



# **DC Family Policy Seminar**

*A community service project of Georgetown University*

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## *Seminar Highlights*

# **Educating with Peers: Others Do—Should You?**

**November 3, 1998**

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*The DC Family Policy Seminar provides District policymakers with accurate, relevant, nonpartisan, timely information and policy options on issues affecting children and families.*

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# **DC Family Policy Seminar**

## **Educating with Peers: Others Do—Should You?**

### *Seminar Highlights*

**Mark Rom, Moderator**  
**Acting Executive Director, Georgetown Public Policy Institute**

#### **Introduction**

Mark Rom introduced the audience to the topic of the November 3rd seminar, “Educating with Peers: Others Do—Should You?” He provided background on the panelists and explained that their presentations would shed light on the potential benefits and limitations of the use of peer education in the District by discussing its application in local and national models and reviewing research on the topic.

The goals of the seminar were to (1) educate participants about the trends in peer education, both in the District and the nation; (2) educate participants about the benefits and limitations of peer education; and (3) identify community resources and create networks within the communities to strengthen peer approaches.

**Cate Lane, M.P.H., Associate Director for International Programs**  
**Advocates for Youth, Washington, DC**

Cate Lane stated that thanks in part to media and migration, teens around the world today share similar concerns and needs, many of which are health related. At the same time, organizations and governments have increasingly focused on the reproductive health of young people in developing and developed countries, largely due to AIDS. To prevent AIDS and to provide youth with other important health information that may change their behavior, many groups have adopted a peer-based approach to reaching and educating teens. This approach takes different forms but ultimately seeks to educate, inform, counsel, and motivate youth to adopt safer sex behaviors.

#### **Supporting Evidence for Peer-Based Approaches**

Lane noted that the World Health Organization (WHO), the United Nations Population Fund (UNPF), and the United Nations International Children’s Emergency Fund (UNICEF) have identified peer-based approaches as one of the most promising ways to promote and facilitate behavior change that reduces the risk of HIV transmission. Peer approaches are a major component of many health education programs whose targets include groups such as practicing homosexual men, intravenous drug users, commercial sex workers, working adults, and youth.

Even though these approaches are promising, good research and evaluation studies of peer approaches are somewhat scarce. Lane shared results from some of the existing studies, such as one by Nancy Fee and Mayada Yaisseiff. The findings suggest that both peer educators and their target population benefit from peer education programs. In addition, she maintained that youth are often more successful than older professionals at relating to their peers, and that peer educators may be the most effective at reaching particularly vulnerable groups of young people who may mistrust traditional education and service delivery approaches. Youth often report that they obtain most of their information on sexuality and reproductive health from the media and their peers; they say they

are embarrassed talking to adults about “sensitive issues” and prefer talking to individuals who are similar in age, background, and interests. Other studies indicate that audiences may respond better to peer educators than to other sources of information.

While there are compelling stories and promising research about the impact of peer educators, Lane emphasized the need for evaluations that better measure outcomes and the effect of peer approaches on their target audiences.

### **Peer Approaches and Behavior Change**

Peer education is based on theoretical and practical rationales, and ideally works within existing social norms and networks. Peer-based approaches bring together key elements in health promotion, namely:

- a strong consideration of the specific social and cultural environments of the target group
- the promotion of social norms and support for positive attitude and behavior change
- the increased participation of the target audience in program development and implementation

Peer approaches targeted to youth often encourage youth to develop safer sex behaviors and/or change behaviors that put them at risk for HIV infection, STDs, or pregnancy. To promote change to more healthy behavior, Lane observed that programs must

- build knowledge by providing information about a specific health issue(s) or concern;
- increase perception of risk by helping the target audience understand and internalize that particular actions or behaviors may put them at risk;
- promote a perception of positive norms by helping other youth believe that the proposed behavior change is acceptable to or approved by other young people, and that their peers have adopted the behavior change;
- effectively translate information into everyday language, help disseminate information through networks, and promote the idea that “everyone is doing it”; and
- build feelings of self-efficacy by helping young people develop the confidence and skills to change their behavior and maintain the behavior change.

### **Types of Peer Approach Programs**

Lane reported that many youth centers or clinics that are trying to attract young people to their services have concluded that trained youth can reach this population. Many programs in developing countries now have a major peer outreach component, and in some cases, youth centers have switched, almost exclusively, from expensive programs to peer outreach.

Peer outreach can occur in a number of settings, including schools, the community, the workplace, and society. In contrast to traditional educators, peers can often reach high-risk groups such as street youth, sex workers, and out-of-school youth. The strategy usually takes one of three approaches: communication, education, or counseling.

### **The West African Youth Initiative**

Citing a concrete example of how youth outreach can be used to promote safer sex behaviors among sexually active youth, Lane shared her experiences in working on the West African Youth Initiative (WAYI), the collaborative peer education effort of Advocates for Youth, Washington, DC; the Association for Reproductive and Family Health, Nigeria; the African Regional Health Education Center, Nigeria; and nine community-based youth-serving organizations in Nigeria.

WAYI aimed to improve adolescent knowledge of sexuality and reproductive health and to promote safer sex behaviors among sexually active youth in Nigeria and Ghana. Researchers and staff wanted to determine if peer education programs in adolescent reproductive health could be successfully implemented in those two countries; to assess the overall impact of such programs on adolescents' knowledge, attitudes, and practices; and to build the capacity of local organizations to implement effective youth information and services programs.

Ten community-based, youth-serving organizations were selected and trained to implement peer education programs in one of three settings: secondary schools, post-secondary schools, and out-of-school or community venues. The program's goals were to increase use of modern contraceptive methods, decrease the number of reported partners, increase sexual abstinence, and increase the knowledge of reproductive health and sexuality. Peer educators in collaboration with adult project staff provided reproductive health information and education, counseling, and outreach services; used drama, pamphlets, and posters to educate teens about sexual choices; and supplied non-prescriptive contraceptives (in some cases) and referrals for STDs, prescriptive contraceptives, counseling, and other services.

When the program was evaluated, some of the findings appeared to justify WAYI's peer education strategy. First, the youth reported peers as one of their top three preferred sources of reproductive health information. Next, youth identified friends/peers as people with whom they would feel most comfortable discussing a variety of health issues, including menstruation, sexual feelings, and dating. (The graphs that Lane presented at the seminar on the findings of the evaluation can be found in the Appendix.)

Overall, Lane said, the evaluation showed that peer education is most effective in the secondary school setting, which she attributes to the fact that clients had repeated contact, rather than just a single intervention, with peer educators. The evaluation also indicated that peer education reaches males somewhat more successfully than females, that adolescent reproductive health is a sensitive issue, and that projects must be driven by adolescents' information and service needs.

