

Perspectives on young parents as peer educators in a teen pregnancy prevention program

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Overview

The peer education approach is a popular way to deliver sexual health information to youth. Ideally, peer educators have similar backgrounds and life experiences to the youth to whom they deliver information. Research on the success of the peer education approach in reducing risky sexual behaviors is mixed. Even so, youth prefer peer educators as facilitators of information, making this approach worthy of further exploration. Peer educators and frontline staff implementing this approach can provide useful insights about what works and what does not, which can inform researchers and program staff who plan to use a peer education approach.



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EngenderHealth developed Re:MIX, a teen pregnancy and STI prevention program that pairs young parent peer educators with adult health educators to facilitate a sexual health curriculum. EngenderHealth provides training and professional development for peer educators. Child Trends evaluated the delivery of Re:MIX, in Austin, Texas, in 2017–2018. Peer educators participated in three activities: training on facilitation of Re:MIX, classroom implementation of program content, and professional development activities. Child Trends conducted focus groups and interviews with peer educators, adult health educators, and program staff to learn more about how this peer education approach worked. This brief includes summaries of their feedback, along with key quotes.

The peer educator approach delivered some key successes:

- Peer educators and adult health educators partnered effectively to deliver program content.
- Peer educators grew their personal and professional skillsets through classroom facilitation of program content.
- Peer educators demonstrated a unique ability to engage youth by telling their personal life stories.

However, future implementers might consider the following in using a peer educator approach:

- Offer support to peer educators, who may have unmet physical, emotional, and mental needs.

- Consider the pros and cons of an added professional development component for peer educators.
- Provide more training on managing a classroom and effectively facilitating lessons

Background

Peer educators make health messages more relevant to youth.¹ Youth noted that they felt more comfortable asking questions of peer educators because the latter come from similar backgrounds and life situations.²⁻⁴ Programs can use peer educators in a variety of ways: storytelling, drama activities, one-on-one counseling, linking to resources, leading other activities, and presenting health information.^{2,5,6}

Studies that explore the effectiveness of a peer education approach in reducing risky sexual behavior among youth and teen pregnancy rates produce mixed findings.⁶⁻¹⁵ Even so, evaluations show that youth prefer peer-facilitated programs.^{4,16} Peer educators benefit from this model, with increased growth in personal and professional skills (including increased organization, confidence, and stronger pro-social networks)^{5,17,18} and reduced risky sexual behaviors.^{19,20} One frequently cited challenge in using a peer educator approach is that peer educators may be less effective in delivering technical health information than an adult health educator.²¹ Therefore, pairing peer educators with adult health educators may be beneficial to program implementation.

Funded by the Office of Adolescent Health, EngenderHealth paired young parent peer educators with adult health educators to co-facilitate and deliver a pregnancy and STI (sexually transmitted infection) prevention program to youth. This program, called Re:MIX, uses storytelling by peer educators as a central feature of program delivery. Storytelling is a participatory method for delivering information through personal narratives, and gives agency to the experiences of peer educators. Peer educators may tell stories of their decisions regarding their own sexual health, past relationships, and what they have learned by being a young parent. Peer educators model storytelling and encourage youth to share their own stories. Although promising, storytelling is relatively new for sex education and more research is needed to determine its effectiveness.²²

Through the program, peer educators and health educators received training in facilitation and delivered the program content as a team. Peer educators received additional professional development training in four core leadership and professional skills: accountability, communication, leadership, and personal motivation. These included developing skills related to college and career readiness, personal responsibility, public speaking, professionalism, time management, and reliability, among others. Peer educators also received consistent supervision, linkages to community health resources, and support tailored to their needs from adult health educators and EngenderHealth program staff. This professional development was delivered through trainings, workshops, and community presentations.

Peer educators in the program were young mothers (ages 18–24 at entrance into the program) and were employed 15 hours per week. While EngenderHealth tried to recruit male peer educators, only females participated. Peer educators were screened for prior leadership or training experience and their interest in sharing their stories with others. Peer educators were typically recruited through their school, a counselor, a social worker, a caseworker, an internship specialist, or online through the Indeed job search site.

Data Source/Methods

We structured our research questions to address the following overarching questions:

1. What are your experiences with the peer educator approach to deliver a pregnancy prevention intervention?
2. What worked?
3. What are some lessons learned?

