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European Youth Health Champions Project

# Report on the use and effectiveness of health peer education for young people in European countries

Elaborated by Royal Society for Public Health



February 2018

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## Introduction

The following report presents the findings of a series of research activities undertaken by the RSPH during May to October 2017 to support the design for the European Youth Health Champions project.

The European Youth Health Champions project is a six-country initiative led by StreetGames in the UK and funded by the European Commission through its Erasmus+ programme. The organisations taking part in this project are

- Aġenzija Żgħażaġħ in Malta
- BG BE ACTIVE in Bulgaria
- Birmingham City Council in the UK
- Mine Vaganti NGO in Italy
- The International Sport and Culture Association (ISCA)
- Vlaams Instituut voor Sportbeheer en Recreatiebeleid vzw in Belgium
- and the RSPH in the UK

The project aims to provide young people that have fewer opportunities across Europe, with open and accessible resources to support their development as peer health educators.

The four specified outputs/results for this project are:

1. New learning resources in youth peer education to promote health enhancing physical activity.
2. A new online learning portal of project resources that is open and accessible for all.
3. Young people with fewer opportunities will have contributed to the design and testing of the new e-learning resources
4. Successful advocacy and dissemination to policy makers and stakeholders in each participating country and Europe-wide level.

To this end, RSPH undertook a series of research activities to identify the existing evidence for, and outcomes of peer education with a particular emphasis on young people. A mix of documentary and primary research was used to achieve wider view.

The objective of this report is to inform the development of the project as a whole by providing the theoretical background, evidence of effectiveness, current good practice and the views of young people around peer education. It is hoped it will influence the plans for an evidence-based training and development package for peer educators, which is up to date, accessible, relevant to its audience, and fit for purpose.

## Executive Summary

The following report presents the findings of a series of research activities undertaken by the RSPH during May to October 2017. The aim was to support the development of the European Youth Health Champions project, a six-country initiative led by StreetGames in the UK and funded by the European Commission through its Erasmus+ programme.

The European Youth Health Champions project aims to provide young people that have fewer opportunities across Europe with open and accessible resources to support their development as peer health educators in their localities.

The research activities included:

- A review of existing literature on the theory and the effectiveness of peer education
- Two focus groups with young peer educators aged between 14 – 25 years exploring their views and preferences around training and development
- A survey with 161 young people from 18 European countries exploring their views around the role and competences of young peer educators
- A compilation of case studies of successful peer education projects across five European countries.

The results of the research show that there is a case for using peer education with young people. This is rooted to the versatility and acceptability of peer education approaches amongst young people. Furthermore, although there is no consensus on the direct impact of peer education on behaviour change and the improvement of health outcomes, there is clear evidence that it increases knowledge and skills of those involved.

The research found that the use of peer educators are:

- a) To be a highly acceptable approach to health education with young people, particularly on sensitive issues such as sexual health, HIV prevention, and domestic violence among others.
- b) To be an effective method for introducing young people to healthier lifestyles in European countries.
- c) That there are a wide range of factors that influence the success of peer education programmes that should be taken into consideration for the project design, including:
  - The use of theory and evidence to ensure a clear understanding of the mechanisms that can drive behaviour change and the intervention expected outcomes.
  - There is already a large number of evidence based and high quality resources available to support the design and evaluation of peer education programmes on a wide range of topics.

- A systematic and sustained approach to delivery of peer education programmes is essential.
- Strategies for recruitment of peer educators should aim to ensure a team that reflects the characteristics and diversity of the target group, the mix of personalities and learning styles.
- The active participation of the target audience, in this case, young people in the design and development of interventions is highly recommended.

Furthermore, on the role, competencies and training of peer educators, the results of the primary and secondary research agreed that:

- Training should have clear goals and structure, but should be flexible and adaptable to different settings and contexts.
- Accreditation of training is appreciated as it provides something tangible to participants
- Trainers and peer educators should be treated as equals through collective ownership of the content of the training and involvement in planning and evaluating.
- Training should take place in youth settings.
- Trainers should be aware of the flexible development of peer educator roles and allow participants to develop at their own pace
- The most popular training methods were practical approaches, shadowing experienced leaders, group work and outdoor activities.
- The most important competencies for a peer educator were seen to be a combination of interpersonal skills and knowledge: communication skills, core health and wellbeing knowledge, specific topic knowledge, presentation skills and leadership.
- That the use of e-learning on peer education is limited but it may be used as part of a wider approach (with physical interaction).

From a young person's perspective, whilst the preferred training method is group based face-to-face sessions; the literature research and the focus groups highlighted that e-learning has potential advantages including wider interactivity, personalisation and using technology to learn at convenience. Recommendations included making it fun, using multiple choice content, enabling meaningful interactivity and feedback, use of quizzes, including a degree of accountability and providing support.

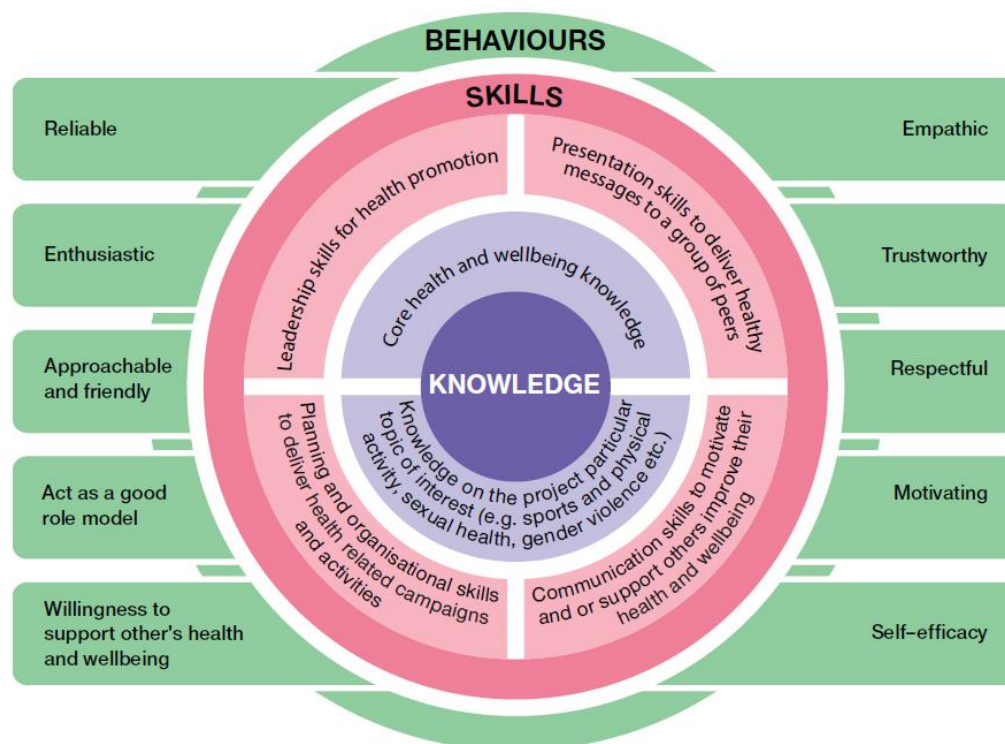
Furthermore, the literature research indicates that the use of e-learning with young people is still not wide-spread and therefore there is no evidence of its effectiveness (or lack of it). The project collaboration sees this gap as an opportunity for trialing this methodology as an innovation to peer education for young people.

The analysis conducted had some limitations. For instance, the literature review did not include an analysis on the impact of the peer education process on the peer educators themselves. Finally, the sixteen case studies utilised a broad definition of a peer educator that did not acknowledge potential distinctions in the terminology of peer educator roles.

Overall, the main output of the research presented in this report is a competencies framework presenting core knowledge, skills and behaviours for the development of young peer educators. It is important to highlight that the perspective of this framework includes the views and preferences of young people, including young peer educators themselves.

## EUROPEAN YOUTH HEALTH CHAMPIONS COMPETENCIES FRAMEWORK

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## Literature background for the project European Youth Health Champions

The objective of this literature review report is to inform the development of the project as a whole by providing the theoretical background, and evidence of effectiveness and current good practice for peer education with young people across Europe.

### *Methodology*

The methodology of this report included identification of relevant academic research; evidence based documents and reports around peer education in general and applied to young people. Academic papers were obtained from Science Direct, and internet search engines were used for other documents and reports. The researchers also used the British Library to access historical research around peer education.

Project partners were asked to provide local case studies of successful peer educator projects and evidence-based documents on the subject, particularly relating to their home countries. Although, the case studies are referenced in this section, they are explored in more detail later in the report.

The project focuses on peer education with young people, though the research team considered it important to review general documents and research and set wide inclusion criteria for the documentation:

- Books and articles with content on theory and conceptual frameworks of peer education as an approach to health promotion.
- Documents or research around the effectiveness of peer education, including systematic reviews, articles, case studies (from partners) and evaluation reports. The initial focus was in the European region, but the lack of high quality systematic reviews for comparison drove the researchers to explore other areas.
- Evaluation reports or research around the effectiveness of e-learning as a training methodology for young people.
- Case studies of successful peer education programmes with young people.
- All documents to be written in the English language.

In total, 25 documents were identified as relevant, however following an initial review, a smaller number of documents (18) were prioritised for use in the report. The criteria were based on their comprehensiveness, up-to-date information, analysis, and robustness of their research design.

The main limitation for the methodology was the lack of access to literature from all six European countries participating in the project due to language barriers. All documents used in this report are written in the English language and most of them are of a European/international nature.



Furthermore, although the focus was on the European experience, a number of documents from different regions and of international relevance were used where appropriate to support findings and fill knowledge gaps.

## What is health peer education?

Peer education as an educational approach has a long and established history. It is possible to trace its use as far back as the first century with Aristotle using young students to support learning activities in the “University” of Athens (Wagner, 1982).

In England, and subsequently in Europe, peer education became embedded in the educational system during the nineteenth century through a teaching method developed independently by two British Educators, Dr Andrew Bell and Joseph Lancaster. The method was called “mutual instruction” or “monitorial system” which involved the use of cross-age teaching, namely an older student teaching a younger student. The method responded to efforts to extend education to disadvantaged populations, particularly for religious purposes (Wagner, 1982).

Within the health realm, peer education appears to have become a popular approach from the 1960s with the influence of social science theories in health promotion, and the success of a student influenza immunization initiative at the University of Nebraska in America in 1957.

Nowadays peer education for health promotion purposes is used to address a variety of health issues with different populations, particularly sexual health in hard to reach populations<sup>1</sup> including the homeless, drug users, people living with HIV, people from sexual minority communities, asylum seekers, refugees and black and ethnic minority communities.

## Definition of peer education

There is no single agreed definition of peer education. The literature review found a range of different academic and non-academic definitions, half of them concern peer education with young people, which seems to confirm peer education as a popular approach for promoting health among young people.

*“It is the process of sharing information among members of a specific community or group of young people to achieve positive outcomes for health and well-being.” (Topping, 2005)*

*“... Young people teaching other young people...” (Clements, 1993)*

*“... An approach whereby a minority of peer representatives from a group or population actively attempt to inform and influence the majority.” (Svenson, 2003)*

*“... An approach which empowers young people to work with other young people, and which draws on the positive strengths of the peer group. By means of appropriate training and support*

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<sup>1</sup> A term used by health services providers and other agencies to describe groups with poor engagement with health and welfare services who are in most need of them.

*the young people become active players in the educational process rather than the passive recipients of a set message.” (Jacquet, 1996)*

*“... a process whereby well trained and motivated young people undertake informal or organised educational activities with their peers (those similar to themselves in age, background or interests).” (United Nations Population Fund and Family Health International, 2005)*

*“The teaching or sharing of information, values and behaviours by members of similar age or status group.” (Sciacca, 1987)*

*“...learning from other peers.” (Curtin University, Western Australian Centre for Health Promotion Research, 2010)*

The research team proposed a definition for the purpose of the project, which builds on a discussion that Jackie Green (2001) makes of Sciacca’s definition of peer education (1987).

*“Peer education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their community. Peer education is the teaching or sharing of health information, values and behaviour in educating others who may share similar social backgrounds, life experiences or interests.” (Green, 2001)<sup>2</sup>*

Key elements of peer education can be drawn from the above definitions:

- The versatility of peer education as an approach, which can be adapted to different backgrounds and topics.
- Peer education seeks to influence behavioural change through an educational process
- The notion of “peer” goes beyond age or sex and extends to community in the widest sense (e.g. faith community, neighbourhood, ethnic group, sexual minority communities, school community etc.)
- Peer education harnesses the already occurring social dynamics in a community (friendships, family bonds, trust, leadership)
- Peer educators require training and support to be able to influence change in their community.

## What is the theory behind peer education?

One of the most used definitions of the concept of theory is to “systematically organise knowledge devised to analyse, predict or explain observable phenomena that could be used as the basis for action” (Van Ryn, 1992).

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<sup>2</sup> Adapted from Green, J. (2001). Peer education. *Promotion and Education*, 8(2), 65-68.  
doi:10.1177/102538230100800203

All successful health promotion and initiatives are based on an understanding of health behaviours and the context in which they occur. Therefore, interventions to improve health behaviour can be best designed with the aid of relevant behavioural theories (Changeology, , n.d.).

In line with the variety of definitions, the literature highlights that peer education as an approach to health promotion is used in a wide range of modalities. There isn't a single theory or conceptual framework that can provide an overall systematic approach to peer education. Often peer education interventions seem to use a combination of theories or conceptual frameworks in an attempt to address the complexity of the issues they are intending to solve.

The literature indicates that in health promotion some of the most used behavioural theories in peer education are the Health Belief Model; Social Learning Theory; Diffusion of Innovations Theory and the Social Ecological Model, as described below:

### *The Health Belief Model*

Developed in the 1950s by social physiologist Godfrey Hochbaum, this model proposes that if individuals are made aware of their susceptibility to an issue, in this case a health issue, and its possible serious consequences, they will be open to consider taking actions that will reduce or eliminate their susceptibility. The caveat is that the individual needs to recognise that the benefits of taking action will outweigh the costs or barriers in order to change behaviour (Liza Cragg, 2013).

In the context of peer education, this theory provides a framework for initiatives where individuals from a community are trained to raise awareness of particular health issues and to offer information and referrals to health services to help the individual prevent or reduce the impact of the problem. A project with clear roots in this theory is **Peer Education Project for the Prevention of HIV Infection** in Italy, which trained and supported peer educators to run awareness sessions around sexual health with emphasis on risk behaviours linked to sexually transmitted diseases such as HIV.

### *Social Learning Theory*

Created by psychologist Albert Bandura during the decades of 1970's and 1980's, this theory is one of the most widely applied theories in health promotion. The theory explores how behaviours are the result of the interaction between the individual and their environment (Liza Cragg, 2013). It proposes that people learn behaviours both by direct experience and indirectly by observing others (United Nations Population Fund and Family Health International, 2005).

This theory applied to peer education can be used to design initiatives where a selected group of peers are expected to act as role models and influence beliefs and behaviours in the community by means of systematic processes that usually involve goal-setting and self-monitoring. An example of a peer education initiative with clear links to this theory is **Start 2** in Belgium, a project that provides support for young people who had not been able to find or retain a suitable job or training, by participating in the Start 2 six-month programme. The programme involves peer education sessions, mental coaching, personal target-setting and readiness for intake interviews.

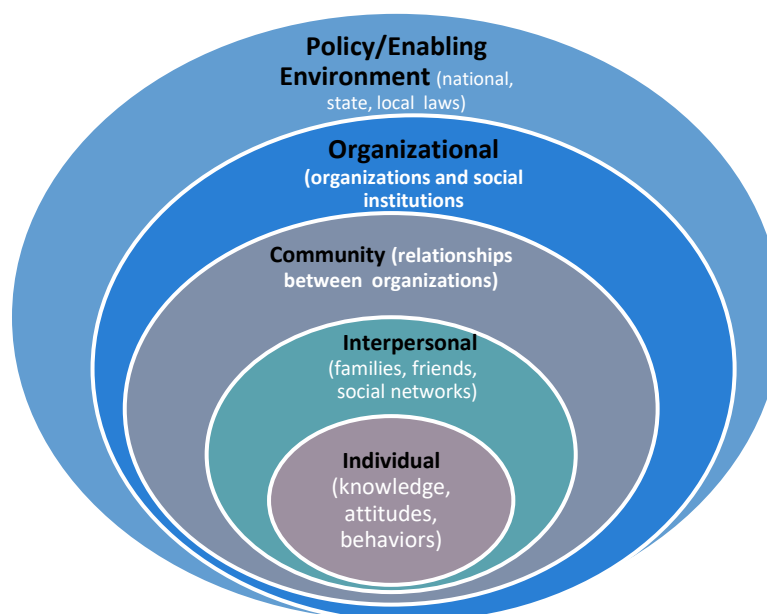
### *Diffusion of Innovations Theory*

Originally designed to explain how new ideas and technology spread, this theory proposes that social groups have “opinion leaders” or “early adopters” of innovations who have the ability to influence group norms and behavioural change by disseminating information (Rogers, 2003). In peer education, this theory provides a framework for initiatives where peers are selected by their ability to influence others to introduce new information and behaviours. An example of an initiative with links to this theory is **Us Girls Alive** in the UK, a project in which a selected group of young women support and encourage other young women in their community to try new physical activities with a view to improving their health and wellbeing.

### *Social Ecological Models*

Formally introduced as conceptual framework in 1970's, the Social Ecological Model draws attention to the multiple levels of influence that shape the development of a person, such as individual, interpersonal, community, organisational, and public policy. It also explores the idea that behaviours are shaped by interactions between the individual and the environment. The model proposes that it is not just about changing individual behaviours but also about influencing the external factors that foster those behaviours (Changeology, , n.d.).

In health promotion, this model helps to support initiatives that use peer education which tackle personal and interpersonal determinants, and seeks to influence the community and possibly social institutions and public policy.



Source: Centers for Disease Control and Prevention (CDC), The Social Ecological Model: A Framework for Prevention, <http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>

An example of an initiative with links to the Social Ecological Model, the ***Malta Girl Guides – Stop the Violence: Voices against Violence*** where peer leaders were supported to launch a national campaign to raise awareness of domestic violence. This resulted in changes in public opinion, and legislative proposals, some of which have influenced government decisions.

## Effectiveness of peer education

The research team selected three robust systematic reviews carried out between 2009 and 2017 to assess the effectiveness of peer education. Although the focus of this document is the European experience with young people, the research team also presents a systematic review of peer education interventions in Developing Countries and another in the United States due to their particularly robust methodology and large-scale studies.

Two of the systematic reviews are on projects or interventions related to sexual health and HIV prevention, and the other examines health and wellbeing.

### *Effectiveness of Peer Education Interventions for HIV Prevention in Developing Countries (Amy Medley, 2009)*

This systematic review is based on thirty studies published between January 1990 and November 2006. The aim was to establish whether peer education interventions were associated with increases in HIV knowledge.

The target population of these interventions included youth (n=8), commercial sex workers (n=12), injection drug users (n=4), transport workers (n=3), heterosexual adults (n=6), prisoners (n=2) and miners (n1)

The meta-analysis and systematic review indicates there is evidence that peer education interventions are significantly associated with increased HIV knowledge, reduced equipment sharing among injection drug users, STI infection and increased condom use. However, whilst the interventions consistently yielded small increases in knowledge, behaviour change was less consistent.

The analysis suggests peer education programs in developing countries are ‘moderately’ effective at improving behavioural outcomes, but not biological outcomes. It is also noted that peer education can be an effective strategy for changing behaviour among hard to reach populations including commercial sex workers.

There is further research needed to determine the factors that maximize the likelihood of success. The articles reported low amounts of information on how the educators were trained, placed and recruited. Compensation (e.g. for travel) showed positive results in retaining educators, though overall retention was low. In sum, peer education interventions were associated with increases in knowledge and behaviour, and these were encouraging. While statistically significant, the effect sizes were moderate.

### *A Systemic Review of Peer-Supported Interventions for Health Promotion and Disease Prevention in the US (Rajeew Ramchand, 2017)*

The authors conducted a systematic review of 116 randomized control trials (RCTs) of peer interventions to promote health and wellness. Their main question was ‘how and to what effect are peer interventions currently being used?’ 45% of studies were conducted among adult populations, 25% focused on women and 24% were on adolescents.

