



Youth Led Health Promotion, Youth Engagement and Youth Participation: A Research Review

**Douglas S. McCall, Mary M. Shannon
Canadian Association for School Health**

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Introduction

Health Canada has defined a set of turning points⁶ for Canadian society in regard to the development of children and adolescents. One of those national goals for the healthy development of children and youth in Canada states, in part, that we should "*ensure that young people have opportunities to participate in decisions about their healthy development.*"

This paper has been prepared to set out a potential framework for understanding health promotion activities, programs and services that are led by young people in deciding their nature, purposes and direction.

From the outset, it should be noted that we are not discussing the remaining part of the national goal quoted above, namely to "*encourage them to make healthy lifestyle choices*" thorough other activities that are adult led. Consequently, we are excluding formal forms of education, health services delivered by medical, community groups and other personnel as well as other traditional health promoting strategies.

Youth led health promotion activities have the potential to enable young people to make those choices. It is this potential as well as limits that will be discussed here. Our purpose is to construct a lens through which we can view such peer or youth led initiatives critically based on the current research available.

As a result, we will be better placed to making decisions about which youth led models should be supported, developed and disseminated. It is simply not sufficient that youth leadership be funded. We need to know which approaches are more effective, which are more sustainable and which are more suitable for which groups of young people.

Methodology

This brief overview is based on a preliminary review of published research and selected documents from the Canadian Centre on Community & School Health. Search terms used in the ERIC database include health activities, school activities, outdoor activities, youth, behaviour, behaviour change, adolescents, service education, outdoor education, tobacco, smoking, prevention, health promotion, experiential and active learning, after school programs, leadership training, student rights, youth leaders and youth groups and clubs. Terms used in the Medline database include youth culture, groups, diffusion, psychographics, demographics, peers, youth, smoking, tobacco, prevention, youth programs, health, activities and empowerment. The search of the Centre's materials was based on previous collections on related topics such as youth groups, empowerment, social support and extracurricular learning activities in health promotion.

Defining Youth Led Health Promotion

The Canadian Mental Health Association³⁷⁹ has defined the meaning of youth participation as "*recognizing and nurturing the strengths, interests, and abilities of young people through the provision of real opportunities for youth to become involved in decisions that affect them at individual and systemic levels*".

A workshop sponsored by the Partners for Children Fund²⁶⁷ has further described youth-driven community development and participation as having these characteristics:

Youth Led Health Promotion

- youth feel safe to speak
 - the opinions of youth are solicited, respected and applied
- youth determine what constitutes youth participation and empowerment
 - youth identify their own issues, problems and possible solutions
 - youth and adults feel fully informed about what matters to youth
 - youth initiate project ideas
 - youth drive the process and make things happen
 - youth are involved in all stages of decision-making
 - youth carry out planning and goal setting
 - youth are involved in project design, implementation, evaluation and follow-up
 - youth decide on spending priorities
- youth are involved in, and responsible for, budgeting, allocation of funds and cheques
 - youth teach other youth and pass along the skills and
 - youth are satisfied with the results of their participation

The Potential

There is considerable evidence that children and youth are facing new risks and opportunities as they grow up in today's world and prepare for tomorrow's.

Several Canadian reports, including those of the National Crime Prevention Council, the National Longitudinal Survey of Children and Youth, the Canadian Institute on Child Health, the Canadian Council on Social Development and the National Forum on Health have underlined the importance of early child development.

Other reports, including the international report on the Health Behaviours of School-Age Children,^{TBA} the Coalition for Children, Families and Communities³⁷⁷ the work of the Carnegie Foundation on Adolescents^{22, 266}, DiClemente et al²⁰², Shain et al²¹, have emphasized the new risks faced by adolescents making the transition to adulthood.

