the value of evaluation for peer educators and peer education programs, and share their experience with evaluation processes.

Interviews were transcribed verbatim by the youth transcribers. Data were coded independently by two members of the research team, and one youth researcher, who worked together to achieve consensus on the codes. Coding was done in NUD*IST QSR N6, a qualitative analysis software program. The research team grouped the codes into themes and subcategories and selected phrases or quotes that illustrated the themes. Validity was enhanced by including experienced youth sexual health peer educators in the data analysis process and checking preliminary results with the Community Advisory Board.

3. Results

Participants ranged in age from 16 to 28 years, with a median age of 24 years. The majority of participants were female (72%), resided in metropolitan Toronto (83%) and identified as Caucasian (67%). Most participants had worked or volunteered as a youth sexual health peer educator for 1-3 years (61%), with a range of 3 weeks to 8 years. Table 1 presents participant demographic characteristics.

Table 1. Demographic characteristics of participants (N=18)

| Characteristic | Number of participants (%) |
|--------------------------------|----------------------------|
| Age (years) | |
| 16-20 | 4 (22.2) |
| 21-24 | 7 (38.9) |
| 25-28 | 7 (38.9) |
| Gender | |
| Female | 13 (72.2) |
| Male | 5 (27.8) |
| Ethnicity | |
| Caucasian | 12 (66.7) |
| Southeast Asian | 2 (11.1) |
| African / Caribbean | 3 (16.7) |
| Not specified | 1 (5.6) |
| Geographic Location | |
| Metropolitan Toronto | 15 (83.3) |
| Northern Ontario | 1 (5.6) |
| Rural Region | 2 (11.1) |
| Time as a Peer Educator | |
| <1 year | 1 (5.6) |
| 1-3 years | 11 (61.1) |
| 4-6 years | 4 (22.2) |
| 7-8 years | 2 (11.1) |

Table 1 describes demographic characteristics of participants. Absolute numbers are listed followed by percentages in parentheses.

Through analysis of the data four key themes were identified that relate to youth sexual health peer education

evaluation: i) varied program goals; ii) benefits to peer educators; iii) methods of evaluation; and iv) challenges in conducting evaluation.

3.1 Varied Program Goals

Participants worked as youth sexual health peer educators in a diverse range of program formats including workshops, mentorship, awareness campaigns, the arts, counselling and longitudinal leadership programs. Within these programs, they identified many different goals or outcomes.

Health promotion was frequently identified as a major focus. Within sexual health promotion, goals included developing healthy sex skills, maintaining overall health, increasing sexually transmitted infection testing, and promoting behavioural change and risk reduction. Connecting youth to sexual health services was also a priority:

[My goals include] linking youth to different services in the community. So informing them of, increasing their knowledge of services that are available in the community...

Another major goal was education and awareness. Youth sexual health peer education programs aimed to increase knowledge, create dialogue, promote an understanding of sexual health in the context of determinants of health, encourage youth to ask questions, and distribute information materials. This participant highlighted the need to provide tangible skills in addition to increasing knowledge:

I think we were certainly increasing youth knowledge about sexual health and sexuality and helping them better understand their bodies and physical issues but also practical skills that they could take away like putting on condoms or whatever.

A third key goal was to change attitudes. This involved promoting sexual empowerment among youth by encouraging them to become critical thinkers about dominant messages about sexuality. Some peer educators used popular culture as a tool to encourage youth to reflect on the ways sexuality is represented and the relevance for safer sex practices:

...and then he put out his hand and...said, "Yeah when was the last time you saw a mainstream Hollywood film shoot a scene where someone is negotiating condom use?" The entire class was like, "Oh my goodness, you are so right..." and it was just amazing to see that transform in a classroom...they were talking about how do we get that, how do we create films that depict healthy relationships and condom use, how do we reframe condom advertising?

Additional goals included getting youth interested and involved in sexual health programs and psychosocial goals with an emphasis on fostering healthy relationships, helping youth improve self esteem and developing longitudinal relationships with peer educators and others involved in the peer education programs. A complete list of sexual health topics identified by participants is included in Table 2.

Table 2. Sexual health topics identified by participants

| | | |
|--|-----------------------------|----------------------------------|
| Sexually transmitted infections (knowledge, prevention, testing) | Self esteem | Healthy relationships |
| Condom use | Positive attitude about sex | Treating people well |
| Sexual orientation | Making informed decisions | Social support networks |
| Birth control | Spirituality | Negotiation within relationships |
| Anatomy | Mental well being | Awareness of services |
| Pregnancy options | Sexual pleasure | |

Table 2 lists the various topics identified by participants when asked to describe what "sexual health" means to them.