Beneficial effects on mental health were observed in 22 instances; beneficial physical effects were observed in 28 cases.

There are more null than positive effects across peer interventions, with some exceptions: group-based interventions that use peers as educators or group facilitators commonly improve knowledge, attitudes, beliefs, and perceptions. The cases observed concerned the management of chronic diseases, preventing eating disorders and weight loss.

Dyadic peer support reported beneficial effects, most frequently regarding behaviour change. Positive effects were reported with peers as ‘buddies’, promoting diet, sleep therapies and smoking cessation.

In general, the studies that were analysed reported that peer educators also improved social health/connectedness and engagement.

The study concludes that the surge of peer education programs in the US indicates that health promotion practitioners consider peer education approaches as an effective tool to reach their target audiences and achieve better health outcomes. The study proposes that there is some evidence of the effectiveness of peer education based on peer led group facilitation. However, in general there are more null than positive effects across all the RCTs included in the study.

### *Effectiveness of Peer Education Interventions for HIV Prevention, Adolescent Pregnancy Prevention and Sexual Health Promotion of Young People: A Systematic Review of European Studies (Tolli, 2012)*

This systematic review included studies of five peer education interventions in the European Union that were published between 1999 and 2010. The objective was to determine the effectiveness of peer education programmes for human immunodeficiency virus (HIV) prevention, adolescent pregnancy prevention and promotion of sexual health among young people.

The interventions examined by the study were carried out in secondary schools in Italy, Germany, United Kingdom and Greece and the participants were students of both sexes aged between 12 and 20 years old.

Of the five interventions considered, two studies consisted of cluster-randomised trials with comparison arm and three evaluations used a quasi-experimental design with a control group.

The results of the review indicate that only one study demonstrated evidence of improvement in knowledge about HIV and another on changes in attitudes related to sexual behaviour. One study found some evidence of a positive trend on knowledge of sexual health services and communication skills.

In one study, the percentage of students who started having sexual intercourse during the intervention was higher in the intervention group. The researchers do not mention whether this may have been associated with increased knowledge and change in attitudes related to sexual behaviour.

The study did not identify significant impacts around contraception use, unintended pregnancy, and number of sexual partners or behavioural intentions.

The review concluded that overall, when compared to standard practice or no intervention; there is no clear evidence of the effectiveness of peer education concerning HIV prevention, adolescent pregnancy prevention and sexual health promotion for young people. However, further research is needed to determine factors that contributed (or did not) to the programme effectiveness.

The researchers propose that the benefits of peer education are not as evident as the popularity of the method suggests and that the mixed results could be due to implementation issues. For example, they mention that they do not uniformly follow the European guidelines for youth AIDS peer education in the methods for the recruitment of peer educators or ensure their involvement in the design and direction of the interventions. The studies did not provide enough information to assess whether training and supervision approaches of these interventions adhered to the guidelines with only one study describing the type of training and another one reporting that peer educators were supervised.

### *Training for young peer educators*

From a training and development perspective, typically peer education programmes with young people have two aim routes:

- a) To facilitate the access to services and information around health and wellbeing. Using this approach, peer educator development is the means of bridging health improvement initiatives with a wider group of young people. The training of the peer educators is focused on equipping them to deliver information. This approach appears to be more appropriate and effective in school-based projects where a process of selection and/or self-selection tends to attract reasonably academic students who are comfortable with working within a structure plan according to the traditional methods that are acceptable or viable in school settings.
- b) To develop peer educators. These types of programme hold the view it is the educators rather than the educated who benefit most from peer interventions (Resnik and Gibbs, 1988, Dorn and Murji, 1992) and a great deal of the implementation work is directed towards training, guidance and support of peer educators. These programmes are usually implemented in youth and community settings where it targets marginalised young people with less academic or professional orientation.

Training as a key element for the success of a peer education programme is highlighted throughout the literature compiled. Although there is little information about the actual content of training for peer

educators in Europe, different methods of training delivery are often proposed. The primary model appears to utilize face to face training with interactive strategies such as small group presentations, role plays, or games. The use of coaching and tutoring is also a recurrent suggestion.

The European Guidelines for Youth AIDs Peer Education also highlights that after an initial training programme, the peer educators continue their learning experience and need continuous support and assistance in developing activities and delivering them. They recommend the use of small supervision groups facilitated by professionals (teachers, youth workers, older peers) to be set up to meet on a regular basis. Other forms of assistance can be made available, such as supplementary training, use of localities and local sponsorship (Svenson, 2003).

In terms of knowledge and skills that are to be acquired through training by peer educators, the literature suggests that these will depend on the project topic, model and action plan (Svenson, 2003). For example, the literature search found a number of manuals and guidelines to support the development of peer education skills around sexual health and HIV prevention (some of them are mentioned in the section on existing resources for peer education with young people). However, communication skills, presentation skills and topic-based knowledge are often mentioned as core regardless of the topic or format of the intervention.

### *E-learning as a method of training delivery*

As one of the proposed outputs of the overall project is an e-learning<sup>3</sup> training programme for young peer educators, the research team searched for evidence to support the effectiveness of e-learning as a methodology for the delivery of training with young peer educators.

Unfortunately, the research team was not able to find such evidence, and only one example of peer education programme that uses e-learning as part of their training strategy was found (Girlguiding UK).

In general, the lack of literature seems to indicate that e-learning is not an approach widely used in the context of peer education with young people. However, some of the literature suggests that “informal e-learning” often takes place to aid education processes for young people in educational settings such as schools and universities (UK Department for Education, 2003).

A consultation about the evidence of the effectiveness of e-learning in the post-16 sector<sup>4</sup> undertaken by the University of Sussex in the UK (Benedict du Boulay, 2008), proposed that the key factors that contribute to the effectiveness of e-learning are:

- Physical Accessibility, can the person get to an appropriate device and access to internet?
- Social Accessibility, linked to social and cultural context, even if there is a computer available does the person feel comfortable, and have the training, to use it?

<sup>3</sup> The Learning and Skills Council (LSC) defines e-Learning as learning with the aid of information and communications technology tools. These may include the Internet, intranets, computer-based technology, or interactive television. They may also include the use of e-technology to support traditional methods of learning, for example using electronic whiteboards or video conferencing.

<sup>4</sup> The researchers refer to organisations that provide education to undergraduates in higher education, medical students and medical practitioners and work-based Learning



- Accessibility linked to HCI<sup>5</sup> design issues, when the person has a computer and is willing to use it, but the software is not suitable for the purpose.
- Assessment that supports student learning and participation, for example activity-based.
- Social presence, particularly where the educational process involves participants learning completely independently, for example a distance learning course.
  - The ability to define social relationships with reference to the environmental context, divorced from pre-existing relationships.
  - The presence of a virtual tutor mediated by: verbal written information; written information and various personal views; written and spoken information; text; views and spoken language.
  - The sense of being together created by the use of telecommunications systems
  - The disappearance of the computer interface in an interaction.
- Personalisation, the tailoring of the learning facilities to meet individual needs and current activity.
- Willingness to engage with e-learning, rather than being required to use it.

Based on the finding of this consultation, it can be concluded that the design of an e-learning programme must be based on the understanding of target audience needs in terms of accessibility and acceptability of an e-learning platform. Furthermore, it must be accompanied with mechanisms to foster motivation, social interaction and communication, and practical learning.

### *Existing resources around peer education*

There is a wealth of evidence-based resources for groups and organisations wishing to design and deliver peer education programmes. These resources usually provide advice on planning of peer education programmes, selection of managers/coordinators, train the trainer programmes, training methodologies, recruitment of peer educators, safeguarding, and evaluation, among others.

The most comprehensive and complete resources found by this literature review are:

- **Youth Peer Education Toolkit (2006).** This is a group of resources designed to help develop and maintain effective peer education programs. The five parts of the toolkit are based on research and evidence from the field as well as local examples and experiences. They are designed to be adapted locally as needed. The toolkit resulted from collaboration between the United Nations Population Fund (UNFPA), Family Health International and Youth Peer Education Network (Y-PEER), (United Nations Population Fund and Family Health International, 2005).
- **HIV Prevention Among Young People: Life Skills Training Kit, Volume 1.** Developed by United Nations, Economic and Social Commission for Asia and the Pacific, this training kit is a comprehensive guide for coordinators of peer education programmes in the context of HIV/AIDS prevention. The package includes guidance on peer education and life skills; content

<sup>5</sup> HCI (human-computer interaction) is the study of how people interact with computers and to what extent computers are or are not developed for successful interaction with human beings.

<http://searchsoftwarequality.techtarget.com/definition/HCI-human-computer-interaction>

on sexual health and HIV/AIDS; content on substance use and HIV/AIDS; skills building training for peer educators; CD-ROM on street theatre training techniques and a user guide (United Nations, Economic and Social Commission for Asia and the Pacific, 2006).

- **My-PEER Toolkit.** Developed by the Western Australian Centre for Health Promotion Research at Curtin University in Perth, Western Australia, this toolkit is an evidence-based resource aimed at supporting agencies in the implementation and evaluation of peer-based programs for young people (Curtin University, Western Australian Centre for Health Promotion Research, 2010).
- **Included, involved, inspired, a framework for good practice for an effective IPPF peer education programme.** Developed by the International Planned Parenthood Federation, this framework is a guide that can be used by programme designers, managers and coordinators, as well as by senior managers overseeing larger peer education initiatives. (International Planned Parenthood Federation (IPPF), 2007)
- **Approaches to Peer-led Health Education: A Guide for Youth Workers Paperback (1993).** This guide is intended to help youth and community workers to examine the use of peer-led education for health promotion. It provides a series of training exercises for youth-work teams and contains practical ideas for raising health issues with young people (Clements, I. and Buczkiewicz, M, 1993).
- **European guidelines for youth AIDS peer education (1998).** This is an evidence-based resource for the design and implementation of peer education programmes with emphasis on AIDs prevention. However, the guidelines are transferable to other subjects (Svenson, 2003).

Hyperlinks to these resources are provided in Annex 1.

### *Discussion from literature review*

Peer education is a popular approach to promote health with young people due to its versatility and effectiveness in engaging with the target audience.

Although clear links or roots to theories can be identified in the design of peer education initiatives, most of the literature around peer education projects provided in this report (and in general) does not offer explicit details on the theories that have been used to support the design of such initiatives. This may indicate an indirect influence of theories through well-established health promotion approaches/practical tools or perhaps inadvertent omissions.

Social behavioural theory is a strong influence in the development of peer education interventions through current well-established health promotion approaches. However, careful consideration of theory should still be given in the design of each intervention to ensure a clear understanding of the mechanisms that can drive behaviour change and the intervention expected outcomes.

Overall, the evidence presented by the reviews used in this report show mixed results in terms of the effectiveness of peer education. Whilst the review that studied interventions in development countries found evidence of positive health knowledge and behaviours, the reviews of interventions in the US and Europe did not find clear evidence of effectiveness on health outcomes for the population target. However, all three reviews seem to agree that there is evidence of effectiveness concerning an increase

in health knowledge and skills. Further research is needed to explore all aspects of peer education interventions in detail and what drives behaviour change in this context.

There are a vast number of evidence based and high quality resources to support the design and evaluation of peer education programmes, a list of examples of these can be found in Annex 1. The European Guidelines for Youth AIDs Peer Education are particular relevant for any European peer education programme, most of the guidance is transferable to topics other than HIV/AIDS prevention. Nevertheless, the research found there is a gap in competencies-based content for core training of peer educators, which is an opportunity for this project.

None of the reviews explored the benefits and effects of the peer education experience to the peer educator themselves, for example in increasing knowledge and skills, job acquisition and retention, behavioural change and empowerment. This is another gap in knowledge.

The literature suggests that the use of e-learning for training peer educators is limited, and therefore its effectiveness could not be established. However, the research yielded some empirical evidence from a consultation with education experts, which proposes a number of key factors to consider in the design of effective e-learning, which this project could take into consideration.

## Competences of young peer educators from young people perspectives

As part of the research strategy for the European Youth Health Champions Project, the RSPH led on the delivery of a survey exploring the skills, knowledge and behaviours of young peer educators. The idea was to consult with a large number of young people the proposed competencies framework and their preferred training methods, to ensure their opinions inform the design of the project output: training and development package for young peer educators.

The proposed competencies framework was based on the literature research and information provided by partner's organisations through case studies about successful peer educator programmes in their countries, and other complementary information such as reports, role descriptions, training curriculums.

The survey targeted young people between the ages of 14 and 25 years old across five European countries: Belgium, Bulgaria, Italy, Malta and the United Kingdom (UK). However, thanks to wider connections of a partner organisation it had some responses from other European countries.

### Methodology

The main body of the survey was designed to ask two types of questions for each of proposed knowledge, skills and behaviours:

- The importance of the particular knowledge, skill or behaviour
- The preferred training method to gain the particular knowledge or skills.

Fig 1- Proposed competencies framework for peer educators

Knowledge	Skills	Behaviours
<ul style="list-style-type: none"> <li>•Core health and wellbeing knowledge</li> <li>•Knowledge on the project particular topic of interest (e.g. sports and physical activity, sexual health, gender violence etc.)</li> </ul>	<ul style="list-style-type: none"> <li>•Research skills to find and access health services and information</li> <li>•Presentation skills to deliver healthy messages to a group of peers</li> <li>•Skills on the use social media and digital technology for peer health education purposes</li> <li>•Communication skills to motivate and or support others improve their health and wellbeing</li> <li>•Problem solving skills to address practical issues</li> <li>•Planning and organisational skills to deliver health related campaigns and activities</li> <li>•Leadership skills for health promotion</li> <li>•Skills on how to provide health and wellbeing advice (coaching skills)</li> </ul>	<ul style="list-style-type: none"> <li>•Reliable</li> <li>•Enthusiastic</li> <li>•Approachable and friendly</li> <li>•Interest in health (or a particular health related topic)</li> <li>•Act as a good role model</li> <li>•Willingness to learn new skills</li> <li>•Be a good team player</li> <li>•Willingness to support other's health and wellbeing</li> <li>•Empathy</li> </ul>

The answers were delimited to the use of ratings on 6-point Likert scales and preferences ranking scales. This was in order to facilitate response analysis from a varied group of individuals using a variety of languages.

The RSPH research team piloted the questionnaire internally with four young members of staff (ages between 23 and 29 years old). The survey was then sent to partner organisations for comments or suggestions.

To ensure the widest possible reach, partner organisations were asked to translate the questionnaire from English into their local language with exception of the UK based organisations and ISCA, an international organisation which communicates with partners and stakeholders in English language.

The survey was translated to Bulgarian, Dutch, Italian and Maltese by

- Piet Van der Sypt and Marjolein van Poppel at Vlaams Instituut voor Sportbeheer en Recreatiebeleid vzw, from Belgium, translated to Dutch.
- Bilyana Mileva at BG BE ACTIVE, from Bulgaria, translated to Bulgarian.
- Gabi Calleja at Aġenzija Żgħażaġh, from Malta, translated to Maltese.
- Paolo Menescardi at Mine Vaganti NGO, from Italy, translated to Italian.

Each translation of the questionnaire was separately sent in SurveyMonkey, an online tool for creating, delivering surveys and gathering responses. A unique web link for each questionnaire was provided to partners for dissemination. The reach of survey is as follows:

- In Belgium, Vlaams Instituut voor Sportbeheer en Recreatiebeleid vzw disseminated the survey through five local youth coordinators across Flemish cities. The local coordinators reported to have distributed the survey with 130 young volunteers between the ages of 16 to 25 years of age.
- In Bulgaria, BG BE ACTIVE disseminated the survey via newsletter to 10 European partner organisations, which were encouraged to distribute the survey amongst their young people. BG BE ACTIVE also promoted the survey through their Facebook page.
- In Italy, Mine Vaganti NGO sent the survey to their database of approximately 100 young people. Around three quarters of the group are between the ages of 12 to 25 years old and the rest are over 25 years old.
- In Malta, Aġenzija Żgħażaġh sent the survey to their European Youth Card Holders subscribers, which is a database of around 10,000 young people between the ages of 13 and 30 years of age. It was also sent via newsletter to a database of 140 youth organisations registered with Aġenzija Żgħażaġh.
- International organisation ISCA, sent the survey via newsletter to 2600 recipients of a varied age range. They promoted survey through their Twitter account, which has 2200 followers, LinkedIn, which has 1670 followers, and Facebook, which has 4300 followers. They also paid for an advert, which reached 8232 individuals Europeans through Facebook.

- In the UK, RSPH sent it to a database of approximately 500 young people between the ages of 14 to 25 years of age. StreetGames distributed it to 186 young people between the ages of 16 to 25 years of age in England and Wales.

In total, the survey was open from 03 August 2017 until 30 October 2017. Dates for dissemination and promotion per country were varied; however, partners were advised to promote the survey actively for two weeks.

The responses to the survey were downloaded separately per language and then combined into a central database in Excel. The RSPH research team recoded some of the data that had been logged by SurveyMonkey, both in text and numerical, into a consistent format. Percentages and averages were then calculated and displayed in graphs using Excel.

### *Methodological issues*

Although the survey was disseminated widely, the uptake was relatively low. This could be due mainly to “bad timing” as the survey was promoted during the summer holidays and early 2017-2018 academic year in Europe. Many of the organisations and individuals who were asked to complete or disseminate the survey may have been taking a break and therefore may not have seen the communication.

It is also possible that in September, a good proportion of young people who were asked to complete the survey were busy with the transition back to education. The survey that had the highest completion rate was the one circulated in Belgium, which was circulated in late October when many young people would have settled in their new routines.

Another issue could have been that in some countries, partners had limited access to communication with young people and had to rely on third party organisations to disseminate and encourage participation of the survey.

Finally, there was a couple of technical problem with the link to the survey in Maltese, although the issues were resolved and Agenzija Zghazagh circulated the survey again, it is likely that may have affected the response rate.

### *Results*

One hundred and sixty-two responses were received from 18 countries, but the majority were from Belgium (42.59%), the UK (31.18%), Bulgaria (26.88%), and Italy (15.05%) (Table 1.). However, over half of the respondents (58%) failed to complete the whole questionnaire, so later responses are based on a diminishing sample (see Tables 1-3).

Table 1- Responses by country

Country	N	%	Did not complete	
			N	%
Belgium	69	42.6%	44	45.8%
United Kingdom	29	17.9%	13	13.5%
Bulgaria	25	15.4%	17	17.7%
Italy	14	8.6%	3	3.1%
Malta	8	4.9%	4	4.2%
Romania	3	1.9%	3	3.1%
Denmark	2	1.2%	1	1.0%
Germany	2	1.2%	1	1.0%
Austria	1	0.6%	1	1.0%
Belgium	1	0.6%	1	1.0%
Cyprus	1	0.6%	1	1.0%
Estonia	1	0.6%	1	1.0%
France	1	0.6%	1	1.0%
Greece	1	0.6%	1	1.0%
Hungary	1	0.6%	1	1.0%
Ireland	1	0.6%	1	1.0%
Portugal	1	0.6%	1	1.0%
Slovakia	1	0.6%	1	1.0%
<b>Total</b>	<b>162</b>	<b>100.0%</b>	<b>96</b>	<b>100.0%</b>

The majority of the respondents were in the 18 to 21 years of age group, representing 47% of the total, followed by the 14 to 17 years old with 20%; then the 23 to 25 years of old with 17% and the over 25 years old with 16% (Table 2).

Table 2. Age of respondents

Age range	N	%	Did not complete	
			N	%
14 – 17 years	33	20%	24	29%
18 – 21 years	75	47%	46	56%
22 – 25 years	28	17%	1	1%
over 25 years	25	16%	11	13%
Total	161	100%	82	100%

Respondents were asked about their relationship with peer education, whether:

- They were themselves a peer educator (of any subject)
- They are training to be one
- They are a friend of a peer educator or knew one
- They had no contact with peer education (none of the above)

The largest proportion of respondents were peer educators (54%) whilst a quarter of respondents reported not to have contact with peer education (25%). The remaining fifth were either training to be a peer educator, were friends with a peer educator or knew one (Table 3).

