

DC Family Policy Seminar

A community service project of Georgetown University

Educating with Peers: Others Do—Should You?



BACKGROUND BRIEFING REPORT

The DC Family Policy Seminar provides District policy-makers with accurate, relevant, non-partisan, timely information and policy options concerning issues affecting children and families.

The DC Family Policy Seminar is part of the National Network of State Family Policy Seminars, a project of the Family Impact Seminars, a nonpartisan public policy institute in Washington, DC.

A collaborative project of the Georgetown Public Policy Institute (GPPI) and its affiliate, the National Center for Education in Maternal and Child Health (NCEMCH).

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By

Katherine Shoemaker

Leslie Gordon, M.P.P, Vince Hutchins, M.D., and Mark Rom, Ph.D. (eds.)

Organization and resource lists prepared by
Susan Rogers

Georgetown University
Georgetown Public Policy Institute

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Abstract

The children and families of the District of Columbia face many social concerns and challenges. Substance abuse, youth violence, access to and information about health care, and AIDS and HIV head the list of issues that national and local government, nonprofits, service providers, and schools try to address each day. Though a number of potential interventions exist, many organizations have turned to peer education programs as a partial solution to these social issues.

As the number of peer education programs in the District grows, it is important to examine the strengths and weaknesses of this approach and its use among different populations. This briefing report will examine the theoretical basis of peer education, review the research, and highlight peer education's use in specific local and national models.

This seminar, the 20th in a series sponsored by the DC Family Policy Seminars at Georgetown University, will focus on national and local peer education models and specific program evaluations. The goal is to bring different ideas to light and to discuss alternatives that District service providers, agencies, and citizens can use to encourage change. The policy objectives of this seminar are to (1) recognize the wide variety of uses of peer education in different populations and for different purposes; (2) review research and evaluations of peer education programs in the District, the nation, and other countries; (3) bring together key District participants to strengthen a coordinated response; and (4) provide policymakers with knowledge that allows them to make informed decisions.

This report provides a brief introduction to the issue addressed by the DC Family Policy Seminar on November 3, 1998. The authors thank the numerous individuals in the District of Columbia government and in local and national organizations for contributing their time and effort to this seminar. Special thanks are given to Leslie Gordon, Vince Hutchins, Mark Rom, and the staff of the National Center for Education in Maternal and Child Health for hosting this seminar, and to Stephen Moseley and the staff of the Academy for Educational Development for providing space and technical assistance.

Educating with Peers: Others Do—Should You?

This seminar is the 20th in a series designed to bring a family focus to policymaking. The panel features the following speakers:

- **Quannita Favorite**, Peer Educator, Advocates for Youth
- **Gwendolyn West**, Coordinator, Breastfeeding Peer Counselor Program, The WIC State Agency, District of Columbia
- **Billie Lindsey**, Assistant Professor of Health Promotion, Lynchburg College
- **Cate Lane**, Advocates for Youth

This seminar focuses on peer education in the District of Columbia and aims to provide research and program information on peer education models. The organizers of this seminar hope to encourage increased collaboration among community, government, and business members to ensure quality services for all children and families in the District. This background report summarizes the essentials on several topics. It discusses the theory and background of peer education; provides an overview of different models being used both locally and nationally; and presents a review of the research into peer education. The contents of this briefing report are as follows:

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I. Introduction

The children and families of the District of Columbia face many social concerns and challenges. Substance abuse, youth violence, and access to and information about health care, AIDS, and HIV head the list of issues that national and local government, nonprofits, service providers, and schools try to address each day. Though a number of potential interventions exist, many organizations have turned to peer education and peer mediation programs as a partial solution to these social issues. This seminar will examine the pluses and minuses of peer education and review its use in specific local and national models.

Peer education takes many forms: counseling, education, training, mediation, facilitating, tutoring, leadership, and helping. For the purpose of this seminar, peer education refers to any program that uses peers to educate or facilitate access to education for an individual or peer group. Therefore, the concept of peer education can apply to virtually any age group and to a wide variety of issues, problems, and prevention efforts.

II. Theoretical Background

The concept of peer education is not new. In fact, some date its origins back to Greek and Roman times (Center for Population Options, 1993). Peer education is rooted in the following three theories (Milburn, 1995):

- **Social learning theory** uses role models to which the client or audience can relate. Role models convey factual information to the client and model appropriate behavior, teach social skills, and rehearse possible roles and responses to stressful situations in which a client may be involved.
- **Social inoculation theory** teaches or provides peers with techniques for using persuasive arguments and facts to counter peer pressures.

- **Differential association theory** “asserts that criminal behavior is learned in small personal groups . . . this learning involves not just specific techniques, but also their supporting motivations, rationalizations, and attitudes” (Milburn, 1995). Thus, since learning negative behavior occurs in small groups, educators and others attempt to use the same venue to teach skills and rationales for more socially desirable actions.

Peer education borrows from each of these theories to create a new model for social education and capitalizes on the powerful influence peers can have on people’s lives. To channel that influence constructively, community leaders have taken the peer education concept and applied it to diverse populations to meet different educational needs.

III. National Models

The following programs represent a cross section of traditional peer education models and innovative applications.

Boot Camp for New Dads

Operating at 60 hospitals in 32 states, Boot Camp for New Dads is a peer education program for new fathers. Founded in 1990, Boot Camp pairs new fathers with Boot Camp veterans and their 2–3-month-old babies to teach them the basics of child care and child safety. In turn, “the new dads return as veterans, continuing the cycle, offering their best advice to the next class” (Boot Camp, 1998).

These veterans act as coaches, teaching first-time fathers how to hold a baby, swaddle it, and change its diaper. They give advice on what to do—and what not to do—when babies cry, using dolls to demonstrate how not to shake a baby. They also explain to “rookies” how their sleeping patterns and sex lives may change, and they discuss the impact that postpartum depression and increasingly involved in-laws can have on their

new family (Boot Camp, 1998).

The program's strength lies in fathers learning from each other. Boot Camp's founder, Greg Bishop, finds that "men training other men is a powerful formula for fatherhood success. Boot Camp veterans also benefit from networking and mutual support when they return with their babies at a subsequent workshop" (Bishop, 1998).

