Chapter 11

Youth, peer education and health: a questionable solution to reduce social inequalities in health (SIH)

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> The question of young people's health engages the attention of all public authorities today, from local to European authorities by way of conurbations, countries, districts and regions; all levels of decision profess interest in this question. Likewise, many structures dedicated to youth now include the health dimension in their actions (schools, youth information centres, local task forces, young workers' hostels, etc.) and new specialised facilities are frequently created (young people's care and counselling desks; youth centres, for example). Conversely, health mechanisms hitherto of general scope deploy more systematic actions directed at the "young" public; this is true especially of mobile psychiatric teams, standby services for hospital admission and care, area-based health promotion, urban health workshops or low-threshold reception centres. (Amsellem-Mainguy and Loncle 2010)

As Patrick Peretti-Watel explains,

> Health has applications in every sphere today: a pupil with poor marks is "maladjusted to school", just as a man dissatisfied with his erections may consider himself in "ill health" sexually. Health is therefore supposed to be happiness … In this context, when prevention campaigns conduct promotion of "good" health behaviours (balanced diet, physical exercise, etc.) and combat "risk behaviour" (smoking, alcohol abuse, illicit drug use, etc.), this antithesis between wholesome and unwholesome conduct necessarily takes on a moral complexion (moreover, etymologically unwholesomeness is at once what is detrimental to health and contrary to morality) … With regard to juvenile risk behaviour in particular, prevention campaigns are very likely influenced by a stereotyped conception of the "young person". (Peretti-Watel 2010)

The health policies directed at young people (16-25) are still built for the most part on representations linked with the risks attending this age group, to the detriment of an approach bearing on the "resources and aspirations of youth" as regards their health issues. This aspect shows the inadequacy of young people's effective participation in framing the official policies that concern them, as well as arousing in them the sense of being stigmatised by "grown-up" society, possibly leading to distrust or even defiance of the actions implemented by the professionals. Although this "gap between young and adult society" on various planes (young people's representations, poor participation in the political realm) is not specific to the health context alone, it is clearly necessary to propose alternative arrangements for prevention and health education targeting young people which best meet their expectations and needs. In that sense, peer education for health can be a genuine opportunity to narrow this "gap" and to help limit the development of social inequalities in respect of health.

Enlarging on her analysis in the case of AIDS, Florence Maillochon accordingly suggests that

> the projection of young people into midfield of the preventive apparatus is presumably the outcome of syncretism between epidemiology, sociology and psychology. This syncretism has succeeded in associating with an age band that defines youth as a plain demographic category the idea of a nature peculiar to young people, one characterised by irresponsibility, carelessness, proneness to influence and hostility towards adult society, and expressed by provocations, transgressions and deliberate risk-taking.

This is the background against which peer prevention actions are conducted today throughout the territory. Yet this unprecedented escalation of the problem of young people's health is not correlated with a worsening of their state of health.

Education for health aimed at young people cannot be apprehended in just one way, quite the contrary; it necessitates a strategy of multiple interventions taking different forms (on the initiative of adults under a programme defined or prompted by young people on the basis of a shared appraisal) and addressing the issues in a varied way. All the cogitations pursued underline the importance of reflection on health education methods and their diversification, emphasising young people's active and interactive participation with the overall aim of involving them in their learning processes and enabling them, as it were, to realise their capacity to act and gain more power over their lives (in other words, empowerment). Among the approaches which have set out to strengthen young people's position as agents of health education and promotion, peer approaches have had the wind in their sails for 20 or so years in France and require a closer look.[35] Numerous peer health prevention-education-promotion schemes flourish in France, particularly aimed at young people. The interest in this type of prevention scheme[36] on different health-related themes (addictions, diet,

35. One should note, however, the French "lag" on this question of peer education behind the English-speaking countries for example, which made arrangements as early as the 1970s, particularly in the field of preventing addictions. This move followed the finding by researchers and prevention operatives that it was more effective to involve young people and to build their competence than to gear the programmes to risk alone.