**Billie Lindsey, M.A., Ed.D., C.H.E.S., Assistant Professor of Health Promotion  
Department of Health, Movement, Science and Recreation,  
Lynchburg College, Lynchburg, VA**

Stating that peer education as a means of presenting health information or educating about health has grown in popularity, Lindsey reported three common "working hypotheses" or assumptions appearing in the literature about peer education:

- Assumption 1—Target audience members prefer learning from people who are similar to themselves and thus will be more responsive to peer educators.
- Assumption 2—Peer education is an effective and productive means to disseminate information: it reaches more people.
- Assumption 3—Peer education is a useful and inexpensive alternative to traditional education when funding for professionals is limited.

Based on the research she reviewed, Lindsey said, the veracity of these assumptions depends on the specific setting and health concern.

### **Assumption 1: Are Peer Educators Credible and Preferred?**

Lindsey's experience working on several college campuses in health education programs taught her that college students, like most of the adult population, neither prefer peer educators as their source of health information nor find them to be the most credible source for health information. (See Table 1.)

Lindsey emphasized that these studies' findings indicate that students view a number of professionals as the most credible source of health information and as the individuals or groups to whom they are most likely to turn. These findings challenge assumptions about the credibility of peers.

### **Assumption 2: Will Peer Educators Expand Outreach?**

In Lindsey's experience as a director of several college health programs, she did not find that incorporating a peer education program expanded outreach. Instead, she and other professionals spent much time recruiting, selecting, training, supervising, providing in-services to, and scheduling peer educators—and then repeating the entire process each year with each new group of recruits. When professionals are involved in training and other responsibilities associated with a peer education program rather than in delivering education themselves, there is an opportunity cost for their time: the cost of doing one thing (e.g., training) when they could be doing something else (e.g., holding meetings with students).

Lindsey has found no published data to support the claim that peer education is time- and cost-effective. Using data from her experience, she compared the effectiveness of four programs she directed at various colleges, all but one of which used students in some manner. As the sole health educator at one school, she said, she reached more students and conducted more seminars than a staff of four to five full-time professionals and a group of peer educators. Lindsey said she held 200 outreach sessions, compared with their 80. In addition, she provided 25–30 different health-related choices vs. the peers' 3. These choices included 1-hour talks on a wide variety of topics such as alcohol, sexual assault, contraception, sexually transmitted diseases, HIV/AIDS, eating disorders, nutrition, sports nutrition, stress management, time management, healthy relationships, how to avoid hangovers, the profile of the healthy drinker, alcohol and advertising, fitness, acquaintance rape, sex 101, self-awareness, and mental and emotional health issues.

Based on her experience, Lindsey believes that the opportunity cost of using professionals' time to run peer education programs is significant. The target audience loses out on knowing all the health options available to them, and they do not benefit from the teaching ability of professionals who often recognize and have the requisite knowledge to exploit teachable moments with students.

### **The Need for Evaluation**

Lindsey emphasized the importance of ongoing extensive evaluation of peer education programs, both in terms of quality assurance of the training programs and their outcomes. As an example, she relayed her findings about a comprehensive training program for peer educators at Columbia University. On average, students scored only 70 percent on a test of their knowledge on the health information that they would present as peer educators, even after a weekend of training. Ironically, her evaluation found that students on average felt "highly competent" to educate fellow students about topics covered in the training (Lindsey, in press).

The gap Lindsey found between the actual knowledge of the students and what they thought they knew concerns many professional educators considering the use of peer outreach: the peer educators do not know what they do not know, and program organizers do not know what the peer educators do not know if they do not evaluate their programs.

**Table 1: Two Studies of College Students' Preferences for Sources of Health Information**

<b>Most Credible Source of Health Information</b>	<b>Source to Whom Students Would Most Likely Turn for More Information</b>
<b>Cline and Engle<sup>a</sup></b>	<b>Cline and Engle<sup>a (1991)</sup></b>
<ol style="list-style-type: none"> <li>1. National AIDS Hotline</li> <li>2. American AIDS Foundation<sup>b</sup></li> <li>3. Surgeon General</li> <li>4. Doctors</li> <li>5. Centers for Disease Control and Prevention</li> <li>6. University AIDS Task Force</li> <li>7. Doctor at the campus health center</li> <li>8. Leaflets and pamphlets</li> <li>9. Health educator at health center</li> <li>10. County Health Department</li> <li>11. Person with AIDS</li> <li>12. Classrooms, TV news, nurses, and campus peer educators</li> </ol>	<ol style="list-style-type: none"> <li>1. Doctors</li> <li>2. National AIDS Hotline</li> <li>3. Local hotline</li> <li>4. Doctor at the campus health center</li> <li>5. Leaflets</li> <li>6. Surgeon General</li> <li>7. American AIDS Foundation<sup>b</sup></li> <li>8. Centers for Disease Control and Prevention</li> <li>9. TV news</li> <li>10. News magazines</li> </ol>
<b>Northern Illinois (Haines, 1995)</b>	<b>Northern Illinois</b>
<ol style="list-style-type: none"> <li>1. Doctors</li> <li>2. Health educators</li> <li>3. Nurses</li> <li>4. Leaflets</li> <li>5. Parents</li> <li>6. Romantic partners</li> <li>7. Campus newspaper</li> </ol>	<ol style="list-style-type: none"> <li>1. Health educators and nutritionists</li> <li>2. Doctors</li> <li>3. Pamphlets</li> <li>4. Videos</li> <li>5. Posters</li> <li>6. Nurses</li> <li>7. Fellow students</li> </ol>

8. Classroom	8. Resident assistants (RAs)
9. Peer educators	
10. Friends	

<sup>a</sup>Sources are listed in order of preference, out of 35 possible choices.

<sup>b</sup>Researchers intentionally used a fictitious name.

## **Considerations for Using Peer Approaches**

Lindsey acknowledged that peer educators have important roles to play in health programs as lay advisors, community health change agents, gatekeepers, and opinion leaders. Furthermore, students or other peers can use dramatic skits to relay information or spark a conversation, approaches that one professional educator, acting alone, cannot use.

However, Lindsey stressed the need for program directors to evaluate whether they have the time and resources to implement and maintain peer education programs, noting the opportunity costs of using this method of health education. To make these types of determinations, the health community must continue to evaluate what kinds of health education sources different target populations prefer and which educators—peers or professionals—effectively change the knowledge, attitudes, or behaviors of the target population. Program organizers and researchers must evaluate trainings and provide in-services and updates for those who do not meet set performance standards. In Lindsey's view, to use peers as supplements, but not substitutes, for professionals is the most ethical and appropriate approach.