Hospitals that implement Boot Camp have noted increases in the number of new fathers who are interested in parenting information. The program appeals to hospitals and health plans because well-prepared dads strengthen the family support system. Furthermore, as hospital stays for giving birth continually grow shorter, a skilled and capable father who knows when and how to access the family's health care system benefits the entire family (Boot Camp, 1998).

The Fathers Foundation, a nonprofit organization, sponsors the Boot Camp program, conducting workshops and developing programs specifically geared to teen fathers, fathers of different cultural backgrounds, and men with varied financial circumstances (Boot Camp, 1998). Currently, Boot Camp for Dads does not operate in Washington, DC, although the program can be implemented in any number of venues—wherever a number of new fathers participate, such as hospital birthing centers or churches (Boot Camp, 1998).

Sobriety Treatment and Recovery Teams (START)

In Ohio, the Cuyahoga County Department of Children and Family Services implemented peer education in its Sobriety Treatment and Recovery Teams (START) units in "response to the rising drug problem in [the] community, specifically the use of crack cocaine by young women who are pregnant or who have just delivered a child" (Cuyahoga County Department of Children and Family Services, 1998).

When a child is born with a positive toxicology, or when a new mother tests positive for drugs, an intake caseworker refers the family to START. The hospital's intake unit and the START team work together to coordinate intervention efforts for the family. While the intake worker maintains control of investigations involving abuse or neglect, a START team, comprised of social workers and family advocates, initiates services for the family and refers the mother for treatment. Social workers and family advocates (who are themselves in recovery from drug addiction and who may have already dealt with the child welfare system) accompany mothers to a drug assessment that then enables the mother to begin treatment (Cuyahoga County Department of Children and Family Services, 1998).

START involves recovered drug addicts to engage drug-affected parents, serve as role models for parents, and assess each client's potential for relapse. START believes these advocates harbor more credibility with clients and, as a result, clients may be more likely to talk about problems or to seek help when advocates accompany case workers. Additionally, this practice gives social workers the opportunity to enhance their teamwork and substance abuse skills through interactions with advocates who have experience with crack, the recovery process, and life in challenging communities (Cuyahoga County Department of Children and Family Services, 1998).

Advocates are paid for their work. In addition, if they qualify, their pay is subsidized by the JOBS program for 6 months after they are hired (Cuyahoga County Department of Children and Family Services, 1998). START will assess the effectiveness of its program with an extensive evaluation, and it expects to modify the program as needed, based on evaluation results.

IV. District Models

Metro TeenAIDS (MTA)

HIV and AIDS are critical issues in the District, particularly among youth. Experts estimate that the rate of HIV infection among Washington, DC, teens is 20 times greater than the national rate (Metro TeenAIDS, Internet, 1998). As a result, organizations like Metro TeenAIDS (MTA), which is dedicated to preventing HIV infection among young people in the Washington, DC, metropolitan area and improving the quality of life of those affected by the virus, have developed a multifaceted approach to addressing the problem (Metro TeenAIDS, 1998).

MTA's philosophy of youth outreach and education is incorporated into a number of peer models in the organization. For example, young peer educators collaborate with adult education staff and then meet with parents and other heads of households to discuss talking about AIDS with their children. MTA's National Youth Conference, which in 1996 was jointly held with the National Association of People with AIDS and the Ryan White Foundation, provides a professional development opportunity for adolescent HIV/AIDS activists and educators (Metro TeenAIDS, 1998).

MTA has expanded its outreach beyond the District to the Maryland and Virginia suburban population. Program staff estimate that they have reached approximately 85,000 young people in the metropolitan area (Bazzi, 1997). Health policymakers believe in this peer-to-peer approach. Susan Pollard, a spokeswoman for the Bureau of STD/AIDS at the Virginia Department of Health, which provides funds for MTA, commented that "these peer groups work because a teenager is more likely to listen to another teenager. . . . It can be a challenge for teens to speak to people their own age, earn their respect and form a dialogue" (Bazzi, 1997). However, health officials also acknowledge the difficulty of determining whether street outreach efforts like MTA actually change behavior (Bazzi, 1997).

WIC Breastfeeding Peer Counselor Program

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides food, nutrition counseling, and access to health services to low-income women, infants, and children. The WIC State Agency for the District of Columbia began the first WIC peer education program to support breastfeeding in 1983. Since then, other WIC programs around the country (the Food and Nutrition Service of the U.S. Department of Agriculture administers WIC nationwide) have emulated the DC model (West, 1998). WIC trains mothers who have breastfed one or more infants to advise, support, and educate other WIC participants. Initial training consists of a nine-session program, quizzes and final exams, and a supervised practicum. In addition, WIC counselors participate in ongoing monthly training (WIC, Facts in Brief).

Each breastfeeding counselor works an average of 8 hours every week, at WIC sites in the District or over the telephone, receiving referrals from WIC staff and hospital personnel and recruiting clients through hospital clinics and waiting rooms. Clients include pregnant and lactating WIC participants (WIC, Facts in Brief). Counselors strive, through peer education, to break down barriers to breastfeeding such as embarrassment and lack of family support. Though some counselors have worked with WIC for as long as 10 years, the organization tries to balance experienced workers with new peer educators who provide a fresh outlook.

National research demonstrates that breastfeeding rates are growing faster among WIC participants than among the rest of the population. A study by Ross laboratories, for example, showed that between 1989 and 1995, the percentage of WIC mothers breastfeeding in the hospital increased by more than 36 percent, while the percentage for non-WIC mothers increased only 12.9 percent (WIC, 1998). This accomplishment represents the efforts of a number of components of

WIC's breastfeeding program, perhaps including the breastfeeding peer counselors.

Organizers of the DC program attribute its success to two key components: ongoing contact with and support for peer educators, and integration of peer educators into the entire sponsoring organization. For example, WIC holds meetings in which counselors discuss problems or interesting cases that they encounter, thereby providing opportunities for information updates and additional training. Peer educators are integrated into the system or organization as much as possible, via staff meetings and training that includes peer counselors (Martinez, 1998).

Georgetown University Peer Education Program

Georgetown University has offered peer health education to its students since 1989. Believing that first-year students needed more information about HIV than they were getting, Jack DeGioia, who was Dean of Student Affairs in 1989, helped design a program that used residential life staff to educate students on this topic. DeGioia ultimately expanded the program to cover other health issues, including sexual assault, eating disorders, alcohol abuse, and nutrition (Day, September 1998).