These new circumstances have led to calls for new approaches to adolescent health⁴⁴. One of these approaches has been the empowerment of youth within health promotion activities, programs, services and policy development. This is happening in several countries¹¹⁶, including Sweden, Germany, the United Kingdom, the United States, Australia and Norway as those countries search for new ways to create "social capital.

Levin of the School of Medicine at Yale University has applied the principles of the Ottawa Charter in Health Promotion to such youth empowerment strategies³⁶². He suggest that young people can be empowered in a number of ways, including changes in public policies and procedures, creating supportive environments for youth, youth focused community actions, the development of personal health skills and the re-orientation of health services.

Bonnie Bernard⁸⁷ in the United States and Rey Carr¹⁵ in Canada have made the case for this youth-led approach in peer helper programs in schools. The Carnegie Foundation has described the opportunities for community-based and after school programs³⁸⁰. McLenighan¹⁵⁴ argues for similar changes in the organization of extra-curricular activities in schools. Other have argued for changes in the delivery of services such as guidance programs³⁰.

The Limits

Hahn² has described the difficulties in evaluating and managing youth programs, despite the significant investments that have been made in such programs. The focus is on youth drop-out programs, but the lessons can be applied to health promoting youth programs as well. Problems include inadequate descriptions and replicative strategies for program delivery, targeting and recruiting of youth into such programs, maintaining a consistent program mission and identity and retaining staff and voluntary leadership.

Burnett⁶³ has examined the use of school extra-curricular and co-curricula activities to compensate for various risk factors and found mixed results.

Most evaluations of youth led activities have been anecdotal or formative in nature. For example, the BC Ministry of Health program, Healthy Schools, has considerable evidence of participant enthusiasm and descriptions of student participation in activities but no empirical evidence of changes in attitudes, beliefs, skills, or behaviours of the target audiences. Nor is there much description of changes in the environments, policies or professional practices of those who serve these students. This is typical of most evaluations on such programs.

With the exception of well-established or well-funded school-based peer programs, most evidence is qualitative. Many evaluations assess only the changes in the skills, attitudes and behaviours of the peer leaders, likely because of the difficulties in tracking participant responses.

The Carnegie Council on Adolescent Development¹¹⁴ and Ianni¹³⁸ have suggested more in-depth evaluations based on expressed needs and concerns of youth. Dougherty & Bryant-Taylor⁴⁹ have presented a practitioners set of criteria for evaluating effectiveness. We have more suggestions later in this paper. In particular, we would like to address the issue of sustainability of the program once external or seed funding has expired. A Health Canada review of international youth health projects²⁶⁷ suggests that a high level of community (i.e. adult) participation in the youth-led activity is critical to sustainability.

A Framework for Investigation

In order to assess the effectiveness and sustainability of youth-led health promotion, one has to develop a framework for categorizing and evaluation.

There are several stages that normally occur in research investigations as an issue is explored and then explained.

First, there are case studies. These qualitative works usually are based on participant feedback and observation. They raise issues and develop linkages between observed activities and apparent results.

Second, there are inventories and attempts to catalogue different types of programs and activities based on a variety of criteria. Tentative theories and explanations are advanced based on these groupings.

Third, based on these catalogues and inventories, researchers begin to develop empirical observations using quasi-experimental designs and studies. The results are summative but not yet generalizable to other situations or populations.

Fourth, there are meta-analyses of the case studies, and the development of explanatory theories.

Fifth, these developed theories are tested in large scale, comparative studies.

Finally, this knowledge is widely published and disseminated and appropriate changes are made in policy, programs, services and professional practice.

Most attempts to describe youth led health promotion fall in the first stage of research. The inventories that have been developed have tended to be focused on a single health or social problem or a certain type of youth led program or activity.