Table 3- Relationship with peer education

Relationship with peer education	N	%	Did not complete	
			N	%
Not peer educator, in training, friend or knows a peer educator	41	25%	21	22%
A peer educator (of any subject)	87	54%	52	55%
A friend of a peer educator	12	7%	7	7%
Training to be a peer educator	11	7%	8	8%
A person who knows a peer educator	10	6%	7	7%
Total	161	100%	95	100%



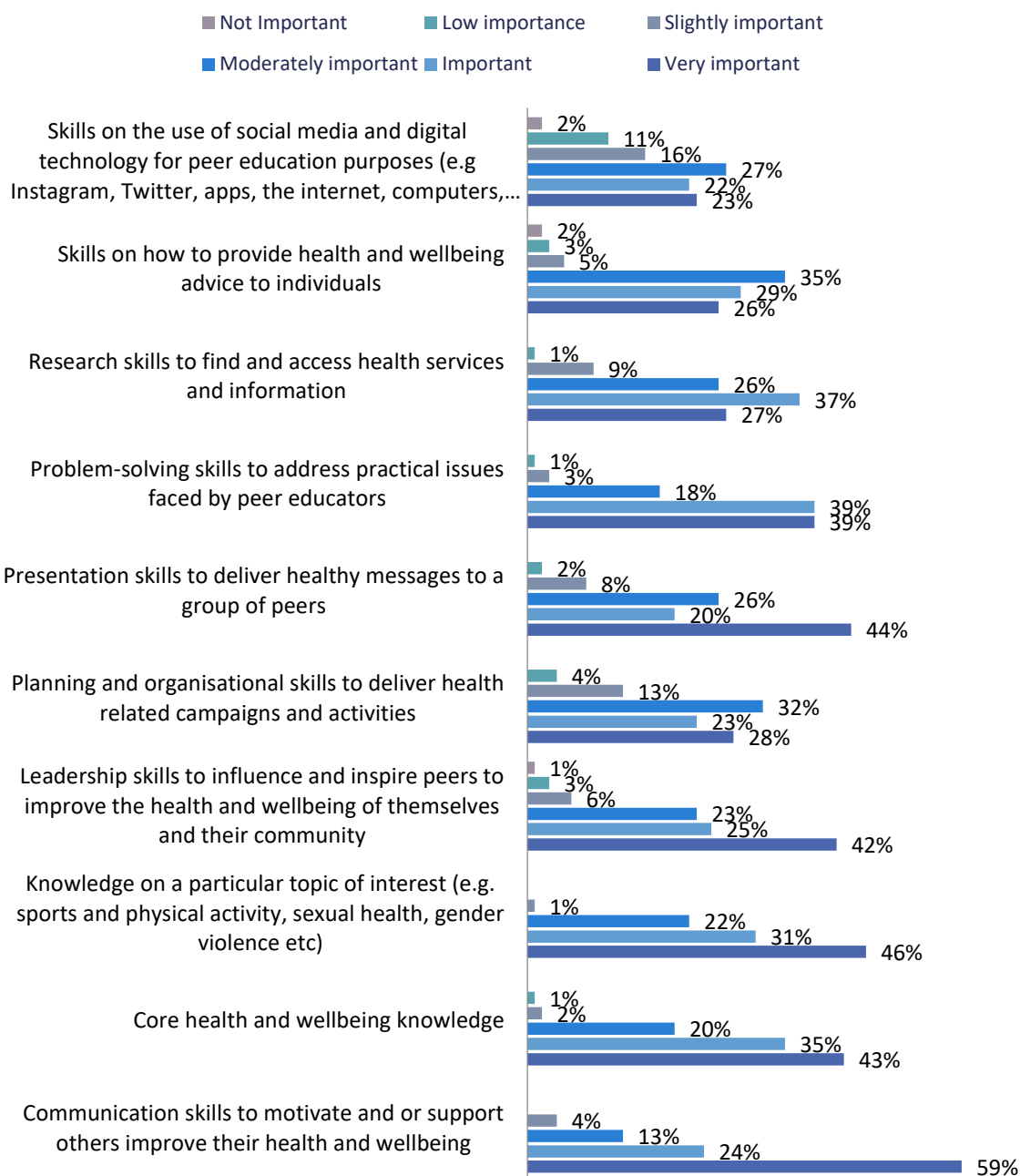
Respondents were then asked a series of questions about the importance of young peer health educators having certain knowledge and skills. Using a 6-point Likert scale, respondents were asked to rate from 0-5, where zero was 'not important' and five was 'very important'. The labels for important (4), moderately important (3), slightly important (2) and low importance (1) were added retrospectively.

The results presented in Table 4 and Fig. 1. All the suggested knowledge and skills areas are considered important to some degree, but the top five competencies areas considered very important were communication skills (59%), knowledge on a particular topic of interest (46%), presentation skills (44%), leadership skills (42%) and problem solving skills (39%).

**Table 4. Importance of young peer health educators having certain knowledge and skills**

Row Labels	Very important	Important	Moderately important	Slightly important	Low importance	Not Important
Communication skills to motivate and or support others improve their health and wellbeing	59%	24%	13%	4%	-	-
Core health and wellbeing knowledge	43%	35%	20%	2%	1%	-
Knowledge on a particular topic of interest (e.g. sports and physical activity, sexual health, gender violence etc.)	46%	31%	22%	1%	-	-
Leadership skills to influence and inspire peers to improve the health and wellbeing of themselves and their community	42%	25%	23%	6%	3%	1%
Planning and organisational skills to deliver health related campaigns and activities	28%	23%	32%	13%	4%	-
Presentation skills to deliver healthy messages to a group of peers	44%	20%	26%	8%	2%	-
Problem-solving skills to address practical issues faced by peer educators	39%	39%	18%	3%	1%	-
Research skills to find and access health services and information	27%	37%	26%	9%	1%	-
Skills on how to provide health and wellbeing advice to individuals	26%	29%	35%	5%	3%	2%
Skills on the use of social media and digital technology for peer education purposes (e.g. Instagram, Twitter, apps, the internet, computers, tablets)	23%	22%	27%	16%	11%	2%

**Fig. 2. Importance of young peer health educators having certain knowledge and skills**



For each of these items, respondents were asked what they thought was the best way for a young peer health educator to gain the knowledge or skills. They were asked to organise the five training preferences in order of suitability using a numeric scale, the first being most suitable and the last being the least suitable (Table 5 & Fig. 2).

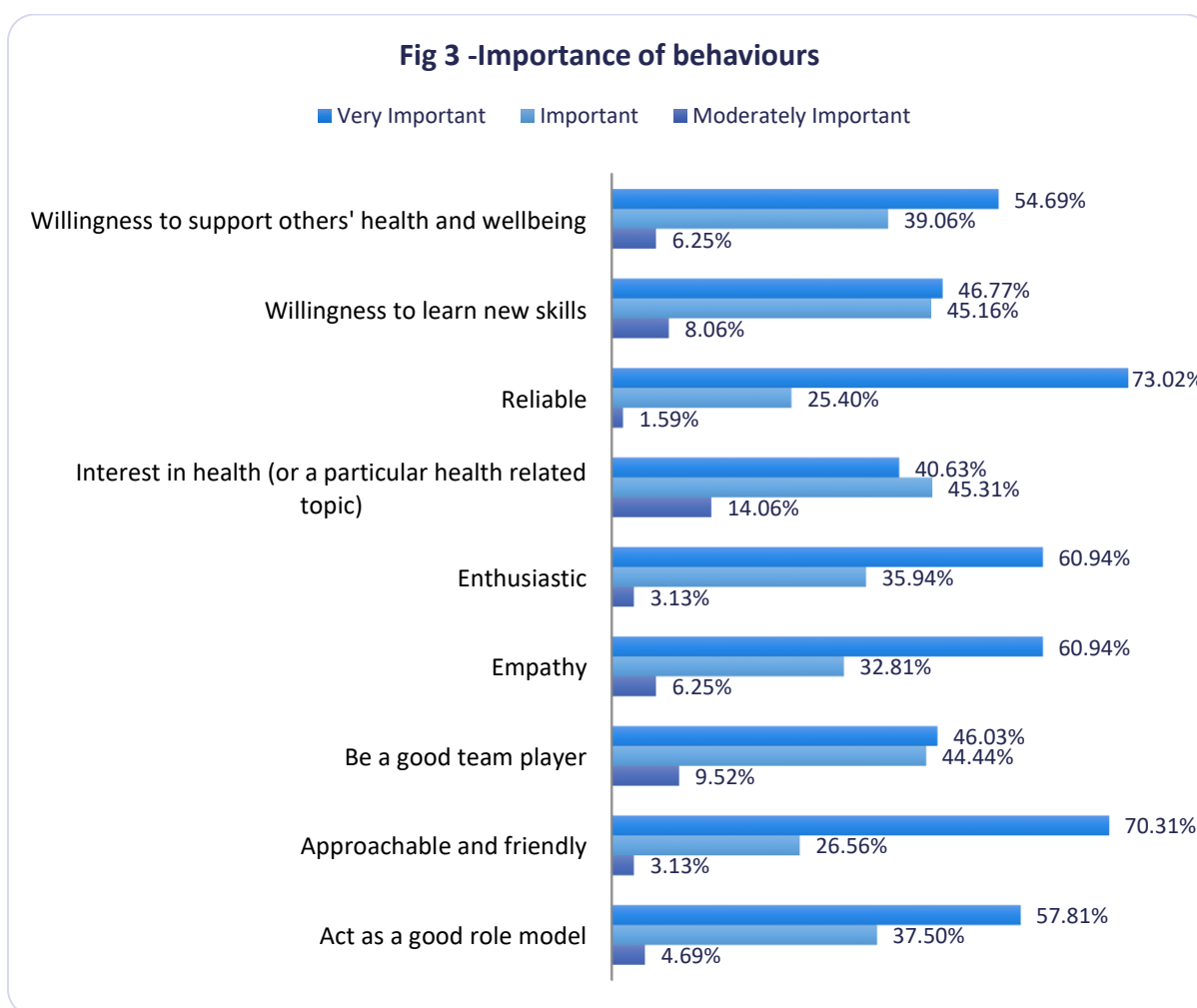
**Table 5. Training methods preferences by knowledge and skills area**

Knowledge and skills	Face to face training	e-learning training	Self-directed learning	On the job learning	Shadowing
Communication skills to motivate and or support others improve their health and wellbeing;	3.6	2.1	2.6	3.5	3.1
Presentation skills to deliver healthy messages to a group of peers; research skills to find and access health services and information;	3.7	2.5	2.5	3.3	3.0
Leadership skills to influence and inspire peers to improve the health and well-being of themselves and their community;	3.7	2.0	2.6	3.7	3.0
Core health and well-being knowledge	3.6	2.4	2.4	3.5	3.1
Good knowledge on a particular topic of interest (e.g. sports and physical activity, sexual health, gender violence etc.);	3.9	2.6	2.4	3.2	2.9
Planning and organisational skills to deliver health-related campaigns and activities;	3.7	2.6	2.4	3.4	3.0
Problem-solving skills to address practical issues faced by peer educators;	3.4	2.1	2.5	3.6	3.3
Research skills to find and access health services and information	3.7	2.8	2.6	3.2	2.8
Use of social media and digital technology for peer education purposes (e.g. Instagram, Twitter, apps, the internet, computers, tablets);	3.3	3.3	2.9	3.1	2.3
How to provide health and well-being advice to individuals	4.0	2.6	2.3	3.2	2.9
All	3.7	2.5	2.5	3.4	2.9

Respondents were given a list of types of behaviour and asked how important they thought it was for young peer health educators to display them on a five-point scale labelled very important, important, moderately important, slightly important and not important.

They were also asked to suggest other behaviours. All the responses were either moderately important, important or very important, indicating that all were considered to be important behaviours to an extent for a young peer educator. Ranking them by very important shows that reliability (73%) and being approachable and friendly (70%) were seen as most important behaviours that a young peer educator should display (Table 6 & Fig. 3). Being enthusiastic (60.9%), empathic (60.9%), acting as a good role model (57.9%) and willingness to support others' health and wellbeing (54.69%) were next.

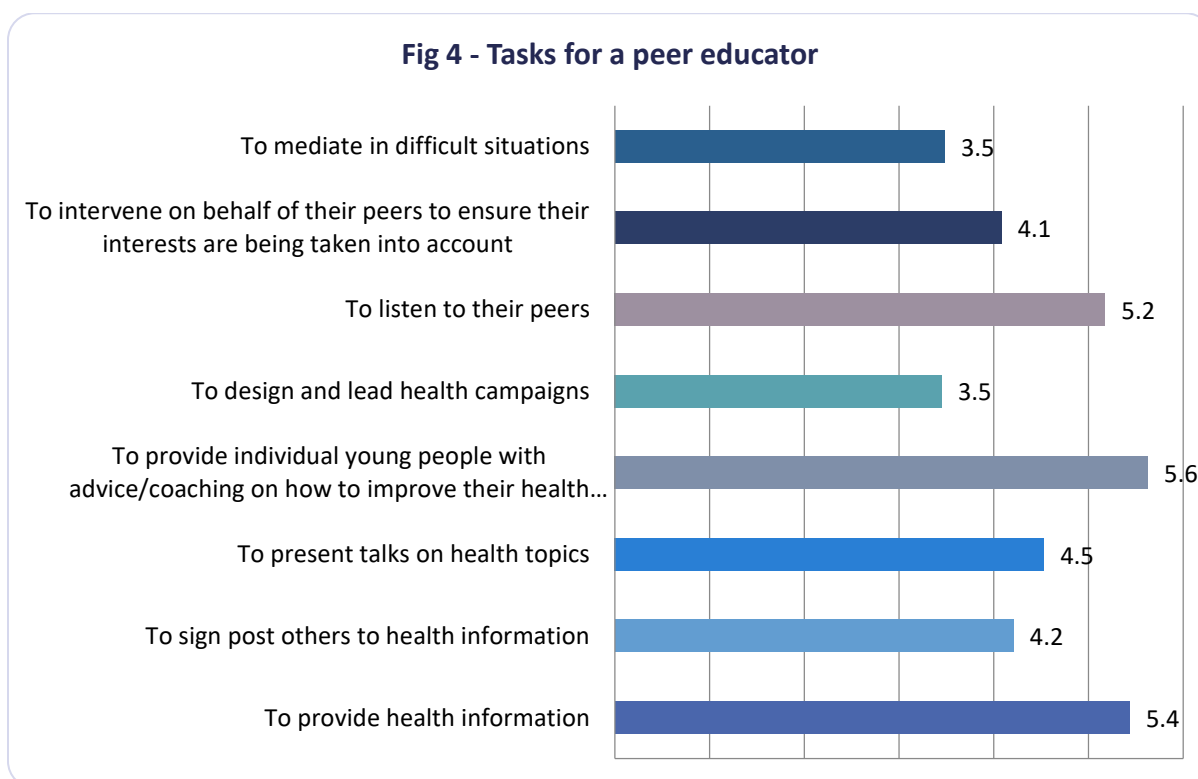
The 'least' important behaviours were: Willingness to learn new skills (46.7%), being a team player (46%) and interest in health 40%. Additional suggestions included: trustworthiness, being non-judgemental, sociable and friendly, positive, culturally aware, showing respect and accepting criticism.



Respondents were asked to organise in order of importance what would be the most and least important tasks for a peer health educator from a list provided:

- to provide health information
- to signpost others to health information
- to present talks on health topics
- to provide individual young people with advice/coaching on how to improve their health and wellbeing
- to design and lead health campaigns
- to listen to their peers
- to intervene on behalf of their peers to ensure their interests are being taken into account
- to mediate in difficult situations

The most important task was to provide individual young people with advice/coaching (5.63); followed by providing health information (5.44) and listen to peers (5.18). The least relevant tasks for young peer educators were considered to be design and lead health promotion campaigns (3.45) and mediating in difficult situations (3.48).



Finally, respondents were asked what would be their preferred source of health information from a given list. The most preferred was a professional (including youth workers, doctors, nurses, social workers, teachers, etc.) (38.7%), and the least, interestingly, was a parent or guardian (11.9%) (Table 8).

**Table 6. Preferred sources of health information.**

Source	%
A parent or guardian	11.97%
A professional (including youth workers, doctors, nurses, social workers, teachers etc.)	38.73%
A slightly older young person (including a family member slightly older than you, a slightly older friend, a slightly older peer educator)	18.31%
Another young person (including a family member of around your age, friend, a peer educator)	18.31%
The internet	12.68%

### *Consultation summary findings*

Further analysis may indicate whether these observations may be disaggregated by country, age, or relationship/experience with peer education, subject to the sample sizes available. However, as was noted earlier, there was a considerable attrition in the sample size further into the survey so it may not be possible.

Of those respondents who commenced the survey, nearly half were in the 18-21 age group, but over half of those did not complete the survey. The age group with the highest response rate was the 22- 25, followed by the over 25.

Three quarters of the respondents had some connection with peer education, with over half of the total being a peer educator. However over half of each category, including peer educators, did not complete the survey.

The most important competencies for a peer educator were seen to be a combination of interpersonal skills and knowledge: communication skills, core health and wellbeing knowledge, specific topic knowledge, presentation skills and leadership.

Perhaps surprisingly, problem-solving skills were next important whilst work related skills such as planning and organisation and research were grouped next.

How to provide advice to individuals was not considered very important, despite communication skills (for motivation and support) being at the top of the rankings. This could indicate that young people see themselves or their peers as potential motivators, and as an equal to advisors and coaches in their ability to provide support rather than advisors or coaches, telling others what to do.

Finally, the use of social media was the least important skill, perhaps because most of the age group are already adept in this area.

When asked about preferred training methods across all subject areas there was a clear preference for personal contact, interaction and work experience as demonstrated by face to face training, on the job

learning and shadowing. E-learning was only favoured, not surprisingly, for use of social media and digital technology, and to some extent, for research skills. Self-directed learning was least popular.

Respondents felt that all the suggested behaviours were important for peer educators to display to some degree, but reliability, approachability and empathy, were the most important. Trustworthiness and being non-judgmental were recurrent suggestions, perhaps indicating the need for assurance that a peer educator would provide confidential and open minded support.

The most important task for a peer educator was providing young people with advice/coaching on how to improve their health and wellbeing, and providing health information. This is somewhat conflictive with the earlier answers to a question about skills, where how to provide advice was seen as one of the least important competences.

Perhaps interestingly they did not think the role of a young peer educator was to design and lead on health campaigns. This confirms the earlier results that rated planning and organisational skills to deliver health related campaigns only moderately important.

Mediating in difficult situations was deemed as the least important task, which is probably an appropriate interpretation of the role.

Professionals came out by far on top in terms of preferred sources of information. Perhaps surprisingly, 'a slightly older young person' or 'another young person' came both second by a distance, which somehow conflicts with a widely recognised assumption that young people prefer to obtain information from peers or the internet.

## Views of young people about their role as peer educators

Two focus groups were held with young people aged between 14 – 25 years, one in the UK (StreetGames, n=5) and one in Malta (Agenzija Zghazagh, n=8). Detailed guidelines were provided for running the focus groups (please see annex 2 and 3) including a template for capturing the discussion responses and also pair work looking in detail at elements of the skills, behaviours and knowledge proposed in the draft training tool.

The group questions focused on:

- The type of training they had received to become a 'peer educator' or similar
- What aspects of the training were most and least helpful
- Experience with completing an e-learning training course
- Advantages or disadvantages of e-learning training
- Top tips for those developing an e-learning tool
- Effectiveness of e-learning
- The best way to train as a young peer health educator

## Findings

Responses showed that not all group participants were formally trained as peer health educators, but all had some training as peer leaders on health or mental health issues. Interestingly the UK group did not associate with the terminology 'peer leaders' and preferred to be referred to as 'Young Advisors'. The range of training in terms of levels and methods was very wide, indicating a breadth of experience to draw upon in the discussions.

Most helpful training methods were practical approaches that enabled them to 'have a go' and receive feedback. Shadowing experienced leaders was also welcomed and group work and outdoor activities were preferred. In contrast, the least helpful aspects of training were too much input from the facilitator, 'being talked at' and lack of engagement in practical activities. While having to complete long written assignments or paper based portfolios of evidence was recognised as being useful for evidencing learning for assessment, it was not thought helpful.