### **Gwendolyn West, Coordinator, Breastfeeding Peer Counselor Program Special Supplemental Food Program for Women, Infants, and Children (WIC), Washington, DC**

West began her presentation with an overview of the WIC Breastfeeding Peer Counselor Program. The program began in 1984 when Lilia Parekh, a nutrition coordinator for Children's Hospital's Comprehensive Care Program, observed the influence that mothers had on each other regarding their decisions to breastfeed. Parekh noticed that new mothers sometimes turned away from the health professional who was providing the information and turned to other mothers for support and affirmation of the information the professional had provided. In particular, participants turned to peers for reassurance that breastfeeding would not hurt or embarrass them and that other people in their lives would accept their decision to breastfeed.

Parekh and others noted that research by Gideon and Associates on peer counseling cited a shortage of professional breastfeeding counselors and then suggested that peer counselors could fill some of this gap. The District's WIC program thus became the first WIC state agency to start a breastfeeding peer counselor program. Since then, 38 other states have emulated the DC program because of its success at increasing breastfeeding rates.

The new mothers' questions and concerns about breastfeeding gave the peer counselor program its purpose: to promote breastfeeding and to overcome barriers to breastfeeding. The WIC program in DC serves approximately 19,000 pregnant women a year, with 10 peer counselors at 9 WIC sites throughout the District. Counselors are predominantly former program participants. Program participants may enter the program as pregnant, soon-to-be mothers and are assured of support from the first meeting, through delivery and birth, and continuing throughout the postpartum year, for as long as the mothers want to breastfeed.

The coordinator of the counselor program and the WIC staff ensure ongoing communication and training for their peer counselors. They, in turn, meet with program participants in person or via telephone to offer one-on-one education and counseling. Counselors also offer group instruction using hands-on information and interactive materials. Other staff at WIC recruit new clients, and breastfeeding counseling becomes part of the nutrition education that new clients receive.

## **Effective Approaches and Strategies for Working with Youth, Families, and Communities**

From their lessons learned, the DC WIC Breastfeeding Peer Counselor Program offers the following recommendations:

- *Build in flexibility; trust the instincts of your peer counselors.* WIC learned the importance of changing the model and program format to better serve its clients. When organizational changes need to be made, WIC leaders consult peer counselors so that their perspectives are incorporated. Because counselors have often moved from service recipients to paraprofessionals, they have a broader view that may yield valuable insights into program development.
- *Recognize cultural competence/target population issues.* First, peer counselors must be trained in knowing what works in the culture of the target population. In addition, organizers must realize that different peer counselors appeal to different clients. For example, teen mothers tend to respond to younger or younger-looking counselors, whereas other, perhaps older, new mothers like the calming, loving approach of an older peer educator—the “grandmother” who nurtures and talks about her experiences raising children. Finally, counselors must adjust to the preferences of the specific community in which the program operates, learning and utilizing effective counseling skills. West offered the example of one Hispanic community in which the mothers preferred the peer counselor who took a very “professional” approach. This community has internalized the breastfeeding message in its culture, and seeks support more than promotion from clinical advisors.
- *Clarify organizational structure.* Community professionals play an important developmental role and must remain a part of any peer counseling program. Peer counselors are a complementary piece of an overall program, not a substitute for professionals. It may be useful to employ a coordinator/trainer with a specialized background who serves as the immediate administrator to the peer counselors and as the conduit for communication between the agency and program.
- *Establish fit vis-à-vis program and peer counselor needs.* New mothers are excited about their new roles. Their enthusiasm can sell your program to new clients. Recognize that there is an emotional component to the project, and that peer counseling needs to respond to emotional as well as educational needs. Be aware of the support peer counselors themselves need in order to function effectively. Such support may include compensation, child care, transportation assistance or placement proximity to residence, and the development of a program interface with outside programs such as educational institutions and social service agencies.
- *Anticipate turnover.* Counselors may eventually outgrow their roles, in part because they have found “self-efficacy” through the work and realized the social and economic value of the information gained. Once peer counselors are no longer formally engaged by your agency, some account should be made for the likelihood that they continue to circulate the message. It may be resourceful to consider the suitability of experienced peer counselors for other agency positions.
- *Make synergy work for you.* Find organizations that have goals similar to yours and see if they are willing to exchange manpower to develop a peer education program. This capitalizes start-up energy and can save costs.
- *Extend the peer counselor concept into the target population’s spheres of influence.* Incorporate family members and others who interact with members of the target population into the program by creating peer counselor roles for them and/or designing messages that acknowledge their influence.
- *Make peer counselors aware of competing belief systems and why they prevail.* Peer counselors can then strategically use words, language, tactics, and approaches similar to those used by competitors to encourage the targeted behavior.
- *Spotlight peer counselors as role models.* Peer counselors who are most effective are those whose lifestyles and belief systems reflect the message, and those who have overcome perceived barriers. Use peer counselors in media and other promotions.

- *Support peer counselors by circulating literature in the service community.* Repeat easily remembered logos and slogans in training materials and agency promotions. Create an environment for the message in which the peer counselor serves as the human element.
- *Trust the likelihood that change will take place, albeit ever so slowly.*

**Quanitta Favorite, Peer Educator, Advocates for Youth  
Member, Board of Trustees, National 4-H Council  
Sophomore, Howard University, Washington, DC**

In her role as a peer educator, Favorite leads training and workshops for peers, trains other peer educators, develops resources about HIV and AIDS and African-American women, and writes articles about adolescent, sexual, and reproductive health. Favorite began by briefly summarizing how she came to be a peer educator.

### **Snapshot of a Peer Educator**

Originally from New Orleans, Favorite is the daughter of a Baptist minister and a substitute teacher and credits her family with providing an abundance of love, knowledge, wisdom, and guidance. Favorite began her work as a peer educator in South Carolina, where she obtained her high school diploma. If she had not been involved in peer education, Favorite reflected, she would probably be attending community college in South Carolina, struggling to support herself and a couple of children.

Favorite joked that her original motivation to become a certified peer educator significantly differed from her motivation to continue as one: her first 6-week training seminar got her out of class. However, once she became actively involved she realized that peer education was becoming a driving force in her life. For example, at the end of her certification training, Favorite cofacilitated an HIV/AIDS workshop. She said the women in the workshop walked away enlightened because they gained knowledge, relieved because they could communicate their feelings without being judged, and comforted because they knew they were not alone. This experience of empowering others affected her deeply. In addition, she realized that basic issues like human sexuality were not discussed as much as they should be. She consequently decided that she would work to bring about more discussion and education on human sexuality.

Favorite finds that program participants motivate and inspire her to “keep on keeping on.” One of her most touching experiences occurred when, after her workshop on human sexuality, a young woman told her that she had decided to postpone sexual intercourse because Favorite’s workshop helped her realize her self-worth.