There are two Canadian documents found in our search that begin the next stage of cataloguing youth led participation. The report on international youth projects funded under the Partners for Children Fund²⁶⁷ listed two "approaches": youth exchanges and video/arts projects. The Canadian Mental Health Association³⁷⁹ has suggested three other "approaches":

- **episodic**: to provide short-term and issue specific ways of involving youth
- **developmental**: to ensure structured and on-going ways for youth to participate
- **networking**: to develop a coordinating group of youth to connect youth groups

A Suggested Framework

In this part of our paper, we suggest a framework for cataloguing youth led health promotion activities and provide a brief rationale for each of the categories. In order to be valid for inclusion in such a framework a category should help us to understand and facilitate youth involvement. The categorization should lead to better planning, implementation and evaluation of such youth led activities.

Categories of Youth Led Health Promotion

Audience Segmentation

By age.		This should include recognition of the stages of physical, social and intellectual development and key transitions faced by the audience. General breakdowns by age could include young children, older children, pre-adolescents, adolescents, late adolescents and young adults
By Culture		This category could include program planning based on culture and ethnic origin and language. Different ethnocultural groups, aboriginal are traditionally used to differentiate such programs in other health promotion endeavours.
By Gender		This include programs aimed at females and males.
By Ability		Traditionally, this has been used to target programs for people with disabilities, Occasionally, peer programs have been designed for gifted children.
By Local Community Characteristics		These include rural, urban, northern and other physical, social or economic characteristics of the communities in which the youth live.
By Youth Cultures (Psychographics)		This application of social marketing research has been suggested by Health Canada and explored somewhat in the research literature
By Youth Situations		This has been defined in one way by categories such as "Out of Mainstream" Youth, Troubled Youth, Youth at Risk, Street Youth etc.

Program Focus

By Health Issue		Many different types programs have been listed under heading such as tobacco, drugs, violence./crime etc.
By Program Characteristics		These include Peer Education, Peer Leadership, Peer Counselling, etc. These could also include the PFC categories such as student exchanges, video/arts projects etc.

Intensity of Program

Episodic		short-term and issue specific activities
Developmental		structured and on-going organizations for youth
Networking		coordinating group of youth to connect other youth groups

Purposes or Intended Health Outcomes (Tied to influencing Health Determinants)

For Intended Audience

Improved Coping Skills		This category would need to be broken down into a stages of changes model (awareness ⇒ ινφορματιον ⇒ κνωωλεδγε ⇒ σκιλλ δεπελοπμεντ ⇒ αττιυδες/ βελιεφσ χηανγεσ ⇒ πραχιχε ιν νεω σκιλλσ ανδ βεηαπιουρσ ⇒ σ υππορτ φορ νεω βεηαπιουρσ)
Better Health practices		
Healthier Physical Environments		
Re-oriented, improved health services		
More, better social support		
More physical, economic resources		

For Youth Leaders

Improved Coping Skills		This category would need to be broken down into a stages of changes models (awareness⇒ινφορματιον⇒κνωωλεδγε⇒σκιλλ δεπελοπμεντ⇒αττιυδες/βελιεφσ χηανγεσ⇒ πραχιχε ιν νεω σκιλλσ ανδ βεηαπιουρσ ⇒ σ υππορτ φορ νεω βεηαπιουρσ)
Better Health practices		

Sites/Settings to Deliver Programs and Activities

WHO²⁶⁹ suggests that sites/settings are the practical means by which a population health approach is implemented. Consequently, we should examine which sites offer the most effective or efficient.

National/ International Sites/Settings

Student Exchanges		
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Community Sites/Settings

Municipal		
Recreational		
Youth serving		
Religious		
Aboriginal		
Ethnocultural		
Local Voluntary Groups		
Business/ Training Centres		
Youth Centres		
Youth Camps		
Public Health		
Vol. Health Orgs		

School Sites

Curriculum based		Health/ Personal Planning/ Service Learning Physical Education/ Recreation Outdoor Education Comprehensive Guidance Programs
Co-Curricular		Special Events, video, speakers, health fairs etc.
Extra-Curricular		Clubs
Student Leadership		Students Councils
Concerns-based		Concerns Identification, Student Health Model etc.
Peer Helpers		Peer Education Peer Counselling
Social Climate		School and Classroom Climate, Discipline, Harassment, Violence
Externally Sponsored, School Delivered		Vol Health Groups, Community Service Groups, Business Groups etc.
After School		
Combined Programs		Where youth leadership is part of broader program and services approach

