



THE PEER EDUCATOR MODEL FOR HEALTH PROMOTION

LITERATURE REVIEW

3 Cheers for the Early Years
ALBERTA HEALTH SERVICES - CALGARY

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EXECUTIVE SUMMARY

The population served by Alberta Health Services - Calgary is ethnically and culturally diverse, necessitating the development, implementation and evaluation of innovative health strategies. Health disparities among newcomers to Canada, as well as negative post-immigration experiences and barriers to health care, further contribute to the need for culturally-appropriate health strategies.

This paper examines, through a review of the literature, the peer educator model of health promotion as one such strategy. Specifically, this paper identifies the variants of the peer educator model, the scope of duties of peer educators, and the applications of the model in historical and current contexts. The effectiveness of the model is examined and explained by the embeddedness of peer educator programs in the cultural and social networks of target communities. The efficacy of peer educators is attributed to their unique position as 'cultural insiders,' and as trusted, respected and credible members of their communities. Research evidence is then presented supporting the premise that peer educators are as effective as professional health care workers in delivering educational material to diverse, and often underserved, populations.

Benefits of peer education to participants are also examined, and are found to include the acquisition of culturally-relevant health-related information and potentially a shift toward the acceptance of more positive social norms; increased linkages to health services; and potentially, social support and a sense of belonging. Benefits to communities are identified as increased community capacity and the ability to influence the provision of health care that is culturally sensitive and appropriate. Benefits to peer educators are found to include skill development and experience that can facilitate future employment, and intrinsic rewards of increased self-confidence, personal empowerment, and a sense of satisfaction.

The report then shifts to an examination of the literature pertaining to the 'logistics' of peer educator programs. Program development is discussed, and recommendations are identified in the literature for including members of the target community in the planning and implementation of peer educator programs, for conducting community needs assessment in the development of the course content, and ensuring course materials are congruent with the literacy, and health literacy, levels of the participants. The literature suggests the importance of delineating the responsibilities of peer educators, and ensuring that peer educators are not 'overloaded' with administrative responsibilities. The literature also reveals that peer educators with more formalized roles are more likely to receive remuneration, and that remuneration can communicate the message that peer educators are valued and can help raise the status of the peer educator in the community. Job satisfaction of peer educators is identified as an under-researched area, though some studies acknowledge its importance and emphasize the need for peer educators and program organizers to communicate honestly and as equals.

Recruitment and training issues are also examined. Desirable characteristics of peer educators are identified as including shared experiences, the ability to model the desired behaviour, personal characteristics such as an enthusiasm for helping others, and ties to and knowledge of the target community. Methods of recruitment are discussed, with an emphasis on the reputational model of recruitment. Issues identified in the literature on peer educator training include the danger of 'professional imperialism' and the benefits of providing peer educators with cultural competency training, as well as other skills training, such as behaviour change techniques and advocacy skills. Training sessions are also identified as an appropriate forum for

discussing role expectations and ensuring peer educators are equipped to manage requests for assistance that transcend role boundaries. Qualities of effective training materials and formats as well as the need to conduct evaluations of peer educator training are explored, and the recommendation is put forth that peer educators be provided with opportunities for continuing education and networking.

In the final section on program logistics we identify characteristics of strong evaluation tools, and review common methods of evaluating the effectiveness of peer educator programs, including measures of behaviour and knowledge change and participant satisfaction. The importance of garnering feedback from peer educators and methods of doing so are presented, and the section concludes with a look at how the evaluation of the peer educator program can contribute to the overall measure of the organization's cultural competency.

The paper then takes a brief look at two of the challenges facing the peer educator model: losing the essence of the sociocultural model as the program becomes more closely aligned with mainstream health care services and the biomedical model of health; and the professionalization of the peer educator and the paradox this presents.

In the final section, the findings of the review of the literature are summarized, and, based on these findings, a series of recommendations in the areas of program development, peer educator recruitment and training, and program evaluation are presented.