The program began with a prepared script and video clips designed to spark discussion. However, it has evolved into "a more spontaneous, interactive, multidimensional, theater-based format" (Day, 1998). Peer educators improvise scenes involving health behaviors and social norms to promote critical thinking and dialogue about these issues among the audience. Rather than supplying the "right" answers or acting as the ultimate authority on complex questions, the peer educators explore differences and raise awareness about social issues (Day, October 1998).

Peer educators receive cross-training in improvisational techniques and health information by participating in a collaborative course developed

by Student Affairs and the Department of Art, Music, and Theater. Approximately 17 students take the multidisciplinary three-credit course each year. Trained students then hold about three meetings per year with up to 80 students per session (Day, September 1998).

Carol Day, Director of Health Education, believes the program's success lies in the diversity and talent of the participating students. Peer educators act as a bridge between students and health professionals. As student members of the Georgetown academic community, they understand student culture and experiences (Day, September 1998). Day views peer educators as an asset to the Georgetown safety net because of their ability to connect students and resources (October 1998).

V. Research Findings: Advantages of Peer Education

As the number of peer education models has increased, so have corresponding research and evaluations. However, peer education programs vary a great deal, so it remains difficult to apply evaluation results to the entire field. Nonetheless, this review of peer education evaluation and research examines the pros and cons so as to be useful to practitioners and program administrators considering adopting this approach.

Advocates of peer education believe that its advantages include credibility, lower costs, increased outreach, positive behavioral change, and increased content knowledge for both educators and their targets. Furthermore, advocates note that the use of role models and social inoculation separates peer education from standard educational approaches, thus creating a unique contribution. Some proponents maintain that peer programs "are the most powerful tool for the prevention of problems facing young people today" (Tindall, 1990).

In her publication, "The Case For Peers," Benard details a number of peer education's advan-

tages. First, Benard notes that peer education fosters peer relationships, a key component of social development. Further, she notes, research has shown that “peer interaction is conducive, perhaps even essential, to a host of important early achievements” (Damon and Phelps in Benard, 1990).

Peer education also provides key social support to youth. This social support can protect students’ physical and mental health and can also serve as a “buffer” for those experiencing stressful life events or situations (Benard, 1990). Wade Nobels observes that, in contrast to other groups and cultures, the dominant culture in the United States does not base its value system on peer cooperation and mutual support. Thus, Nobles suggests that by stressing the value of friendships and support, society could “mitigate the societal alienation which may be at the base of many social and psychological problems, including alcohol and drug abuse” (in Benard, 1990). This social support may be particularly important for youth who do not receive adequate support from adults. Peer educators may fill a key social support gap (Benard, 1990).

Credibility

The benefits of peer education hinge on the credibility of the educator. Advocates for peer education believe that “people are more likely to hear and personalize messages resulting in changing attitudes and behaviors if they believe the messenger is similar to them and faces the same concerns and pressures” (Stevens, 1997). They argue that peer educators communicate in a manner and a language like those of their targets, and a unique sense of trust may develop when peers identify with educators from similar backgrounds or experiences. An educator from a different age group, experience, or background is less likely to earn the same level of trust. For example, researchers have found that “inner city youth said they would be more likely to listen to and believe what an HIV-infected person their age said about the disease,

rather than what an older person or a famous person said” (Center for Population Options in Black et al., 1993).

This increased trust can produce significant results. For example, a study by Jay S. Rickett, VI, and A. Gottlieb found that when comparing peer-to-peer vs. adult-to-adolescent education programs, “peer counselors produced the greatest attitude changes related to the adolescents’ perception of personal risk of HIV infection and improved their inclination to help prevent transmission” (in Stevens, 1997). These attitude changes lead many researchers to suggest that peers are in the best position to “win the respect and trust of their peers and have the proximity to exert a positive social influence. . . . Adolescents can be extremely influential in shaping the behavior and values of their friends, particularly in risk-taking situations” (Center for Population Options, 1993).

Cost

Advocates maintain that the peer education programs cost less than hiring full-time professional educators or staff (various authors in Stevens, 1997). Often peer educators work on a volunteer or hourly basis, which is less expensive than hiring a full-time paid professional. In addition, training a group of peer educators exponentially affects the number of clients reached. Reaching a larger audience reduces the cost per client. This is a key advantage for institutions facing budget cuts or resource limitations (Sawyer, 1997).

Behavior Modification

Proponents cite numerous studies showing that peer education results in changed behavior. One meta-analysis of 120 drug-prevention programs showed that programs led by or involving peers were rated significantly better than those led by teachers (Black et al., 1997). In another analysis of multiple peer education programs, researchers found that when the program’s intensity (i.e.,

hours spent in prevention programming) was higher, the positive effects of peer education were even greater (Banger-Drowns in Benard, 1990).

Another evaluation examined a specific peer education effort that targeted young urban females. The evaluation revealed “significant improvements between baseline and follow-up scores regarding general information about AIDS and increased rates of preventative behaviors. Before the program, 44 percent of the sexually active participants reported no use of condoms; after the intervention, only 33 percent reported no condom use” (Stevens, 1997).

Benefits to Peer Educators

Many researchers note that peer educators benefit significantly from their role in helping others (Benard, 1990; Center for Population Options, 1993; Stevens, 1997). Peer educators feel positive, develop a sense of independence and empowerment, create a sense of social usefulness, and are more receptive to learning (Riessman in Benard, 1990). The chance to help someone else gives the educators “the experience of being needed, valued, and respected by another person,” which can produce “a new view of self as a worthwhile human being” (Benard, 1990).

Peer educators may change their own behavior when they are cast as role models. Advocates For Youth cites a study in which peer leaders among a group of gay men reduced unprotected anal intercourse by 15 percent. (Kelly, St. Lawrence, Diaz, et al. in Stevens, 1997). Other benefits to educators include developing an appreciation and tolerance of diverse life styles and cultures; becoming more comfortable with discussing sensitive issues (various authors in Stevens, 1997); and honing collaboration and conflict resolution skills (Benard, 1990).

These findings suggest that the benefits to peer educators may prove one of the best justifications for peer programs (Sawyer, 1997).

VI. Research Findings: Limitations of Peer Education

Critics of peer education programs express concerns about the concept itself and about specific applications or expectations for its use. They disagree with proponents about its credibility, cost effectiveness, impact in terms of behavior modification, and the quality of knowledge that peer educators develop. One researcher, Kathryn Milburn, disagrees with the use of peer education among young people because she sees it as a “manipulation of young people’s social worlds to promote ‘healthier’ behaviors or lifestyles” (1995). She questions the fact that in some cases adults determine the agenda for youth instead of engaging them in a dialogue to determine issues of importance to them.