Parents/ Adults as Delivery Mechanism

Mentoring Programs		
Parent Effectiveness Programs		

Interactive Media

Television		
Radio		
Celebrities Testimonials		
Telephone Help Lines		
Web Sites		
Chat Lines		
Web-based Promotional Messages		
Video Projects		

The Rationale for and Uses of this Framework

In order to be of value this categorization of youth led health promotion activities should enable us to understand and apply new knowledge to enhance program impact. We will discuss the potential of this framework and hope that other research can be done to test some of these hypotheses.

Audience Segmentation

The selection of a specific audience in any form of communications and participation is obviously of value. But can we probe deeper? Can we determine if age, culture, gender, ability, community characteristics, particular youth situations or psychographics can lead to more strategic decision-making about program content, design and delivery?

For example, does delineation by age help program effect? There is evidence found in this preliminary review^{TBA} that cross-age tutoring is effective. Should we build on such models to involve children at a younger age?

Also, we know that adolescents in Canadian society are facing higher levels of risks than ever before^{7,8,42,240,79,180,198}. We also know that adolescents have particular needs to become recognized, to gain competence, to take risks (hopefully positive ones) and to have opportunities to socialize with their peers^{CARR,18,235}. Do current programs explicitly recognize those adolescent transitions and particular characteristics?

Are there cultures that are more prone to such activism by youth? Do all ethnocultural groups readily accept that youth should be able to challenge adult conventions and ideas? Most evaluations have tended to describe particular prevention programs, aimed at a particular cultural group without generalizing about the process of youth empowerment^{71,72,91,144,247,248,319,322,352}.

We identified a couple of program evaluations that describe case studies for rural and urban youth^{139,227,344}, but we did not locate any evaluative summaries of how to approach youth in those different circumstances. Nevertheless, the programs and facilities available to youth in such different communities is considerable. Consequently, we should be differentiating the types of programs recommended for such vastly different settings.

There are several types of youth-led activities that we have identified in this review^{70,85,110,111,243,249,263,296,302,318,365,391} that have targeted girls and young women. Yet we know that young and older boys (not men) are increasingly falling behind girls in academic achievement, participation and post-secondary education. We also know that girls tend to be more effective in social situations than boys, particularly in adolescence. Has there been a gender related breakdown of the impact and participation of youth in such programs? Are we training more female leaders than males? Should we be designing programs for boys only?

We know that social integration programs are effective and particularly needed to support the inclusion of youth with disabilities into regular classes and social activities^{ROEHR} as well as being needed to prevent particular health problems²⁹⁴ We also know that peer-based programs led by non-handicapped or handicapped students can provide such support^{341,195} and that teachers can work with students to support such social integration²⁰¹. Should we make this a priority in program selection and funding?

Street youth have become a central concern to many and peer-based programs have been used to reach them. Caputo et al²⁰⁹ have developed a framework for Health Canada that has categorized the different programs that try to reach such youth (contacts/ support services, transition/reintegration services and prevention/education services). The nature of "out-of-mainstream youth" has also been defined in a paper for Health Canada²⁰⁴. The authors of this paper describe such youth as "curbsiders, throwaways, delinquent youth and entrenched street youth". Case studies have been found in this review that indicate that prevention programs can reach out of the mainstream youth with targeted messages³³⁵, that school-based programs can reach such at-risk youth²⁵³ and that street-based programs can convey greater awareness and knowledge of health risks, but may not lead to behavioural change³³⁴. What are the most effective and cost-efficient ways of having youth peers reach this audience? Should we concentrate on prevention in more conventional settings rather than trying to retrieve youth once they are entrenched on the street? Given that the research described above seems to indicate that out of mainstream youth seem to float between the street, the home and the school, what is the most stable and appropriate site to locate such programs?