1.0 INTRODUCTION

1.1 Purpose of the Report

Peer education is a recommended model of health promotion for underserved populations, including immigrants and refugees (Chick and Holmes, 2009). The peer educator model is premised on the belief that the biomedical culture of Western health care should not be the only, or most privileged, context for the provision of health promotion; rather, the peer educator model recognizes, acknowledges, and values the beliefs, practices and preferences of diverse communities.

As Alberta Health Services - Calgary strives to become diversity competent, the need arises for a fuller understanding of existing culturally- and diversity-competent practices, programs and strategies. The peer educator model, as one such strategy, is explored in this paper, in order to inform the development, implementation and evaluation of peer educator initiatives in Alberta Health Services - Calgary generally and within the *3 Cheers for the Early Years* initiative in particular.

“A key to health care transformation is the shift from a traditional hierarchical, clinician-centred approach to a patient or relationship-centred approach in interpersonal communication and service delivery strategies” (Auger and Verbiest, 2007: 333).

To this end, Section 1.0 of this report briefly outlines the need for diversity-competent initiatives in light of the great, and increasing, diversity of the Canadian population and that served by Alberta Health Services - Calgary. It also identifies health disparities documented among immigrant and refugee populations, and discusses some of the determinants of health that are particularly salient for newcomers to Canada. The section concludes with evidence for the underutilization of health care services among immigrant and refugee populations and an overview of barriers to access to health care.

Following a review of methods (Section 2.0), Section 3.0 provides an overview of the peer educator model, including the types of peer educators and their roles; the origins of peer education; applications of the peer educator model in present day health and related services; and characteristics of the peer educator model that are considered germane to its effectiveness. We turn in Section 4.0 to consider the benefits of the peer educator model for the individual and the target community, as well as for the peer educator. Section 5.0 considers elements of program design, including the engagement of lay versus professional educators; the importance of community collaboration; issues related to curriculum development; responsibilities of peer educators; remuneration; and job satisfaction.

Sections 6.0 and 7.0 pertain, respectively, to the recruitment and the training of peer educators, and Section 8.0 addresses issues related to program assessment and evaluation. The report concludes with consideration of some of the challenges associated with peer educator programs (Section 9.0) and with a summary of the key findings and recommendations (Section 10.0).

1.2 Population Diversity

The Canadian population is ethnically and culturally diverse. As of 2006, the immigrant population comprised 19.8% of the Canadian population, up from

“Canada accepts proportionately more immigrants and refugees than any other country” (Perez, 2002: 1).

15.6% in 2001 (Statistics Canada, 2008), and individuals self-identifying as a member of a visible minority group comprised 16.2% of the population¹ (up from 13% in 2001; Statistics Canada, 2007a). The Chinese population is the largest visible minority group in Canada, followed by South Asians and the black population, though increases over time are expected in West Asian, Korean and Arab populations (Statistics Canada, 2008). Of the foreign-born population in 2006, 70.2% reported a mother tongue other than English or French; of those, 18.6% reported Chinese languages (Chui et al., 2007).

A significant proportion of Canada's immigrants are recent immigrants, with 17.9% having arrived in Canada between 2001 and 2006 (Chui et al., 2007). Newcomers to Canada are most likely to be from Asia (between 2001 and 2006, just over 60% of newcomers were from Asia; Statistics Canada, 2008), to be between the ages of 25 and 42,² and to have arrived as an economic immigrant³ (Ibid.).

The population served by Alberta Health Services – Calgary is also ethnically and culturally diverse. In 2006, 5.2% of Canada's newcomers settled in Calgary (Statistics Canada, 2007b). Nearly one-quarter of the population served by Alberta Health Services – Calgary is comprised of immigrants (22.1%; Statistics Canada, 2007b), and 5% is comprised of recent immigrants (having immigrated to Canada since 2001; Statistics Canada, 2007b). One-in-five (20.3%) individuals served self-identifies as a member of a visible minority group, and Chinese and South Asians comprise over half of the visible minority population served by Alberta Health Services - Calgary⁴ (27.6% and 24.0%, respectively; Statistics Canada, 2007b). The population served is also linguistically diverse; as of 2006, 1.8% had no knowledge of English or French, and 12.3% spoke neither English nor French most often at home (Statistics Canada, 2007b).