The entire UK group had used an e-learning course, but none of the Maltese group had. Advantages of e-learning included:

- anonymity,
- speed,
- interactivity,
- personalisation,
- modern method,
- done at your own time and pace,
- and potentially sociable.

Disadvantages included:

- Lack of interaction and feedback
- Inability to build relationships
- Finding the time and motivation when have other work and study demands
- Lack of accountability in anonymous responses, an 'idiots' heaven'
- May be complicated, may not save responses and hard to get help if needed
- Lack of access to computer

Top tips for people developing an e-learning tool were:

*'Use Quizzes*

*Make it fun and interesting*

*Use multiple-choice questions so there is less chance of silly answers*

*Use different levels for different people without other people knowing*

*Don't let it be long! Be short and fun!'*



The next question asked about agreement with the statement that e-learning is an effective way to train as a peer health educator, which was immediately challenged in one group as being a leading question. Critically while there was some agreement that e-learning could be used for aspects of training, there was a strong feeling that this needed to be balanced with human engagement.

*‘Yes, but needs to be the right balance with people!’*

*Yes BUT needs to be a combo with practical and face-to-face*

*Yes but with physical engagement*

*Yes in small parts – not the whole learning, need face to face learning too’*

The best way to train was considered to be face to face and in a group environment. The importance of being able to try new skills and receive feedback, ‘a safe place to have a go and try things’, and ‘being put in the role and taught through experience’, was felt strongly. Practising skills, at a ‘challenging but do-able’ level, with access to mentoring were key elements of effective training.

The second part of the focus group asked the participants to mark a list of skills as essential and desirable at level 1 or 2. The UK group ranked the essential skills of a peer educator from 1 (most important) to 5 (least important), although all were considered as important.

- |   |   |
|---|---|
| 1 | Knowledge of the role<br>Punctual/be on time<br>Presentable and a good example  |
| 2 | Confident on what is happening (Good clear instructions)<br>Clear and concise<br>Planning ability<br>Flexible and able to change style of delivery/conversation |
| 3 | Organised<br>Clear Communication  |
| 4 | Vocal<br>Confident  |
| 5 | Adaptable<br>Improvisation skills   |

The Maltese group felt that all the basic skills identified were important for peer health educators.

The young people felt that all the advanced skills were important although possibly the one considered least necessary was skills on how to provide health and wellbeing advice. This group did not complete the grid in detail.

The UK group felt that Level 1 research skills were less important as it was not necessary to 'have all the answers straight away' and they could 'look stuff up together'. Conversation skills were considered more important than presentation skills, 'the role would be more about conversations to peers rather than standing up and presenting'. Planning and organisational skills to deliver campaigns and activities was considered to be too broad, and the types of activity would need to be specified to know whether it was relevant or not e.g. physical activity was considered important.

In terms of behaviours, the UK group first brainstormed the essential behaviours of a peer educator:

Responsive	Understanding
Motivating	Trustworthy
Polite	Reliable
Yes/can do attitude	Approachable
Encouraging	A swan (i.e. 'being calm to look at, but underneath there is lots of work going on to make sure everything goes smoothly and is positive')
Supportive	
Calm	
Caring/nurturing	

All the behaviours on the grid were thought essential with the exception of 'willingness to learn new skills' which was considered desirable. 'Interest in health (or a particular health-related topic)' was not thought to be necessary; it was thought that young people would 'just need to be happy to talk to others positively about being healthy and active'. In general, the Maltese group considered all of the behaviours to be important, although being enthusiastic and approachable were considered to be the least important. They were also conflicted when it came to being a role model especially when some of them confessed to being smokers and potentially engaging in other behaviours that they would not classify as healthy.

In terms of knowledge, while the Maltese group considered all the knowledge requirements to be important, the UK group were less concerned about specific aspects of health knowledge being important. They noted that having a baseline knowledge would be good e.g. 'what it means to be healthy' but this needs to be applied to the community youth world. For example, 'saying don't smoke or don't drink, is rubbish, but messages about confidence or beating anxiety, being active for wellbeing or talking about mental health would be good things to talk about – more topical in today's world.'

They did not seem to engage in specialising in areas such as sexual health, etc., but mental health and wellbeing was of interest at a basic level. They were all also interested in physical activity for health rather than sport. It is notable that they were not keen on using terms like 'Health promotion' or 'Health Educator' when describing what they do or could do, instead they preferred the phrase 'wellbeing or healthy conversations' supporter'. In addition, they would welcome a 'bank' of conversation starters and ideas to get people active. They felt they could access sports advice and support elsewhere but that for this project they needed more support with things like 'silly energizer games that could be used to

get a group moving'. Further advice on access to social media and youth friendly websites on mental health would also be welcomed.

### *Discussion from focus groups results*

While the numbers involved in the focus groups was small, the findings were generally consistent with the survey results and provide some clear direction for the further development of the learning materials.

In line with the survey, the young people saw the peer educator role as being one of providing advice, support and encouragement to other young people, in an informal way. Respondents emphasised the importance of skills for holding conversations rather than formal teaching with their peers, and were less concerned about having expertise on particular health topics, as they felt this was something they could research themselves. Knowledge of appropriate sources of information for young people would be useful here. Interestingly there was some feedback about terminology, which was not covered in the survey. Some young people were not comfortable with the term 'peer educator', and preferred 'young advisor'. Whilst peer educator is the professional term for the role, it may be useful to test this out further and consider other terms for the training course and qualification.

Clear messages came out about the training across both the focus groups. While e-learning had some recognised merits it was not the preferred learning style for this age group, and for acquiring the skills required for this role. Respondents clearly saw the importance of group based, face-to-face training, and the opportunity to practice communication skills in a safe environment with feedback from experienced colleagues. The chance to experience the role through shadowing or observation and to develop practical skills was preferred. Help with practical tips, examples of activities and conversation was suggested.

However, it is important to highlight that for more than half of the participants (8) e-learning is a learning method that had not been experienced; as such their responses may have been biased towards their existing experience of training.

## Use of peer education to improve health and wellbeing of young people across Europe

### Introduction

As indicated in the literature review presented in the first section of this report, peer education is a popular approach for health promotion with young people. To exemplify the breadth and depth of the approach in Europe, project partners nominated case studies of successful youth peer education programmes in their country.

While the primary focus for the research was health-oriented peer education, it was agreed that examples of peer education approaches in other fields would also be of interest. The broad objectives for this included establishing the extent to which health-oriented (or other) peer education programmes are used in each of the six partner countries and to learn more about various attributes such as: the range of training and resources available; who are the target groups involved, and what is known about how effective the projects are.

The definition of peer education provided was:

*“Peer education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their community. Peer education is the teaching or sharing of health information, values and behaviour in educating others who may share similar social backgrounds or life experiences.” (Green, 2001) <sup>6</sup>*

A recent systematic review of peer intervention in the US, (Ramchard R, Ahluwalia SC, Xnakis L et al, 2017) provided a consolidated typology of peer roles and outcomes describing five different roles: peer counsellor; peer educator; peer support; peer facilitator; and peer case manager. In terms of this definition, the roles described in the case studies included:

- peer educator-where formal education and training was provided
- peer support- where informal and unstructured support was given
- peer facilitator- the facilitation of group discussions and interactions.

A case study template (Annex 4) was provided, requesting structured information about the programme including methodological details, evaluation design, and information about outputs and outcomes. Respondents were asked to give their opinion of what it was that made the project successful, and to provide references to reports or other supportive information. The researcher also requested further information or clarification to respondents by email as necessary.

15 case study descriptions were collated and nine are highlighted in the main body of this document for their features with particular reference to understanding the development and training needs of peer educator, and key success factors to help inform the development of new training resources. The full list of case studies is presented in Annex 5.

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<sup>6</sup> Adapted from Green, J. (2001). Peer education. *Promotion and Education*, 8(2), 65-68. doi: 10.1177/102538230100800203

### *Case study 1: MOVE Week Bulgaria (Bulgaria, 2015)*

Move Week Bulgaria is a campaign run by BG Be Active Association, coordinator of MOVE Week in Bulgaria, and the Municipality of Plovdiv, as part of NowWeMOVE (NWM), Europe's biggest civil campaign promoting sport and physical activity as established by the International Sports and Culture Association (ISCA). The campaign involved the participation of young peer educators called Youth Move Agents, who were recruited from youth organisations, NGOs, sport clubs and schools. Youth Move Agents received training on the aims, objectives, scope, and core messages of the campaign and had responsibility over its promotion and delivery activities within their setting. The project also provided training for teachers, youth workers and other professionals who work with young people on a methodology, which encourages them to teach through sport. The project provided central on-going support and a wide range of materials for the use of Youth Move Agents and professionals. The first MOVE Week initiative in Bulgaria was in 2012, and it has continued until 2016.

The overall objectives are to:

- Promote physical activity and healthy lifestyle for all
- Empower young people as main actors and organisers of the activities – not just as participants or supporters

The strategies employed to achieve this included:

- Development of resources on different topics such as project management, event management, fundraising, communication and PR, marketing, work with volunteers, etc.
- Organising training for youth workers and young people based on the available resources
- Possibility for internship in BGBA
- Trying to establish a network between the young people that were trained and local organisations that are part of MOVE Week and NWM campaigns, so the organisations can offer further support
- National communication campaign and development of marketing materials, e.g. t-shirts, bracelets, pins, along with open resources, designs and templates

The target groups were youth organisations and NGOs, sports clubs, schools, and young people – either as representatives of the above or as potential volunteers and event organizers.

In the first year (2013 – 2014) the resources were only disseminated online, but in 2015 there were 24 training courses around the country for PE teachers and youth workers on the methodology of Education through sport, reaching over 600 people (volunteers, youth workers, teachers and other school administrative staff). In 2016, 13 courses in 11 cities trained around 200 young people in the country, especially from disadvantaged areas. These Youth MOVE Agents then became ambassadors in their local communities and organised more than 13 events in the following MOVE Week 2016 and European No Elevators Day 2016. The training was focused on the resources, which NWM campaign offers to young people and how they can use them to gain experience and to work with other young people in order to promote healthy lifestyles and physical activity.

The programme was evaluated through reports and feedback for event organizers, and national research was undertaken in 2015. A survey was conducted by face-to-face interview with 1030 participants who were representative of the population aged over 15 years. From the findings, the campaign had reached a large section of the population who had heard of it, although fewer had been motivated to participate. The strongest influence on participation in sport or physical activity was the example of peers, colleagues and friends.

Success factors for the project as a whole were:

- Marketing and promotional materials
- Communicational campaign and developed image
- Ongoing Support – National coordinator for NWM - a person who is supporting the organisers of events

### *Case study 2 - Peer-to-Peer Tutoring: Transferring successful methodology and learning strategy to reduce drop-outs in IVET (P2Peertutoring, 2014)*

This project was started in 2010-11 by the Higher Professional Technical Institute “Cesi Casagrande” in Terni, Italy, one of the biggest schools of the area (about 1,200 students). It uses a peer to peer tutoring approach to tackle the high level of drop outs in initial education and training of young people aged between 14 and 19 years old. Students are selected for their qualities and aptitudes and are trained by teachers on communication skills, and strategies to prevent distress and enhance wellbeing. Peer tutors would then be prepared to initiate support to other students on academic work and day to day issues including, alcohol, drugs, physical and psychological violence and bullying. Peer-to-peer education is an approach that empowers young people to work with other young people.

The program aims to: -

- Involve stakeholders in the area (local authorities, third sector associations, senior executives of schools, employees, citizens, productive entities)
- Strengthen the culture of peer education among school personnel and supporting the staff involved in the project
- Promote initiatives on the culture of legality, respect of people and property and the promotion of values
- Communicate vision, mission, values and strategic and operational objectives to all members of the organization and to all stakeholders
- Stimulate and encourage the transfer of responsibilities, collaboration, empowerment, creativity and innovation, by improving peer leadership
- Develop partnerships and networks with stakeholders.

The project involved 170 tutors (peer educators) and 25 senior tutors. Target groups included: students as users of the education service; parents; teachers; health teachers and policy makers. The programme was evaluated using questionnaires for students, parents and teachers. The tutor guide for students and teachers was shared with other schools interested in using the methodology.

Participants reported that peer-to-peer methodology is a way to improve student's self-esteem, life skills and school results. It helped to increase self-awareness, the ability to develop interpersonal relationships and increase understanding of others and empathy. Tutors also developed their communication skills, and were able to empathize with their peers, motivate learning, help them overcome dependencies and develop social skills. Tutees are more likely to call their tutors to help with problems, which helps to prevent bullying and related issues and in turn builds the tutors sense of responsibility and self-confidence.

Key success factors: the appropriate training and support given to peer educators; and a focus on the combination of academic tutoring for colleagues with learning difficulties with development of life skills.

### *Case study 3 -Educazione tra Pari: Programma di promozione della salute nelle Scuole secondary di Il grado (ASL Milano, 2011)*

The project is organised by ASL Milano and has been run at a high school in Milan, Italy since 2011. It utilises a peer education model, which is described as having as its main objective the development of youth empowerment. While work objectives are determined by adults, the implementation phase is planned and run by students. The project aims, therefore, to recognize and promote an active role for teenagers who become champions of their training within a path of promoting socio-educational well-being for themselves and for other school students. Parents are also trained and educated about the prevention of risk behaviours (relational, sexual and substance abuse). The educated students subsequently carry out interventions and events within their own school aimed at encouraging discussion between peers on the topics proposed and promoting a change in knowledge, attitudes and beliefs.

The direct recipients of the project are some 3rd grade students selected for peer education training, different categories of recipients may be agreed depending on the needs of the school. The indirect beneficiaries of the intervention are the remaining students of the school. Providers of preventive medicine and addiction services support the project. In 2017, the project involved 150 young peer educators, 10 teachers and 5 ASL staff. Over the three years of the project, the training requires a commitment of approximately 20 hours of school time over 15 days. Evaluation seems to have been built into the design of the training programme but is otherwise not specified. The objectives of the project are to:

- Encourage the empowerment and active participation of youngsters within the school, in particular on the subject of health and wellbeing.
- To form a stable peer group within three academic years, focused on knowledge and mutual collaboration, through an experiential path and an active type model.
- Increase Life Skills and Knowledge on Health Issues (HIV/AIDS Prevention and Sexually Transmitted Diseases, Contraception, Bullying, Prevention of Use/Substance Abuse, Alcohol and Drugs).
- Introduce the socio-health services of ASL in order that educators can present them to their peers.
- Encourage the recognition of peer educators as a resource within the school (by the Executive, the Health Commission and teachers).

As a result, of the project, peer educators have increased their sense of responsibility, their capacity for self-observation and reflection, as well as increasing their own knowledge of the health issues to be conveyed to their schoolmates. The training course aims to develop individual skills and abilities (Life Skills), increasing the ability to manage relationships with others in a positive way, enhancing self-efficacy and resisting negative peer pressure, improving communication and managing emotions.

Feedback showed that of all the topics addressed during the project, sexuality was the hardest to deal with owing to inhibitions and the taboo nature of the subject. Overall, the interventions have allowed the peer educators to provide more information and, despite some previous knowledge, the school students said they had received new information and clarified some doubts about knowledge previously acquired. There was also interest in issues affecting affection, topics that youngsters feel very close to them, but of which they hardly speak.

Success factors for the project were:

- The collaboration and support of the teaching staff. It was necessary to identify a teacher who played the role of the referent in the School for the internal organisation and to maintain the relationship between the Educators of Equality, the ASL Operators and the Class Coordinators /teachers.
- In terms of methodology, the effective tools used were Knowledge and presentation games; widgets in an enlarged group and subgroups; brainstorming; discussion groups and reflection on themes; role-plays.

#### *Case study 4 -Street Action (Buelens, 2016)*

Street Action, powered by Buurtsport, created low-threshold offer of sports, physical activity and health activities in 23 municipalities or towns in Flanders (Belgium) for 12-18 year olds from vulnerable groups. A local sports worker who was encouraged to work in a network of social partners while the young people were empowered to act on their own initiative as much as possible facilitated the offer. Street Action, powered by Buurtsport was a project of ISB (Belgium), with the support of The Coca-Cola Foundation and Coca-Cola Belgium-Luxemburg in partnership with the Vrije Universiteit Brussel (2012-2014). Street Action gives youngsters the chance to participate in a coaching programme. They can further develop their skills during courses given by other young people. Being active as sports teachers during events and sport activities in their own neighbourhood also gives them the possibility to grow in their specific role. Participation in and through physical activity and sport is probably the best conceptualisation of this challenging project.

On average (n: 23) each local Street Action-project:

- Organised activities in 4 locations
- Reached a range of 300 to 400 participants of which 33% were girls, and 78% of them were from the targeted group
- Engaged 12 volunteers (16-25 year olds from vulnerable groups), of which 40% were girls, and 50% followed a specific course



Specific courses included:

- Youth animator: these were given by volunteers of Jeugd en Stad, Youth and City (JES), an organisation who is active in Brussels, Antwerp and Ghent. The young volunteers are trained to give a youth leader course, which has a focus on sport and physical activity. The co-creation between them and the knowledge of sport and welfare was very meaningful and essential for the process.
- Recreation and physical activity animator: a specific course of the Vlaamse Trainersschool (Flemish Trainers School).
- First aid

The project was evaluated, and research into the in-depth conditions for successfully increasing adolescent's engagement in volunteering in community sport were translated into a competence toolkit. There were more than 100 trained volunteers, most of whom are still active in the organisation where they followed a course and did their internship. They are considered the 'engine' of the projects and an important link between the involved organisation and the specific neighbourhoods.

One of the crucial conditions for reaching and keeping socially vulnerable youngsters in a sports program is the type of guidance given. In addition to a sports technical background, it is important as a teacher or guide to have knowledge and expertise about working with the target group to keep them motivated and enthusiastic. This includes the style of teaching; the social and pedagogical competences; patience; communication; positive feedback; and empathy. A relationship of trust and investment in a safe environment are crucial to create a setting where youngsters can be themselves and build up a bond with other youngsters and teachers. An online competence toolkit was also produced combining practical instruments and instruction.

The authors listed a number of success factors and learning from the project:

- Working with vulnerable youngsters to take up more responsibilities is a difficult task and it takes more time than anticipated to stimulate active involvement and engagement
- For the young people participation was interesting and held different advantages (social surplus value):
  - gaining experience with regard to guiding and organizing (sport)activities
  - improving social and personal competences (working together, planning, taking responsibilities
  - handling children (punishing and rewarding)
  - meaningful leisure time
  - earning respect in the neighbourhood
  - expanding their social network
  - building up their CV.

Critical Success Factors for the project overall included:

- Youngsters need to have an affinity with sports and interest in taking up engagement and responsibilities.
- Youngsters need to have a say in the design of the programme. This can lead to an increased
- Motivation and interest.

- They need to be supported and motivated, and shown appreciation. This improves their self-
- Image and self-esteem.
- Communication must be clear and unequivocal
- Identify key figures within the youngsters as role models
- Collaborate with neighbourhood youth projects to broaden the guidance and opportunities beyond the sport element
- Partners must be aware of the need for patience and time
- Implement a systematic approach

*Case study 5 -Jongerenadviseurs J@, Youth Advisors (Bertels J, 2002) (Petto, 2000) (Howest, 2017)*

Jongerenadviseurs J@, is a methodology with a focus on friends helping friends (peer support). It is run by different youth advice centres (JACs) in Flanders. The basic framework is similar for all J@ projects, but the specific implementation differs according to the local context. JACs are low threshold meeting points for 12-25 year olds where they can meet a social worker who gives advice, information and practical assistance, or contact them via phone, e-mail or chat. This service is free of charge and anonymous, and is subsidised from government funding.