Health Canada has tried to use marketing techniques to improve its messages placed in advertising and other social marketing campaigns³⁶¹. The marketing division of Health Canada categorized youth into such sub-groups as TGIF(19%), quiet conformers(16%), concerned moralists(15%), transitional adults(13%), tomorrow's leaders(14%), big city independents(8%) and small town traditionalists (10%). Commercial advertisers have long used psychographics ("the constellation of attitudes, beliefs, opinions, hopes, fears, prejudices, needs and desires that taken together, govern how one behaves"). But we found little evidence that such research is applied to youth oriented programming.

Many researchers have analyzed the social influences of peer groups in health promotion. Traditionally, these explanations are placed within a broader social context such as community, adult culture or ethnic background²⁹³. Others have described such peer social influences in terms of the development of the child and adolescent¹⁸⁴. However, more in-depth analyses have begun to examine the sub-groups and specific social networks that influence health behaviours^{289,292,225,331,313,194}. However, while this research is helping to explain behaviour, it is not being used to plan programs and interventions.

For example, can we use this psychographic research to determine if peer helper programs reach the Health Canada defined groups of "TGIFers, concerned moralists and quiet conformists"? Or, are we really only reaching "tomorrow's leaders and transitional adults"?

The Focus of Youth Programs

Much of our efforts in health promotion are focused on preventing particular health problems. Consequently, we often see youth programs being focused on health issues such as tobacco, alcohol, sexuality, violence or drugs.

If this is to be the way we organize such programs, we will need to have comprehensive understandings of the issue, how it affects children and adolescents, the specific messages that need to be addressed to youth, the efficacy of prevention efforts and the role that can be played by youth led health promotion.

For example, Perry & Stauffer^{204a} have explained how smoking begins and is maintained among young people in the United States. They review prevalence, the consequences, onset, the psychosocial influences, the effectiveness of prevention programs and the role of media and advertising. Several other sources provide us with more specific understandings, including psychological and social influences^{358,357,300,280,351,349,348,286}, the steps to cessation^{307,169}, various cultural and national influences^{287,305,310,308,284} and the influence of disabilities²⁸⁵. We employ such rigour when we design school-based instructional programs, but what about when we implement youth led programs? Indeed, there is some evidence that we need to be careful about this. Some studies indicate that peer discussions about risk behaviours may be correlated with actually participating in those behaviours²⁷⁸.

Program Intensity

The logic of the categories developed by the Canadian Mental Health Association³⁷⁹ are somewhat obvious in program planning. If we are aiming at only episodic involvement of youth, we need be less concerned about issues such as sustainability. If we are trying, on the other hand, to develop a permanent youth organization, then we need to plan for such. If our goal is to network existing youth organizations, we should be studying the appropriateness and the organizational politics of such a plan.

How many of our youth programs are started with a vague hope of sustainability, but with no real plan that would attract on-going financial support as well as a self-renewing process to recruit young people to participate? Too often our "youth" organizations are, in fact, a temporary job for a young adult with no real hope to renew funding or participation from young people.

The West End Youth Project in Vancouver¹⁹ has used a similar measure to assess the involvement of individual youth in such projects. They have established some measures of the actual time that different individual youth actually spent on such activities as well as the nature of those activities.

Program Outcomes

The logic of being explicit about desired health outcomes is again clear without reference to research. However, our findings indicate that most evaluation of impact is done for the leaders in youth-led health promotion activities rather than the intended audience. This is likely because the participants are available for short periods of time in largely voluntary and uncontrollable circumstances.

However, there could be more attention paid to the impacts on audience awareness and potentially, tracking of increased student requests for information and counselling. As well, the program assessments could examine changes in the environments surrounding the youth. Were health services enhanced? Were policies changed? Did the young people gain access to better social support? In other words, the determinants of health could be monitored more closely in regard to program outcomes.