The increasing diversity of the population served by Alberta Health Services - Calgary necessitates the development, implementation and evaluation of innovative health promotion strategies. Understanding health disparities, determinants of health, and access to health care issues of diverse populations, and of immigrant and refugee populations in particular, can help inform such strategies. Each is considered in the remainder of this section.

1.3 Health Disparities

Data from the Longitudinal Survey of Immigrants to Canada (LSIC) reveal that the vast majority (97%) of newcomers (including immigrants and refugees) to Canada rate their health as good, very good or excellent (Chui, 2003). In addition to self-reported good health, data from the 2000/01 Canadian Community Health Survey⁵ (CCHS) reveal that recent immigrants are less likely than their Canadian-born counterparts to have a chronic disease or disability⁶ (Perez, 2002). These findings are attributed to the self-selection of healthier people into the immigration

¹ This increase is attributed to increased immigration from non-European countries in recent years (Statistics Canada, 2008).

² In 2006 the median age of newcomers to Canada was 29.8 years (Statistics Canada, 2008).

³ In 2006, 54% of immigrants were admitted to Canada as economic immigrants; 12.9% were refugees (Statistics Canada, 2008).

⁴ The remaining visible minority population is Filipino (10.0%), Black (8.9%), Southeast Asian (6.6%), Latin American (5.7%), Arab (4.9%), and West Asian, Korean, Japanese and other (8.7%), and individuals self-identifying as multiple visible minority (2.3%; Statistics Canada, 2007b).

⁵ The CCHS does not collect data on refugee status; therefore, the term 'immigrant' is used to refer to both immigrants and refugees. Refugees accounted for 13% of all immigrants to Canada in 1999 (Perez, 2002) and therefore likely make up a relatively small proportion of 'immigrants' surveyed in the CCHS.

⁶ This finding of better immigrant health does not hold for certain infectious diseases, such as tuberculosis (Perez, 2002).

process and to the health status criteria, stipulated in the Immigration Act, which must be met by candidates for immigration (Ibid.).

As recency of immigration declines, however, the health status of the immigrant population converges with that of the general population (Perez, 2002). Data from the National Population Health Survey⁷ (NPHS) show that compared to the general population, immigrants (excluding refugees) are more likely to indicate a drop in health status over time (from good, very good or excellent to fair or poor⁸; Ng et al., 2005). Over time, social isolation, poor economic conditions, and other cultural, behavioural, environmental and biological factors can lead to a decline in health status among immigrants (Perez, 2002).

It is misleading then to conclude that immigrant groups have better health; not only does health status diminish as recency of immigration declines, but an increase in newcomers arriving from Third World countries is creating a growing population of newcomers with less positive health status than the general Canadian population (Ahmed, 2005). Data from Cycle 2 (1996/97) of the National Longitudinal Survey of Children and Youth⁹ (NLSCY) further illustrate the diversity in the Canadian immigrant population; taken as a group, the health status of children in immigrant families is similar to their Canadian-born counterparts. However, children in Asian immigrant families exhibit poorer health status than children in American and European immigrant families and in Canadian-born families (Ahmed, 2005). The health disparity of immigrant children of Asian parents is in part a function of the poorer health of children in Asian countries, but is also attributed to lower household incomes after immigration (Ibid.).

1.4 Determinants of Health

The immigration experience, itself a determinant of health, is associated with unemployment, low income, visible minority status, and housing and language difficulties. While these experiences are not generalizable across immigrant and refugee populations, there is evidence that some immigrants and refugees are at heightened risk for negative experiences in these areas¹⁰.