Another researcher, Dr. Billie J. Lindsey, also questions the use of peer education among young people. Her article, “Peer Education: A Viewpoint and Critique,” examines the underlying assumptions of peer education and its limitations. She questions the validity of two assumptions of peer education: (1) students prefer to learn about health issues from peers rather than professionals; and (2) peer education expands outreach (1997).

Credibility

Several studies refute the idea that “friends seek advice from friends” (Lindsey, 1997). A study by Cline and Engel finds that college students did not prefer to ask peers for information about AIDS, nor did they believe peer educators were as believable as other sources concerning AIDS (in Lindsey, 1997). Researchers at Northern Illinois University concur with Cline and Engel that students prefer other sources such as doctors, hotlines, pamphlets, or nurses in addition to or before peer educators (Lindsey, 1997).

Cost

Lindsey maintains that peer education programs may not expand outreach capacity. While at

Columbia University, she observed that “professional staff members were spending the majority of their time each semester recruiting, screening, planning content, training, scheduling, and supervising peers for a total of three health presentations” (Lindsey, 1997). Thus, the time that salaried employees spend recruiting, selecting, training and organizing peer educators may mitigate the cost-effective claims made by others (Lindsey, 1997).

Behavior Modification

Critics maintain that peer health education may fulfill its goals of raising awareness but that this does not necessarily change behavior. Evidence indicates that even among young people who have expanded their knowledge, shifted their attitudes and beliefs, and acquired new skills, critical changes in everyday health behaviors have not followed (Fabiano, 1994).

In terms of the extent of real influence that peer educators can hope to achieve in health behavior, perhaps other mechanisms that have a greater effect on behavior should be considered (Milburn, 1995). Milburn remarks that “only occasionally does a peer health intervention appear to have had demonstrable effects on behavior and this is usually in a tightly structured and targeted intervention” (1995). Thus, in contrast to studies by other researchers that find peer education significant, Milburn and Fabiano cite studies finding that peer education had little or no effect on the target group’s behavior.

Lindsey consequently recommends that organizers should evaluate changes in participants’ knowledge, behavior, and attitudes following peer education (1997).

The Issue of Professionalism

Lindsey stresses the difficulty of having only 20 or 30 hours to train peer educators in highly complex subject areas or facilitation techniques (Lindsey, 1997). She argues that many health education professionals receive comprehen-

sive training in a variety of subject areas, and in teaching and group facilitation skills. In addition, they bring a wide range of life experience to the task. As a result, they can offer “more variations in health programs and can capitalize on the many teachable moments that students, no matter how well trained, will ever be able to do” (Lindsey, 1997). Thus, the advanced experience, knowledge, and skills of health education professionals may produce better results.

Recommendations for Improvement

Lindsey suggests that health education programs need greater funding: more professionals are needed to provide programs and to train peer educators (Lindsey, 1997). In addition, she recommends that schools evaluate the knowledge and skills of peer educators before using them for outreach. Finally, Lindsey urges scholars to research the issue more thoroughly. For example, she calls for researchers to determine if peer education is more appropriate for certain topics or certain groups.

Fabiano promotes the idea of strengthening peer education so that it can evolve another step, because information alone does not change anyone’s behavior. Health education programs need to change, she stresses, from focusing on individualistic concerns about making personal choices to emphasizing each individual’s intricate involvement with the community (Lindsey, 1997).

Milburn further advises researchers and practitioners to consider the context of the intervention. The process itself, she maintains, will affect outcomes. Peer education will be more effective in some situations than in others. “It cannot be assumed that the same social mechanisms are at work in different settings” (Milburn, 1995). Therefore, peer education cannot be applied as a panacea to all social problems.

Further Research

Lindsey and Milburn concur that peer education should be researched further before definitive

conclusions about its success can be drawn. Professional health educators may spend too much time training peer educators in lieu of providing professional health education, and this may be a disservice to clients.

Lindsey argues that the two major assumptions underlying peer education (that of greater credibility and decreased cost) have led to extensive peer education programs that exclude or limit professional outreach. In light of the research, she argues that “health educators must carefully assess how to use peer educators to enhance their health promotion and disease prevention efforts” (1997). Milburn says that “in the face of contradictory and inconclusive evidence, the premise that young people will be more effectively informed and their behaviors altered by sexual health education from their peers should still be treated with caution” (1995).

VII. Conclusion and Policy Recommendations

In the District, peer education can complement other techniques, programs, and policies designed to address complex social problems. Peer educators bridge a gap between certain populations or communities and other service providers because of the trust that community members place in their peers. Thus, their role complements that of professional educators. However, programs with limited resources must strike a balance between peer education and other professional programs. This can be difficult, because training peer educators is time consuming.

Researchers and practitioners must continue to investigate peer education’s effectiveness at reaching different populations or addressing particular social behaviors that have been hard to change with traditional educational techniques. Further experimentation and evaluation will help determine if peer education contributes significantly to positive outcomes for District residents.

Although peer education models vary widely, and evaluations of one program may not apply to others, evaluations of individual programs will reduce gaps in the research and help organizations assess the impact of their programs.

Community members should share information that sheds light on the benefits and limitations of this approach to social problems. Program organizers must be mindful to use peer education programs judiciously, keeping in mind their strengths and weaknesses, and evaluate their effectiveness accordingly.

Finally, those seeking to implement or strengthen peer education programs may wish to consult Appendix A, which contains pertinent recommendations from Advocates for Youth on one type of peer education program. The lessons learned may be applicable to areas beyond sexual health education as well. ■

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APPENDICES

Appendix B

National Resources

American Self-Help Clearinghouse

c/o Northwest Covenant Medical Center
25 Pocono Road
Denville, NJ 07834
Phone: (973) 625-9565, TTD (973) 625-9053
Web site: <http://www.cmhc.com/selfhelp/>

The American Self-Help Clearinghouse maintains a database of national self-help groups and model one-of-a-kind self-help peer support groups for a wide range of problems. The organization provides referrals to self-help clearinghouses worldwide and assistance to persons interested in starting new groups. It publishes a directory of national support groups and a newsletter and maintains a comprehensive contact list of professional organizations and associations.

