Community-based Peer Sexual Health Educators: Lessons from Marginalized Youth

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Abstract

Developing and utilizing youth community members as peer educators is a growing and common phenomenon in health and social services, largely because of the organic learning and modelling processes in their everyday lives made possible by peer-to-peer processes. Part of what makes peer education effective over professional education is the potential rapport and trust built through shared lived experiences and identities between peers. There is significant potential for engaging peers in sexual health education specifically. This small-scale qualitative study explores the sexual health education needs of marginalized youth staying/living in York Region (LGBTQ+ youth and youth experiencing homelessness) who identify as marginalized youth and using a focus group methodology. The objective of this study is to better understand the sexual health education needs of marginalized youth and their attitudes toward peer sexual health education in order to make better use of PLSHE. Findings demonstrate that overall, marginalized youth prefer peer sexual health education. This group discussed priorities for sexual health education that go beyond safer sex practices and to extend to matters of relationship, specifically consent and navigating the complexity of mental health challenges and healthy relationships. The paper concludes with observations of social processes during the focus group, demonstrating the value of peer education.

Keywords: Peer sexual health education, sexual health educators, marginalized youth.

Résumé

Le développement et l'utilisation des jeunes de la communauté comme éducateurs de pairs est un phénomène croissant et commun dans les services sociaux et de santé, en grande partie à cause des processus d'apprentissage et de modélisation naturels dans leur vie quotidienne rendues possibles par le processus pair à pair. D'une part, le rapport potentiel et la confiance établie par le partage des expériences vécues et des identités entre pairs rend l'éducation des pairs plus efficace que l'éducation professionnelle. D'autre part, il existe un potentiel significatif pour

impliquer les pairs dans l'éducation de la santé sexuelle plus spécifiquement. Cette étude qualitative à petite échelle explore les besoins en matière d'éducation en santé sexuelle des jeunes marginalisés séjournant/vivant dans la région de York (jeunes LGBTQ + et jeunes qui vivent sans-abri) qui s'identifient comme marginalisés en utilisant une méthodologie de groupe de discussion. L'objectif de cette étude est de mieux comprendre les besoins des jeunes marginalisés en éducation de la santé sexuelle et leurs attitudes envers les éducateurs de pairs en santé sexuelle afin d'utiliser plus efficacement le PLSHE. Les résultats démontrent que les jeunes marginalisés préfèrent l'éducation en santé sexuelle par les pairs. Ce groupe a identifié des priorités pour l'éducation en santé sexuelle qui vont au-delà des pratiques sexuelles sécuritaires afin d'inclure les relations saines et l'impact des défis en santé mentale ou physique sur les relations. Cet article se termine par des observations des processus sociaux lors du groupe de discussion qui ont démontré la valeur de l'éducation par les pairs.

Mots clés : Éducation à la santé sexuelle par les pairs, éducateurs à la santé sexuelle, les jeunes marginalisés.

Introduction

Seen as a cost-effective and destigmatizing method for health promotion, peer-based lay sexual health education (PLSHE) for youth is a promising approach to supporting and improving health and sexual health. Community health and social services looking to take up PLSHE need to be aware of its effectiveness in order to make the best use of this approach, and this needs to be informed by youth themselves. This small-scale focus group study explores the attitudes of young people toward PLSHE, their priorities for sexual health education, and sought to learn from marginalized youth how PLSHE can be planned effectively in order to address their needs. Peer lay educators typically are recruited from community by service organizations and provided with topic-specific training to deliver educational sessions and activities to others who are considered their peers in terms of shared experience. Depending on the health or social issue at hand, some level of personal disclosure of a shared lived experience may be involved. Being a peer can mean having a shared lived experience of a health matter such as living with HIV/AIDs or having had experienced school bullying, for example. It can also refer to belonging to the same age cohort or social identity location, for example, identifying as being transgender. PLSHE workers are then are community members who use their personal lived experience and training to engage their peers in sexual health education activities such as safer sex practices specific to their social context. Developing and utilizing youth community members as lay peer educators is a growing and common phenomenon in health and social services (Becasen, Ford, & Hogben, 2015; Rowena, Flynn, Jorge, & Virani, 2014), largely because of the organic learning and modelling processes in their everyday lives made possible by peer-to-peer processes (Carr, Thomas, Doyle, Redman & Myles, 1994). Peer education is thought to be effective because peers play an important role in the psychosocial development of adolescents via role modelling and other opportunities presented by less professionalized, more personal relationships. Part of what