Newcomers to Canada and those arriving from non-English speaking and Third World countries in particular, are more likely to have poor labour market outcomes than their Canadian-born or European-immigrant counterparts (Ahmed, 2005). For example, 54% of immigrants and 35% of refugees surveyed in the LSIC cited finding an adequate job as a main difficulty in their early experience in Canada¹¹ (Schellenberg and Maheux, 2007). In addition, recent immigrants¹² are two to three times more likely to experience low income than other Canadians (Palameta,

⁷ The National Population Health Survey (NPHS) collected information from the same individuals over an 8-year period from 1994/95 to 2002/03 and includes data enabling the comparison of patterns of change in health status, health care use, and health-related behaviours among immigrants (excluding refugees) with those of the Canadian-born population (Ng et al., 2005).

⁸ This finding applied to immigrants with non-European origins; immigrants with European origins tend to have similar health status as the Canadian-born population (Ng et al., 2005).

⁹ Data from the 2005 Longitudinal Survey of Immigrants to Canada (LSIC) provide insight into the experiences of new immigrants (economic class and family class) and refugees. The Statistics Canada survey was conducted in three waves; 7,700 immigrants were interviewed at about 6 months after arrival, in 2001 and 2002, and again at 2 years (2003) and 4 years (2005) after arrival (Schellenberg and Maheux, 2007).

¹⁰ The relationship between immigration and health is discussed in greater detail in Chick and Holmes (2009).

¹¹ Barriers to finding employment often include lack of work experience, language problems, lack of foreign credential recognition, lack of job contacts or networks, and discrimination by employers (Schellenberg and Maheux, 2007).

¹² Data are from the 1993-98 panel of the Survey of Labour and Income Dynamics; 'recent immigrants' include immigrants who arrived in Canada within six years of the survey; the dataset excludes refugees (Palameta, 2004).

2004), and the gap in the low-income rate is increasing¹³ (Picot and Sweetman, 2005). Immigrants¹⁴ who are also members of visible minority groups are more likely to experience low income than other immigrants, regardless of length of time since immigration¹⁵ (Palameta, 2004).

Difficulty finding adequate and affordable housing may also contribute to poor health among newcomers to Canada. Data from the LSIC indicate that recent immigrants and refugees frequently have difficulty finding housing within six months of arrival, due to housing cost, lack of credit, poor knowledge of the city, lack of transportation, and difficulty finding housing large enough to accommodate the larger than average households of immigrant families¹⁶ (Schellenberg and Maheux, 2007).

Language barriers contribute to challenges associated with finding employment, developing friendships, and accessing health care. Data from the Longitudinal Survey of Immigrants to Canada show that 14.3% of economic class immigrants, 22.4% of family class immigrants, and 29.6% of refugees cite learning English or French as the most difficult challenge associated with their early experience in Canada (Schellenberg and Maheux, 2007).

1.5 Access to Health Care

Data from the Longitudinal Survey of Immigrants to Canada reveal that after six months in Canada, 97% of newcomers (including immigrants and refugees) had obtained a health card, and the majority of the 122,500 newcomers to had tried to access health services did so without difficulty (Chui, 2003). At the same time, however, 18% of recent immigrants and refugees reported having had difficulty accessing or using health services in Canada, 24% experienced language problems as an obstacle to health care, and one-in-ten did not know where to go for health care 6 months after arrival (Schellenberg and Maheux, 2007).

While barriers to health care are not the focus of the present review, a brief overview of some of the main barriers can serve to contextualize the discussion of the peer educator model as appropriate for health promotion among newcomers to Canada¹⁷. These include:

- Inadequate knowledge of available services and programs due to language barriers and a lack of linguistically- and culturally-appropriate information (Sawrikar and Katz, 2008);
- Absence of services that are tailored to culturally and linguistically diverse communities (e.g. scarcity of language-concordant practitioners; lack of fit between health promotion messages and cultural beliefs and traditions; failure to engage interpreter services; Jackson, 2007; Callister, 2005; Reynolds, 2004; Agic, 2003; Betancourt et al., 2003);

¹³ This gap is attributed to changes in source regions of immigrants, with more coming from Third World countries; decreasing economic returns to foreign work experience; and a general decline in the labour market outcomes of all newcomers (Picot and Sweetman, 2005).