Across two years, we spoke to 17 individuals. Interviews and focus groups were 1 to 1.5 hours long.

	Spring 2017	Spring 2018
Peer educator focus groups	1 (n=4)	1 (n=4)
Health educator focus groups	1 (n=3)	0
Health educator interviews	0	2
EngenderHealth staff interviews	0	4

Health educators and peer educators received a \$50 incentive for participating in the interview or focus group. Program staff did not receive an incentive for participating in the interview. Three trained researchers systematically coded data, using NVIVO, and analyzed data for emerging themes.

Key Findings

Six major themes about the peer educator model emerged from Child Trends' conversations with program staff, peer educators, and health educators. These six themes fell within two categories: 1) practices that worked, and 2) factors to consider when using a peer educator approach in the future. We provide more detail on these themes in the following sections of this brief, using personal anecdotes and insights (in the form of direct quotes) to put them into perspective.

What worked

Theme 1: Co-facilitation between peer and health educators was the perfect marriage of skills.

Peer educators and health educators praised the co-facilitation component of the program. They felt it was important to have someone in the classroom with technical sexual health knowledge, as well as someone who could share personal stories about being a young parent. One health educator described co-facilitation as “the perfect mix and marriage of all these different skills and opportunities.”

The health educators helped peer educators improve their facilitation and provided them with informal mentoring. One peer educator said, “Throughout the sessions I gained confidence and developed a bond with the health educator. We talked about my strengths and weaknesses and how we can compensate for some of those [weaknesses].” Peer educators described how health educators provided them with guidance—not just within the classroom, but also outside it: “she [health educator] goes above and beyond with you ... she’s not there just professional[ly] for you, but she’s there personally when you need her.”

“Co-facilitation between a health educator and a peer educator is ‘the perfect mix and marriage of all these different skills and opportunities.’”

— health educator

Peer educators and health educators also felt that sharing responsibility for facilitation and relying on each other in the classroom was a success. According to one peer educator, “I think I couldn’t have done it without a co-facilitator. Being with [health educator] who has a lot of experience—and I can trust her answering kids’ questions—brings a lot of trust, and I think that the co-facilitation is meant to do that.”

Theme 2: The facilitation experience enhanced the career trajectories of peer educators.

Program staff and peer educators both noted that the peer educator model enhanced the latter’s professional skills and career trajectories. Specifically, the model helped them gain sexual and reproductive health knowledge, confidence in presenting and facilitating; and provided opportunities to network with others in the field and secure new jobs.

Peer educators highlighted improvements to their presentation, interpersonal, and communication skills. One peer educator talked about their growth: “[In the beginning] I was just super nervous ... I barely made eye contact and now I’m talking

straight to them [students], doing the activities with them, and helping them get out of their shells. It’s a huge improvement for me.”

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-peer educator

Additionally, program staff recalled an example of how peer educators secured new employment as a result of the program: “[she] identified ... a passion for preventing sexual assault and abuse. We helped them explore that more ... and that flowered into their decision to work full-time for an organization as a facilitator ... She’s a huge advocate now. Like attending rallies and proactively speaking at engagements because we helped build up her confidence in finding her voice.”

Theme 3: Young parents as peer educators engaged students through storytelling.

One of the most powerful aspects of the peer educator model was the influence of peer educators on student engagement through storytelling (i.e., sharing their experiences as young parents and encouraging students to share their own stories throughout the curriculum). Peer educators told stories of when they learned they were pregnant, the decisions that came after, the costs of having a child, parenting successes, and their experiences with healthy or unhealthy relationships. One peer educator said, “I think what really brings the curriculum home to these kids is that it’s being implemented by a young parent. We’re coming in and saying ‘Hey, I’ve personally not known that there’s free and low-cost birth control and I had a second pregnancy within 6 months of having my first kid.’”

Staff, peer educators, and health educators alike noted that the unique aspect of storytelling seemed to especially engage students in the program. One program staff member said, “The storytelling aspect of our work is unique ... youth are very attentive during those story shares.” The staff member continued, saying that students “have a lot of questions for them” afterwards, and that the storytelling gives youth “a space to ask a young parent ‘what has it really been like?’”

Student impressions of peer educators:

90% of students in RE:MIX reported that they liked the peer educators

77% reported that they trusted the peer educators

77% reported that they felt peer educators engaged students

Young parents as peer educators also engaged students simply by being closer to them in age and coming from similar backgrounds. One program staff member commented, “Peer educators feel very relevant to youth ... They are closer in age, they speak in their vernacular, they are close to having just come out of high school so they understand the complexities and those systems and relationships.”