Bacchus & Gamma

P.O. Box 100430
Denver, CO 80250-0430
Phone: (303) 871-0901
Web site: <http://www.bacchusgamma.org>

The Bacchus and Gamma Peer Education Network, an international association of college- and university-based peer education programs, focuses on alcohol abuse prevention and other related student health and safety issues. The association seeks to actively promote peer education as a useful element of campus health education and wellness efforts by developing and maintaining a thriving student network; providing resources that promote and support peer education activities; providing high-quality training opportunities locally, regionally, and nationally; promoting a national forum on student alcohol-abuse prevention and other student health and safety concerns; and creating, promoting, and disseminating new research on alcohol and other student health and safety issues.

“Because I Love You”

The Parent Support Group
P.O. Box 473
Santa Monica, CA 90406-0473
Phone: (310) 659-5289; (818) 882-4881
Web site: <http://www.becauseiloveyou.org>
E-mail: bily1982@aol.com

Washington, DC, area group: Karen, Gaithersburg
Parents Support Group, phone (301) 840-4780
until 3:00 PM, (301) 972-2847 after 5:00 PM

“Because I Love You” (B.I.L.Y.) is a nonprofit organization dedicated to supporting parents of troubled children of any age. For the past 16 years B.I.L.Y. has helped thousands of families promote the use of structure, consequences, and consistency in raising children. The organization helps parents deal with serious issues such as drugs, running away, truancy, verbal and physical abuse, curfew, dress codes, and “problem” friends, as well as less-serious concerns like messy rooms, neglected chores, and lower-than-expected school grades.

Boot Camp for New Dads

Contact: Gary Radvansky, Program Director, or
Debbie Sykes, Coordinator
4605 Barranca Parkway, Suite 101-E
Irvine, CA 92604
Phone: (949) 786-3597
Web site: <http://www.newdads.com>

Boot Camp for New Dads was developed in 1988 to orient new fathers to their role. “Veteran” fathers (with their babies as models) lead 3-hour workshops that cover topics like baby care, fatherhood, and the needs of the new mothers. Each workshop offers hands-on opportunities for prospective dads to practice baby care skills under the guidance of the veteran dads and features an

interactive session of advice, questions, and answers.

California Association of Peer Programs

Contact: Kathy Grant, Executive Director
Box 50725
Pasadena, California 91115-0678
Phone: (818) 564-0099
Web site: <http://www.pomona.k12.ca.us/~capp>

The California Association of Peer Programs is dedicated to the initiation, enhancement, and promotion of youth services through quality peer programs. More specifically, their goals are to strengthen the network among peer helpers and peer-helping professionals; to increase the number and quality of peer programs in California; to spread awareness and support for the peer-helping model at the local, county, and state levels; to provide statewide ethics and standards for the development and maintenance of quality peer-helping programs; and to link with state and national organizations and promote peer helping throughout the country.

Community Matters

P.O. Box 14816
Santa Rosa, CA 95402
Phone: (707) 823-6159
E-mail: team@commatters.com

This organization provides peer training for faculty, staff, and students.

Family Voices

P. O. Box 769
Algodones, New Mexico 87001
Phone: (888) 835-5669; (505) 867-2368
Web site: <http://www.familyvoices.org>

Family Voices is a national, grassroots clearinghouse for information and education concerning the health care of children with special health care needs. Its goal is to advocate the inclusion of certain basic health care principles in every health care reform proposal. Member families share their expertise and experiences with state and national policymakers, the media, health professionals, and other families.

Green Mountain Prevention Projects

109 South Winooski Avenue, Suite 201
Burlington, Vermont, 05401
Phone: (800) 639-1487; (802) 863-8451
Fax: (802) 863-8451
Web site: <http://sequoia.together.net/~gmpp/PLP.htm>

An organization that plans and facilitates peer leadership projects for schools, the Green Mountain Prevention Projects' mission is to reduce the likelihood that people of any age will become harmfully involved with tobacco, alcohol, and other drugs. The organization provides primary prevention programs and leadership training to Vermonters of all ages. Its goal is to provide a safe and empowering training atmosphere where students become peer leaders and educators.

The Health Oakland Teens Project (HOT)

Center for AIDS Prevention Studies
Contact: Maria Ekstrand, Project Director
74 New Montgomery, Suite 600
San Francisco, CA 94105
Web site: <http://www.caps.ucsf.edu/hotindex.html>

The HOT program educates and trains ninth-grade students to become HIV peer helpers for seventh-grade students. The peer helpers deliver weekly interactive sessions in seventh-grade science classes, focusing on values, decision-making, communication, and prevention skills. Each year, the program trains 30 ninth-grade peer helpers who in turn teach 300 seventh-graders.

National Peer Helpers Association

Contact: Dr. Judith Tindall, Development
Chairperson
P.O. Box 2684
Greenville, NC 27836
Phone: (919) 522-3959

The National Peer Helpers Association sets standards for peer programs in the United States and sponsors a yearly conference and a quarterly journal.

National Self-Help Clearinghouse

c/o CUNY, Graduate School and University Center
25 West 43rd Street, Room 620
New York, NY 10036
Phone: (212) 354-8525

The National Self-Help Clearinghouse provides information and referrals to self-help groups. The organization conducts training for professionals about self-help and research activities, in addition to publishing manuals, training materials, and a newsletter.

The North Carolina Peer Helper Association

204 Twin Acres Drive
Lexington, NC 27292
Phone: (910) 885-3591

Web site: <http://members.aol.com/ncpha>

The North Carolina Peer Helper Association, established in 1981, is a professional organization dedicated to encouraging, promoting, and improving peer-helping programs in schools, business and industry, and the community. Its specific goals are to foster the development of new and innovative peer programs at the school, community, and state level; to provide support and training to new and existing programs; and to set standards and ethics for peer programs in North Carolina.

Northern Virginia AIDS Ministry

Contact: Leslie Buchon, Youth Speaker
Coordinator

413 Duke Street
Alexandria, VA 22314
Phone: (703) 739-2437

Founded in 1987, NOVAM is an independent, nonprofit agency whose mission is to provide direct services to meet the needs of those who are living with HIV/AIDS, to educate the community about HIV/AIDS, and to combat the fear and prejudice that surround the disease. NOVAM seeks to affirm God's love for all those who have been touched by this epidemic, regardless of gender, race, disability, creed, sexual orientation, or national origin.