### **Trust and Credibility**

Favorite noted that teenagers in today’s world face hard decisions and problems that differ from those experienced by previous generations. Peer educators are important, she said, because teens relate to each other better knowing they face the same challenges. She said young people confide in her because she understands their situation, is nonjudgmental, and answers their questions with accurate information.

Echoing Cate Lane’s observation that peer educators can effectively reach certain populations that do not relate to professionals, Favorite mentioned that she is originally from a “hood” and that this gives her credibility with like clients. She cited song lyrics that reinforced the point: “If you ain’t never ever been to the ghetto, don’t ever come to the ghetto ‘cuz you wouldn’t understand.”

Yet, she stated, even though peer education is an effective tool in helping young people make healthier decisions, it is not the only tool. Part of being a good peer educator is recognizing when a situation is beyond your capabilities so that you know when to refer the case to a trained professional. Favorite emphasized the importance of adult involvement in peer approach programs: adults provide knowledge and help solve problems, she said.

### **Looking Ahead**

Favorite cautioned the audience not to assume that she is unique: she believes there are thousands of young people around the country and the world who share her passion for helping her peers. Unfortunately many adults tend to depict all youth as rebellious, irresponsible, naive, lazy, and trifling, she said. Instead, in her view, today's youth have identified community problems, expressed a desire for change, and are making a concerted effort to transform their communities into peaceful, safe, and beautiful places to live where the right to a secure childhood will be restored.

Favorite stated that while peer education has won many battles, the war continues. Young people bring strength, determination, and ambition to the table, but they need adults and trained professionals to contribute their wisdom and experience. She challenged the audience to team up in youth and adult partnerships so that together "we can save what's left of the world."

## **Question and Answer Session**

### **Evaluating Peer Education Programs**

First, rigorous process and outcome evaluation is essential. It is important to look for peripheral positive outcomes (outside of effects) that peer education has on participants. For example, a program may have positive effects on peer educators or counselors but may also provide good employment skills, educational opportunities, and valuable personal experiences. This information needs to be captured in evaluations.

Second, it is important to note factors that distinguish effective programs from ineffective programs. For example, if people are going to make changes in behavior and be supported in those changes, the program must include a follow-up component.

Lane and Lindsey may not actually have disparate views [about whether or not peer education works]. The context in which peer education was studied was quite different: American college youth and African adolescents. The two groups have different educational levels and the setting was quite different—community vs. campus. This should guide us to look at differences across settings. *Valerie Uccellani, Academy for Educational Development*

Two studies of communities found that people prefer professionals to peers [when getting health information]. Harris, Harris, and Davis asked Hispanics in California, "Who would you feel comfortable with if you needed to talk to someone about AIDS?" (1991). The sample population mentioned professionals first. Also, Marin and Marin asked a similar question of a group in Texas (1990). Again the community said they would ask professionals and family members before they would raise the subject with friends and peers.

*Billie Lindsey*

WAYI saw that peer counseling had more impact in younger populations: younger adolescents tended to turn to their peers more frequently than did older adolescents. Older populations in Nigeria and Ghana were more likely to turn to professionals. Also, the peer education program had less of an impact in the out-of-school setting. Perhaps this was because secondary schools provide an opportunity for sustained contact, which is more effective in behavioral change. A one-time

encounter with a peer educator is not going to promote or sustain changes in behavior or knowledge. It would be feasible to do the type of follow-up study that Valerie Uccellani mentioned.  
*Cate Lane*

### **Survey Format and Survey Responses**

Dr. Lindsey, with regard to the studies you cited on preferred sources of information, were the responses spontaneously generated or were survey respondents given a generated list of options? The survey format can make a difference.  
*Jane Norman, Advocates for Youth*

Both the Northern Illinois study and the Cline and Engle survey provided a list of 35 sources to respondents. At the University of New Mexico, I surveyed students about their preferred source of information for a variety of topics. Again, they preferred professionals. Perhaps this is because of their education level. About three students out of 100 responded that they would trust peers who have been well trained in contraception. This trend has emerged in substance abuse also. Students feel that a peer who was an alcoholic could deliver a powerful message.  
*Billie Lindsey*

### **Lay Health Workers' Contributions to Communities**

I was very excited to hear about and attend this seminar. The project that I oversee deals with 19 community-based projects throughout the United States that target traditionally underserved families, specifically around health issues. Were any of the panelists able to come up with any research about the value of the contribution of lay health workers to communities, specifically with regard to the value of their training and their impact on the growth of the community after their experiences?  
*Elizabeth Ford, Director of Special Projects for the National Association for the Education of Young Children*

There is some anecdotal evidence. I know that in developing countries, a lot of community-based health workers are trained to provide basic primary health care for malaria, diarrhea, and acute respiratory infection. There is definitely a need for good training, supervision, monitoring, and follow-up of those lay health workers. Quanitta pointed out that she had to complete 6 weeks of training to become a certified peer educator in the U.S., whereas in Nigeria and Ghana, we trained peer educators for only 7–10 days. We found that when the peer educators were not well supervised and recognized, they felt burned out—like they were not contributing anything.

Lay health people have an important role to play, but the role needs to be specifically defined, very well monitored, and supervised by a health care professional from either a government or a private health care facility.

Also, a study in Guatemala revealed that when peer educators were not constantly retrained, they began to take misinformation that they heard from clients and repeat it to others. Retraining peer educators in information that they are disseminating is key.  
*Cate Lane*

WIC provides peer counselors with 15 hours of training after the peer counselors are recruited and selected through an interview process. We also hold monthly meetings. Counselors train with other staff members and receive recurrent education about information they will disseminate and about when to refer a case to a professional.  
*Gwendolyn West*

Another example that fortifies my concerns: in San Bernadino County, project organizers recruited parents to present workshops on nutrition and on shopping with a limited budget. However, as in my own experience in teaching nutrition, teachers often get asked questions beyond the scope of their presentations. Because peer educators may lack professional expertise, the teachable moment is lost unless there is a professional present to intervene.

Unfortunately, professionals often use peers not just because of their similarities to the target audience but also because professionals do not want to do a lot of the workshops. In my own experience in college health, my colleagues promoted and perpetuated assumptions that peer education was the preferred method of health education because they did not want to travel and do workshops at night. This is a problem—we need to be honest about professionals’ motivations for encouraging peer education.

*Billie Lindsey*

### **Providing Information vs. Sending Cultural Messages**

Can we compare providing information through peer education, which may or may not work well, with giving cultural messages, such as “it’s okay to breastfeed or postpone sex”? Perhaps the messages about cultural norms are easier than factual information for peer educators to give.