3.2 Benefits to Peer Educators

Every participant identified personal benefits of being a peer educator. They gained experience that was valuable for jobs, reference letters, and in some cases, education and career direction:

Having that volunteer experience under your belt is very useful when you are applying to universities and applying to jobs. It built character. It built skills. You make contacts with professionals but also with other peers that have similar interests to yourself.

The peer educators interviewed also acquired transferable skills in communication, counselling, presentation development and delivery, conflict negotiation, facilitation, listening, leadership, and problem solving. Many

claimed that being a peer educator contributed to their personal growth by helping them build confidence, develop a sense of fulfillment and become more open-minded, self-aware and mature. For some, the experience transformed the way they view the world and their social interactions:

...my experiences have totally changed the kind of person I am, the values I have, the way that I approach other people, the way that I approach people that are different than me, the way that I listen when people talk...

As peer educators, participants also gained a strong sense of community as they became part of a social network and met people with similar interests. One participant explained:

I am always learning and things are always changing and always kind of in a state of flux and it is just inspiring meeting other people doing the work and feeling like you are a part of something that is much bigger.

3.3 Methods of Evaluation

Given the diversity within youth sexual health peer education programs, it is not surprising that peer educators described a variety of methods used to evaluate their programs. Many use quantitative methods such as tracking the materials taken by program participants (condoms, brochures, etc), handing out quizzes, looking at changes in numbers of people accessing services, and taking attendance at program events. Qualitative methods such as focus groups, interviews and informal comments from participants were also used. Many peer educators found that mixed quantitative and qualitative methods allowed for the collection of more complete and representative feedback:

You know, combine the qualitative with the quantitative...trying to realize you won't be able to in every setting but doing your best to do so by having these different techniques and trying to include youth wherever possible...

Evaluation was done both formally and informally. Formal evaluation included evaluation forms, structured feedback sessions and awards. Informal feedback included listening to participants' comments, solicited or unsolicited, and was by far the most common form of evaluation. For many peer educators, it was also the most meaningful form of evaluation, as illustrated by this participant:

It will never be captured on a piece of paper and it also won't be captured on my informal conversations with my coordinator because she's often not there for the presentation or for the little experiences after when someone comes up to me after and says, 'You know what? This [is] really [an] important moment...This is the first time I ever learned how I can have an orgasm as a female. Thank you for changing my life.' But there are some important moments...in classrooms or presentations and I wish it would be captured.

Developing more creative, youth-friendly forms of evaluation was considered important for improving the quality of evaluation data and getting valuable feedback:

There [are] a lot of neat arts-based evaluation forms you can use...you can...collect a mural on a huge sheet of paper and people join in and use paints and markers or chalk or whatever and you get people to draw an image that speaks to a moment...they had during the workshop that they felt was particularly relevant.

3.4 Challenges in Conducting Evaluation

Many peer educators found that their organization lacked the capacity to perform evaluation and that no one in the organization was properly trained in evaluation practices:

So I think it was very, um, primitive evaluation measures that we were using and we really didn't understand or have the know how to conduct a formal or proper program evaluation. And I think that is something, you know, a lot of community youth organizations are lacking in..they just don't know, a) how to collect the right information and b) what to do with it.

Participants also found there were limited resources available for program evaluation of youth sexual health peer education. They want surveys and other tools to be available and easy to use. Translating the literature on peer education evaluation into more accessible forms would also make evaluation easier. As one participant proposed:

So kind of break down those barriers so people know how to....take the literature and make it user friendly and person friendly.

Another major evaluation challenge identified was time. Community organizations are often overburdened and do not have enough time to dedicate to program evaluation:

I mean there was never enough time in the day to really think about...what we were doing and the quality of it and...evaluating it right.

For many participants, the challenges in carrying out program evaluation can be attributed to the larger problem of chronically underfunded community organizations:

...it's more of a larger systemic issue related to management of community based organizations and a lack of resources... prioritizing program evaluations...it's not always on the top of the list.

4. Discussion

Research participants identified health promotion, education and awareness, changing attitudes, engaging youth and psychosocial outcomes as the major goals of youth sexual health peer education. The identification of diverse goals is important for two reasons. First, it suggests that a single standardized evaluation method may not be appropriate for the evaluation of all youth sexual health peer education programs. One single method or evaluation format may not adequately measure successes and challenges within the heterogeneity of these programs. For example, if an evaluation form focuses on knowledge acquisition, a program that aims to raise awareness about sexually transmitted infections may appear to have greater efficacy than a program that focuses on healthy relationships. Thus, it is important for program evaluation design to reflect the specific goals of the program and for program evaluation resources to be developed with the flexibility needed to assess a wide range of program outcomes. Better promotion of existing validated evaluation tools, such as those in the instrument bank collected by the Center for AIDS Prevention Studies, may provide organizations with effective evaluation tools and avoid the need to “reinvent the wheel” (Center for AIDS Prevention Studies, 2012).