The core methodology for Youth Advisors has been in use for about 25 years, Youth Advisors is about friends helping friends. Research among 14-20-year-old Flemish school pupils points out that youngsters above all consult their friends when they have a problem (In Petto, 2011). This project builds on the positive forces of support and influence that are present in social interaction between young people. It focusses on prevention and has three main goals:

1. Reduce the threshold to the Youth Advisement Centre
2. Support young people by young people in their own environment
3. Keep up with the concerns of youngsters and adjust the activities to meet needs of the target groups

Youth Advisors are youngsters between 15 and 25 years old, their role is listening to peers, giving them advice and when necessary redirecting them to specialised help. They are not professionals, but remain informal peers. They are often seen as a good listener and someone who is approachable. Training and counselling is provided to Youth Advisors to enable them to develop the skills and knowledge to manage the role. During this training they learn how to support their peers and become aware of their own possibilities and limitations. The starting point of the training is empowerment (youngster learn from each other) and interactive and experiential learning methodologies form the basis of the course. In 2-weekly follow-up meetings a variety of themes are discussed e.g. alcohol, drugs, depression, suicide, self-confidence, teenage pregnancy, bullying. Data on self-assessment of competence is collected at the start of the course and after one year. Good practice that has developed includes involving Youth Advisers in the training of a new group; focussing on the socially vulnerable and providing extended training.

There are no general figures available across all the projects but as an example of scale, one JAC trained 530 Youth Advisers in 20 years. The authors report the following keys for success, and possible pitfalls:

- Cooperation with other (social) partners is desirable and mapping social partners is a valuable exercise
- Having Youth Advisers from diverse backgrounds helps to broaden the reference framework of the participants
- Working with Youth Advisers is time and money consuming. Applying for grants/subsidies is important and projects need to be sensitive to the changing political context and flexible in how projects operate.
- Recruitment processes are key to ensuring commitment to participate in a training course to become a Youth Advisor. It is advised to recruit individuals rather than groups that already exist because the prehistory of the latter can hinder the dynamic of the training course. A 10-minute presentation in school classes is an approach that several organisations apply, linking the information with a face reduces the threshold to engage in the course.
- Timing and accessibility of the training needs careful consideration. It is also useful to provide at least a part of the course in the setting of the youth centre to increase familiarity with the organisation.
- As the Youth Advisers work for their peers, the setting in which they operate needs to be a natural setting like youth club, pub, street, lunchbreak at school etc.
- For projects like this with a long history, it is important to keep highlighting the benefits and refreshing it as necessary.

### *Case Study 6 - Kent Youth Health Champions (Walpole, 2017)*

The Kent Youth Health Champions (YHC) Programme ran from 2015-17. The main objective was to deliver a number of accredited and non-accredited training courses to Schools and Community groups in Kent. The Royal Society of Public Health (RSPH) accredited YHC courses enable young people to learn new practical skills and knowledge for promoting health and wellbeing to friends, families and wider communities. These were delivered over four days in each venue and the unaccredited courses were delivered over two days per group. The target groups were primarily young people aged 14+ in School and Community settings within areas of high deprivation in Kent; and the secondary targets were teachers, youth workers and early help workers from the local communities. The programme was commissioned by HeadStart Kent and provided by StreetGames who had experience in delivering YHC programmes for its own network of local projects working with young people in community settings in areas of deprivation throughout the UK. The aim was for young people to create and deliver peer to peer positive health promotion campaigns in their setting. In the first year eight training courses were delivered to 67 young people, and in the second year a further 13 courses were delivered with exact numbers trained pending.

Following training, the roles undertaken by the YHCs varied, but examples included:

- Organising a campaign e.g. via a school assembly, Board meetings
- Informal chats to peers at the park or in social settings
- Informal discussions with family members

- Providing static displays with information
- Signposting to services on site such as the school counsellor
- Signposting to information such as self-help books
- Mentoring of younger YHCs by older YHCs
- Follow-on peer mentoring support such as walk and talk before school and at lunchtimes, support groups for younger pupils.

An external evaluation of the Youth Health Champion Programme was undertaken (Walpole, 2017). It included a qualitative evaluation of projects that had completed the YHC training and campaign in the last twelve months, collecting data from: the coordinators, the YHCs themselves and from their peers by: semi-structured phone interviews with coordinators and one evaluation workshop in a community setting involving the coordinator, youth workers and the YHCs. The evaluation highlighted that the YHCs benefited in a number of ways from their involvement in the programme including:

- Gaining a wider understanding and knowledge of public health
- Gaining new skills such as communication and organisational skills, increased confidence, advocacy experience and a health-related qualification
- The qualification was important for young people wanting to pursue a career in healthcare or who wanted to study in further or higher education. A number of young people had already used it to help with college or university applications, or to gain employment in healthcare.
- For groups of hard to reach young people in two different community settings who were struggling in a traditional learning environment, this was their first qualification and was recognised as a significant achievement
- New friends were made whilst undergoing the YHC training and they had remained in contact either socially or digitally. In some cases, the young people felt as though they belonged to the group that they had trained with and wanted it to continue

The evaluation highlighted the following as success factors:

- The flexibility of the YHC programme has resulted in different types of organisations using it to support young people who are interested in either a career in healthcare or who have a general interest in health issues
- It is suitable for both formal settings such as schools and healthcare environments as well as informal settings such as youth and community projects
- In some instances, joint working between different organisations has strengthened partnerships and brought additional resources and skills to the YHC programme resulting in additional benefits for the young people and the organisations themselves
- Having a dedicated coordinator – one who has the support of the organisation's leadership team, time allocated within their workload and access to resources, knowledge and training. (This is important for all areas of the YHC programme including the recruitment of the YHCs, the training programme itself, the campaign and any follow-up work that YHCs carry out in their roles as peer mentors)
- Support provided - co-ordinators with dedicated time and access to resources were able to give more time to their YHCs and help them to set up new formal types of peer support. Cross-age peer support was particularly successful in one setting, benefiting from the maturity and experience of the older YHC peer mentors.

### *Case Study 7 - Żgħażaġh Azzjoni Kattolika, Youth Catholic Action Leadership Programme (Żgħażaġh Azzjoni Kattolika (ŻAK), 2018)*

Żgħażaġh Azzjoni Kattolika (ŻAK) is a branch of Maltese Catholic Action and its fundamental purpose is to provide programs of spiritual, social and personal development for young people aged from 10 years onwards. It is a voluntary, non-profit organisation with currently 48 ZAK youth groups in 12 different parishes/localities with around a total of 750 young people between the ages of 10 and 30. The biggest cohort is young people aged 14 - 16. The socio economic and educational background of the young people varies also depending on the community where the group is based. Each ŻAK group has a regular weekly meeting where, under the direction of their youth leaders, members not only socialise, but also develop and experience life skills, through structured and unstructured sessions e.g. discussions, role-plays, hands-on activities, reflections and games. ŻAK gives utmost importance to the active involvement of its members. At the early stages of the group, especially when the members are still young, most of the planning of meetings and activities is carried out by the leaders with little involvement from the participants. However, as the group grows within the organisation, the members gradually involve themselves more in the thinking and action process. The leaders' responsibility is to ensure that the material covered and other social and educational activities meet the real needs of the young people. Sports activities are limited unless they are project based.

When the members are 16 they are invited to attend leadership training held over a period of 3 residential weekends. Approx. 40 young people per year attend Leadership 1 training after which they are invited to follow a one-year training programme at MQF (Malta Qualifications Framework) Level 4. If they choose to continue they then do the Leadership 2 (25 per year) followed by a two-year programme interspersed with the Leadership 3 (15 per year) training. The Leadership training includes a placement of 50 hours each year and in the 2nd and 3rd year an additional 25hrs each year of activity planning. The young leaders are also assigned a mentor who they meet up with periodically. The Leadership Course 1 has 10 credits while the Leadership Course 2 has 30 credits.

This process ensures that ZAK Malta has a pool of young leaders to continue its activities. The process provides the young people with:

- An understanding of what leadership entails
- A support network with other leaders
- An understanding of what the management of an organisation entails
- Peer mentoring skills.

Factors that made the project successful are cited as:

- Allowing different levels of participation depending on the interests of the young people
- The leadership programme provides an internal support network enabling aspiring leaders develop their leadership knowledge and skills alongside more experienced volunteers

- Investment in continuous evaluation has allowed the organisation to adapt to new contexts
- Whilst there are some benefits in terms of facilities from association with Catholic Action, ZAK has to fund raise to be responsive to local needs.

*Case study 8 - Stop the Violence: Voices against Violence (Malta Girl Guides, n.d.) (World Association of Girl Guides and Girl Scouts and UN Women, 2012)*

This is a worldwide initiative promoted by the United Nations in collaboration with the World Association of Girl Guides and Scouts. The programme works with children and young people from the ages of 5 to 25 to raise awareness of their rights and responsibilities in relation to violence and violence prevention. It also looks at recognising signs and symptoms, self-esteem and assertiveness. A baseline secondary school survey showed over 90% had experienced or witnessed violence. Running since 2011, the programme in Malta targets mainly domestic violence, child abuse, teenage dating violence, homophobia and transphobia, bullying and cyber bullying. Girl Guides instituted a badge curriculum involving a number of workshops, which address the following six themes: being safe; think; identify; support; speak out and take action. Some of the actions implemented include videos, posters, silent marches, sit-down protests in their communities. The approach includes critical consciousness-raising techniques about violence in the community and taking social action e.g. legislative proposal to government on female genital mutilation and the minimum age for criminal responsibility.

The programme targets children and young people aged 5-25 who are members of the Girl Guides and Girl Scouts association, as well as teachers and youth workers who promote the programme in schools and youth settings. Around 700 children and young people have been involved in campaign activities and approx. 50 leaders have been trained in delivering the programme. Leaders vary in age but many are young women between the ages of 18 and 25 years old.

Outcomes of the campaign include:

- Training of leaders and professionals
- Training of children and young people
- Identification of cases of violence and referral to appropriate services
- Setting up of reporting and referral mechanisms
- A number of campaign actions organised by children and young people
- Legislative proposals some of which have been taken up by the government
- A publication on teenage dating violence aimed at young people
- Partners in an EU funded project, which involves the training of Scout leaders to train boys in the programme.

Authors report that the project was successful because:

- The programme is research-based and transnational
- It includes a train the trainer programme to ensure consistency in quality of delivery
- It is based on non-formal education methodologies and has well-structured curriculum content
- The Girl Guides have invested time and energy in establishing networks and building partnerships
- They are also motivated and committed to addressing the issue of gender violence

### *Case Study 9- Us Girls Alive (Adams, 2015)*

Us Girls Alive aimed to improve the health of young women aged 16-25 living in areas of high deprivation in England through social, educational and healthy lifestyle activities. It did this by empowering young women from deprived areas to take a mentoring and leadership role within their existing sporting groups to encourage increased participation in sport/physical activity amongst their peer group and in doing so help to promote improved health and wellbeing. The programme was developed using a youth-led approach and ran for three years from Nov 2012 – Nov 2015. A total of 31 Us Girls Alive Clubs were established by StreetGames in 19 different locations across England. Sessions took place in a range of community settings within disadvantaged areas, typically this included community/youth centres and sports centres. Motivators (peer volunteers) were recruited from the young women attending the Clubs and provided with training to support them in their role. The training aimed to equip them to set up and run Lifestyle and Wellbeing Clubs, offering a range of health and educational activities. Clubs were intended to be self-managed and self-sustaining.

An independent evaluation was undertaken by the British Heart Foundation, which included: interviews and focus groups with a sample of Us Girls Motivators; interviews with Club leads; interviews with other stakeholders e.g. public health leads; and surveys with participants and motivators at two time points (see references).

Over the three-year funding period, the initiative delivered over 1,200 Us Girls Alive sessions, which involved 451 young female volunteers (Motivators) from areas of high deprivation helping to engage over 5,100 female participants from disadvantaged areas in the activity sessions. The external evaluation stated that this type of programme can: 'Boost the confidence of young women in disadvantaged areas which empowers them to take on challenges which they previously thought they were incapable of'. Specifically, that:

- The initiative was successful at reaching the intended target audience of disadvantaged and inactive young women and at increasing their access to opportunities. This demographic is unlikely to seek information on important health topics such as sexual health, smoking, alcohol, mental health and drug use, however the Clubs provided a safe environment in which young women could learn about such things and make decisions to improve their behaviour.
- Through their involvement at the Us Girls Alive Clubs, young women have been linked into a wide variety of health and youth services.
- The Motivators and Club Leads perceive there to be a great deal of benefit to participants because of receiving advice, instruction and support from their peers. Qualitative data suggests that the clubs were highly successful in encouraging young women to try new physical activities and had a positive impact on their health and wellbeing – with many individuals overcoming substantial individual challenges.
- The experience of the volunteer Motivators was an overwhelmingly positive one – with a number going on to secure paid employment at their Club.
- However generally the Motivators played a less formal role in leading a Club than anticipated, and more usually acted as a role model, encouraging others to take part.

The external evaluation identified the following key success factors:



- Having Motivators with a variety of personalities and skills
- The Motivator role being flexible – which enabled young women to develop at a rate which they were comfortable with
- The provision of a wide variety of formal and informal training and qualifications for the young volunteers, so that there was appeal to girls with different personalities and motivations (e.g. some of the Motivators saw the role as a stepping stone to qualifications and employment, whilst for others it was seen more as a way to be involved in a friendly support network)
- Using existing volunteers initially to act as role models for new volunteers
- Ensuring that extra support was provided for the Motivators during the early stages to help them adjust to their increased role which may have introduced more responsibility and structure into their lives than they were used to.
- The provision of support to the delivery organisations via StreetGames Us Girls Specialist Doorstep Sport Advisors who were able to assist the clubs with general queries, training and come up with ideas to engage the target audience.

### *Discussion from case studies*

The case studies were requested around peer education projects that were: evidence based, i.e. there was a clear peer education model; addressed health inequalities by focusing on young people with fewer opportunities, and could show proven outcomes through evaluation or feedback. While peer education was defined as the ‘teaching or sharing of health information, values and behaviour in educating others who may share similar social backgrounds or life experiences’, this was interpreted differently by some of the cases. The types of peers and the nature of the interaction they had with their peers varied across the projects, but fell into the categories of peer educator, peer supporter or peer facilitator. No attempt has been made to separate these roles out and they all are referred to as peer educator here, in line with the definition provided to partners.

The research had also indicated that while the focus of the project was on health-enhancing behaviours, especially increasing physical activity, peer education projects with different goals would be of interest at this stage. By no means did all case studies focus on physical activity, although many combined physical activities within a broader scope. One or two appeared, from the information given, not to be peer education projects but physical activity promotion projects. All the projects focussed on young people, many of whom were disadvantaged in some way, and all had been evaluated, whether formally or informally.

The recipients or beneficiaries of projects are multiple but the two key groups were: those young people who were being trained and supported to become peer educators and deliver some form of intervention and those young people who were being supported or engaged in the intervention process in some way. In some projects these two groups overlapped, often intentionally as young people became more involved and were then supported to take on more leadership roles themselves as peer educators. The evaluations demonstrated a wide range of benefits for both groups. Those who were receiving the intervention, dependant on its nature, generally showed improvements in the health-related behaviours and attitudes, and in many cases self-esteem and self-confidence. Those being trained as peer educators gained a range of interpersonal and life skills, in addition to the specific knowledge and information related to the project.



Looking at the success factors stated, there were considerable consistencies across cases despite the differences in the detail of the projects. These are success factors in terms of the overall success of the project in reaching its target group and influencing behaviour, and in recruiting and developing peer educators, and they were not necessarily separated into these categories. They can be grouped under the headings of: encouraging physical activity; recruitment of peer educators; the education and training given to peer educators; and organisational issues.

### **Encouraging physical activity**

- Offer activities other than traditional sport that are fun to do, and require little or no equipment.
- Make sure activities are held in locations that are physically accessible, and comfortable for the target group to visit.
- Activities should be free of charge.
- Understand barriers to participation e.g. self-consciousness, fear of injury or failure, lack of enjoyment of competition.
- Be sensitive to cultural, religious and gender issues.

### **Recruitment of peer educators**

- Recruit peers from diverse backgrounds that reflect the characteristics and diversity of the target group.
- Recruit peers with varied personalities and skills, and with potential to empathise with a range of young people.
- Be conscious of existing group identities when recruiting and, where possible, allow new group identities to form around the project.
- Engage young people through communications in person where possible
- Involve peers in the selection of peer educators.
- Provide opportunities to draw project participants into future peer leadership development.
- Peer educators should be interested in the issues and see the advantages of the opportunity to acquire new skills.

### **Education and training for peer educators**

- The quality, extent and sensitivity of the training and support given to peer educators is vital for success.
- Training should have clear goals and structure, but should be flexible and adaptable to different settings and contexts.
- Accreditation of training is appreciated as it provides something tangible to participants.
- Trainers and peer educators should be treated as equals through collective ownership of the content of the training and involvement in planning and evaluating.
- While there should be a structured curriculum, delivery should be informal e.g. through group discussion and practical activities such as role plays and games.
- Courses should be run in youth settings.

- Trainers should be aware of the flexible development of peer educator roles and allow participants to develop at their own pace.

### **Organisational issues**

- There should be a clear plan and systematic approach to delivery of the project, but one that allows for adaptability and customisation as necessary.
- A Train the Trainer programme is necessary to ensure consistency and quality of delivery of training.
- Understanding who the local stakeholders are and collaboration with other local partners is essential.
- Build networks of local supports and develop partnerships.
- The collaboration and support of an identified local contact (e.g. teacher in school based projects) is vital.
- Support for peer educators should be built in at all stages but especially as they develop their roles.
- Projects take time and money, and commitments from partners need to be clear at the outset.
- Build in continuous evaluation at an appropriate scale for the project and resources available.
- Be sensitive to a potentially changing political climate.
- Develop clear communications and marketing, in collaboration with young people.
- Projects should strive at all times to remove potential power imbalances between peer educators, peers and other supporters.

## Research conclusions

The results of the research show that there is a case for using peer education with young people rooted in the versatility and acceptability of peer education approaches amongst young people. Furthermore, although there is no consensus on the direct impact of peer education on behaviour change and the improvement health outcomes, there is clear evidence that it increases knowledge and skills of those involved.

The research found the prospects of the use of peer educators:

- a) To be a highly acceptable approach to health education with young people, particularly on sensitive issues such as sexual health, HIV prevention, domestic violence among others
- b) To be an effective method for introducing young people to healthier lifestyles in European countries
- c) That there are a wide range of factors that influence the success of peer education programs that should be taken into consideration for the project design, including:
  - The use of theory and evidence to ensure a clear understanding of the mechanisms that can drive behaviour change and the intervention expected outcomes
  - The large number of evidence based and high quality resources available to support the design and evaluation of peer education programmes
  - A systematic approach to delivery of peer education programmes
  - Strategies for recruitment of peer educators that aim to ensure a team that reflects the characteristics and diversity of the target group, the mix of personalities and learning styles.

Furthermore, on the role, competencies and training of peer educators, the results of the primary and secondary research agreed that:

- Training should have clear goals and structure, but should be flexible and adaptable to different settings and contexts
- Accreditation of training is appreciated as it provides something tangible to participants
- Trainers and peer educators should be treated as equals through collective ownership of the content of the training and involvement in planning and evaluating
- Training should take place in youth settings
- Trainers should be aware of the flexible development of peer educator roles and allow participants to develop at their own pace
- The most popular training methods were practical approaches, shadowing experienced leaders, group work and outdoor activities.
- The most important competencies for a peer educator were seen to be a combination of interpersonal skills and knowledge: communication skills, core health and wellbeing knowledge, specific topic knowledge, presentation skills and leadership.

- That the use of e-learning on peer education is limited but it may be used as part of a wider approach (with physical interaction).

From a young person's perspective, whilst the preferred training method is group based face-to-face sessions; the literature research and the focus groups highlighted that e-learning has potential advantages including wider interactivity, personalisation and using technology to learn at convenience. Recommendations included making it fun, using multiple choice content, enabling meaningful interactivity and feedback, use of quizzes, including a degree of accountability and providing support.

Furthermore, as stated in the literature research the use of e-learning with young people is still not wide-spread and therefore there is no evidence of its effectiveness (or lack of it). The project collaboration sees this gap as an opportunity for trialing this methodology as an innovation to peer education for young people.

The analysis conducted had some limitations. For instance, the literature review did not include an analysis on the impact of the peer education process on the peer educators themselves. The survey had a relatively low response and completion rate, with 58% of those who participated failed to finish the whole questionnaire. Finally, the sixteen case studies utilised a broad definition of a peer educator that did not acknowledge potential distinctions in the terminology of peer educator roles.