Oregon Peer Courts

Contact: Sherry Pressler
Bend City Police Department
P.O. Box 108
Bend, OR 97709
Phone: (541) 388-5566

In 1986, the city of Bend established Oregon's first teen court. Peer court, also known as teen court, is a sentencing court for first-time youth offenders. The teenager who has committed an offense pleads guilty to the charge in juvenile court and agrees (with the court's permission) to abide by the terms of a sentence to be set forth by other teenagers of the same age. A key component of peer court is that the offender must sit in on one or more future peer juries to determine a sentence for other offenders.

Peer Resources Network

1052 Davie Street
Victoria, British Columbia
V8S 4E3 Canada
Phone: (800) 567-3700

Web site: <http://www.peer.ca/peer.html>

The Peer Resources Network aims to provide high-quality training, educational resources, and practical consultation to persons who wish to establish or strengthen peer helping, peer support, peer mediation, peer referral, peer education, peer coaching, and mentor programs in schools, universities, communities, and corporations. The network provides Internet and print resources, training, and networking for all levels and all types of peer work. In addition, the organization maintains the world's largest database of peer programs and provides no-cost, expert peer-program consultation to its members.

The Pennsylvania Peer Helpers Association

Contact: Carl Graver, Executive Director
1150 Holtwood Road
Holtwood, PA, 17532
Phone: (800) 807-PEER

Web site: <http://maccowboy.epix.net/ppha/ppha.html>

PPHA is a nonprofit organization dedicated to encouraging, promoting, and improving peer-helping programs in schools and communities throughout Pennsylvania. "Peer helping" is a program wherein persons are trained to provide helping services to their peers: those who share similar characteristics and experiences. PPHA focuses primarily on adolescents, but all age groups are eligible for service.

S.O.S., Inc: Students for Other Students

Contact: James F. Trumm, President
3171 North Republic Boulevard
Toledo, Ohio 43615
Phone: (419) 843-5798
E-mail: sos@cauffiel.com.

This organization raises funds to help public elementary and high schools implement peer tutoring programs. Peer tutors are typically paid \$5.00 per hour for their services, of which S.O.S. pays half (the other half is paid by the local school district). The design of the peer tutoring program is left completely up to the individual schools. S.O.S. has been in operation since 1990 and is currently running programs in six Northwest Ohio school districts.

START Program

Cuyahoga County Department of Children & Family Services
Contact: Tammy Chapman-Wagner
3955 Euclid Avenue
Cleveland, OH 44113
Phone: (216) 432-3508

The START (Sobriety Treatment and Recovery Teams) program is an experimental project designed to address the use of crack cocaine and other substances by young women who are pregnant or new mothers. Each team consists of a supervisor, five family-services social workers, and five family advocates. Nearly all of the advocates are recovering crack addicts who have attended extensive workers-in-training and in-service seminars.

University of California at Davis Health Education and Peer Counseling

Cowell Student Health Center
University of California, Davis
Davis, CA 95616
Phone: (530) 752-2300
Web site: <http://healthcenter.ucdavis.edu/healthed.html>

This wellness and disease/injury prevention program recruits students to serve as peer educators; it uses confidential peer-counseling services, small- or large-group education, and a variety of publications to provide education in several specialty areas. These specialties include sexuality educators who provide information on birth control, pregnancy, sexually transmitted diseases (including HIV), relationships, sex roles, sexual orientation, and other sexual issues; health advocates who provide information on nutrition, exercise, stress management, eating disorders, and other wellness issues; support and referral services for students who have, or know someone with, a substance abuse problem; and BikeRight advocates who provide information and presentations on bicycle safety, rider courtesy, helmet use, and injury prevention. Its Peer Counselors in Athletics program uses trained student athletes to educate athletes and coaches about substance abuse prevention and other health information and education topics.

Appendix C

District Resources

City at Peace

Contact: Paul Griffin, Artistic Director
3305 8th Street, NE
Studio A
Washington, DC 20017-3504
Phone: (202) 529-2828

City at Peace is a youth development program that uses the performing arts as a vehicle for teaching conflict resolution skills. In this program, teenagers learn how to address and deal constructively with problems such as violence, racism, substance abuse, and sexuality. City at Peace provides a support network in which teenagers from the most diverse backgrounds come to know, understand, respect, and care for each other. They also form lasting friendships that transcend barriers of race, culture, and class.

The George Washington University

Contact: Susan L. Haney, Outreach Coordinator
Student Health Services
2150 Pennsylvania Avenue, NW
Washington, DC 20011
Phone: (202) 994-6799

HOPEs (HIV and Other Sexual Health Issues Peer Education) is in its twelfth year. Its mission is to participate in campus health prevention and promotion activities related to sexually transmitted diseases, including HIV. The HOPEs educators facilitate workshops and discussions, implement outreach activities, and serve as opinion leaders on campus.

Georgetown University Health Advocacy

Contact: Carol Day, Director of Health Education
Health Education Services
207 Village C West
Georgetown University

Washington, DC 20057

Phone: (202) 687-8942

Georgetown University has used peer health educators since 1989. The initial program was designed to educate first-year students about HIV/AIDS. Since that time the program has grown to cover other health issues, including sexual assault and nutrition. Peer educators take a required three-credit course to prepare them for their roles in the spontaneous, interactive, multidimensional, theater-based format used to raise awareness about relevant issues.

Metro TeenAIDS

Contact: Cassandra McPherson
651 Pennsylvania Avenue, SE
Washington, DC 20003
Phone: (202) 543-9355

Web site: <http://www.metroteenaids.org>

MetroTeenAIDS is dedicated to preventing HIV infection among young people in the Washington, DC, metropolitan area and improving the quality of life of those affected by the virus.

MetroTeenAIDS advances community prevention efforts by mobilizing young people in support of their peers and battling denial and indifference by raising community awareness about the threat HIV/AIDS poses to young people. MetroTeenAIDS works to achieve its goals through specially designed outreach and education programs; imparting HIV information and innovative prevention strategies to young people as well as to adults in contact with adolescents; and uniting with other organizations to ensure that adolescents receive appropriate prevention, health care, and counseling services.