*Mark Rom*

Yes, peer counselors need to relay cultural messages as well. They also need training in basic counseling skills, so that even if they are not equipped to provide basic health information, they can listen, observe body language, and respond objectively.

*Gwendolyn West*

The issue is not youth or adults, professional or peer. Instead, the issue is youth and adult partnerships—it is about us working together. We all bring unique things to the table and you cannot have one without the other. Professionals need peers when dealing with young people and vice versa.

*Quanitta Favorite*

I like Dr. Rom’s idea of recognizing the differences between peer educators relaying cultural messages vs. dispensing sophisticated health information. It points to the strength of combining professionals and peers. Peers can use techniques such as dramatic skits that a sole health educator cannot. Again we need to evaluate whether this fun and entertaining medium actually makes youth change their behavior or expands their knowledge.

*Billie Lindsey*

In this country and in the developing world, people jump on new ideas. As Billie said, we have jumped on peer education because it appears cheap and empowers youth. In Nigeria and Ghana, WAYI found that program implementers cannot give young people a little training and expect them to go into the communities and work miracles.

Also, young people are in transition. In that she has continued with peer education, Quanitta (and young people like her) is probably the exception and not the rule. People’s interests change, and that is not the fault of the program or the audience. Program organizers need to honor and respect that and not take it personally when peer educators move on. Therefore, program developers need to be very specific about the goals of peer education and consider it a piece of a bigger program.

*Cate Lane*

I want to emphasize that training is ongoing in Advocates for Youth. Peer educators and program coordinators meet twice weekly to refresh ourselves on current issues and to review strategies that we can use when dealing with peers. Peer educators must take it upon themselves to continue

training. Independent of this training, we must read and better ourselves personally. It is a situation analogous to school, in which textbooks have little information about African American history. Students must seek that information themselves. Our training and workshops provide these new ideas.

*Quanitta Favorite*

Program organizers and researchers need to ask if there are other methods of health education that could have more of an impact on the audience. For example, Michael Haines at Northern Illinois University is changing the social norms of the campus community through outreach on behavior related to drinking and drugs. He and his coworkers have seen the amount of drinking and drug use on campus decrease. They surveyed the amount of drinking, drug use, and sexual activity on campus and then asked students for their perception of how much of this kind of activity occurred. Students perceived a higher activity level in these areas than was actually reported. So, Haines shares this information with the campus community through media. It is a much less labor-intensive means of changing norms than peer education.

*Billie Lindsey*

The media is very important in changing sexual, eating, and abusive behavior. Peer counselors must understand the role of the media, which has a very sophisticated understanding of human behavior and sends the dominant messages, because they need to understand what shapes social norms. Therefore, use of the media is an important part of the information/education network, just as peer education is part of the network. Peer counselors must perceive themselves as part of the network. The umbrella organization must understand the roles of peer counselors as well and know which information the peer counselors disseminate into the community.

Another factor in the efficacy of peer approaches is identifying the target population: Are you training people to talk informally to just friends and family, or to a more defined target population that is part of an existing infrastructure of service (so that the target population gets repeated and related messages from other parts of the service)? In WIC, the entire organization must understand the role of peer counselors; otherwise counselors can “float away” and become an entity unto themselves. When peer educators and the rest of the organization send the same message, it creates an environment of information and support. Participants begin to see themselves as informed and supported within this new environment.

*Gwendolyn West*

At Community of Hope in Northwest Washington, we trained our advocates for a number of activities. Part of the strategy was to work with homeless women not just on their own lifestyle issues, but to train them to serve as a resource to others in the community since they are always present. I come and go from the community between 9 and 5, but advocates are always available for emergencies.

*Representative from Community of Hope*

## Other Resources

Dr. Frank Reiseman (of the graduate school of the City University of New York) writes a lot about the world of self-help, mutual support, and peer education and the opportunities for them to come together in different exciting ways.

*Linda A. Randolph, The National Women's Resource Center*

## Recruiting and Efficacy of the “Natural Helper”

There is a theory of natural helpers within communities to whom others naturally go for advice. Some programs have targeted the natural helpers and trained them as peer educators. This training basically augments the natural helper's skills. How does the recruitment of peers used in peer education programs relate to the efficacy of the program?

*Tom Vallin, National Center for Education in Maternal and Child Health*

At WIC, it has been a matter of trial and error. Our original cohort of peer counselors came from the WIC population. WIC has fairly liberal income guidelines so there is some variety in the service population in terms of background and belief systems. We just watched and saw what worked.

For example, sometimes the peer counselor is a grandmother and does not share a lot of technical information. Although the factual information comes from someone else, the peer counselor is able to impart emotional support. Another WIC site predominantly serves Hispanic participants who share a common social and cultural background. Whereas breastfeeding is traditional in many Hispanic cultures, families arriving in the U.S. find a different cultural message. In this community, the WIC peer counselor reinforces, in a professional way, a positive message about breastfeeding. In other populations, breastfeeding is no longer traditional. In these areas, WIC must develop a culture.

Two patterns for encouraging breastfeeding emerge: (1) Communities in which a breastfeeding culture exists or existed originally need a professional person to reinforce the traditional culture. (2) In other populations, WIC needs to develop the culture through peers. Therefore, WIC must determine which pattern exists in the target population before determining a strategy.

*Gwendolyn West*

I am familiar with natural helper research—implementing it is a pretty sophisticated endeavor. I have recommended this approach before, at colleges. For example, professionals could go into Greek Systems to determine to whom students talk. If those are the leaders whom students consult, than professionals should try to elicit their participation as peer educators. Most peer educators volunteer because they have an interest in the area and some want it on their résumé.

An example of an effective implementation is work by the Agency for International Development in Guatemala. They train midwives on complications in the birth process and have linked them to doctors and transportation so they can get the mothers to medical help when needed. Since implementation of the project, maternal mortality has dropped 30–40 percent. The natural helper approach is one that we need to look at more carefully.

*Billie Lindsey*

The concept of peer helpers is sometimes used in developing countries. People and organizations are trying to work with traditional networks, such as herbalists or pharmacists, on health care service delivery.

Also, it's important to recognize that the target population must view the peer educator as credible or as a leader. In one instance in Nigeria, the Planned Parenthood affiliate had a different definition of “out-of-school” youth than the community. They selected youth who had completed secondary

school and were awaiting admission to universities. The community felt uncomfortable with these youth because peer educators did not speak the local language and therefore were not credible within the community. It was a challenge to return to Planned Parenthood and ask them to start over and hire new people as peer educators.

*Cate Lane*

The key is employing a different approach for different target populations. For example, college students listen to educated professionals because they can identify with them. Quanitta brought up a very good point—people from poor or African American communities are going to listen to those with whom they identify.