makes lay peer education effective over professional education is the potential rapport and trust built through shared lived experiences and identities between peers (Mitchell, Nyakake, & Oling, 2007). Peer youth-led approaches also tend to have stronger effect on knowledge transmission than adult-led approaches (Sun, Miu, Wong, Tucker, & Wong, 2018).

There is strong evidence for the use of peer educators in sexual health education specifically (Agha & Van Rossem, 2004; Mellanby, Newcombe, Rees, & Tripp, 2001; Smith & DiClemente, 2000; Visser, 2007) and this is suggested to improve sexual health outcomes (Becasen, Ford, & Hogben, 2015). Peer education is increasingly popular in terms of programming to reduce STIs, unintended pregnancy, and HIV prevention, and is becoming increasingly important in terms of effectiveness in reducing prejudice against sexual and gender minority youth (Bailey et al., 2010) while providing sexual health information unique to marginalized groups. What constitutes a peer is based on context, and could mean various aspects of shared identity or social location, including age, gender or gender expression, sexual or relationship orientation, or disclosure of having a shared lived experience such as having been diagnosed with a mental health disorder or having experienced homelessness or problematic substance use. Peer education is recognized as most effective when age, gender, and shared lived experience are matched (Mitchell et al., 2007). Mitchell et al. (2007) determined that some youth preferred education by adults because they were perceived as authorities in these particular topics. Therefore the credibility factor is a significant consideration when training youth peer sexual health educators. Overall the literature seems to suggest that shared experiences are the power behind the trust and rapport necessary for genuine reciprocity that makes peer education so unique and may be a factor in its effectiveness in the changing attitudes toward sexual and relationship health education.

Despite promising opportunities, all health promotion approaches have limitations that need to be considered. A 2018 systematic review and meta-analysis determined peer-led sexual health education improved knowledge, attitudes, and to some degree self-efficacy, but found little evidence for its effectiveness in changing behaviours (Sun, Miu, Wong, Tucker, & Wong, 2018). To have an effect on behaviour, a prolonged intervention is usually necessary, and is often not realistic in terms of community programming. Overall, six systematic reviews of PLSHE demonstrated that there is no conclusive evidence for the overall effectiveness of this method when behavioural change is considered (Harden, Oakley, & Oliver, 2001; Kim & Free, 2008; Maticka-Tyndale, & Barrett, 2010; Medley, Kennedy, O'Reilly, & Sweat, 2009; Sun, et al., 2018; Tolli, 2012). As a caution though, Sun et al., (2018) suggest that effectiveness outcomes vary in relation to the level of genuine participation or leadership of youth educators in the education effort. PLSHE perhaps is more effective on sexual health outcomes when it is youth-directed, led, and controlled versus professional/adult-controlled and merely delivered by youth as token messengers of content.

PLSHE remains a popular approach to sexual health education relied upon by community health and social services education despite the inconclusive evidence for its effectiveness to improve sexual health behaviour. However, it is the promising effectiveness on attitudes that is

especially relevant to this study involving marginalized youth. A systematic review of studies employing comparison group methodologies suggested that there were significant improvements in attitudes toward people living with HIV/AIDs, sexual and dating violence, and reproductive health (Sun et al., 2018).

Methods

This is a small-scale qualitative needs assessment study exploring the expressed sexual health education needs and preferences of marginalized (all participants identified as either identifying as LGBTQ+ and/or currently experiencing homelessness). The intent was to learn about these participants' perceptions and openness toward PLSHE given their experiences, their priorities for PLSHE, and to learn as much as possible about PLSHE with marginalized youth to inform community social services programming. This study received ethical review approval from Seneca College's research ethics board.