An example of this type of evaluation is found in Vancouver¹⁹ where a case study reported changes in the composition of neighbourhood governing boards and in the creation of new "action groups" of youth as well as in a management team dedicated to serving youth.

Sites/Settings for Youth Led Health Promotion

This paper lists many sites in the community, at school and elsewhere that can be used to offer youth led health promotion programming. The argument for differentiating by such sites is again obvious.

The World Health Organization²⁶⁹ suggests that settings or sites within the community is the practical answer or way to implement a health determinants/population health approach. The recent National Forum on Health⁴⁰¹ listed four key settings, families, schools, the workplace and the community. Consequently, it makes sense that an examination of youth-led health promotion include all of these sites or settings.

We have identified sites or settings at the national/international, community, school and family and electronic levels for this review. There may be some overlap between community and school sites insofar as community and health groups offering programs in community sites but needing to recruit their participants in schools.

The previously mentioned Health Canada report²⁶⁷ on international **student exchanges** programs that provide training and awareness in health issues.

Later in this report we will describe youth led programs that are based in community sites. These include **municipal, recreational, religious, ethnocultural, voluntary community groups, business or training organizations and various youth centres** in communities. The traditional **youth-serving organizations** such as YM-YWCA, 4-H Clubs, Boys & Girls Clubs are included in such community settings.

In schools, **peer helper programs** have been at the forefront of research into program impact. They and other programs in student activities and **student leadership** are the most stable and best evaluated sites for youth-led health promotion.

As well, it may be useful to note here that "**curriculum-based**" sites within the school setting may be particularly advantageous to investigate. Several Canadian provinces and territories are now implementing "service learning" curricula (such as the CAPP program in BC, the CALM programs in AB, NS, etc.) that have a requirement that students perform community service as part of their graduation requirements. Imagine the potential if we could introduce health related activities and youth led activities in such programs. Students would get course credit and health would be promoted.

Another relatively new approach being used in the school setting is focussed on the **social climate of the school**. Bennett & Offord⁴⁰² articulated this for the National Forum on Health. **Co-curricular and extra-curricular activities** that are designed to raise student awareness and involvement in health issues are commonplace in Canada and in most countries. However, what is not often done is a rigorous evaluation of outcomes. One exception to this is the Child to Child approach that originated in the United Kingdom²¹¹. Health Canada has developed a pilot of this activity-based approach.

There are several examples of this approach related to specific health issues such as tobacco, healthy environments, physical activity, alcohol and drugs, violence and sexuality. Some are delivered by **external groups** in the community.

Another similar but different approach is widespread in BC and is moving into other provinces. We have called this a "**concerns-based**" approach because the initial step is to identify the health concerns of the youth population. Health Canada has developed and piloted an extension of this approach whereby youth concerns are tabulated and analyzed scientifically in a computer model, thereby lending greater weight to the concerns.

We also note that schools can be used in **after-school** hours to organize youth-led activities and programs. And we suggest that there are models of **combined programs** wherein youth leadership and involvement is coordinated with relevant education, support from parents or the community and appropriate health or other services.

In another paper for the National Forum on Health, Gottlieb⁴⁰³ extends the logic on peer led approaches calling for greater attention to **mentoring, parent/family support** and adolescent health services programs that are linked with health education and "social competence curricula. Consequently we have included such programs in our list of sites/settings.

We did not locate any references to youth leadership or **involvement in designing social marketing** campaigns that deliver specific messages to youth. We think that it is likely that evaluations of such youth-directed messages are scarce. We also searched and found only a few references to other **interactive electronic media**. However, as more youth are using these media, they should be included in our list of sites and settings

Channels to Reach Those Sites

However, there is one factor that did not get covered much in the research literature. In order to access youth on an on-going basis, we need easy access to the sites listed later in this paper. But we also need easy access to those sites.