Regarding the survey of preferred sources of information that Dr. Lindsey cited, often when people are completing a survey, they want to put down the “best” answer. Some people might tell surveyors that they would go to the Surgeon General or the CDC, but are those people or groups really accessible? That is where peer educators are so important—because they link the professionals with the community. They bring the community to professionals who may not have an intimate understanding of the people with whom they are dealing.

Adults want to impart a lot of wisdom and knowledge to youth, but they often disregard the knowledge that youth already have. Young people deal with problems in ways that may differ from how an older person would deal with them. That’s an invaluable lesson that peer counselors bring to the organization. They can speak for youth and still serve organizational goals as well.

Peer educators are important to youth who are out of school, who do not have strong family ties, or whose families do not have this kind of information. These young people need role models. They are not going to model their behavior after professionals. However, if someone such as a peer educator is close to them but doing something a little differently—and it’s working—then a young person might follow that model.

Finally, training and evaluation are definitely important, especially with sophisticated information.

*Quentin Manson, MetroTeenAIDS*

### **Sexual Assault and Domestic Violence Peer Counseling and Education Programs**

I volunteered for a short time with Sexual Assault Services. At the time, they were developing a peer educator/peer counselor program to respond to issues of sexual and physical violence against women on campus. Since sexual assault involves a lot of shame, do any of the panelists know how effective peer educators or counselors would be in that situation at both the high school and college level?

*Carly McVey, Georgetown Public Policy Institute*

At Columbia, when I recruited for sexual assault peer counseling and peer education programs, the majority wanted to be peer counselors, and not peer educators, because the term “counselor” had more prestige. Educating about sexual assault, especially about acquaintance rape, is probably the most difficult topic (compared to drug and alcohol use or sexuality). One study in California looked at a peer-led intervention on acquaintance rape and found that while women’s attitudes improved significantly after the intervention, men’s worsened (Lenihan et al., 1992). Men felt attacked and continued to hold rape-myth beliefs. This underscores the importance of who’s doing the teaching: peers or professionals.

*Billie Lindsey*

While a student at Pennsylvania State, I volunteered at a shelter that provided counseling and legal advocacy for women and children who were victims of domestic violence and sexual assault. It is so important to emphasize that peer educators need appropriate information, which is achieved through

the proper amount of training. For example, for that position I completed a 90-hour training. The people I worked with felt they could relate to me as a young person. More importantly, I felt that I could empower them to take control of their lives. If you don't have appropriate information, you can do harm.

*Nicole Kresch, Center for Education and Research, Coalition of Labor Union Women (CLUW)*

Peer counselors need to anticipate critical decision-making situations. For example, in breastfeeding, WIC knows to strongly focus on the period a few weeks postpartum. With sexuality and young people, the critical decision-making point is often prom night. There are moments when an intervention will have the most impact. These moments need to be identified.

*Gwendolyn West*

A few points about evaluations: (1) When measuring outcomes, consider informal as well as formal contacts. Evaluators can measure this by asking peer educators to keep logs or journals of informal contacts. (2) Peers can note "Frequently Asked Questions" (FAQs) that can be summarized and distributed so that peer educators are more prepared to respond.

*Billie Lindsey*

Program directors must understand the culture with which they are dealing. I see the value of peer educators as collaborating with professionals in helping determine the mores of the culture.

*Elizabeth Ford*

Programs always have to build in cultural competence through training. Also, meetings with community groups must be a collaborative effort. As a professional, I provide information and facilitate the dialogue, but I ensure that I have a peer with me who can speak to that population. Finally, it is essential to know the population of any room before entering to disseminate information. If you need to call in someone to help with cultural competence that's fine; just have a strategy session beforehand.

*Cheryl Spann Edwards, Metro DC Collaborative for Women*

Peer educators allow professional access to our clientele. Most of our clientele would not interact with a professional if a peer educator did not open the door.

*Maxine Blocker, DC Healthy Start*

Service providers must be prepared to deal with the influx of clients following peer educators. Service providers in much of the world are still not "on board" with the idea that young people have the right to information and services, contraceptive or otherwise.

*Cate Lane*

## **Competing Theories and Other Obstacles**

Ms. West, you mentioned that it is important that WIC peer counselors know about the competing theories regarding breastfeeding. Could you talk about those competing theories and other obstacles counselors encounter?

*Jennifer Schwab, National Center for Education in Maternal and Child Health and the Georgetown Public Policy Institute*

A large part of the WIC population does not receive information through scholarly research. Typically, they get information from can labels, soap operas, and the media. Therefore, one major obstacle is advertisements against behavior that we are trying to support. The WIC population is vulnerable to that kind of information.

Another obstacle is the set of prevailing cultural beliefs about feeding infants. In cultures around the world, there tends to be a lag in belief systems about behaviors such as feeding and nutrition. For

example, 40–50 years ago it was the norm for most American women to breastfeed. Then media interventions and new scientific principles implied that women should feed their babies formula. Women who could afford formula and who read about new products changed to formula, which they perceived as more valuable. Poor women continued to feed their babies with their breast milk, which they perceived as cheap.

However, some women continued to read the reports of formula companies that took samples of human milk to research its benefits for babies. (Most formula companies no longer publish these results.) These women asked themselves why they were buying formula if their own milk was so good for their babies, and they switched back to breastfeeding. Meanwhile other populations were just catching up to the previous belief system. They finally could afford to buy formula, and they thought it was better for their baby.

The leaders or rebels of the community buck the prevailing cultural beliefs of their subculture and start to breastfeed. They are often the people in a community who can have the most influence. They also might be more willing to listen to professionals or peer counselors simply because breastfeeding is something their own peers will not do.

In addition, WIC frequently hears the following cultural beliefs that are obstacles to breastfeeding: (1) it is sexual and therefore not something I would do in public; (2) it hurts; (3) it is free and therefore without value; and (4) my friends are not breastfeeding.

Finally, medical professionals do not supply good information or support to mothers, particularly when they are dealing with people who do not ask them a lot of questions or challenge them. Unless a doctor or nurse tells a mother that it is good for her to breastfeed, she may not even consider the idea.

To sum up, cultural and scientific beliefs and advertising are the major obstacles to breastfeeding in the WIC population.  
*Gwendolyn West*

### **Concluding Remarks**

Through today's seminar we have learned that peer education is a potentially useful tool for us. In order to use peer education effectively, we must consider four questions:

- (1) What is the goal of our project: e.g., to disseminate information or to provide cultural support?
- (2) Will the goals differ based on the type of program (sexual behavior, breastfeeding, smoking, education)?
- (3) Who are the peers whom we hope to use? Are they already leaders in the community? Are they airlifted in? Are they knowledgeable about and familiar with the community?
- (4) Who are the targets of our education? Are they college educated? Segregated by race or by gender? Are there issues that are particularly sensitive to that community?