Setting and Respondent Group

Youth community members were invited by community flyers and invitations made to local social services and shelters. All willing volunteers were accepted to participate as long as they met the age criteria and self-reported that they identified as having some experience of marginalization (self-defined). The convenience sampling method was also enhanced by snowball recruitment, as participants spontaneously brought friends or other shelter residents along with them. The focus group was held over four hours to allow for the frequent coming and going of participants for dinner, smoke breaks, and social media use. In total, there were 12 participants for the entire focus group session, ranging in age from 14-22 years old. (Although the literature reflects a broad range of what is considered "youth", this study employed the definition of the local youth homeless shelters. Most of the participants who identified as homeless were staying in a local youth shelter, which considers youth up to the age of 22). Five participants identified as men, all of whom also identified as currently experiencing homelessness and also as straight. Seven participants identified as women, with one participant currently experiencing homelessness; four identified as lesbian or bisexual. Three identified as having serious and diagnosed mental health challenges; one participant was a newcomer to Canada. Four of the participants identified as belonging to racialized groups.

Data Collection

Data was collected using a conversational focus group methodology. Questions posed were based on the scholarly literature but also the input of a local youth sexual health educator from the local AIDS-service organization (which provides most of the community's sexual health education programming). Questions involved the core concepts under study: did participants understand PLSHE, did they believe this was an effective method of sexual health knowledge exchange and education, would they participate in PLSHE, and what their priorities were for sexual health education and information given their unique contexts and experiences as marginalized youth. The focus group facilitator explained PLSHE and took questions from the participants, and then led a conversation about information and education needs and priorities.

Models and approaches were not offered due to time constraints, as participants had a lot to say immediately. Prompts were offered but were rarely needed, as participants seemed eager to discuss their needs and experience. The principal investigator and a research assistant were present to assist, explain ethics approval, group confidentiality, and the research process. The session was audio-recorded, and transcribed by a transcription service.

Data Analysis

Participants' responses and discussion were transcribed verbatim. Data were manually coded and analysed by themes by the principal investigator. The results are presented below with verbatim quotes from the focus group transcripts, as well as researchers' observations of the social interactions occurring during the focus group, and their implications for future PLSHE groups.

Results

The participants of this focus group could be considered significantly marginalized given many were currently homeless and several disclosed serious mental health diagnoses, and several also identified as members of LGBTQ+ communities. As potentially highly stigmatized young people, facing a myriad discriminatory attitudes and ideas especially in the realm of their intimate and relationship domains, the social processes that took place during the focus group demonstrated the significant potential to change attitudes toward LGBTQ+ youth. The results of this focus group that explored the attitudes toward and needs for PLSHE of diverse identity and experience youth included that they were very open to the idea, and echoed some of the literature in terms of the need for shared lived experience and shared demographic factors such as age, but that specifically they felt they needed sexual health and relationship health education that spoke directly to the impact of mental health problems on relationships. Also, through the dynamic social interaction that occurred during the focus group, the concept of consent developed into an important aspect of needed education. LGBTQ+ participants unanimously agreed that any programming needed to involve a social dimension as this was an area particularly lacking in young people's experiences who did not want to rely on the bar scene for socializing. Their responses to questions regarding their experiences of, and preferences for, sexual health information and education are presented as well as observations from the focus group session dynamics that might inform PLSHE practice.

Peer Education

Participants were in favour of a peer model for receiving sexual health information and education. Their positioning of seeing their peers as effective educators over "professional educators" lends support to the idea of lay sexual health education, but that an important dimension was the peer status; overall there had to be a shared identity (e.g. in terms age) as well as shared experience, the kind of experience that it not academic but rather lived and disclosed, which is the essence of peer-to-peer mutual aid.

I'd feel more comfortable with somebody that I can relate to, somebody my age just because they've been through what I've been through, but I feel professionals

haven't been through what we've been through, they just read the books and they just explain it. I'd trust that person more, you know? (male-identified participant, 18 years old)

Perhaps as an example of the effectiveness of the more social character of peer education settings, a humorous exchange followed when this participant gestured to the researcher and research assistant (more than 20 years older than the participants and positioned as researchers explicitly in the group) and said: "clearly professionals" with a laugh. This exchange signified the overall distinction between peer-to-peer health education and lay health education, where the idea of "the professional" is somewhat problematized.