For example, we may want to use 4-H Clubs to reach rural youth. But it may not be possible for the national and provincial organizations active within the 4-H network to comply with such a request. Or, we may find that youth organizations at the national level are constantly changing as their personnel changes.

We probably have four basic options in respect to channels to sites that can involve youth directly. First, we can create and maintain network youth organizations concerned with health or single health issues. This would be expensive but effective.

Second, we can use established youth organizations that are not focussed on health. We can support them in taking action on health issues. There would be limits on the scope of activities but it would be less expensive.

As a combination of the two approaches above, we can create and maintain networks of youth organizations and continually "feed" health messages into those networks.

Third, we can use established youth serving or adult organizations that involve youth directly in their activities. Again the scope would be limited by their primary mission but the "reach" would be assured.

Fourth, we can use schools through already established peer helper programs, through student activities advisors and through curriculum based projects.

In deciding where to place our efforts and scarce resources, we need to build in a consideration of the channels that will be used to sustain and initiate youth led health promotion programs. And we need to consider the costs, convenience, and effectiveness of such channels.

Sustainability

This final category for our cataloguing of youth led health promotion was largely untouched in the literature that we reviewed for this paper.

The notion of a large community (including adults) was described in the Health Canada review of international projects. This can be developed into a criterion for effectiveness.

The second notion is based on our observations of youth led health promotion. We need to ensure that youth led health promotion programs have easy access to youth. This means that there are established and sustainable communications vehicles in place that can be used without external funding, that youth are regularly involved in meetings or events that can be used to recruit participants, this means that there is an appropriate turn-over in the leaders of the youth programs so that youth, as opposed to young adults, are continuously involved. This notion would also include adequate access to training and other forms of support (such as readily available adult advisors) for the young people.

The third component of sustainability is the nature of youth interest in the focus or issue of the program. Peer helping seems to be a sustainable activity as young people need to test their limits and to be recognized by their peers. Does organizing special events have the same appeal on an on-going basis?

Similarly, do all health issues have sustainable interest for youth? Or do we need to mix in other issues and focus on generic skills or problem solving?

Finally, the issue of sustainable funding needs to be considered. What are the on-going costs? Who will pay for the costs? Why would they add this to their budgets?

This discussion of the framework for investigating youth led health promotion is important because it should form the basis of our future decisions about peer led activities. By examining these issues, we can be more strategic about which programs to investigate, which to evaluate and which to promote across Canada.

The Theoretical Basis for Youth-Led Health Promotion

There are several sources of research and theory that support the use of youth-led health promotion strategies.

From Health Promotion/Population Health Theory

The theoretical basis for investing in youth-led health promotion is considerable and varied. Social learning theory^{Bandura, 1977}TBA as well as Fishbein & Ajzen's^{TBA} theory of reasoned action can explain that peers an important part of the environment with which young people interact, thereby forming part of their attitudes, beliefs, intentions and behaviour. In particular, peer-led interventions may be able to alter the person's perception of the social norms related to the behaviour, or his/her attitudes towards the behaviour³³⁶.

Health Determinants

Social Support/ Influences

More recently, social support has come to be seen as one of the major determinants of health^{HC-TBA}. Consequently, it is logical that youth led activities and programs will have an impact. However, we should be careful to apply well-researched health promotion theories carefully to the development of youth led programs. Risk reduction models^{TBA} and the PRECEDE approach^{TBA} have been used to ensure that our attention is not solely focussed on changing the health beliefs or health behaviours of the target population. Similarly, we should ensure that youth led approaches include attention to changes in the physical and social environment as well as in the health services and educational programs offered to youth.

There is considerable evidence, based on social influences theory, of the impact that peers have on health behaviours^{246,275,277,320,321,338}. Researchers have examined the influence of peer pressure, of connections to the social development of the child, to cultural considerations and to specific risks such as alcohol/drugs or tobacco.