## European Youth Health Champions Competencies Framework

The main output of the research results presented in this report is a competencies framework for the development of young peer educators.

Competency can be defined as the ability to do a particular job, role or a task successfully or efficiently. It is proposed that the competences are divided in three sections:

- **Knowledge**, involves providing peer educators with underpinning concepts and theory around health and wellbeing and peer education for health promotion.
- **Skills**, implicates the acquisition of practical skills to undertake a variety of tasks associated with their role as peer educators.
- **Behaviours**, interwoven with knowledge and skills, peer educators should be encouraged to discover, mirror and adopt behaviours related to their role as peer educator.

The perspective of this framework favours the views and preferences of young people and young peer educators themselves, although it has also been informed by the literature and case studies of successful peer education approaches. However, as explained above, the project team is keen to explore the use of e-learning as an innovation to peer education for young people.

Knowledge	Suggested mechanism/training	Learning outcome
Core health and wellbeing knowledge	Face to face training or on the job learning, experimental use of e-learning.	Understand what is meant by health and wellbeing, the effects of lifestyle on health and how to improve their own physical and mental health. Peer education as a health promotion approach.
Knowledge on the project particular topic of interest (e.g. sports and physical activity, sexual health, gender violence etc.)	Face to face training, self-directed learning, on the job-learning, experimental use of e-learning.	To gain in-depth knowledge on a particular topic in order to promote awareness.

Skills	Suggested mechanism/training	Learning outcome
Presentation skills to deliver healthy messages to a group of peers	Formal face to face training or on the job learning, experimental use of e-learning.	To be able to plan and deliver a topic presentation to a group of peers.

Skills	Suggested mechanism/training	Learning outcome
Communication skills to motivate and or support others improve their health and wellbeing	Formal training and on the job activities, experimental use of e-learning.	To acquire and/develop communication skills to motivate and/or support others improve their health and wellbeing.
Planning and organisational skills to deliver health related campaigns and activities	Formal face to face training or on the job learning, experimental use of e-learning.	To gain the capacity to lay out a simple plan for the delivery of health activities.
Leadership skills for health promotion	Formal face to face training or on the job learning, experimental use of e-learning.	To gain the ability to influence and inspire peers to improve the health and wellbeing of themselves and their community.

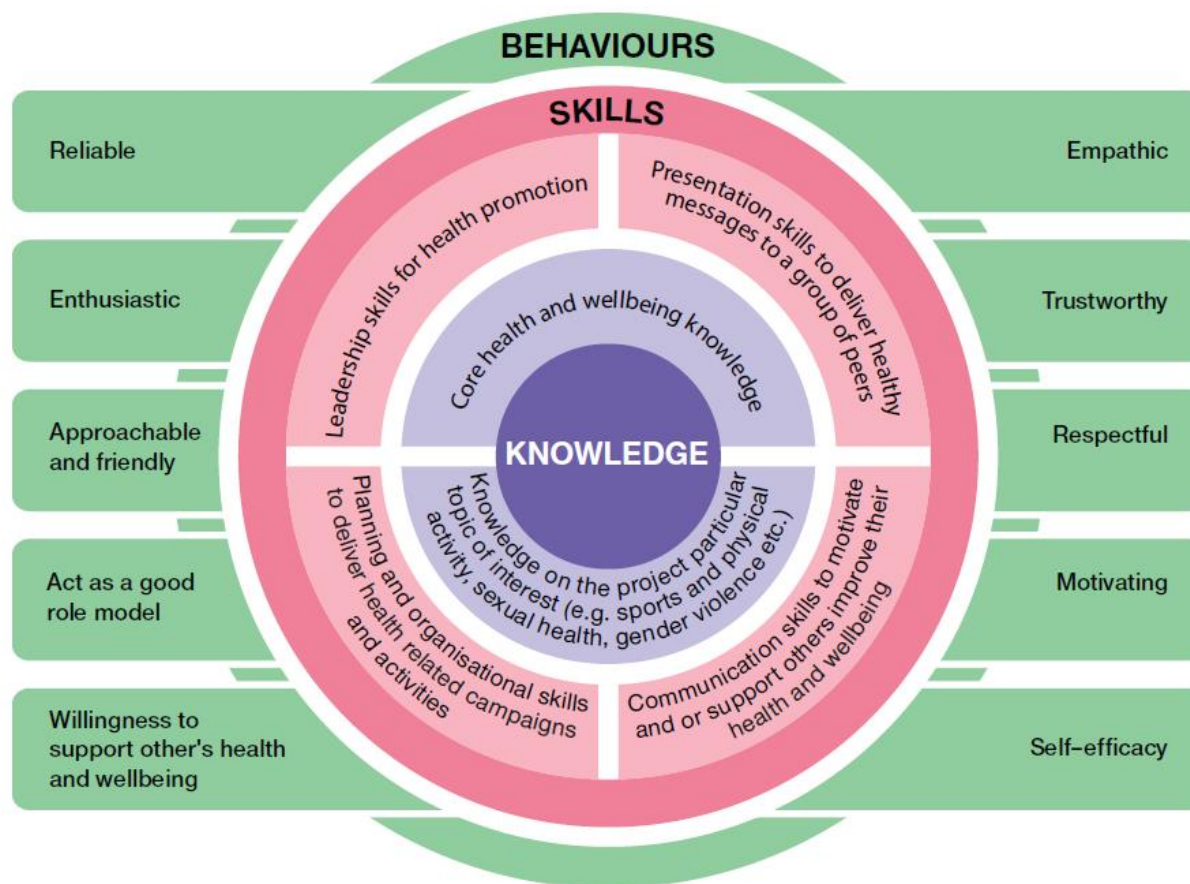
Behaviours	Description
<b>Reliable</b>	Commitment to completing all designated project activities in a timely way and to the best of their ability.
<b>Enthusiastic</b>	Show an interest and eagerness in improving health and with the project activities
<b>Approachable and friendly</b>	Show willingness to be approached by their peers to help them access health information and/or services
<b>Act as a good role model</b>	Championing and practising the health behaviours being promoted by the project.
<b>Willingness to support other's health and wellbeing</b>	Listening and talking to other young people about their issues.
<b>Empathic</b>	Ability to understand and share the feelings of another person.
<b>Trustworthy</b>	Able to be relied on as honest or truthful.
<b>Respectful</b>	Including politeness and culturally aware.
<b>Motivating</b>	Ability to positively encourage others to achieve their goals
<b>Self –efficacy</b>	Believing in oneself capacity to achieve things

Each section is interlinked and acquisition or competences can be achieved through training, experience, feedback and from observing others. It is recommended that experienced and knowledgeable professionals in youth work direct this training process.

Fig 2 – Final competencies framework for European peer educators

## EUROPEAN YOUTH HEALTH CHAMPIONS COMPETENCIES FRAMEWORK

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## Annexes

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### *Annex 1 - Useful sites and further information*

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#### **Youth Peer Education Toolkit (2006)**

A group of resources designed to help program managers and trainers of peer educators. Collectively, these tools aim to help develop and maintain effective peer education programs. The five parts of the toolkit are based on research and evidence from the field as well as local examples and experiences. They are designed to be adapted locally as needed. The toolkit resulted from collaboration between the United Nations Population Fund (UNFPA), Family Health International and Youth Peer Education Network (Y-PEER).

<http://www.unfpa.org/resources/peer-education-toolkit> (last accessed 1 November 2017)

#### **HIV Prevention among Young People: Life Skills Training Kit, Volume 1 (2006)**

A manual developed by United Nations, Economic and Social Commission for Asia and the Pacific. This is a training kit for trainers of peer educators which focuses on HIV prevention but that has standard elements for any peer education programme.

<https://tinyurl.com/y8oaauky> (last accessed 1 November 2017)

[http://www.unodc.org/pdf/youthnet/action/message/escap\\_peers\\_01.pdf](http://www.unodc.org/pdf/youthnet/action/message/escap_peers_01.pdf) (last accessed 1 November 2017)

#### **Girlguiding**

Practical guidance and tools to deliver Girl guiding programmes and run activities in a safe and creative way.

<http://www.unfpa.org/resources/peer-education-toolkit> (last accessed 1 November 2017)

The resources include an open peer educator e-learning programme.

<https://www.girlguiding.org.uk/making-guiding-happen/resources/resource-library/e-learning/become-a-peer-educator-e-learning/> (last accessed 1 November 2017)

### **My-PEER Toolkit (2010)**

Developed by the Western Australian Centre for Health Promotion Research at Curtin University in Perth, Western Australia, this toolkit is a resource aimed at supporting agencies to implement and evaluate peer-based programs for young people using good practice guidelines.

<http://mypeer.org.au/> (last accessed 1 November 2017)

### **Approaches to Peer-led Health Education: A Guide for Youth Workers Paperback – 1 May 1993**

Published by the then Health Education Authority in England and written by Ian Clements and Martin Buczkiewicz, this guide is intended to help youth and community workers to examine the use of peer-led education and methods in health-promotion work. It provides a series of training exercises for youth-work teams and contains practical ideas for raising health issues with young people

<https://www.amazon.co.uk/Approaches-Peer-led-Health-Education-Workers/dp/1854485458>

### **European guidelines for youth AIDS peer education (1998)**

This is an evidence-based resource for the design and implementation of peer education programmes with emphasis on AIDs prevention. However, the guidelines are transferable to other subjects.

<http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/HIV%20AIDS%20102e.pdf>

### **Included, involved, inspired, a framework for good practice for an effective IPPF peer education programme**

Developed by the International Planned Parenthood Federation, this framework is a guide that can be used by programme designers, managers and coordinators, as well as by senior managers overseeing larger peer education initiatives.

[https://www.ippf.org/sites/default/files/peer\\_education\\_framework.pdf](https://www.ippf.org/sites/default/files/peer_education_framework.pdf)

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## *Annex 2 - European Youth Health Champions Focus group template*

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### **Terms of reference**

#### **Participants**

- Please select young people between 14-25 years old with some experience on peer education of any subject. If the participants of your group are slightly younger or older, please specify it in your report.
- 5 to 10 people per group
- 6-8 preferred
- No more than two groups per country

#### **Environment**

- Comfortable
- Circle seating
- Tape recorded if possible (please ask for verbal or written authorisation by the individual if over than 18 years of age or by the parent/guardian if less than 18 years of age)

#### **Moderator**

- Skilful in group discussions (experienced in working with young people)
- Adheres to pre-determined questions
- Establishes permissive environment
- Make a smooth & snappy introduction Standard introduction 1. Welcome 2. Overview of topic 3. Ground rules 4. First question
- Use pauses and probes 5 second pause Probes: "Would you explain further?" "Would you give an example?" "I don't understand."
- Gets at least half of the number of participants views before moving to the next question.
- If possible, there is support of an assistant who makes quick notes of the comments made by participants.

#### **Analysis and Reporting**

- Systematic analysis, within hours if possible listen again to all the answers per question, make notes, and provide a summary per question.
- Translate to English
- Send your reports to Nelly Araujo [naraujo@rsph.org.uk](mailto:naraujo@rsph.org.uk) using the template.

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### *Annex 3- Focus group introduction guidelines*

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#### **Introduction**

- Introduce moderator and assistant (if applicable)
- Our topic is health peer education for young people.
- The results will be used as part of the findings of research which will inform the design of a package in support for young peer health educators across Europe.
- You were selected because you are a young health peer educator or training to become one and your experience and thoughts about the process of becoming a peer educator will help us understand what works best.
- The focus group will have a duration of about one hour.

#### *Key points*

- No right or wrong answers, only differing points of view.
- We're tape recording, one person speaking at a time.
- You don't need to agree with others, but you must listen respectfully as others share their views.
- Second part of the session is to be completed in pairs.
- Rules for mobile phones if applicable. For example: We ask that you turn off your phones. If you cannot and if you must respond to a call, please do so as quietly as possible and re-join us as quickly as you can.
- The role of the moderator will be to guide the discussion only.

#### **Questions**

##### **Part 1**

Prior to starting with the first question, please ask the participants to think about training as a process which involves a variety of activities over a period of time until you feel confident with the role, including attending a face to face course, undertaking an e-learning course, observing others do the job, doing your own research, practicing on the job, receiving advice from tutors etc. In other words, to think about training in the widest possible sense.

1. Could each of you explain how did you train or are you training to become a young health peer educator? E.g. Attended a training programme, attended workshops, I was asked to prepare presentations for my classmates etc.
2. What part of your training process to become a peer health educator was OR has been the **most helpful** and why?

3. What part of your training process to become a peer health educator was OR has been the **least helpful** and why?
4. Have any of you ever completed an e-learning course? – either as part of the training process to become a young peer educator or as part of a different training process.
5. Whether or not you have done an e-learning training course, in your view, what are the advantages of an e-learning training course?
6. What are the disadvantages of an e-learning training course?
7. In your opinion, would you agree that doing e-learning is an effective way to train as a health peer educator? Yes/no and why? (MODERATOR- This is a general question about the young health peer educator role in general but answers could point out that e-learning is only good to train for particular aspects of the role, please dig in)
8. In your opinion, what do you think is the best way to train as a young health peer educator?

## **Part 2- (To work in pairs or individually)**

As part of the initial research, we have come across a set of knowledge, skills and behaviours for young peer health educators. Skills and knowledge are presented at two levels of the development, level one being for mastering the basic/core knowledge and skills and level two to acquire some more advanced/particular knowledge and skills.

9. In pairs, take a look at the **skills first**, can you mark as essential all the ones that you think should be “indispensable” at that level (level 1 or 2) and as “desirable” the ones you think are not so important at that level? Can you add any missing? Would you change the level of any of those? (MODERATOR- Please ask for any marked as desirable or changed of level and the reasons. Please also ask for any additions and the reasons as to why those should be added)
10. Please look now look at the **behaviours**, can you mark as essential all the ones that you think should be “indispensable” and as “desirable”, the ones you think are not so important? Can you add any missing? (MODERATOR- Please ask for any marked as desirable and ask for the reasons. Please also ask for any additions and the reasons as to why those should be added)
11. Now please consider the knowledge requirements. Are they enough? Yes/no why? What other knowledge would you add? Do you agree with the levels?
12. As a young peer educator, what other training needs do you think you have? (MODERATOR- This is a question to exhaust thoughts that could have come up in questions 9-11)

## Tool for part 2 (to work in pairs)

	Essential or desirable	Is the level right? Yes/no	Any comments
LEVEL 1 Skills - Basic			
<b>Research skills to find and access health services and information</b>			
<b>Presentation skills to deliver healthy messages to a group of peers</b>			
<b>Communication skills to motivate and or support others improve their health and wellbeing</b>			
<b>Planning and organisational skills to deliver health related campaigns and activities</b>			
<b>Please add any knowledge you think is missing</b>			
<i>(add any missing skills here)</i>			

	Essential or desirable	Is the level right? Yes/no	Any comments
LEVEL 2 Skills - Advanced			
<b>Problem solving skills to address practical issues</b>			
<b>Leadership skills for health promotion</b>			
<b>Skills on how to provide health and wellbeing advice (coaching skills)</b>			
<b>Skills on the use social media and digital technology for peer health education purposes</b>			
<i>(add any missing skills here)</i>			

		Essential or desirable	Any comments
Behaviours	Description		
<b>Reliable</b>	Commitment to completing all designated project activities in a timely way and to the best of their ability.		
<b>Enthusiastic</b>	Show an interest and eagerness on improving health and the project activities		
<b>Approachable and friendly</b>	Show willingness to be approached by their peers to help them access health information and/or services		
<b>Interest in health (or a particular health related topic)</b>	Show an interest learning and disseminating health knowledge and messages		
<b>Act as a good role model</b>	Championing and practising the health behaviours being promoted by the project.		
<b>Willingness to learn new skills</b>	Showing eagerness to challenge themselves and go out of their comfort zone.		
<b>Be a good team player</b>	Practices and promotes co-operation and mutual support.		
<b>Willingness to support other's health and wellbeing</b>	Listening and talking to other young people about their issues.		
<b>Empathy</b>	Ability to understand and share the feelings of another person.		
<i>(add any missing behaviours here)</i>	SEE ABOVE		



LEVEL 1 Knowledge- Basic	Essential or desirable	Is the level right? Yes/no	Any comments
<b>Core health and wellbeing knowledge (e.g. what is health, how to keep healthy and how promote health and wellbeing among our community)</b>			
<i>(add any missing knowledge here)</i>			

LEVEL 2 Knowledge- Advanced	Essential or desirable	Is the level right? Yes/no	Any comments
<b>More in-depth knowledge on a particular topic of interest (e.g. sports and physical activity, sexual health, gender violence etc.)</b>			
<i>(add any missing knowledge here)</i>			

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### Annex 4 – Case study template

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#### European Youth Health Champions Case Study Template

Please provide 3 case studies of successful youth peer education programmes in your country. The three conditions for a successful programme are, evidence based (there is a clear peer education model), addresses health inequalities (focusing on young people with fewer opportunities) and has proven outcomes (through evaluation/feedback).

Please bear in mind the following definition of peer education:

*“Peer education is an approach to health promotion, in which community members are supported to promote health-enhancing change among their community. Peer education is the teaching or sharing of health information, values and behaviour in educating others who may share similar social backgrounds or life experiences.” Adapted from Green, J. (2001). Peer education. Promotion and Education, 8(2), 65-68. doi: 10.1177/102538230100800203*

#### Programme name and organisation

Please state the name of the programme and the organisation.

#### Brief description of the programme (up to 300 words)

Provide a brief description of the project including details about:

- The programme objectives, strategies (training, workshop sessions, health campaigns) and key outputs (just briefly as more detail will be asked in the following section).
- The target groups (primary and secondary, examples of primary groups are 14-25 Young people in settings such as schools, universities, youth clubs, health services, in the workplace; young people not in education or training, young carers, young offenders. Examples of secondary groups are teachers, carers and health professional supporting the project).
- How was the programme evaluated?
- How the needs and views of the primary and secondary target groups were incorporated in the development of the project.
- The setting in which it was delivered and the geographic areas where these settings are located.
- The period in which the programme was or is being delivered.

#### Outputs

The direct and measurable products of a program’s activities or services, often expressed in terms of units (hours, number of people or completed actions). For example, 200 youth peer educators were trained in x number of districts during the 3 years of the project; 10 health campaigns delivered by youth peer educators in the area of the project during 2016.

## Outcomes

The results or impact of these activities or services, often expressed in terms of an increase in understanding, and improvements in desired behaviours or attitudes of participants. In your logic model, outcomes refer to the short-term, mid-term, and long-term goals of your program. For example, 80% of the youth peer educators reported an increase in confidence in the delivery of health messages with their peers; 15% of students at x number of schools reported to have had requested and received support from a peer educator.

## What made the project successful?

Based on the information you have gathered, please provide an overview of the elements you think should be highlighted as key to the success of the project/programme, for example the training methodology, secured funding, partnership working etc.

## References

Please provide where possible complete references of the sources of information including, reports, journal papers, interviews, communications, lectures/presentations. A complete reference would include, name of all the author (in order), organisation (if applicable), year, issue details (for journals and other publications), pages, country and language. If possible, provide copies of hyperlinks to the documents consulted.

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### *Annex 5- Youth peer education case studies*

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#### **Case study 1- Active Future Programme: using physical activity to promote education amongst adolescents at risk of early school leaving**

##### **Ireland**

The Active Future Programme (AFP) is an eight-week health and education programme that aims to promote physical activity and mental health, encourage healthy living and facilitate third level educational progression amongst marginalized adolescents (16-18 years old) who are at risk of leaving school early and/or suffering mental health difficulties. It is a partnership between a school and higher education college. The participants in the programme are identified by the school and third year Sports Science students provide peer education in the form of a physical health workshop and a physical activity session. In addition, a psychotherapist provided input on mental health. As well as the positive outcomes anticipated in the attendees, the programme also aimed to develop the skills set of the students to engage more effectively with the cohort and to continue to mentor them through further education.

The programme was delivered after school on a Friday afternoon in eight two hour-long sessions. 20 participants were recruited to the programme and 15 Sports Science students were trained as peer educators to deliver it. It was evaluated using pre- and post-intervention focus groups with the participants, and feedback was sought from the students about how the programme had met their learning needs. Focus groups with participants found an increase in social connectedness, a desire to attend college and a reported increase in physical activity. A lack of judgement, the variety of activities and the supportive environment were the key factors that empowered participants to become more active.