Participants were clear that to be most effective, PLSHE workers should come from the same age group. "Sometimes they might be intimidated to talk to someone who's older or you don't want to talk to someone who's younger" (male participant, 18 years old). Here an interesting social dimension of the focus group was observed. A young woman, 14 years old, spoke at length about what she knew about consent, engaging in very thoughtful and sophisticated knowledge transmission about healthy intimate relationships. These were messages that all of the young men who identified as homeless were taking in, sometimes challenging these messages, but taking in nonetheless. This was a spontaneous sexual health education session, although brief, and was delivered so effectively by someone who was the youngest in the room and not in the shared age/experiences category of those taking in her messages. She was asked how she knew so much about this important topic, and she noted that she had recently received the revised Ontario sex education curriculum at her school. Also she took part in her school's gay/straight alliance group with a very supportive educator who talked with the group about these important topics. The young men in the focus group noted that as they had been living homeless for quite some time, they were not in school environments, often taking alternative education classes at various youth shelters in which sex education was not covered. If it were not for the spontaneous opportunity provided in this focus group, perhaps the opportunity to learn more complex ideas around consent and healthy intimate relationships would not present itself in their compromised access to education due to homelessness.

For some participants, however, age did not matter as much as the explicit disclosure of shared experience. This was particularly relevant to the participants who identified as currently homeless or who were struggling with diagnosed serious mental health challenges.

"Where you learn from other people in a workshop format that you felt you could relate to, you're like, this guy gets me, he's been me, he knows me" (participant).

I don't think they have to be my age or 40 years old to sit down in front of me and say, hey, this is this. As long as they've experienced what I have, whether they're male or straight or even if they're the opposite person of me. As long as they've experienced what I have, I would be able to learn from it. (female-identified participant, 19 years old)

When asked to clarify, it was not the shared experience in terms of sex or relationships, but rather the shared experience of having been homeless or having had mental health struggles that was the important dimension.

Priorities for Sexual Health Education Content

Participants were asked what topics they felt were priorities for PLSHE based on their current individual needs. Participants arrived at a consensus about three topics, but noted these were not prioritized in order but rather the three priorities that addressed their current needs in general. Participants responded that priorities for lay sexual health education were i) understanding consent; ii) healthy relationships and sex/intimacy in the context of serious mental health concerns and homelessness; and iii) safer sex and harm reduction (including harm reduction for substance use, but also around safe sexual behaviour while using narcotics or party drugs). Safer sex and harm reduction was a particular concern for the participants who identified as currently homeless. Most noted that because they were not in school, they were missing out on sexual education curriculum, and were getting most of their knowledge from online porn sites. Our early conversation about consent began like this, demonstrating the rather basic concept of consent the men in the group were discussing, juxtaposed by the responses by the young women's responses.

R1 (male-identified participant, 20, currently homeless): "Of course, you can't touch a girl without consent. A lady is not an object, you've got a human being, you know what I mean?"

R2 (female-identified participant, queer-identifying, 18): "Thank you. "

R1: "But at the same time, I'm not going to go up to a girl and ask her if I can have sex with her, I'm going to read her movements. That would make me a nerd, hey, can I have sex with you?"

R2: "A good nerd to be though."

Demonstrating the complexity of mixed identity groups in terms of gender and sexual orientation, and the opportunities for gender analysis and heteronormative analysis these social processes in group represent, a female-identified participant who identified earlier as queer is still assumed to be having sex with men by one of the male participants.

R3 (female-identified participant, queer-identifying, 20): "I think with me, I've always talked to a partner beforehand of just their being a boundary of like, if I say no midway through, then that's ... regardless, for me it's no means no. If you stop at one point, and I've always told them, if we're drinking and I say yes, it's still no because I'm not in my right mindset, so for me, it's just no means no..."