Peer Education Program—Advocates for Youth

Contact: Jane Norman

1025 Vermont Avenue, NW, Suite 200

Washington, DC 20005

Phone: (202) 347-5700

Advocates for Youth's Peer Education Program Clearinghouse serves as a national source of information and support. It includes a database of peer-led sexual health education programs across the nation; technical assistance; peer education networking; identification of programs with specific focuses; referrals; and articles from peer-reviewed journals.

WIC Breastfeeding Peer Counselor Program

Department of Health, Office of Nutrition

Programs

WIC State Agency

2100 MLK Avenue, SE

Washington, DC 20020

Phone: (202) 645-5662

This program trains WIC Breastfeeding Peer Counselors to provide guidance, advice, support, and up-to-date information on breastfeeding and lactation to pregnant and lactating WIC participants. The Breastfeeding Peer Counselors must successfully complete a 27-hour, nine-session training program; pass five quizzes and a final examination; and complete a supervised practicum at an assigned site before beginning counseling.

About the DC Family Policy Seminars

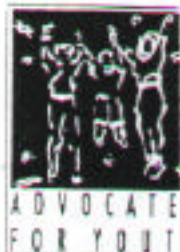
The DC Family Policy Seminar (DC FPS) is a collaborative project of the Georgetown Public Policy Institute (GPPI) and its affiliate, the National Center for Education in Maternal and Child Health (NCEMCH). The mission of the DC FPS is to provide District policymakers with accurate, relevant, nonpartisan, and timely information and policy options concerning issues affecting children and families.

The DC Family Policy Seminar is coordinated by Leslie Gordon, Project Director, National Center for Education in Maternal and Child Health, 2000 15th Street, North, Suite 701, Arlington, VA 22201; (703) 524-7802.

To receive additional information about the DC Family Policy Seminar, or to request copies of the following briefing reports or highlights, please contact Katherine Shoemaker or Susan Rogers at (703) 524-7802.

- *Saving Our Schools: Would Vouchers Create New Solutions or New Problems?* April 1998.
- *Finding Families: DC's Foster Family Deficit.* February 1998.
- *Building the Future: Strategies to Serve Immigrant Families in the District.* October 1997.
- *Diverting Our Children from Crime: Family-Centered, Community-Based Strategies for Prevention.* May 1997.
- *The Child Care Crisis in the District of Columbia: Can (or Should) Businesses Fill the Gap?* March 1997.
- *Feeding Our Families: Community Food Security in the District of Columbia.* November 1996.
- *Keeping Our Kids Safe: Preventing Injury in DC Schools.* September 1996.
- *Fundraising for Family-Centered Organizations in the District.* July 1996.
- *Strengthening Families: Parenting Programs and Policies in the District.* April 1996.
- *Transitioning from Welfare to Work in the District: A Family-Centered Perspective.* February 1996.
- *Helping Families and Schools Get It Done: Mentoring Interventions in the District.* November 1995.
- *Caring for Our Children: Meeting the Needs of Low-Income, Working Families in the District.* September 1995.
- *Families That Play Together: Recreation and Leisure in the District.* July 1995.
- *HIV/AIDS: Helping Families Cope.* April 1995.
- *Substance Abuse Prevention and Treatment Programs: A Family Approach.* February 1995.
- *Family-Friendly Welfare Reform: Using Welfare Policies to Strengthen the Family.* November 1994.
- *Preventing Family Violence.* September 1994.
- *Preventing Adolescent Violence.* May 1994.
- *Preventing Teen Pregnancies.* December 1993.

Appendix A



Components of Promising Peer Led Sexual Health Programs

The prevalence of sexual risk behaviors among teenagers and young adults demands continued attention. Eighty five percent of the teenage pregnancies that occur each year are unintended.¹ Each year, about three million teens contract a sexually transmitted disease (STD).² While condom use rates are rising, only 54 percent of sexually active, in-school teens report consistent use.³ Finding effective ways to educate and motivate young people to avoid sexual risk behaviors is an ongoing challenge. Peer education*, with its grounding in social learning theory, draws upon the resources and existing social networks of young people to engage them in disease and pregnancy prevention among their peers. Peer education is experiencing a boom in popularity as programs are established in schools and universities, clinics, youth serving organizations, community based groups, and religious institutions.

Overwhelming amounts of anecdotal evidence vouch for the positive effects of peer education. Even more significantly, preliminary research indicates the promise and exciting possibilities of peer education. Despite the compelling stories and promising research, however, more scientific evaluation is needed. Specifically, more impact evaluation data must be collected and analyzed before peer education can be unequivocally touted as an effective prevention method.

While the goals of peer education programs may be similar, the philosophies and methods guiding such programs are often very different. Currently, centralized monitoring does not exist for the hundreds of peer education initiatives being implemented. Assistance in designing programs can be expensive and hard to find. As with any approach, certain programs will be more successful than others. This monograph presents a synthesis of elements of the most promising prevention strategies identified and used by peer led sexual health programs.^{4,5,6,7,8} By using the existing body of knowledge, program funders, planners, coordinators, and administrators can make the best use of scarce prevention dollars and maximize the positive benefits of programs for peer educators, their audiences, and the sponsoring organizations.

Designing the Program

- Begin with a clearly defined target population. Consider age, gender, race/ethnicity, sexual orientation, socioeconomic factors, neighborhoods, whether the youth are in or out-of-school, etc. If data is available from local health departments, consider which groups of youth appear to have the highest rates of STDs or unintended pregnancy when targeting the intervention. Research other existing programs, and look for underserved members of the community.