¹⁴ The data set used by Palameta (2004) excludes refugees.

¹⁵ Visible minority immigrants may be less likely to have a working knowledge of English, may be less likely to have their educational credentials recognized, and may be more likely to experience discrimination from employers (Palameta, 2004).

¹⁶ While most of these challenges diminished over time, four years after immigration respondents continue to report housing cost and inadequate housing size as difficulties (Schellenberg and Maheux, 2007).

¹⁷ For a more complete look at barriers to health care please refer to Chick and Holmes (2009).

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- Scarcity of health care environments that are inclusive and welcoming, and of services offered in locations and at times that are convenient (Wynia and Matiasek, 2006); and
 - Fear of or experience with health practitioners failing to acknowledge, respect and accommodate diverse explanatory models for health and illness (including attribution of symptoms) and diverse beliefs about the efficacy of, and preference for, treatment options (including dislike of medication; engagement of traditional healers; Sawrikar and Katz, 2008; Campinha-Bacote, 2002; Purnell, 2002).

The literature clearly indicates the need for health care systems to develop, implement, and evaluate health care options that are relevant to and effective for diverse populations. The remainder of this paper concentrates on one such option: the peer educator model for health promotion.

2.0 METHODS

2.1 Literature Review

English language articles published in peer-reviewed journals between 1990 and 2008 were included in the review. Articles were excluded from selection if their main focus was: children, youth or adolescents; the peer educator model in developing nations; or self-help groups, peer support programs or peer counselling programs that did not have an educational component.

The literature review was prepared with computer-assisted database searches (PubMed, CINAHL, Medline, Academic Search complete, Social Work Abstracts, Social Services Abstracts, PsycINFO, SocIndex, and Web of Knowledge). The first search was conducted using key words “peer educators, peer education, peer facilitators.” These terms were combined with “immigrant, refugee, cultural diversity, and health” using wild card and MeSH headings. This search identified 65 articles, 10 of which were within the scope of interest. A second search was conducted using the same key words, but without the term “health” in order to access articles in other fields. This second search yielded 227 articles, 73 of which were within the scope of inquiry. A third search, performed with key words “lay advisor, lay educator, lay facilitator, peer advisor, peer facilitator, peer educator” combined with “health” yielded 353 articles, 37 of which were within the scope of inquiry.

A ‘snowball’ technique was also used in which the references of articles were scanned for additional articles of interest not identified in the computer-assisted searched. This technique resulted in the review of an additional eight articles.

2.2 Limitation of the Study

This literature review will summarize key features of the peer educator model identified in published studies and will present evidence for the efficacy of the peer educator model. However, it should be noted that there remain gaps in our knowledge about the model. Evidence of the efficacy or impact of peer-led education interventions, though beginning to emerge, remains scarce (Fisher et al., 2007; Rhodes et al., 2007; Martijn et al., 2004; Yoshikawa et al., 2003; Taylor et al., 2000). The nature of interventions engaging peer educators in various fields of health promotion and disease prevention remain relatively under explored in the literature (Rhodes et al., 2007; Yoshikawa et al., 2003). Published studies tend to lack detail about the processes involved in selecting peer educators (Rhodes et al., 2007; Jackson and Parks, 1997), failing for example to document the characteristics perceived as important for peer educators to possess in order to achieve positive client outcomes (Bergland et al., 2006), and few studies fully articulate the processes involved in training peer health educators (Rhodes et al., 2007; Yu et al., 2007).