*Mark Rom*

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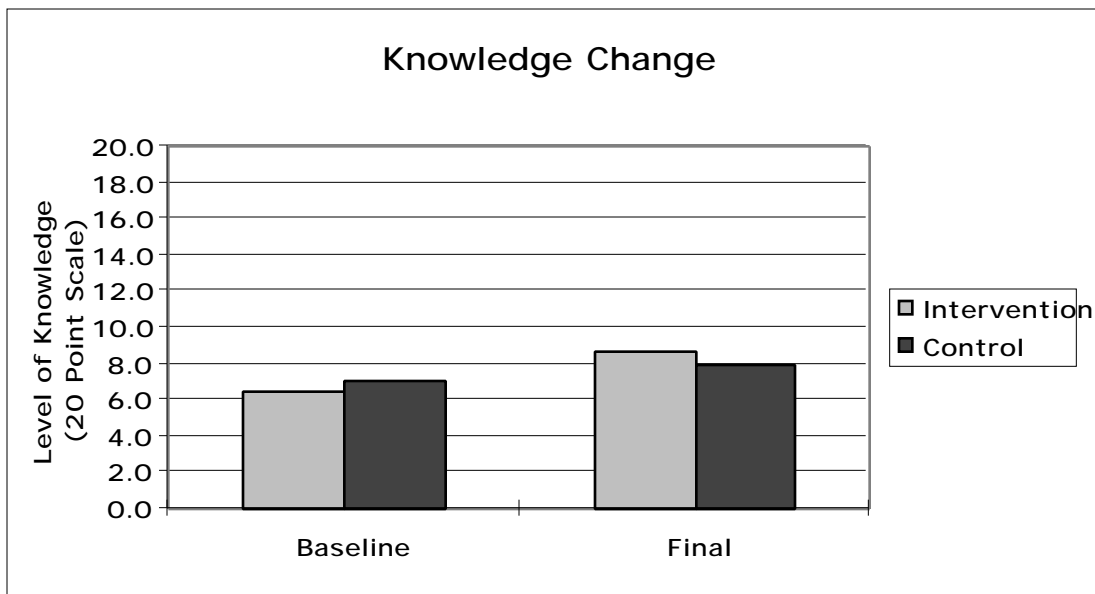
## Appendix

During her presentation, Cate Lane displayed the following findings of the West African Youth Initiative's peer education effort.

### Nigerian and Ghanaian Adolescents' Changes in Knowledge of Reproductive Health Issues

	Intervention	Control
Baseline	6.4	7.0
Final	8.7	7.9

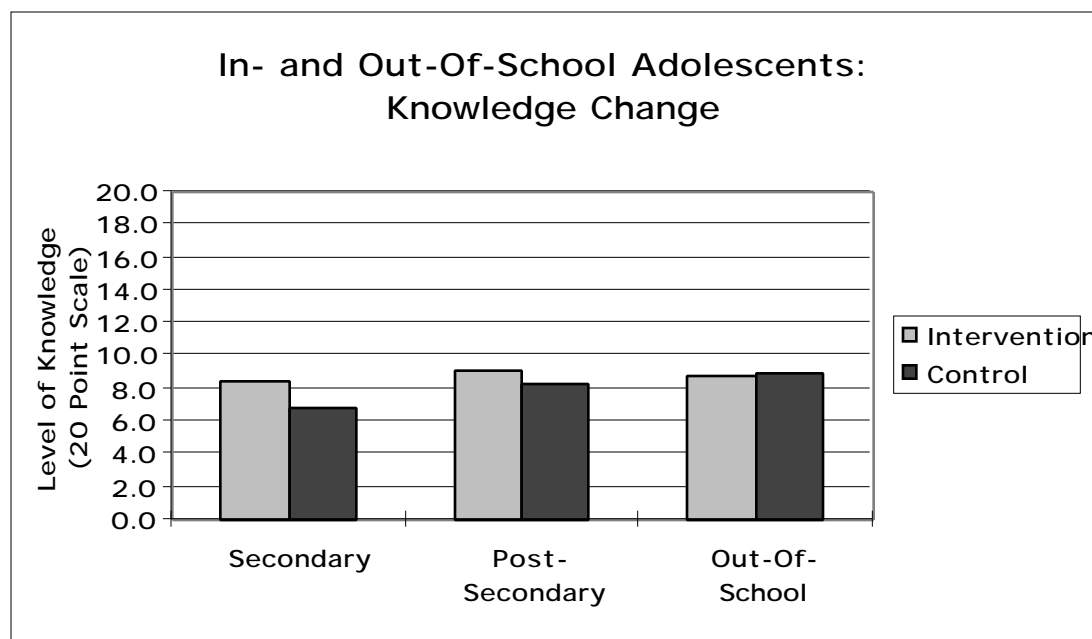
*Note:* Scores are based on a 20-point scale.



## Change in Knowledge of Reproductive Health Issues: In-School vs. Out-Of-School Adolescents in Nigeria and Ghana

	Intervention	Control	<i>p</i> Value
<b>Secondary</b>	8.5	6.9	0.000
<b>Post-secondary</b>	9.1	8.3	0.011
<b>Out of school</b>	8.7	9.0	0.142

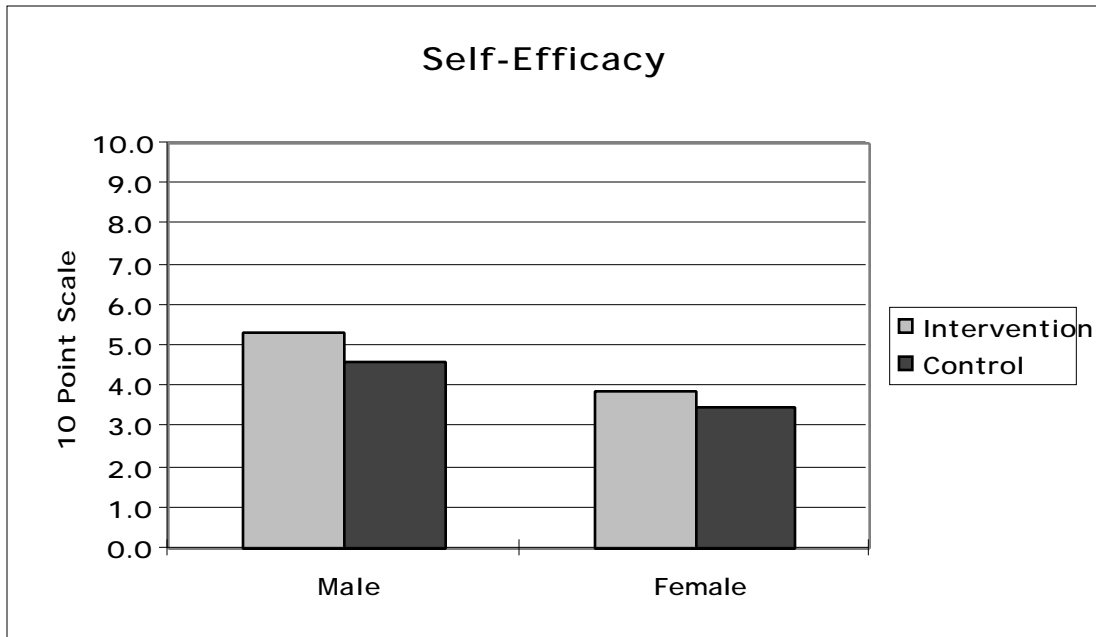
*Note:* Scores are based on a 20-point scale.