Secondly, our findings highlight the need for program evaluation to be holistic. Often quantitative evaluations will use pre- and post-test scores to compare levels of knowledge or attitudes before and after a program (Mahat, Scoloveno, Ruales, & Scoloveno, 2006; Morrison et al., 2007; Smith, & DiClemente, 2000). The results of this study suggest that program evaluations would benefit from including measures that go beyond factual information learned to also assess psychosocial outcomes such as improved self-esteem and healthy relationships.

The finding that youth personally gain from their work as sexual health peer educators is relevant for program evaluation. Data on the impact of participation on the peer educators themselves should be included in measuring a program's success. This data could take different forms such as self-reflection by the peer educators or evaluations of peer educators conducted by their program directors or their peers. Administering scales that quantify leadership, confidence and communication skills among peer educators could also be a helpful measure. This is an important outcome of youth sexual health peer education programs as peer educators often become sexual health ambassadors who are known as reputable sources even outside the confines of the “official” program mandates. Additional research could build on work that looks at the impact of being a peer educator on particularly vulnerable youth such as street-involved youth, survivors of sexual assault or youth living with HIV (Flicker, 2008).

The participants of this study identified many different factors they consider to determine if their programs are successful. Interesting quantitative methods they used to measure these factors included tracking the quantity of materials distributed and looking at changes in numbers of people accessing services. Peer educators recognize these outcomes as important measures of success, so further research and consultations are required to support the development and practical utility of these quantitative measures. For example, consultations with funding agencies, peer educators and public health officials would help to determine if these outcomes would be accepted as reliable indicators of success and if they can corroborate other measures. Discussions are also needed to identify measurable outcomes that can be reported to stakeholders including program directors, funding bodies and public health agencies. For example, a partnership with a local community health centre may enable a youth sexual health peer education program to determine how many youth accessed services at the health centre because of information distributed through the peer education program.

This study identified many challenges that restrict the use or utility of program evaluation for youth sexual health peer education programs including lack of time to conduct evaluation and a limited capacity to do so. One suggestion to address these barriers is to develop comprehensive toolkits that community-based organizations could employ in program evaluation activities. These toolkits should be developed with meaningful involvement of youth and written in language accessible to both youth and service providers. Content for these toolkits could include: i) information on the evaluation process, ii) descriptions of qualitative and quantitative methodology, iii) a guide to data analysis, and iv) examples of surveys and open-ended questions that can be used in program evaluation. Suggestions of youth-friendly language for Likert-scale type questions could also be included. For

example, some studies have developed youth-friendly response categories, such as “YES!,” “yes,” “no” and “NO!” to measure participants’ intentions to exhibit certain behaviour or response categories such as “not like me,” “somewhat like me,” and “very much like me” (CyferNet, n.d.).

More resources need to be devoted to enhancing the capacity of youth and service providers to conduct research and program evaluation. Capacity building activities could include mentorship programs where youth or service providers are paired with members from the academic community. This would allow youth and service providers to learn about research and evaluation methodology while allowing academics to learn about youth programs, their evaluation needs and innovative approaches. Community-academic partnerships would also facilitate future research collaborations. Another example of a capacity building activity is program evaluation workshops that bring together youth peer educators and members from different programs and organizations to learn about program evaluation in a supportive environment where partnerships could be developed.

According to our participants, translating research on peer education evaluation into more accessible forms would also be valuable. Taking up their suggestion, we developed a community bulletin on peer sexual health education and evaluation using the background literature, findings and recommendations from this study (Gendering Adolescent AIDS Prevention, 2010). This is just one example of a knowledge dissemination strategy that can make research more user-friendly so that organizations are more likely to benefit from the findings.

5. Conclusion

Despite the many challenges, the peer educators extol the benefits of program evaluation for their personal development and for the improvement of the programs they deliver. Recommendations for youth sexual health peer education program evaluation include: i) evaluating the impact on the peer educators as a part of evaluations; ii) using a mix of qualitative and quantitative methods in program evaluation; and iii) building program evaluation capacity among community organizations through workshops, mentorship, user-friendly resources and time-saving toolkits. These practices may help to build the capacity and the resources to conduct effective evaluations so that the value of peer sexual health education programs can be both assessed and enhanced.

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