36. As illustrated by the call for submission of projects under the Fonds d'expérimentation pour la jeunesse AP2, issued in 2010 by the ministry responsible for youth, which gave rise to a national assessment by ESPAIR (Education santé par les pairs) conducted by Éric Le Grand.

access to care, sexuality, etc.) is also growing among varied populations: the elderly, persons engaged in prostitution, in a situation of hardship, etc.

From the outset, the term peer education has been used to describe "the education of young people by young people", but behind this simplistic description lurks a diversity of approaches and interests at stake (INSERM 2001). Thus it is already possible to query the idea that membership of one age group suffices to define peer status to the extent that inequalities between young people are considerable (Labadie 2012), that the diversity of life paths no longer requires proof, and that the process of identity building is also conditioned by the existence of groups of affiliation marked by affinities, lifestyles, etc. often contrasting with each other.

The peer approach was initially used for primary prevention (heading off the health problem or illness; it is found to include, for example, vaccination or actions on risk factors). Peer health education promotion is now also used for secondary prevention (acting more at an early developmental stage of the illness) and risk reduction (the main aim being to reduce risks of damage linked with drug consumption). These actions should be conceived today in a non-competitive, but rather complementary and cumulative, light.

DEFINITIONS

Prevention for health

Prevention comprises all "actions aimed at lessening the impact of determinants of diseases or health problems, at averting the onset of diseases or health problems, at halting their progression or at limiting their consequences. Preventive measures may consist in medical intervention, control of the environment, legislative, financial or behavioural measures, political pressure or education for health".* The actions range from the means to be applied for preventing the appearance of pathologies to the control of their evolution; it may also be a matter of eliminating risk factors and possibly attending to patients' social rehabilitation.

Education for health

"Health education should enable the citizen to acquire through life the proficiencies and the means to protect, ideally to improve, his own and the community's health."**

"A strategy principally centred on learning processes, with an effect on knowledge, attitudes, behaviours, values and modes of decision-making. These are linked with objectives of health prevention, protection or promotion, and also of rehabilitation and adherence to medical and pharmaceutical treatment. It is also concerned with the contexts in which the learning processes are the most favourable (relationship of interpersonal assistance, clinic, small group, mass audience)."***

"Health education should be viewed in a long-term perspective of developing individual and collective capacities to ensure improvement in both length and quality of life ... It should not settle for information on risks – although this step in awareness-raising is necessary – but should set itself the objective at least of bringing about significant changes in opinions and attitudes in individuals and, better still, of seeing wishes for change of behaviour expressed, together with a higher level of ability to carry them out."****

Promotion of health

The definition of health promotion refers to the text of the 1986 Ottawa Charter for Health Promotion,***** issued by WHO:

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

Health requires a number of prior conditions and resources; the individual must be able to have housing, access to education, suitable diet, a certain income and the benefit of a stable ecosystem, to rely on lasting provision of resources, and be entitled to social justice and fair treatment."

* Definition proposed by the public health database: http://asp.bdsp.ehesp.fr/Glossaire/.

** French national plan for health education, ministry responsible for health, presented in the Council of Ministers in February 2001.

*** "La promotion de la santé comme perspective", Santé Société, series "Promotion de la santé", Government of Quebec, Ministry of Health and Social Services, p. 9.

**** Lévy E., *L'éducation pour la santé*, opinion of the Economic and Social Council, Paris 1982, p. 858.

***** www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf. www.sante.gouv.fr/cdrom_lpsp/pdf/Charte_d_Ottawa.pdf.

"PEER PREVENTION" OR "PEER EDUCATION"?

The European Commission defines peer education as follows:

> This educational approach calls upon peers (persons of like age, social background, position, education or experience) to provide information and promote types of conduct and values. Peer education is an alternative or an adjunct to traditional health education strategies. This approach is founded on the fact that at certain stages of life, particularly among adolescents, the impact is greater than other influences."