## Self-Efficacy Scores of Male and Female Youth

	Intervention	Control	<i>p</i> Value
<b>Male</b>	5.3	4.6	0.001
<b>Female</b>	3.9	3.5	0.036

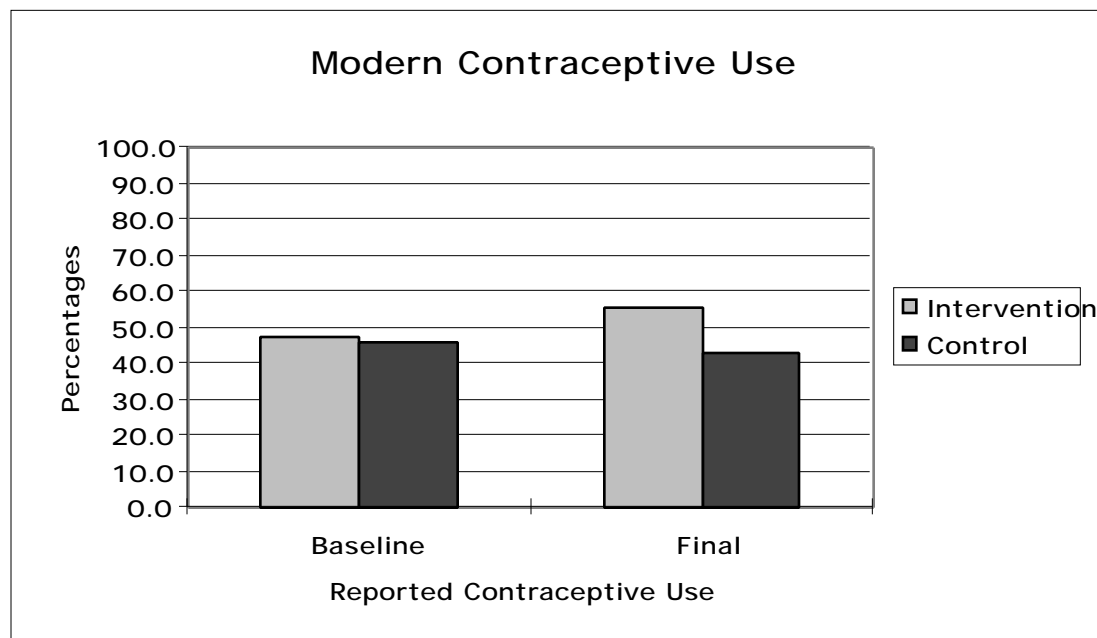
*Note:* Scores are based on a 10-point scale.



## Nigerian and Ghanaian Adolescents' Use of Modern Contraceptives, Pre- and Post-Intervention

	Intervention, %	Control, %
<b>Baseline</b>	47.2	45.9
<b>Final</b>	55.6	43.3

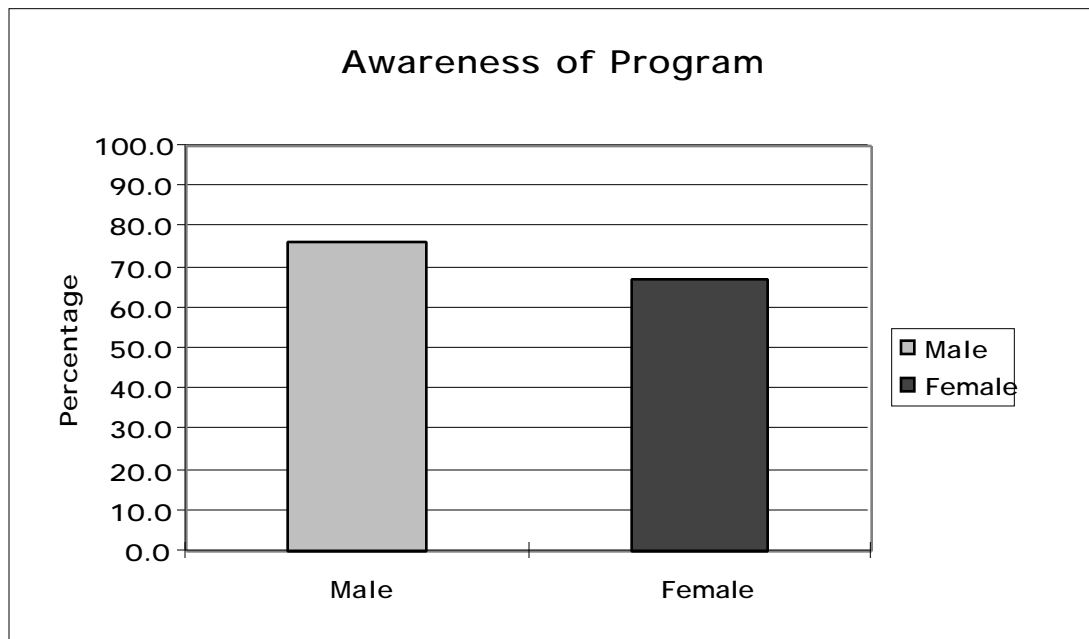
$p = 0.005$  (T2: intervention vs. control).



## Nigerian and Ghanaian Adolescents' Contraceptive Use, by Educational Status

	Secondary, %	Post-Secondary, %	Out of School, %
<b>Intervention baseline</b>	47.7	44.0	48.6
<b>Intervention final</b>	64.0	58.8	46.6
<b>Control baseline</b>	46.2	49.1	44.6
<b>Control final</b>	46.9	42.9	40.7

## Percentage of Nigerian and Ghanaian Adolescents Who Were Aware of the Intervention



*Note:* These youth were targeted by the intervention.