* *A note about terminology: although many people use the terms peer helping, peer tutoring, peer counseling, and peer education interchangeably, they represent different concepts and different goals. For the purposes of this document, peer education refers to sexual health workshops given by and for adolescents.*

- Include members of the defined population from the beginning of the planning process. This means youth. Their participation will ensure that the program is a product of the community, helping create a feeling of ownership in the program and its goals rather than that it has been foisted upon the community by 'outsiders.' Youth must be invited not merely as tokens but as full participants. Young people should be present from the beginning, and their opinions and suggestions considered seriously. Meetings should be after school, accessible by public transportation or with transportation provided. Snacks and, perhaps, child care can also help to keep young representatives participating.
- Set a clearly defined program with realistic goals and objectives. One program cannot address all the issues facing teens, and a group of ten teenagers will not be able to reduce rates of STDs or pregnancy in a state, county, or town in six months. However, ten teenagers could present 12 workshops to 200 students over a period of 9 months and host a health fair that reaches 350 students or, over the period of 6 months, implement a curriculum in 10 health classes at the local high school, reaching 70 students. A time period and the number of people to be reached for each objective will help define the program and target population as well as ensure measurable goals and objectives.
- Plan realistically for evaluation in the time line and budget. Whether a detailed process evaluation or a long-term impact evaluation, it must be planned from the beginning, or data gathered will be partial and inconclusive. The quantifiable objectives developed for the program will define the data to be gathered. Changes in knowledge will be measured by pre- and post-testing peer educators and participants. Process evaluation data may include numbers and characteristics of program activity participants, post-workshop satisfaction measures, focus groups data from workshop participants, and peer educator journal entries recording activities and referrals. Evaluation is a worthy investment. Demonstrating success encourages funders to support the program. Process evaluation allows ongoing assessment of program strengths and weaknesses.
- Find the right person or people to coordinate the program. Much of the success of a peer education program will rest on the program coordinator(s) who must understand youth and enjoy working with them. The coordinator must also be comfortable with the goals and objectives of the program. The coordinator should display a non-judgmental perspective while establishing high standards of expectation for program participants.

Implementing the Program

- Recruit peer educators from a broad base of potential candidates. Consider opinion leaders within the defined population, but look also for those who strongly believe in the program's goals and objectives and want to help achieve them. Some of the most effective peer educators do not initially appear to be ideal candidates. Successful recruiters will search out young people, rather than simply expecting them to respond to a flyer or notice. Enlist teachers and other community and agency staff to make recommendations and to publicize the program among their youth.
- Decide what incentives the program will provide for the peer educators. Some programs offer school credit or volunteer service hours. Local merchants may be willing to donate shirts, snacks, or discount coupons. Other programs build peer educator wages into their budgets. Programs that do not pay the peer educators may attract a limited or non-representative group of candidates.
- Provide sufficient training for the peer educators. Skills development is as crucial as knowledge. Training empowers peer educators to recognize when to refer a peer to a professional. The training should model the supportive and interactive techniques that peer educators themselves will use. Successful programs will have ongoing training for the peer educators, times to practice existing skills and to develop new ones.

- Select a curriculum to maximize interactive and experiential learning. Peer education works best when young people work with one another to learn new things or to develop new skills. Youth lectures are no more effective than adult lectures. Peer educators should be trained in facilitating and processing as well as in giving clear directions. Peer educators gain ownership of the program when they play a role in deciding which activities to use or in designing new ways to present the information.
- Remember that research shows peer education to be most effective when part of a comprehensive initiative. Link peer educators with school nurses, 'youth friendly' local clinics, community agencies, and programs with similar goals. Ensure that peer educators know when and where to refer another young person. A local health professional from a teen clinic or other 'youth friendly' health provider may serve as an advisor to the peer educators and program staff and as a link to health services.
- Monitor the peer educators' work. After the initial training, peer educators will need ongoing supervision of their work and training. Peer educators should keep a log of informal activities. Monitoring will highlight skills or knowledge that need strengthening. Feedback will also help the young people become more skillful and effective educators.
- Provide ongoing encouragement and support. Peer educators work hard and their work is not always easy. Positive feedback and support will help keep trained youth involved, as will encouraging them to support each other and providing occasional incentives, such as pizza parties or small trips.
- Expect attrition and have a formal structure for recruiting and training new peer educators. Youth have many competing interests; some may decide they do not enjoy being peer educators. Exit interviews will help gauge whether they are leaving for personal or programmatic reasons. Involving current peer educators in the recruitment and training of new peer educators will also empower them and help them develop new skills.
- Provide opportunities for peer educators to give feedback about the program, its activities, and their own performance. The peer educators usually know what they need to become more effective and to enjoy their work more.
- Finally, promote the program. Develop literature showcasing services and highlighting accomplishments. Positive stories from the peer educators and feedback from workshop participants will enliven data-based reports. These materials will increase visibility and encourage potential funders to invest in the peer education program.

Written by Jane Norman, February 1998

Sources for Information, Technical Assistance, and Curricula

Advocates for Youth established the Peer Education Clearinghouse to serve as a national source of information and support. It includes a database of peer led sexual health education programs across the nation. For more information, or to register your program, contact the Peer Education Clearinghouse, Advocates for Youth, Suite 200, 1025 Vermont Avenue NW, Washington, DC 20005. Or call: 202/347-5700; fax: 202/347-2263; e-mail: jane@advocatesforyouth.org

Guide to Implementing TAP: Teens for AIDS Prevention

A step-by-step guide to developing and implementing an HIV prevention peer education program in schools and communities. For ordering information, contact Advocates for Youth, Suite 200, 1025 Vermont Avenue NW, Washington, DC 20005; or call 202/347-5700.

Peer Education...a Little Help from Your Friends: A How-To Manual

Developed by Planned Parenthood Centers of Western Michigan, this 40-hour comprehensive health training provides a multitude of original as well as adapted ideas, activities, and materials. For ordering information, contact Planned Parenthood Centers of West Michigan, 425 Cherry SE, Grand Rapids, MI 49503; or call 616/774-7005.

Healthy Oakland Teens

A school-based, peer-led AIDS prevention program for junior high school students. Evaluation showed that students who received AIDS prevention counseling from their peers were significantly less likely to engage in potentially risky vaginal intercourse than students who were not involved in the peer-led counseling. The curriculum is available via the Center for AIDS Prevention Studies Web site, along with a Knowledge, Attitudes, Behavior, Belief questionnaire for use with teens and pre-teens. URL: <http://chanane.ucsf.edu/capsweb/index.html>. Contact Center for AIDS Prevention Studies, 74 New Montgomery, Suite 600, San Francisco, CA 94105; or call 415/597-9100.

Peer Facilitator Quarterly

The official publication of the National Peer Helpers Association. For subscription information, contact Sharon Smith at the National Peer Helpers Association, P.O. Box 2684, Greenville, NC 27834; or call 919/522-3959.

PeerHelp: A New LISTSERV for Peer Helper Programs and Training

Created to help those interested in peer helping share information such as ideas, techniques, and resources this requires access to electronic mail. For more information or to subscribe, contact Dr. Russell Sabella, School of Education, University of Louisville, Louisville, KY 40292; or call 502/852-0625; E-mail: rasabe01@ulkyvm.louisville.edu.

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