R1 (male-identified participant, 18, currently homeless): “But then you’re confusing the guy.”

This exchange resulted in some momentary discomfort as the participant addressed this by having to re-assert that consent is also important concept for her as a lesbian, using her personal experience and identity to educate a fellow participant who perhaps had not listened to her carefully earlier.

Several participants disclosed having been diagnosed as serious mental health challenges, and they were very open about the social and relationship challenges they experience as a result. They noted that sexual health information is not readily available to them about managing sex, relationships, and mental health struggles or disability in general as young people.

I think it [experience of schizophrenia] causes isolation too, that’s why I was going on about isolation. Because it’s already difficult enough to make relationships with people, just like regular relationships with anybody. I’m not speaking for just myself, I know 100% it’s the same for a lot of people and that makes it a whole bunch more difficult. (woman, 16, currently homeless)

Another example was presented regarding particular considerations for harm reduction in the context of compulsive or obsessive behaviours she experiences. Her self-reported obsessive compulsive disorder (OCD) was difficult to manage when it came to harm reduction. What information she did know about STIs, HIV/AIDS specifically, led her to practice what she perceived as “too much protection” that got in the way of her relationships and she had no one to talk to about how to manage safe sex who understood how her OCD impacted her specifically. Another interesting social process was observed in the group. When we asked about where participants usually searched for their sexual health information, all participants reported the internet was one of their primary sources. The men in the group though, all well-acquainted with one another from living in the youth shelter together, spoke quite comfortably about online pornography as one of their main sources of information. When asked to elaborate about how pornography delivered sexual health information like safer sex or consent, participants conveyed that they meant they learned about how “to do” sex with someone from online pornography. Information about safer sex or harm reduction was not something they sought out online, but rather learned about from friends. However, this was in stark contrast with the women in the group who identified as LGBTQ+. They seemed to have a much more pragmatic approach to their information needs, seeking triangulation from multiple sources they were proactive in accessing: the internet, knowledgeable friends they could trust, as well as sexual health education curricula.

Discussion

This small-scale study makes an interesting contribution to the existing literature. The importance of shared identity and shared experience to the effectiveness of PLSHE is confirmed, as well as PLSHE’s unique capacity to serve and address needs of marginalized groups, such as LGBTQ+ youth. The rapport and trust dimension of the effectiveness of peer education was

definitely demonstrated in this focus group, in that the very disparate experiences of this heterogeneous group did not present significant challenge to dialogue or group dynamics. Rather, the young women (many of whom also identified as LGBTQ+) centred their knowledge and needs in the same space with the homeless male youth who primarily identified as straight and despite some unintentional heteronormative statements made to them, provided invaluable information about gender and consent to their male peers nonetheless and continued on with their participation.

Lesson #1: Knowledge Exchange Among Participants

Although the group was convened for research purposes, the natural process of knowledge exchange was allowed to take priority on several occasions. As noted above, the young women in the group took the opportunity to provide education about consent when asked more questions by the male participants. The lived knowledge of the participants who identified as homeless at the time of the group was also shared. All were accessing social services, including staying at local emergency shelters, and at several points in the session they were able to share information about service availability and access, including community health services designated for youth.

The findings about knowledge exchange extend the knowledge about PLSHE in the literature by confirming its value for marginalized groups not only in having their needs better addressed, but also demonstrates that there is some power in the delivery of PLSHE by some communities (such as LGBTQ+ youth) for other groups experiencing a different kind of marginalization (such as homelessness and abject poverty). The spontaneous knowledge exchange that occurred within this group also confirms the literature that discusses the enhanced value of PLSHE that is youth-driven and led (Sun et al., 2018). This group of participants took advantage and control over the opportunity of this session to discuss matters of importance to them more fully, not just as a focus group responding to researchers, but as an opportunity to exchange sexual health knowledge relevant to them and their unique contexts of being LGBTQ+ youth, or youth experiencing homelessness and mental health challenges. They made the session relevant and valuable for them, and not just for needs assessment purposes of the researchers and facilitator. How effective this was in terms of centring the experiences of women and LGBTQ+ participants was an important realization, and should be considered as strengthening the practice of peer-led and peer-controlled LSHE.