Chevannes²⁹⁸ goes further, explaining how children acquire their health beliefs in interactions with their peers and parents. Evans et al²⁹³ explain how adolescent's perceptions about their peers' health norms influences their own choices. Botvin⁴¹ explains how the social influences theory has been used to re-design health education and to develop peer programs.

Resiliency

The Crime Prevention Council⁴⁰⁵, Mangham^{TBA}, and several other researchers^{1,107,186,190} have explained how resiliency can be promoted and nourished in children and youth. Youth-led health promotion activities are consistently included in these analyses of how schools and community groups can enhance resiliency.

Empowerment

Empowerment Models have emerged in health promotion and they are consistent with the use of youth-led health promotion strategies. However, it is useful to go beyond simplistic views of empowerment to determine if such theories can be usefully applied to the development of peer-led health promotion programs.

The West End Youth Project¹⁹ was commissioned to develop a quantifiable measure of youth being empowered but found it impossible to accomplish for reasons external to the project. There are case studies that use empowerment theory to explain community

development and coalition-building projects involving adults^{256,281,283}. These include analyses that assess both individual and group empowerment and help to explain the process as a interaction among context, groups, institutions and individuals.

The Canadian Association for School Health⁴⁰⁷ has reviewed the literature and concludes that empowerment is a complex process with many dimensions. Their description includes a list of different types of power that can be shared through empowerment. This list could be refined into measures that can assess changes in individual participants, youth groups, and in the context surrounding the youth-led programs. These types of power include: informational power, recognition of expertise, status, procedural control or influence, contractual obligations and authority over resources. These criteria could be used to develop quantifiable measures and descriptors of youth-led programs.

From Child Development and Learning Theory

Oei & Baldwin¹⁸¹ suggest that a developmental approach be used to preventing smoking. They suggest that young children are influenced more by parents, that peers may be the strongest influence on pre-adolescents and that media may be more significant for adolescents. Similarly, Delaney²⁷⁹ suggests that we all go through certain "rites of passage" and that education programs should take these into account. Consequently, we should design youth-led health promotion programs to take into account the age of the participants.

We know that peer norms have an impact on school related attitudes²⁸² in young children. Peer relationships and social competence may be the most important factor in school success and being at greater risk^{200,197}. Indeed, Doherty suggests that the ability to form relationships with peers is a key element of readiness for school²⁰.

Shain et al²¹ have described the period of adolescence as being characterized by these factors:

1. Becoming less dependent upon parents or primary care-givers for basic needs
2. Dealing with emerging sexuality and hormonal changes that may be accompanied by
rapid physical and emotional changes
3. Acquiring greater inter-personal skills, including those associated with intimacy
4. Acquiring competencies through education and training for adult life and roles
5. Resolving issues associated with basic values and a sense of personal identity

Carr¹⁵ has told us that teens have four basic needs that will appear in all adolescent behaviour: competence, interdependence, recognition and fun. He suggests that to acquire competence, teens need to take risks. To achieve interdependence, adolescents will join groups and define themselves through those groups. Recognition, but not necessarily reward is important. Fun, something we adults undervalue, is something that is prized by youth.

Igra & Irwin²⁰³ have gone into more depth on theories that explain adolescent risk behaviours. They explain the influences of peers, parents, the media and the community. The role of peers is not necessarily seen as a cause of risk behaviours however. It may be that joining the group that is more likely to take risks is the "cause" and the behaviour the effect. Consequently, as youthled programs can create new groups and new norms, they are consistent with this theory base.

More recent public poliy research and forums on adolescent health have identified a developmental approach as being critical to effective health promotion^{75,76}. Indeed, the response of North Carolina to the Turning Points report of the Carnegi Foundation⁷⁷ was to see the Middle School (Junior High) as the " last best chance" to save adolescents at risk. Youth-led health promotion is a key component of that response.

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