The peer approach is consistent with the idea of symmetry but also of reciprocity and equality. In other words, the attraction of the approach lies in the construction

of a relational dynamic which gambles on the resemblance between the individual holding the role of facilitator and the one holding the role of recipient (or beneficiary). This approach is founded on determination of the peer group's importance for the identity-building process, particularly in adolescence, through the establishment of common norms and prescribed/proscribed practices, and more generally on socialisation. Family and school do not operate singly in the process of socialisation, and pass on sometimes contradictory norms. In this context, young people are alert to scrutiny by their peers but also take notice of the messages widely disseminated by the media, also involved in their socialisation. That is to say, young people come to terms with the different agencies of socialisation (family, school, peers, etc.), despite agendas which do not always converge, so that it may be appreciated how closely their representations are linked with a selection of transmitted norms.

In this context, the questions of exchanges and interpersonal relations are central to this method of operating, which sometimes helps strengthen and/or bring to light communities or groups sharing the same concerns. From the outset, the peer's role is thought of as a contact person's, acting in a specific field of prevention.

Initially, health prevention action by peers is not structured in a rigid framework of attitudes and behaviours to adopt or not to adopt, or founded on conviction or persuasion but, on the contrary, embedded in a narrative of self, reflecting the interplay of constraints and possible choices. Preventive action by peers has this proximity and authenticity at its core, all the more significantly in the knowledge that the more credible an information source, the more attractive it appears to the recipient.

POINTERS

Different peer configurations

"A peer is so called because he is 'like'. But if like, how can he be different? How then is he placed at the necessary remove that keeps him a peer without making him an outsider? Which degrees of likeness are necessary, which others are nefarious, or superfluous, or insufficient? Besides, there is always the underlying risk of his being a 'peerot'. A likeable, forceful young person, ready for every good deed, he becomes the mouthpiece for adults' sensible sayings, and passes on their good practices. Often his only claim to peerdom is his age, and does that suffice to be a peer? If a peer is completely like me, what can he offer me? But if he knows and says things otherwise than myself, is he still me? Is he then my peer? And in teenager talk, if he blitzes me with good practices thoroughly learned from the school sick bay, he is a clown, not a peer but a 'peerot'. Thus the peer's proper position would be more as an intermediary between the message and its addressee, as a conveyor rather than spokesman. Someone 'just like me-not quite like me' knowing how to work on this fine distinction." (Chobeaux 2012)

In view of this, different classifications have been proposed to register the diversity of peer approaches. Two main paradigms may be distinguished (Baudier et al. 1996):

- **"multiplier" peers** are responsible for spreading a number of information items and recommendations on a given topic in their living environment;
- **"mutual aid" peers** are trained to listen to their pals and where appropriate to perform a pinpointing role (for young people displaying problems) or of liaison between these young people and specialised persons or facilities.

The recent studies conducted on peer education (Bellot and Rivard 2012) go further and show that three main fields of peer intervention may be distinguished: **social influence** (where the peer's role is shaped around the mechanisms of influence which he can use on those close to him with a rationale of preventing or promoting changes in behaviour, attitudes or values); **social resource** (the peer's role is shaped around the relationships of mutual assistance and exchange which he maintains to ensure his own and other people's well-being – here, the peers form themselves into a group which becomes a resource for all its members); and **social liaison** (where the peer is a person who, by belonging to opposite or different social realms, builds symbolic or material bridges between those realms – here, peers are mediators or "conveyors").

PROXIMITY AND RELATIONSHIP AT THE CORE OF THE APPROACH

Young people's day-to-day life is marked by the strong and significant presence of peers in the identity-building process. But, more broadly, young people, like adults, surround themselves with others resembling themselves. The resemblance may hinge on age (applies to adolescents or young people generally), gender, but also on statuses and roles or again on values and customs (partying) or consumptions (self-support groups). Yet these factors of proximity do not suffice in themselves, and require a strong interaction, a relationship which is chosen and recognised but also prestigious in order that the other may become a peer. In adolescence in fact, young people are torn between the family circle and the peer group, each playing its own part in their lives. The peer group is all the more important for assisting the young people who gradually separate from their birth family and for helping them towards adulthood; nevertheless every individual has some elbow-room to build his own personality vis-à-vis his peers. Thus it is understood that "the concept of peer is not strictly a static concept but indeed a dynamic concept in which the interaction between the self and the other will define this resemblance through the relationship maintained" (Bellot and Rivard 2007).