While facilitating, peer educators saw that they were able to engage students in the program curriculum. One peer educator shared how they impacted students: “In the beginning they’re just like, ‘I’m too cool for school, I don’t want to learn this,’ but at the end like they’re so grateful and they go, ‘Thank you so much for coming. I learned so much.’ You may think that they’re not paying attention, but they actually are and they take at least one or two things with them.” Of the 295 students surveyed after the program, over 75 percent reported positive impressions of their peer educators.

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-program staff

What to think about in the future

Theme 4: Include adequate time for effective implementation of a professional development component.

Peer educators and program staff highlighted the importance of including an added professional development component for peer educators. Program staff felt that peer educators needed additional professional development to be effective facilitators. One staff member explained: “One reason that research around peer education is contradictory and inconclusive is because we are bringing young people in a classroom and expecting that they have the capabilities and skills to [facilitate] ... If you are going to do peer education, they [peer educators] need to have the professional development accompany that process.”

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-program staff

However, peer educators and program staff both noted the inadequate time available for professional development and program delivery in a 15-hour work week. They felt that the professional development and facilitation components of the model often competed for time. One peer educator reflected on how these competing time interests were challenging: “I think the go-getter-ness of our staff is amazing ... but too much was loaded on. They wanted to put on this whole [professional development] program but it was too much and it’s definitely showing ... it just kinda gets passed by the wayside because there’s too many

programs going on.” Peer educators also felt unable to engage in meaningful professional development opportunities due to time constraints. They often completed activities like workbook packets that felt like “busywork” and were “not conducive to learning a lot.” One peer educator noted that increasing time to 20 or 30 hours a week would allow for more in-depth and meaningful professional development activities.

Peer educators appreciated interactive forms of professional development, such as presenting and networking at a symposium and conducting interviews with program staff. However, within a 15-hour time constraint, peer educators felt that professional development was best learned through facilitation and additional training related to facilitation.

Theme 5: Include more training on classroom management and facilitation skills.

Program staff worked throughout the project to improve the facilitation training given to peer educators; across the board, peer educators found these improved trainings helpful. Program staff described the evolution of the facilitation training: “I think what’s changed more than anything is the way we have trained. Before I was here ... I think it was a five-day training, maybe four hours a day. But now it’s a very robust full month onboarding process before they even get in the classroom to teach. And then in between semesters we do intensive revisiting of facilitation methods and content.”

Despite the improvements, peer educators voiced a need for even more training—specifically on classroom management and facilitation. Peer educators suggested a session at the beginning of the program that would allow them to work in the classroom engaging students before delivering curricula, or an additional training module to teach them how to handle different scenarios that could transpire in the classroom. One peer educator explained, “The training needs to have classroom management, dealing with situations if a kid lashes out or walks out, conflict with the teacher or health educator.”

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-peer educator

Peer educators also voiced a need for more trainings to develop their presentation skills. One peer educator recommended, “There has to be time for the new peer educators to demo, to practice every single session. Maybe even record yourself and watch that recording back. How am I presenting this? How am I using my body? Am I using gender-neutral language?”

Theme 6: Be equipped to support the unique needs of peer educators.

Peer educators often need child care, mental health counseling, or housing—needs that program staff may not anticipate when hiring them. According to program staff, “Almost all the peer educators had gone through postpartum depression. A lot of them were living at home with their parents and had transportation needs.” Without supports, these young parents may not be able to perform their jobs as peer educators.

“ Peer educators are both ‘learning how to share [content] ... and learning it themselves.’ ”

-program staff

Peer educators also described how program content could trigger trauma. Program staff noted that peer educators are both “learning how to share [content] ... and learning it themselves.” For example, program staff noted that some peer educators “feel like they’ve made a dumb choice because they’re still with these partners or engaging with their parents who they have an unhealthy relationship with. Or maybe they’re not using a contraceptive other than a condom.” Peer educators were also asked to describe their personal experiences with young parenthood, healthy and

unhealthy relationships, and consent as part of their storytelling and facilitation. However, two peer educators had difficulty overcoming the challenges of dealing with current or past trauma and ultimately left the program.