*“Doing the physical activity, it does make you feel better about your mood, it makes you feel better about yourself... If it was to happen next year I would do it again...I don’t do PE in school but I did it in this programme... I just didn’t feel judged at all.” (F, 17)*

*“I wasn’t thinking about going to college because I thought it was going to be much harder... it made me realise that there is a lot more people there to help you out if you are stuck on any subject...Now I would really think about going to the I.T... I came out of it each week and felt absolutely brilliant. It was what I looked forward to most at the start of the week” (M, 16)*

The students reported that it was a valuable learning experience which improved their skillset and confidence to promote physical activity and health behaviour change with this cohort. They recommended that it should be integrated permanently into their 3rd year curriculum. The project leader stated that AFP is easily scalable and other colleges have been encouraged to replicate it. Success factors related to the focus on physical activity and to the learning styles adopted in the sessions. With regard to increased engagement in physical activity:

- It provided an opportunity to participate in physical activity free of charge
- The pre-intervention focus groups highlighted that participants' disinterest in physical activity was related to traditional sports rather than activity itself. So Zumba, fun games and strength and conditioning activities, especially those where no equipment was needed were emphasised.

With regard to the style of education:

- Workshops included various elements of group discussion and practical elements to keep participants engaged
- The students and participants were seen as equals with collective ownership of the content and involvement in planning and evaluating sessions
- Students and participants all ate and took part in workshops together to remove any potential power imbalances.

To increase participation and sustainability of the initiative five participants will return as leaders for the following year, helping to design and deliver the session with the students.

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### **Case study 2 - Come Together Youth, EWOS 2016**

#### **Across Europe**

The project ComEWOS consisted in organizing a European Week of Sport (EWOS) event in 6 EU countries (Italy, Slovenia, France, Spain, Poland and Denmark). The main objective was to promote 'slow exercise for health' and raise the awareness of young Europeans (aged 16-18 years) on HEPA (Health-enhancing physical activity) focal points and WHO (World Health Organisation) Global recommendations on physical activity for health. The project is co-funded by the EU programme for education, training, youth and sport and realised by Unione Italiana Sport Per tutti (UISP) (Italy), in partnership with 5 associations: Sportno Drustvo Partizan Skofja Loka (Slovenia); Ufolep (France); Red Deporte Y Cooperación (Spain); Fundacja V4Sport (Poland); DGI (Denmark).

Come Together Youth is a sporting event that consists of walking fast, or running slowly in a sort of 'inverted race' or 'reversed match'. Teams are constituted by small groups with the same pace, and the goal is that having started separately, they all arrive at the finish line together, contrasting the traditional idea of one winner. The concept of 'slow exercise' allows participants to learn their ideal pace which is effective to improve health, but not too strong or excessive.

The project involved 600 members of sport organisations, 12 sport operators and 12 school teachers from 6 EU countries who trained 1600 school pupils to be aware of the importance of enhancing health

through physical activity using the slow run/fast walk methodology. As well as changing the young people's behaviour on physical activity it consolidated partnership with other sports and health agencies. The project provided participants with:

- training course for sport organizations operators and Physical Education school teachers from 6 EU countries on the Come Together slow run/fast walk methodology,
- The realization of a 5 dates education modules.
- The Organization of a EU-wide sport's event within the European Week of Sport (EWOS) 2016 based on the slow run/fast walk Come Together methodology, to be hosted by other bigger EWOS events in the same town involved in the project, or to be specifically organized by sport organizations participating to the project.

The authors state that in addition to increasing the level of activity in the participants, the culture of slow and regular exercise for health was transmitted, spread and consolidated in the schools from six EU countries. They also note that the young people introduced this culture to their families. The concept of 'slow exercise' is seen to be a success factor, in addition the production of a smartphone app to test the pace of health gain and provide a tool to identify the right speed. However, there is no information provided about the peer education aspects of the project, and no further information can be gleaned from the references. The project clearly engaged the young people in physical activity but whether the spread was facilitated by peer education cannot be determined.

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### ***Case study 3 - Educazione tra Pari: Programma di promozione della salute nelle Scuole secondary di II grado***

#### ***Italy***

The project is organised by ASL Milano and has been run at a high school in Milan since 2011. It utilises a peer education model which is described as having as its main objective the development of youth empowerment. While work objectives are determined by adults, the implementation phase is planned and run by students. The project aims, therefore, to recognize and promote an active role for teenagers who become champions of their training within a path of promoting socio-educational well-being for themselves and for other school students. Parents are also trained and educated about the prevention of risk behaviours (relational, sexual and substance abuse). The educated students subsequently carry out interventions and events within their own school aimed at encouraging discussion between peers on the topics proposed and promoting a change in knowledge, attitudes and beliefs.

The direct recipients of the project are some 3rd grade students selected for peer education training, different categories of recipients may be agreed depending on the needs of the school. The indirect beneficiaries of the intervention are the remaining students of the school. The project is supported by providers of preventive medicine and addiction services. In 2017 the project involved 150 young peer educators, ten teachers and five ASL staff. Over the three years of the project the training requires a commitment of approximately 20 hours of school time over 15 days. Evaluation seems to have been built into the design of the training programme but is otherwise not specified. The objectives of the project are to:

- Encourage the empowerment and active participation of youngsters within the school, in particular on the subject of health and wellbeing.
- To form a stable peer group within three academic years, focused on knowledge and mutual collaboration, through an experiential path and an active type model.
- Increase Life Skills and Knowledge on Health Issues (HIV/AIDS Prevention and Sexually Transmitted Diseases, Contraception, Bullying, Prevention of Use/Substance Abuse, Alcohol and Drugs).
- Introduce the socio-health services of ASL in order that educators can present them to their peers.
- Encourage the recognition of peer educators as a resource within the school (by the Executive, the Health Commission and teachers).

As a result of the project, peer educators have increased their sense of responsibility, their capacity for self-observation and reflection, as well as increasing their own knowledge of the health issues to be conveyed to their schoolmates. The training course aims to develop individual skills and abilities (Life Skills), increasing the ability to manage relationships with others in a positive way, enhancing self-efficacy and resisting negative peer pressure, improving communication and managing emotions.

Feedback showed that of all the topics addressed during the project, sexuality was the hardest to deal with owing to inhibitions and the taboo nature of the subject. Overall, the interventions have allowed the peer educators to provide more information and, despite some previous knowledge, the school students said they had received new information and clarified some doubts about knowledge previously acquired. There was also interest in issues affecting affection, topics that youngsters feel very close to them, but of which they hardly speak.

Success factors for the project were:

- The collaboration and support of the teaching staff. It was necessary to identify a teacher who played the role of the referent in the School for the internal organisation and to maintain the relationship between the Educators of Equality, the ASL Operators and the Class Coordinators /teachers.
- In terms of methodology, the effective tools used were knowledge and presentation games; widgets in an enlarged group and subgroups; brainstorming; discussion groups and reflection on themes; role-plays.

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### ***Case study 4- Jongerenadviseurs J@ (Youth Advisors)***

#### **Belgium**

Jongerenadviseurs J@ (Youth Advisors) is a methodology with a focus on friends helping friends (peer support). It is run by different youth advice centres (JACs) in Flanders. The basic framework is similar for all J@ projects, but the specific implementation differs according to the local context. JACs are low threshold meeting points for 12-25 year olds where they can meet a social worker who gives advice, information and practical assistance, or contact them via phone, e-mail or chat. This service is free of charge and anonymous, and is subsidised from government funding.

The core methodology for Youth Advisors has been in use for about 25 years, Youth Advisors is about friends helping friends. Research among 14-20-year-old Flemish school pupils points out that youngsters above all consult their friends when they have a problem (In Petto, 2011). This project builds on the positive forces of support and influence that are present in social interaction between young people. It focusses on prevention and has three main goals:

1. Reduce the threshold to the Youth Advisement Centre
2. Support young people by young people in their own environment
3. Keep up with the concerns of youngsters and adjust the activities to meet needs of the target groups

Youth Advisors are youngsters between 15 and 25 years old, their role is listening to peers, giving them advice and when necessary redirecting them to specialised help. They are not professionals, but remain informal peers. They are often seen as a good listener and someone who is approachable. Training and counselling is provided to Youth Advisors to enable them to develop the skills and knowledge to manage the role. During this training they learn how to support their peers and become aware of their own possibilities and limitations. The starting point of the training is empowerment (youngster learn from each other) and interactive and experiential learning methodologies form the basis of the course. In 2-weekly follow-up meetings a variety of themes are discussed e.g. alcohol, drugs, depression, suicide, self-confidence, teenage pregnancy, bullying. Data on self-assessment of competence is collected at the start of the course and after one year. Good practice that has developed includes: involving Youth Advisers in the training of a new group; focussing on the socially vulnerable and providing extended training.

There are no general figures available across all the projects but as an example of scale one JAC trained 530 Youth Advisers in 20 years. The authors report the following keys for success, and possible pitfalls:

- Cooperation with other (social) partners is desirable and mapping social partners is a valuable exercise



- Having Youth Advisors from diverse backgrounds helps to broaden the reference framework of the participants
- Working with Youth Advisors is time and money consuming. Applying for grants/subsidies is important and projects need to be sensitive to the changing political context and flexible in how projects operate.
- Recruitment processes are key to ensuring commitment to participate in a training course to become a Youth Advisor. It is advised to recruit individuals rather than groups that already exist because the prehistory of the latter can hinder the dynamic of the training course. A 10-minute presentation in school classes is an approach that several organisations apply, linking the information with a face reduces the threshold to engage in the course.
- Timing and accessibility of the training needs careful consideration. It is also useful to provide at least a part of the course in the setting of the youth centre to increase familiarity with the organisation.
- As the Youth Advisors work for their peers, the setting in which they operate needs to be a natural setting like youth club, pub, street, lunchbreak at school etc.
- For projects like this with a long history it is important to keep highlighting the benefits and refreshing it as necessary.

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### **Case study 5 - Let's Get Physical, StreetGames and Birmingham City Council**

#### **UK**

Lets Get Physical (LGP) is a StreetGames programme running since 2010 in Birmingham, that provides overweight and inactive children and young people in disadvantaged areas, aged 8 to 14, with opportunities to take part in specially designed physical activity sessions. LGP aims to build their confidence and enjoyment of sport and physical activity, and also to support volunteer and parental involvement, and integrate with and support other local services in the area.

Across Birmingham 28 Primary schools and 6 secondary schools were involved. 141 taster sessions, five 6-week and 21 9-week school based programmes were run. 15 community locations were also used. In all there were over 9,000 attendances. The programmes recruited 30 sessional staff and 25 peer

educators' volunteers, and provided RSPH level 1 & 2 in Health training, to which 20 people attended, and 30 people attended other non-accredited training.

At school based sessions participants completed a PAQ – C Questionnaire at the outset and again in 6 months & 12 months: 2011/12 67% of participants had increased or maintained levels of participation; 2012/13 & 2013/14 73% of participants had increased or maintained levels of participation. Case studies identified that:

- Children had positive views of the sessions
- Pedometers were particularly motivational
- Friendships were important, both having existing friends at the sessions & being able to make new friends.
- The programme is positively changing the attitudes of the children involved, increasing their activity levels, confidence, self-esteem and motivation
- The project operations and support infrastructure were highly rated as effective by coaches, volunteers and schools

Let's Get Physical clearly reaches a large number of young people in the city and has evaluated extremely positively in terms of acceptability and impact on physical activity.

The authors state that the success factors included:

- Understanding the barriers to participating in sports or physical activity for inactive young people including: lack of physical competency and skills; feeling self-conscious e.g. body image, fear of falling or looking foolish; lack of access to suitable activities or social networks and not enjoying competition.
- Techniques and Strategies used to support behaviour change towards adopting a healthier lifestyle, using the FUNdamentals approach introducing young people progressively to physical activity and took them on a journey to develop the basics with balance, agility and coordination, to more complex core skills of running, jumping, throwing, catching and striking.
- Psychological factors. Coaches recruited showed an ability to empathise with non-sporty children and their own personality was instrumental in helping children develop confidence. 1v1 mentoring played an important role with coaches listening carefully to provide support, reassurance, affirmation and guidance rather than instruction.

## References

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## **Case study 6 - Malta Girl Guides, Stop the Violence: Voices against Violence**

### **Malta**

This is a world-wide initiative promoted by the United Nations in collaboration with the World Association of Girl Guides and Scouts. The programme works with children and young people from the ages of 5 to 25 to raise awareness of their rights and responsibilities in relation to violence and violence prevention. It also looks at recognising signs and symptoms, self-esteem and assertiveness. A baseline secondary school survey showed over 90% had experienced or witnessed violence. Running since 2011, the programme in Malta mainly targets domestic violence, child abuse, teenage dating violence, homophobia and transphobia, bullying and cyber bullying. Girl Guides instituted a badge curriculum involving a number of workshops which address the following six themes: being safe; think; identify; support; speak out and take action. Some of the actions implemented include videos, posters, silent marches, sit-down protests in their communities. The approach includes critical consciousness-raising techniques about violence in the community and taking social action e.g. legislative proposal to government on female genital mutilation and the minimum age for criminal responsibility.

The programme targets children and young people aged 5-25 who are members of the Girl Guides and Girl Scouts association, as well as teachers and youth workers who promote the programme in schools and youth settings. Around 700 children and young people have been involved in campaign activities and approx. 50 leaders have been trained in delivering the programme. Leaders vary in age but many are young women between the ages of 18 and 25 years old.

Outcomes of the campaign include:

- Training of leaders and professionals
- Training of children and young people
- Identification of cases of violence and referral to appropriate services
- Setting up of reporting and referral mechanisms
- A number of campaign actions organised by children and young people
- Legislative proposals some of which have been taken up by the government
- A publication on teenage dating violence aimed at young people
- Partners in an EU funded project which involves the training of Scout leaders to train boys in the programme.

Authors report that the project was successful because:

- The programme is research-based and transnational
- It includes a train the trainer programme to ensure consistency in quality of delivery
- It is based on non-formal education methodologies and has well-structured curriculum content
- The Girl Guides have invested time and energy in establishing networks and building partnerships
- They are also motivated and committed to addressing the issue of gender violence

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#### VIDEOS BY MGG UNITS

<https://www.youtube.com/watch?v=1FdEGSYMnPg>

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#### **Case study 7 - MOVE Week Bulgaria**

##### **Bulgaria**

Move Week Bulgaria is a campaign run by BG Be Active Association, coordinator of MOVE Week in Bulgaria, and the Municipality of Plovdiv, as part of NowWeMOVE (NWM), Europe's biggest civil campaign promoting sport and physical activity as established by the International Sports and Culture Association (ISCA). The campaign involved the participation of young peer educators called Youth Move Agents, who were recruited from youth organisations, NGOs, sport clubs and schools. Youth Move Agents received training on the aims, objectives, scope, and core messages of the campaign and had responsibility over its promotion and delivery activities within their setting. The project also provided training for teachers, youth workers and other professionals who work with young people on a methodology which encourages them to teach through sport. The project provided central on-going support and a wide range of materials for the use of Youth Move Agents and professionals. The first MOVE Week initiative in Bulgaria was in 2012, and it has continued until 2016.

The overall objectives are to:

- Promote physical activity and healthy lifestyle for all
- Empower young people as main actors and organisers of the activities – not just as participants or supporters

The strategies employed to achieve this included:

- Development of resources on different topics such as project management, event management, fundraising, communication and PR, marketing, work with volunteers, etc.

- Organising training for youth workers and young people based on the available resources
- Possibility for internship in BGBA
- Trying to establish a network between the young people that were trained and local organisations that are part of MOVE Week and NWM campaigns, so the organisations can offer further support
- National communication campaign and development of marketing materials, e.g. t-shirts, bracelets, pins, along with open resources, designs and templates

The target groups were youth organisations and NGOs, sports clubs, schools, and young people – either as representatives of the above or as potential volunteers and event organizers.

In the first year (2013 – 2014) the resources were only disseminated online, but in 2015 there were 24 training courses around the country for PE teachers and youth workers on the methodology of Education through sport, reaching over 600 people (volunteers, youth workers, teachers and other school administrative staff). In 2016, 13 courses in 11 cities trained around 200 young people in the country, especially from disadvantaged areas. These Youth MOVE Agents then became ambassadors in their local communities and organised more than 13 events in the following MOVE Week 2016 and European No Elevators Day 2016. The training was focused on the resources which NWM campaign offers to young people and how they can use them to gain experience and to work with other young people in order to promote healthy lifestyles and physical activity.

The programme was evaluated through reports and feedback for event organizers, and national research was undertaken in 2015. A survey was conducted by face-to-face interview with 1030 participants who were representative of the population aged over 15 years. From the findings, the campaign had reached a large section of the population who had heard of it, although fewer had been motivated to participate. The strongest influence on participation in sport or physical activity was the example of peers, colleagues and friends.

Success factors for the project as a whole were:

- Marketing and promotional materials
- Communicational campaign and developed image
- Ongoing Support – National coordinator for NWM - a person who is supporting the organisers of events

### *References*

June 2015, Bulgaria - National representative research implemented by Institute for Financial Studies and Innovations, Bulgaria on the topic of Levels of Physical Activity in Bulgarians and Attitude towards PA and Sport – Full report is available in Bulgarian.

### ***Case study 8 - MOVE Transfer International (MTI) project: 8-week program for active lifestyle of students***

#### **Slovenia**

This project is part of the International Sport and Culture Association's programme to support the transfer of learning about successful physical activity projects between countries. It was run by the Faculty of Sport at the University of Ljubljana, Slovenia.

The aim of the project is to implement an experimental eight-week workout program to educate students how to change their lifestyle habits and to live more healthily and be more active now and into the future. The goal was to use sport as a tool, to show students how body composition, motor abilities and their internal feelings change, if they change lifestyle habits.

The primary target group of the programme has been students at the University, who are known to lead unhealthy lifestyles as students. A secondary target group of the programme were the trainers, carers and health professional who provide support to the project. Participants had chosen the free subject Fitness (ECTS) at the Sport University Centre, the total number of participants was 114 students. For the eight-week programme students did a 30 minute workout three times per week, and once a week a 45 minute aerobic workout of walking, jogging or running. Some of the sessions were organized, that is students were given instruction about exercising correctly and also given other lifestyle information, the remaining sessions were conducted unsupported.

The programme was evaluated throughout monitoring the impact of eight-week workout program using standardized fitness tests and the lifestyle habits questionnaire (Majerič et al., 2015). 41 students participated in the full evaluation. The evaluation showed that the intervention had a positive impact on: body composition; strength, aerobic endurance and flexibility; and on the lifestyle and healthy habits.

The authors state that the success factors included:

- The use of the programme as a tool for the students
- The combination of training and guidelines with 'self-trainings'

The success of the programme seems to be the transfer of an effective method of engaging young people in physical activity which provided an opportunity to also consider other aspects of a healthy lifestyle. However, no information is given about the training provided to the secondary target group to provide this intervention, and it does not seem from the information provided that they were peers in terms of age group or other characteristics. There may have been some element of peer support in the individual sessions of those that sustained the intervention but no information was provided about this.

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### ***Case study 9 - Peer-to-Peer Tutoring: Transferring successful methodology and learning strategy to reduce drop-outs in IVET***

**Italy**

This project was started in 2010-11 by the Higher Professional Technical Institute “Cesi Casagrande” in Terni, one of the biggest schools of the area (about 1,200 students). It uses a peer to peer tutoring approach to tackle the high level of drop outs in initial education and training of young people aged between 14 and 19 years old. Students are selected for their qualities and aptitudes and are trained by teachers on communication skills, and strategies to prevent distress and enhance wellbeing. Peer tutors would then be prepared to initiate support to other students on academic work and day to day issues including, alcohol, drugs, physical and psychological violence and bullying. Peer-to-peer education is an approach that empowers young people to work with other young people.