Youth first, specific role second

This proximity, then – actual and sometimes putative – is the primary foundation for the peer approach, but it goes further, on the basis of the relational dynamic,

in assigning specific roles to the peers. If the peer is to be regarded as a "like" or "kindred" individual, it implies closeness to those in respect of whom he will perform a specific role. This peer approach presupposes horizontal communication that is quite opposite to the customary top-down interventions of experts. This smallest common denominator of generational proximity is very often sufficient to set in motion the action of peer intervention. By contrast to what happens in a more "conventional" social intervention, it is indeed crucial for peers to be alike, to be recognised as similar to the young people to whom they relate, before having a specific role to perform in the preventive action to be conducted. This, however, does not make the interaction obvious or simple thereafter: in the context of work in schools, admittedly the young "peers" must, for example, come to terms with the wait-and-see attitude of the other young "pupils", who are accustomed rather to more directive interventions. This frequently observed wait-and-see attitude is often connected with the innovativeness of the approach, requiring this type of action to be sustainable. It is in fact necessary that the other young people get used to these young peer educators and fully grasp their roles.

A relationship based on authenticity

The aforementioned proximity between young people also operates as regards sharing the real-life experiences which young people look forward to, and constitutes a major relational asset. It implies that the young peers are recognised by other young people as authentic, genuine individuals wishing to remain themselves, that is, not seeking to become models but rather conveyors of experience and information. Moreover, because they seek to give what they have received (or on the contrary because they have been deprived of it), peers participate in proposing positive models of young people who stay themselves but act for/with others. This authenticity favours the possibility of feeling secure and respected.

YOUNG PEOPLE VOLUNTEERING AS PEERS BENEFIT MOST

Usually peers are selected on a voluntary basis, even though not all volunteers are accepted and a selection is made according to more or less explicit criteria depending on each programme of action and the objectives set. In other situations, peers are singled out because they have attracted the favourable attention of the adults in the environment where they live (teachers, social workers, association members and others). That is why the profile of young peer people cannot be straightforwardly and uniformly established but must be a subject of discussion and a concern among the adults running these programmes.

As the studies emphasised as early as the start of the present millennium, the effects on young people are variable even though a constant is noted as regards personal enrichment for committed peers (INSERM 2001). This sense of personal development comes out in self-assertion, self-confidence or ability to be effective, and more broadly in the ability to be oneself a producer of well-being for self and others (withstanding group pressure or being able to handle the stress and emotions of certain situations, to mention but two examples). In more general terms, they gain in proficiencies

(listening, empathy, support, mediation) which may be transferable at the time of choosing a specific educational stream and/or entering the world of work.

It may thus be regretted that young peers are very often already committed, involved young people. Now, taking the example of the school setting, peer health education programmes help enhance adult–pupil relations. Where peers are already class delegates or representatives of high school life, they consolidate their attainments and knowledge without making it possible for those who have more of a struggle to improve their proficiencies, beyond the expected school performance. However, all research carried out emphasises that the participation of pupil peers in the life of the school has a positive impact on their self-image and the images they project, and this is not without implications for their quality of life (self-esteem), academic success and for the reduction in absenteeism. The question then arises how to rally the young people in greatest difficulty round to participate in peer health education projects to enable them to turn other proficiencies to account and thereby rediscover some legitimacy in their presence within the school. On a wider plane, young people in a state of vulnerability are those who stand to gain most from becoming "peers", even casually, even if it presupposes a different time and type of training. The risk is that by dint of coaching and exercise in their "peer" role, the young people may turn professional and become, as it were, "peer workers" (in the sense of becoming professionals recruited for their layman's knowledge) or "peer pupils" (thus corresponding to a purely academic exercise with a concern to do right and be well regarded).