Lesson #2: Planning for Education & Safer Spaces

It was during one of these spontaneous knowledge exchange sessions though that a lesson was presented about the need for safety considerations for lay peer educators who may not have the experience needed to deal with challenging situations, including being sexualized and harassed by others in the group. When one of the young women brought up the subject of internal condoms, all of the young men stated they were unaware of internal condoms and curious. The group's facilitator was employed as a sexual health educator with the local AIDS service organization, and she offered to provide some education and a demonstration. It was at this offer that she was met with inappropriate statements from several of the young men. She

ignored it, and carried on, however in the post-meeting she noted that women who do sexual health education “have to deal with a lot of that” and that she sometimes doesn’t “...even notice it anymore.” The safety and comfort of facilitations in mixed groups needs to be carefully considered in training and delivery of PLSHE.

Lesson #3: Centring Experience and Identity

Part of the value of peer sexual health education is the capacity to address the very unique needs for information and support for LGBTQ+ youth in addition to the evidence that PLSHE is effective in reducing prejudice and stigma against LGBTQ+ individuals (Bailey et al., 2010). For the young women in the group, they agreed enthusiastically about the value of the enhanced sexual health curriculum (at this time in Ontario, there was mandatory curriculum covering consent as well as LGBTQ+ specific content) and felt it important to remind professionals that all sexual health education must be specific to gender expression and sexual/relationship orientation.

Practitioners and planners should also consider the value of PLSHE to address the sexual health education and information needs of youth who are not school-involved, such as youth who are homeless and living outside or in shelters.

Lesson #4: Plan for Social Opportunities in Every Aspect of Programming

The participants who identified as LGBTQ+ made special request that emphasis be placed on a lessons learned specific to their needs as well, and that is to ensure that planners and practitioners intentionally provide and plan for social opportunities for LGBTQ+ participants in any and all activity, whether it be in research activities such as focus groups, or in service provision. The participants who identified as LGBTQ+ were very clear that they would both participate in lay or peer education as well as be interested in providing peer education but that the success of these efforts depends heavily on providing social opportunities as part of any programming. Noting the lack of social settings that are both youth and LGBTQ+ friendly, they noted that social health is important and related to sexual health. Social planning might take the form of scheduled time in a session for socializing, organized meals at events where participants sit down and engage with one another (versus milling around with pizza in one hand), and other organized social events offered intentionally as part of all activities involving them. They noted this was even more important for younger LGBTQ+ youth who did not drive, or were too young to attend the party or bar scene and very important for all youth who live in rural or under-serviced communities where they might be very isolated from peers.

Limitations

There are several limitations of this small-scale study in terms of transferrability as it involved a one-time heterogeneous, small, convenience sample and conversational focus group methodology. However, trustworthiness of results was enhanced by using direct verbatim quotes, and reviewing findings with a PLSHE provider. The goal of this study was not to provide generalizable research findings, but rather contribute to more effective use of PLSHE, which was accomplished.

Although this focus group had significant representation of LGBTQ+ (approximately half of the sample participants), Two-Spirit perspectives were not represented. Two-Spirit perspectives would shift some mainstream understanding of peer support in that cultural helpers are often elders and children, rather than only those in one's own age group. More broadly, the solutions that Indigenous communities and cultures hold in mental and physical health inquiries, including sexual health education, warrant intentional inclusion of Two-Spirit and Indigenous perspectives in further research and practice in this area.

Conclusion

The input provided by this unique group of youth was valuable for PLSHE planning and practice purposes. The results of this focus group showed primarily that this particularly diverse group—diverse by social identity as well as life circumstances—were interested in peer-led lay sexual health education both as participants but also perhaps providers. Consent, healthy relationships and intimacy in the context of challenges presented by mental health problems or homelessness, and safer sex and harm reduction (in terms of sexual behaviour involving recreational substance use) were their priorities for PLSHE. Several lessons were learned that should also inform PLSHE efforts.

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