The program is designed to benefit not just the students receiving the curriculum, but also the peer educators who deliver it; therefore, program staff felt it important to hire peer educators with high need, as well as those with lower need. In hiring peer educators with higher need, program staff saw the importance of providing adequate trauma-informed care and supports for peer educator

retention. One staff member remarked, “I think any organization working with [young parents as] peer educators needs to be really clear about what their capacity is to support them ... and then create the systems there for them.” EngenderHealth developed partnerships with various organizations and provided both peer educators and students with referrals to these services. However, program staff also stated that other organizations planning to use peer educators should do one of two things: hire a staff person to provide case management and counseling services to peer educators, or build a strong network of community partners that can provide the same support services. One program staff member reflected, “We should have partnerships for shelter, because we have had peer educators who have lost housing; we need workforce partnerships because a lot of them want to go into technical trades or certificate programs; we need counseling because a lot of them don’t know they need counseling until they start working.”

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-program staff

Implications

Our findings highlight the promise and benefits of the peer educator approach, but future implementers should consider their organization’s capacity and the circumstances of peer educators when using this approach.

Implementers of a peer education model might consider pairing peer educators with adult health educators to deliver sexual health content. Research suggests that this is an effective approach to deliver accurate health information while also establishing attitudes and norms around sexual health.²¹ The findings also confirm that this type of pairing is advantageous for both peer and health educators, and that the delineation of roles (whereby adult health educators deliver health information and peer educators share stories and deliver lessons on the reality of being a young parent) is a natural fit for each group. In addition, a mentorship and mutual support system unexpectedly emerged from this approach.

Other benefits of using a peer education approach emerged from our study, and have been confirmed in the literature.^{5,17-20,23} These benefits include personal and professional benefits to the peer educators themselves and the success of using peer educators to engage program participants. According to peer educators, the facilitation component of the peer education model was sufficient to produce both personal and professional growth. Peer educators also engaged students through personal storytelling, and both program staff and educators agreed that youth would not have been engaged to the same extent without this storytelling component. Given that peer educators also increased their own confidence and presentation skills through storytelling, they seem well-suited for the role. However, peer educators should feel emotionally ready to share their stories to avoid triggering any unaddressed trauma.

Some components of this approach are worth revisiting. First, it may be beneficial to include more demonstration practice in the peer educator facilitation training before these young parents enter the classrooms. Peer educators mentioned feeling uncomfortable implementing the program early on, and stated that additional training on presentation skills and classroom management would have been helpful before delivering the curriculum. In the future, it may be important for peer educators to have experience facilitating before moving into full implementation.

The additional professional development component is also worth revisiting. It is imperative that professional development activities work in conjunction with facilitation activities. Peer educators felt the professional development components were beneficial when they were interactive, provided a forum to practice new skills, or were set up to minimize interruptions to peer educators' time for facilitation. Given that program staff felt that professional development was necessary for the growth of the peer educators—and that peer educators felt they had benefited professionally from their facilitation of the program—future implementers might consider tying professional development more directly to facilitation (rather than as a separate component), particularly if time is a concern.

Lastly, in an ideal situation, peer educators are similar to program participants in terms of backgrounds and life experiences, so it is expected that they would have needs similar to those of a high-risk population. If future implementers plan to hire peer educators similar to the populations they serve, then they should establish adequate support systems for peer educators. Given that some content (such as consent and healthy relationships) may trigger past or current trauma, social workers and researchers may argue that it is an ethical responsibility to provide support. While program staff established community partnerships and provided peer educators with referrals to services, they also suggested that a full-time counselor or case manager would be beneficial for staff. Additionally, male peer educators should also be hired to implement the curriculum so that both female and male students have a male perspective on the program content. While this peer education approach was intended for both male and female peer educators, further research is needed on how to best recruit male peer educators.

Despite the additional costs and time required to support peer educators with unmet needs, program staff still recommend hiring peer educators with high need. However, future implementers of this model must also train peer educators upfront on the potential triggers that delivering their stories and program content may produce, and give them the tools to mitigate these triggers. Additionally, staff should be trained on proactively ensuring that peer educators have the resources and support they need to handle other unmet needs in their lives.

Overall, our findings indicate that this peer education model is a promising approach, but that future implementers may want to plan for and address the unique and sensitive needs of peer educators. In doing so, they will support the best use of a peer education approach to sexual health among youth.



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