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An explanatory model of peer education within a complex medicines information exchange setting

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ABSTRACT

Studies of the effectiveness and value of peer education abound, yet there is little theoretical understanding of what *lay* educators actually do to help their peers. Although different theories have been proposed to explain components of peer education, a more complete explanatory model has not been established empirically that encompasses the many aspects of peer education and how these may operate together. The Australian Seniors Quality Use of Medicines Peer Education Program was developed, in conjunction with community partners, to improve understanding and management of medicines among older people – an Australian and international priority. This research investigated how peer educators facilitated learning about quality use of medicines among older Australians. Participatory action research was undertaken with volunteer peer educators, using a multi-site case study design within eight geographically-defined locations. Qualitative data from 27 participatory meetings with peer educators included transcribed audio recordings and detailed observational and interpretive notes, which were analysed using a grounded theory approach. An explanatory model arising from the data grouped facilitation of peer learning into four broad mechanisms: using educator skills; offering a safe place to learn; pushing for change; and reflecting on self. Peer educators' life experience as older people who have taken medicines was identified as an overarching contributor to peer learning. As lay persons, peer educators understood the potential disempowerment felt when seeking medicines information from health professionals and so were able to provide unique learning experiences that encouraged others to be 'active partners' in their own medicines management. These timely findings are linked to existing education and behaviour change theories, but move beyond these by demonstrating how the different elements of what peer educators do fit together. In-depth examination of peer educators' practice in this context offers potential insights into the practice of lay workers in other related complex health promotion programs.

1. Introduction

Over ten years ago, Turner and Shepherd (1999) argued that peer education was a method in search of a theory – not because there were no findings within the peer education literature that linked to well-known theories. There were and still are. But to date a more complete explanatory model addressing the complex dynamics within peer education programs is lacking in the field. Peer education studies continue to be accused of not discussing theory sufficiently (Campbell and MacPhail, 2002; Peel and Warburton, 2009). This may in part be due to pressure to demonstrate program effectiveness, rather than investigating how a program works and how improvements can be made. Further, theory arising from carefully controlled studies may have poor transferability to real life situations, where the desire of practitioners is for more practice-based evidence (Green, 2006).

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Peer education has been used successfully in countless health promotion programs to address diverse health issues among many different populations. Recent studies have focussed on diverse areas including HIV prevention (Cornish and Campbell, 2009; Sarafian, 2012), increasing use of advanced care planning (Seymour et al., 2013), improving diabetes self-management (Shen et al., 2012) and falls prevention (Peel and Warburton, 2009). In brief, peer education methods train people of similar age, ethnicity or background as educators in order to provide educational messages and support to a population of interest. Peer educators (PEs) are thought to have a unique understanding of their group's attitudes, beliefs and values (COTA Australia & The Pharmacy Guild of Australia, 2001; McDonald et al., 2003) and can act as a trusted bridge between their peers and health professionals (Eng et al., 1997). Further, PEs' existing lay experience and insider knowledge assist health promotion programs to become more culturally appropriate and therefore more effective (Seymour et al., 2013; Wiggins, 2012). 'Peer educator' is the term used in this paper. Programs using other lay workers such as community health workers (CHW) can share common features and objectives (Pinto et al., 2012; Rosenthal et al., 2011), so are considered comparable.

Although studies of the impact of peer education are common, a gap in the empirical literature exists regarding how PEs help their peers achieve desired program outcomes (Pinto et al., 2012; Sarafian, 2012; Swider, 2002). Determining how PEs integrate their personal experience and life skills with technical knowledge acquired through training would assist future programs as well as inform theory. In this paper we examine peer education as used to address medicines management issues faced by Australian seniors, defined as anyone over the age of 55 years. Our aim was to develop a more complete theory of how peer education operates within an education and information session focussing on quality use of medicines, thus building on and extending existing theories. Although two recent studies have investigated how lay educators function in two distinct contexts (Pinto et al., 2012; Sarafian, 2012), no studies were located that examined the process of peer education for medicines management among seniors.

Our research questions were: How do PEs promote awareness and knowledge about medicines issues within an education session, and empower seniors to take greater control of their medication management and health? How does the life experience of PEs as seniors and as lay persons impact on the peer education process? Although PEs' functions in this program occasionally extended beyond educational sessions, this paper focusses on their practice within sessions.

1.1. Quality use of medicines (QUM) context

Improving QUM, also known as 'rational use of medicines', among seniors and those using multiple medicines is a national priority in Australia (Kalisch et al., 2011; Roughead and Semple, 2009) and internationally (Holloway and van Dijk, 2011). Adverse drug events are a significant cause of morbidity in Australia, resulting in an estimated 190,000 hospital admissions per year (Roughead and Semple, 2009). Promoting QUM helps reduce the social and economic burden of medicines mishaps, while improving outcomes where medicines are necessary (WHO, 2006). In Australia, QUM has three fundamental elements: 1) selecting management options wisely; 2) choosing the most suitable medicine, if a medicine is necessary; and 3) using medicines safely and effectively. '*Medicines*' refers to prescription and non-prescription medicines, including over-the-counter medicines, herbal and natural medicines (Commonwealth Department of Health and Ageing (2002)).

The Seniors QUM Peer Education Program was developed in 2003 to train seniors as PEs to convey QUM messages to other seniors. The Program was funded by the Australian Government and managed by NPS MedicineWise in conjunction with COTA Australia and National Seniors. COTA members had advocated for a local peer education approach for years and were closely involved in Program development (COTA Australia & The Pharmacy Guild of Australia (2001)). Teams of volunteer PEs were established in major cities and large regional centres, each supported by a paid coordinator. These teams provided QUM information sessions to a wide range of communities, not necessarily ones where PEs resided or had existing social networks. Within three years, PEs had conducted 1385 QUM sessions with approximately 32,000 seniors across all Australian states and territories. The Program typically provides a single 1-h information session to a seniors' group following a booking (e.g. by a social club). Sessions were supported by take-home aids (e.g. pocket medicines record), print material for individuals and community centres, and information services (e.g. a consumer website and telephone help line). The key topics of a QUM session are shown in Box 1.

Educational messages were based on evidence that seniors may lack appropriate information about medicines management, including understanding medication labels, generic and trade names of the same medicines, dosage, and the value of adherence (COTA Australia & The Pharmacy Guild of Australia (2001)). QUM messages and calls to action are more general (e.g. ask questions, seek reliable information, be active in decisions) than other more discrete peer education messages, e.g. have a mammogram (Earp et al., 2002). Because the population of seniors is diverse (e.g. healthy retirees, those with chronic conditions, non-English speaking), one objective was to make seniors fully aware of the issues, whether immediately required or saved for the future. Another objective was to increase effective partnerships between seniors and health professionals since evidence indicates people modify the use of their medicines with or without the advice of health professionals (Pound et al., 2005). The overall goal was to

Box 1
Key features of a QUM session for seniors.

QUM sessions lasted approximately 1 h (range 45 min to 3 h depending on setting and group needs) and included:

- Introduction emphasising the provision of information, not advice
- Discussion about what constitutes a medicine and ways to access medicines
- The potential risks associated with use or misuse of medicines, including the risks of sharing medicines whether prescription or non-prescription
- The role of seniors as active partners with their health professionals in their own health care and medicines choices
- Avenues for gaining reliable information about medicines (i.e. general practitioners (GPs), pharmacists, Consumer Medicines Information (CMI), Medicines Line telephone information service)
- Suggestions for action, including preparing questions to ask the GP or pharmacist and completing a medicines list
- An informal opportunity to ask questions at the end or after a session.