The program aims to: -

- Involve stakeholders in the area (local authorities, third sector associations, senior executives of schools, employees, citizens, productive entities)
- Strengthen the culture of peer education among school personnel and supporting the staff involved in the project
- Promote initiatives on the culture of legality, respect of people and property and the promotion of values,
- Communicate vision, mission, values and strategic and operational objectives to all members of the organization and to all stakeholders
- Stimulate and encourage the transfer of responsibilities, collaboration, empowerment, creativity and innovation, by improving peer leadership
- Develop partnerships and networks with stakeholders.

The project involved 170 tutors (peer educators) and 25 senior tutors. Target groups included: students as users of the education service; parents; teachers; health teachers and policy makers. The programme was evaluated using questionnaires for students, parents and teachers. The tutor guide for students and teachers was shared with other schools interested in using the methodology.

Participants reported that peer-to-peer methodology is a way to improve student’s self-esteem, life skills and school results. It helped to increase self-awareness, the ability to develop interpersonal relationships and increase understanding of others and empathy. Tutors also developed their communication skills, and were able to empathize with their peers, motivate learning, help them overcome dependencies and develop social skills. Tutees are more likely to call their tutors to help with problems which helps to prevent bullying and related issues and in turn builds the tutors sense of responsibility and self-confidence.

Key success factors: the appropriate training and support given to peer educators; and a focus on the combination of academic tutoring for colleagues with learning difficulties with development of life skills.

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<http://lnx.casagrandecesi.gov.it/peer2peertutoring/>

### ***Case study 10 -Progetto di Peer Education nella prevenzione dell'infezione da HIV***

#### **Italy**

This project was financed by the Italian Advanced Health Institute and promoted by Regione Lazio in 2005. It aimed to prevent risk behaviours in the field of HIV and sexually transmitted diseases (STDs) through educational and training activities. Teenagers aged 14-17 were recruited from 4 secondary schools in Rome, approx. 10-15 students per school. The age was selected on the basis of having had sufficient experience in the school environment while also being expected to remain for a few more years. The project had three phases: presentation of the project, identification and selection of peer educators; training of peer educators; and implementation of initiatives by peer educators. The training programme was held over ten sessions of 2-4 hours each, covering communication and sexual health topic issues. Part of the training programme was devoted to the design of the interventions by the peer educator.

The objectives of the project as stated were to:

- Facilitate young people in acquiring psychosocial well-being by making the values of freedom and responsibility, respect for oneself and the other, by providing the means to live better and with greater awareness of their sexuality
- Modify attitudes and behaviours that can be considered at risk
- Helping young people to take precautionary attitudes and behaviours with respect to the problem of interruptions of pregnancy and STDs

The project was evaluated through ad-hoc evaluation tools including questionnaires about HIV knowledge at different points during the programme.

The outcomes of the project included the development of skills needed to carry out the peer educator function such as: communication; relationships; and group management skills. By promoting the close working together of the peer educators it facilitated the emergence of a culture of prevention. For the school pupils receiving the peer education it made them more aware about risk behaviours in general and HIV prevention in particular.

The authors state that success factors included:

- The ability of the peer education model to guarantee flexibility and adaptability of implementation processes to adapt to realities in different schools, while maintaining a unit of structure.
- Providing an opportunity for young person's knowledge to meet and confront with adult knowledge in a reciprocal relationship
- The ability of the adult and teenager to work together to identify needs and design initiatives
- The selection of peer leaders by their peers based on criteria that have not been imposed by adults.



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## Case Study 11 - Sport4Life

### UK

Sport4Life delivers sports-themed employability programmes in the Sparkbrook area of Birmingham over 3 years to, young people Not in Education, Employment and Training (NEETS)

Key activities involved are employability workshops that focused on life skills and core employability activities plus structured one to one mentoring, which continues up to 12 months beyond the programme. The programme delivers an accredited Level 1 (QCF) Award in Sports Leadership & an entry level 3 (QCF) Award in Life & Living Skills.

The following key outcomes were achieved:

- 79 NEET young people engaged (35% of the 225 (3-year) target)
- 65 young people progressed from NEET to EET (36% of the 180 (3-year) target)
- 72 young people improved self-esteem (34% of the 210 (3-year) target)
- 69 young people gained a qualification (33% of the 210 (3-year) target)
- 10 young people with criminal records did not re-offend after the programme (22% of the 45 (3-year) target)

Of the 65 young people who have progressed from NEET to EET, 15 (23%) have found employment, for most this was their first ever job. In addition to this, we have worked on improving life skills through our personal development and sport sessions – this is supported by the 72 (91% of young people engaged) claiming that the programme has improved their self-esteem.

Feedback from our beneficiaries suggested that they would prefer a programme that is more intense over less amount of time, so the programme structure was changed to run for 3 days per week over 5 weeks with continued one-to-one mentoring for up to 12 months beyond programme. This provides the same level of support allows the young people to move onto positive progressions more quickly. The programme is now delivered quarterly.

Success factors were reported as:

- Implementing social action projects for our young people to lead on. Clients found this both rewarding and useful for their personal development.
- The introduction of accredited qualifications is very useful to our young people, as they feel that they have something tangible to show for enrolling on the programme

Difficulties overcome included predominantly cultural issues:

- In terms of recruitment, we have found it more challenging to engage females. In order to overcome this, we have put activities on that might be more appealing to females – e.g. Glow Sports.
- Another cultural issue has been Ramadan. This is because of the strain it has on our beneficiaries both in terms of energy needed and ability for young people to focus during sessions. To overcome this, we have engaged clients in physical activity that has low physical exertion.

#### References

<http://sport4life.org.uk/>

### Case study 11 - Start 2

#### Belgium

Start 2 focusses on NEET-youngsters (Neither in Employment, Education nor Training) between 18 and 25 years in the city of Genk in a former mining region of Belgium. Through sport, social meaning and mental coaching it aims to help young people to a second start towards the labour market/work floor/employment. Partners include agencies representing youth welfare, social services, employment, and the university to support evaluation.

Start 2 gives socially vulnerable youngsters literally a second start. Young people who for whatever reason in the past weren't able to find or retain a suitable job or training can get their lives back on track by participating in the Start 2 six-month programme. This is done by peer support which includes: mental coaching; personal target-setting; readiness for intake interviews. In addition discipline, persistence and how to keep focus are the skills that will be developed by the training team. In Start 2, sport is used as a metaphor as, as for a competition you must prepare well, you have to focus and you have to perform when it matters. The project uses a "group approach" as a safe group is a powerful learning environment. The added value of this group perspective is considered to be: a platform to discuss personal themes; a reference base; feedback; support and encouragement to change; ability to practice things in a safe environment.

Since the inception of the project participants have mostly remained on the courses and a large proportion of them have succeeded in finding and sustaining work.

Key success factors are considered to be:

- The customised approach
- The intensive supervision and coaching
- The involvement of the local network of social services, supervisors and employers

## References

[https://www.genk.be/Ondernemen\\_Werken/Tewerkstelling/Werkgelegenheid\\_en\\_sociale\\_economie/Werkzoekende/Start2](https://www.genk.be/Ondernemen_Werken/Tewerkstelling/Werkgelegenheid_en_sociale_economie/Werkzoekende/Start2)

[http://www.nieuwsblad.be/cnt/blsme\\_02222574](http://www.nieuwsblad.be/cnt/blsme_02222574)

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## **Case study 12 - Street Action, powered by Buurtsport**

### **Belgium**

Street Action, powered by Buurtsport, created low-threshold offer of sports, physical activity and health activities in 23 municipalities or towns in Flanders (Belgium) for 12-18 year olds from vulnerable groups. The offer was facilitated by a local sports worker who, uniquely, was encouraged to work in a network of social partners while the young people were empowered to act on their own initiative as much as possible. Street Action, powered by Buurtsport was a project of ISB (Belgium), with the support of The Coca-Cola Foundation and Coca-Cola Belgium-Luxemburg in partnership with the Vrije Universiteit Brussel (2012-2014). Street Action gives youngsters the chance to participate in a coaching programme. They can further develop their skills during courses given by other young people. Being active as sports teachers during events and sport activities in their own neighbourhood also gives them the possibility to grow in their specific role. Participation in and through physical activity and sport is probably the best conceptualisation of this challenging project.

On average (n: 23) each local Street Action-project:

- Organised activities in 4 locations
- Reached a range of 300 to 400 participants of which 33% were girls, and 78% of them were from the targeted group
- Engaged 12 volunteers (16-25 year olds from vulnerable groups), of which 40% were girls, and 50% followed a specific course

Specific courses included:

- Youth animator: these were given by volunteers of Jeugd en Stad, Youth and City (JES), an organisation who is active in Brussels, Antwerp and Ghent. The young volunteers are trained to give a youth leader course which has a focus on sport and physical activity. The co-creation between them and the knowledge of sport and welfare was very meaningful and essential for the process.
- Recreation and physical activity animator: a specific course of the Vlaamse Trainersschool (Flemish Trainers School).
- First aid

The project was evaluated, and research into the in-depth conditions for successfully increasing adolescent's engagement in volunteering in community sport were translated into a competence toolkit.

There were more than 100 trained volunteers, most of whom are still active in the organisation where they followed a course and did their internship. They are considered to be the 'engine' of the projects and an important link between the involved organisation and the specific neighbourhoods.

One of the crucial conditions for reaching and keeping socially vulnerable youngsters in a sports program is the type of guidance given. In addition to a sports technical background, it is important as a teacher or guide to have knowledge and expertise about working with the target group to keep them motivated and enthusiastic. This includes: the style of teaching; the social and pedagogical competences; patience; communication; positive feedback; and empathy. A relationship of trust and investment in a safe environment are crucial to create a setting where youngsters can be themselves and build up a bond with other youngsters and teachers. An online competence toolkit was also produced combining practical instruments and instruction.

The authors listed a number of success factors and learning from the project:

- Working with vulnerable youngsters to take up more responsibilities is a difficult task and it takes more time than anticipated to stimulate active involvement and engagement
- For the young people participation was interesting and held different advantages (social surplus value):
  - gaining experience with regard to guiding and organizing (sport)activities
  - improving social and personal competences (working together, planning, taking responsibilities
  - handling children (punishing and rewarding)
  - meaningful leisure time
  - earning respect in the neighbourhood
  - expanding their social network
  - building up their CV.

Critical Success Factors for the project overall included:

- Youngsters need to have an affinity with sports and interest in taking up engagement and responsibilities.
- Youngsters need to have a say in the design of the programme. This can lead to an increased motivation and interest.
- They need to be supported and motivated, and shown appreciation. This improves their self-image and self-esteem.
- Communication must be clear and unequivocal
- Identify key figures within the youngsters as role models
- Collaborate with neighbourhood youth projects to broaden the guidance and opportunities beyond the sport element
- Partners must be aware of the need for patience and time
- Implement a systematic approach

## References

<http://streetaction.be/english>

<http://www.streetaction.be/library/files/Street%20Action%20-%20English.pdf>

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### **Case study 13 - StreetGames – Kent Youth Health Champions**

#### **UK**

The Kent Youth Health Champions (YHC) Programme ran from 2015-17. The main objective was to deliver a number of accredited and non-accredited training courses to Schools and Community groups in Kent. The Royal Society of Public Health (RSPH) accredited YHC courses enable young people to learn new practical skills and knowledge for promoting health and wellbeing to friends, families and wider communities. These were delivered over four days in each venue and the unaccredited courses were delivered over two days per group. The target groups were primarily young people aged 14+ in School and Community settings within areas of high deprivation in Kent; and the secondary targets were teachers, youth workers and early help workers from the local communities. The programme was commissioned by HeadStart Kent and provided by StreetGames who had experience in delivering YHC programmes for its own network of local projects working with young people in community settings in areas of deprivation throughout the UK. The aim was for young people to create and deliver peer to peer positive health promotion campaigns in their setting. In the first year eight training courses were delivered to 67 young people, and in the second year a further 13 courses were delivered with exact numbers trained pending.

Following training, the roles undertaken by the YHCs varied, but examples included:

- Organising a campaign e.g. via a school assembly, Board meetings
- Informal chats to peers at the park or in social settings
- Informal discussions with family members
- Providing static displays with information
- Signposting to services on site such as the school counsellor
- Signposting to information such as self-help books
- Mentoring of younger YHCs by older YHCs

- Follow-on peer mentoring support such as walk and talk before school and at lunchtimes, support groups for younger pupils.

An external evaluation of the Youth Health Champion Programme was undertaken (Walpole, 2017). It included a qualitative evaluation of projects that had completed the YHC training and campaign in the last twelve months, collecting data from: the coordinators, the YHCs themselves and from their peers by: semi-structured phone interviews with coordinators and one evaluation workshop in a community setting involving the coordinator, youth workers and the YHCs. The evaluation highlighted that the YHCs benefited in a number of ways from their involvement in the programme including:

- Gaining a wider understanding and knowledge of public health
- Gaining new skills such as communication and organisational skills, increased confidence, advocacy experience and a health-related qualification
- The qualification was important for young people wanting to pursue a career in healthcare or who wanted to study in further or higher education. A number of young people had already used it to help with college or university applications, or to gain employment in healthcare.
- For groups of hard to reach young people in two different community settings who were struggling in a traditional learning environment, this was their first qualification and was recognised as a significant achievement
- New friends were made whilst undergoing the YHC training and they had remained in contact either socially or digitally. In some cases, the young people felt as though they belonged to the group that they had trained with and wanted it to continue

The evaluation highlighted the following as success factors:

- The flexibility of the YHC programme has resulted in different types of organisations using it to support young people who are interested in either a career in healthcare or who have a general interest in health issues
- It is suitable for both formal settings such as schools and healthcare environments as well as informal settings such as youth and community projects
- In some instances, joint working between different organisations has strengthened partnerships and brought additional resources and skills to the YHC programme resulting in additional benefits for the young people and the organisations themselves
- Having a dedicated coordinator – one who has the support of the organisation's leadership team, time allocated within their workload, and access to resources, knowledge and training. (This is important for all areas of the YHC programme including the recruitment of the YHCs, the training programme itself, the campaign and any follow-up work that YHCs carry out in their roles as peer mentors)
- Support provided - co-ordinators with dedicated time and access to resources were able to give more time to their YHCs and help them to set up new formal types of peer support. Cross-age peer support was particularly successful in one setting, benefiting from the maturity and experience of the older YHC peer mentors.

## References

Walpole C, 2017. *Evaluation of the Youth Health Champion Programme*. Royal Society for Public Health.

### **Case study 14 - Us Girls Alive, StreetGames**

#### **UK**

Us Girls Alive aimed to improve the health of young women aged 16-25 living in areas of high deprivation in England through social, educational and healthy lifestyle activities. It did this by empowering young women from deprived areas to take a mentoring and leadership role within their existing sporting groups to encourage increased participation in sport/physical activity amongst their peer group and in doing so help to promote improved health and wellbeing. The programme was developed using a youth-led approach and ran for three years from Nov 2012 – Nov 2015. A total of 31 Us Girls Alive Clubs were established by StreetGames in 19 different locations across England. Sessions took place in a range of community settings within disadvantaged areas, typically this included community/youth centres and sports centres. Motivators (peer volunteers) were recruited from the young women attending the Clubs and provided with training to support them in their role. The training aimed to equip them to set up and run Lifestyle and Wellbeing Clubs, offering a range of health and educational activities. Clubs were intended to be self-managed and self-sustaining.

An independent evaluation was undertaken by the British Heart Foundation, which included: interviews and focus groups with a sample of Us Girls Motivators; interviews with Club leads; interviews with other stakeholders e.g. public health leads; and surveys with participants and motivators at two time points (see references).

Over the three-year funding period, the initiative delivered over 1,200 Us Girls Alive sessions, which involved 451 young female volunteers (Motivators) from areas of high deprivation helping to engage over 5,100 female participants from disadvantaged areas in the activity sessions. The external evaluation stated that this type of programme can: ‘Boost the confidence of young women in disadvantaged areas which empowers them to take on challenges which they previously thought they were incapable of’. Specifically, that:

- The initiative was successful at reaching the intended target audience of disadvantaged and inactive young women and at increasing their access to opportunities. This demographic is unlikely to seek information on important health topics such as sexual health, smoking, alcohol, mental health and drug use, however the Clubs provided a safe environment in which young women could learn about such things and make decisions to improve their behaviour.
- Through their involvement at the Us Girls Alive Clubs, young women have been linked into a wide variety of health and youth services.
- The Motivators and Club Leads perceive there to be a great deal of added value to participants as a result of receiving advice, instruction and support from their peers. Qualitative data suggests that the clubs were highly successful in encouraging young women to try new physical activities and had a positive impact on their health and wellbeing – with many individuals overcoming substantial individual challenges.
- The experience of the volunteer Motivators was an overwhelmingly positive one – with a number going on to secure paid employment at their Club.

- However generally the Motivators played a less formal role in leading a Club than anticipated, and more usually acted as a role model, encouraging others to take part.

The external evaluation identified the following key success factors:

- Having Motivators with a variety of personalities and skills
- The Motivator role being flexible – which enabled young women to develop at a rate which they were comfortable with
- The provision of a wide variety of formal and informal training and qualifications for the young volunteers, so that there was appeal to girls with different personalities and motivations (e.g. some of the Motivators saw the role as a stepping stone to qualifications and employment, whilst for others it was seen more as a way to be involved in a friendly support network)
- Using existing volunteers initially to act as role models for new volunteers
- Ensuring that extra support was provided for the Motivators during the early stages to help them adjust to their increased role which may have introduced more responsibility and structure into their lives than they were used to.
- The provision of support to the delivery organisations via Street Games Us Girls Specialist Doorstep Sport Advisors who were able to assist the clubs with general queries, training and come up with ideas to engage the target audience.

## References

Knox, E.C.L. & Adams, E.J. (2015) *'Us Girls Alive' Final Evaluation Report*. BHF National Centre for Physical Activity and Health, National Centre for Sport and Exercise Medicine, Loughborough University, Loughborough, UK

## Case study 15 - Zghazagh Azzjoni Kattolika (Youth Catholic Action) Leadership Programme

### Malta

Żgħażaġh Azzjoni Kattolika (ŻAK) is a branch of Maltese Catholic Action and its fundamental purpose is to provide programs of spiritual, social and personal development for young people aged from 10 years onwards. It is a voluntary, non-profit organisation with currently 48 ZAK youth groups in 12 different parishes/localities with around a total of 750 young people between the ages of 10 and 30. The biggest cohort is young people aged 14 - 16. The socio economic and educational background of the young people varies also depending on the community where the group is based. Each ŻAK group has a regular weekly meeting where, under the direction of their youth leaders, members not only socialise, but also develop and experience life skills, through structured and unstructured sessions e.g. discussions, role-plays, hands-on activities, reflections and games. ŻAK gives utmost importance to the active involvement of its members. At the early stages of the group, especially when the members are still young, most of the planning of meetings and activities is carried out by the leaders with little involvement of the participants. However, as the group grows within the organisation, the members gradually involve themselves more in the thinking and action process. The leaders' responsibility is to



ensure that the material covered and other social and educational activities meet the real needs of the young people. Sports activities are limited unless they are project based.

When the members are 16 they are invited to attend leadership training held over a period of 3 residential weekends. Approx. 40 young people per year attend Leadership 1 training after which they are invited to follow a 1-year training programme at MQF (Malta Qualifications Framework) Level 4. If they choose to continue they then do the Leadership 2 (25 per year) followed by a two-year programme interspersed with the Leadership 3 (15 per year) training. The Leadership training includes a placement of 50 hours each year and in the 2nd and 3rd year an additional 25hrs each year of activity planning. The young leaders are also assigned a mentor who they meet up with periodically. The Leadership Course 1 has 10 credits while the Leadership Course 2 has 30 credits.

This process ensures that ZAK Malta has a pool of young leaders to continue its activities. The process provides the young people with:

- An understanding of what leadership entails
- A support network with other leaders
- An understanding of what the management of an organisation entails
- Peer mentoring skills.

Factors that made the project successful are cited as:

- Allowing different levels of participation depending on the interests of the young people
- The leadership programme provides an internal support network enabling aspiring leaders develop their leadership knowledge and skills alongside more experienced volunteers
- Investment in continuous evaluation has allowed the organisation to adapt to new contexts
- Whilst there are some benefits in terms of facilities from association with Catholic Action, ZAK has to fund raise to be responsive to local needs.

### *References*

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