The peer approach to health education/prevention/promotion only becomes meaningful if constructed in tandem with other action programmes, aimed in particular at changing a young person's immediate environment (a perspective of health promotion being adopted). Thus, if young peers highlight dietary questions, organisational aspects, for example the accessibility of the school canteen, also need examination. Likewise, if the young people pinpoint the difficulties of access to care, it may be useful and necessary to ask about the accessibility (timetables, location) of care in the establishments implementing this type of project. Peer health education in no way makes it possible to stand in for and replace the professionals, and it cannot be sufficient in itself, otherwise the young people may be made to shoulder "too great a responsibility". Young people's expectations do not tend in that direction anyway; while they want more room to be left for the experiences of other young people or of persons living in their situation, they do not want it to be exclusive for fear of being isolated.

POINTERS: SOURCES OF INFORMATION ON HEALTH

The question of peer prevention calls for some clarifications regarding sources information on health for young people.

Women seek more information than men

Women are generally more careful of their health than men, it is they who usually handle these questions in the family, and the Internet has not changed behaviour patterns in any way. Accordingly, mothers have a major role in health information

for young people.* Besides, young women are found to be over-represented in their recourse to information on health via the media: 7 out of 10 women as against 1 out of 2 men follow television or radio broadcasts on health.** These findings tie in with the apportionment of domestic tasks according to gender, in which those assigned to women are education and upkeep, care and attention.

Information is also channelled through institutions

The data presented in the survey on sexuality in France provide a worthwhile insight into the sources of health information. For example, on contraception, the results show that the three main sources mentioned by young females*** are, in that order, school, television and mother; young males mention school, television and pals. Evolution over time is marked if the younger and the older generations are compared. There is a relative decline of the peer group and women's magazines, which constituted the first two information sources for the over-50 generation. The school's role is increasing. The mother's is holding its own. Among the youngest females, the doctor is ahead of friends. Among boys however, peers continue to have a specific role.****

The Internet

The Internet has added to the available supply of information on health. Where young people's practices are concerned, the data of the French Baromètre santé 2010 (INPES) show that virtually all those aged 15-30 years are websurfers; slightly under half (48%) have already connected to the Internet in health matters (seeking information, obtaining advice). Use of the Internet for health increases with age: 39% of the 15 to 19-year-olds; 50% of the 20 to 25-year-olds and 55% of the 26 to 30-year-olds. Here again, gender disparities are noted: young females tend more than young males to state that they seek health information on the Internet. The legitimacy of the practice is also to be examined, so apparent is it in interviews that for young people "It's a girl's thing".*****

It must be realised, however, that while information helps to shape knowledge and representations, it also conveys norms. While information on health has the effect of drawing the attention of a given public to a specific issue and thus arousing awareness, all the studies undertaken in the health field emphasise not only that information is indispensable but that informing and convincing do not suffice to bring about a change in behaviour and representations.

* Amsellem-Mainguy Y. (2006), "Prescrire et proscrire des conduites, véhiculer des normes: les mères comme actrices privilégiées en matière de prévention de sexualité and de contraception", *Recherches Familiales* No. 3, pp. 49-59.

** Baromètre santé 2010, "Sentiment d'information et craintes des jeunes en matière santé", INPES.

*** The Internet was not among the suggested replies in this survey.

**** Bozon M. (2008), "Premier rapport sexuel, première relation: des passages attendus", in Bajos N. and Bozon M. (eds), *Enquête sur la sexualité en France, Pratiques genre et santé*, La Découverte, Paris, pp. 118-19.

***** Amsellem-Mainguy Y. (2015), "À la fin tu penses que tu vas mourir, mais tu y retournes!", Jeunes, santé et Internet, INJEP study report (online).

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