Perhaps most importantly for the present study, the vast majority of the peer educator literature pertains to peer education for (largely underserved) racial and ethnic minority populations¹⁸ and

¹⁸ Articles on peer education for racial and ethnic minority populations reviewed in this paper include: Plescia et al. (2008); Navarro et al. (2007); Preyde (2007); Rhodes et al. (2007); Bergland et al. (2006); Paskett et al. (2006); Carr (2005); Hansen et al. (2005); Betancourt et al. (2003); Harrison and Wong (2003); Bronner et al. (2001); Taylor et al. (2001); Thomas et al. (2000); Taylor et al. (2000); Parker et al. (1998); Baker et al. (1997); Eng et al. (1997); Jackson and Parks (1997); Warrick et al. (1992); and Lacey et al. (1991).

for populations with chronic illness¹⁹, with very few studies exploring peer education for refugee populations²⁰. This reflects a broader tendency in the health promotion literature to discuss “immigrants” as a whole rather than distinguishing between refugees and non-refugee immigrants (Gagnon et al., 2006). As a result, our understanding of the effectiveness of the peer educator model for refugees, as well as our understanding of how peer educator programs can be effectively developed, implemented and evaluated for this population, is very limited, and it is necessary to extrapolate from the available information about peer educator programs designed for other populations (e.g., racial and ethnic minorities; chronically ill) information that could inform the development of programs specifically for refugee populations.

¹⁹ Articles on peer education for populations with chronic illness reviewed in this paper include Baksi et al. (2008); Partridge et al. (2008); Carroll et al. (2007); Richert et al. (2007); Barlow et al. (2005); Uitewaal et al. (2004); and Yoshikawa et al. (2003).

²⁰ Only one article was identified that addressed peer education for refugee populations specifically; Martijn et al. (2004) reported the findings of two studies evaluating the outcomes of the provision of AIDS education by lay health advisors in The Netherlands; the first study examined outcomes for Turkish and Moroccan immigrants, and the second examined outcomes for Iraqi refugees. Notably, in addition to the Martijn paper, just six studies were identified in the area of peer education for immigrant populations (Mistry et al., 2008; Yu et al., 2007; Giarratano et al., 2005; Uitewaal et al., 2004; Yoshikawa et al., 2003; McQuiston et al., 2001). It is possible to speculate that the research based on samples of racial and/or ethnic minority populations would include refugees (and immigrants), but whether this is the case is not specified in any of the articles reviewed.

3.0 THE PEER EDUCATOR MODEL

3.1 Peer Educators: Who Are They and What Do They Do?

Peer education is a broad concept and peer educators are variously referred to in the literature as community health workers, community health advisors, lay health workers/advisors, health education aides, indigenous workers, natural helpers, paraprofessionals, peer outreach workers, and, in Hispanic communities, *promotoras* (Hansen et al., 2005; Taylor et al., 2001; Eng et al., 1997). Some programs offer structured one-on-one or group education²¹, while others educate through casual conversations and the distribution of educational materials in social or public settings. Some programs are exclusively designed as educational interventions, while others combine an educational component with a counselling or support component (Rhodes et al., 2007). Peer educators often provide links between health-related services and community members (Rhodes et al., 2007; Yu et al., 2007; Bergland et al., 2006; Baker et al., 1997; Eng et al., 1997). They also serve as role models for desired behaviours in health promotion and disease prevention initiatives and advocate on behalf of underserved communities (Rhodes et al., 2007).

Peer educators tend to be female²² (Richert et al., 2007; Yu et al., 2007) and are generally members of, and share a common identity and language with, the communities they serve (Hansen et al., 2005; Eng et al., 1997). Peer educators are visible, trusted and respected in their communities (Bergland et al., 2006; Hansen et al., 2005) and are often ‘natural helpers’ (Israel, 1982, cited in McQuiston et al., 2001) or people in the community to whom others naturally turn for advice and support (Baker et al., 1997).

3.2 Historical Context

Peer educators or lay health workers are often relied upon in developing countries; they can easily be trained to provide a variety of interventions traditionally performed by physicians and nurses, such as giving immunizations, to compensate for the shortage of health care professionals (Harrison and Wong, 2003; Taylor et al., 2001; Meister et al., 1992; Warrick et al., 1992). In the context of industrialized nations, the engagement of lay health workers in the U.S. is documented as far back as the 1950s, with the *Navajo Community Health Representatives* project and a migrant farm-worker outreach program in Florida (Meister et al., 1992). Lay helping programs began to proliferate in the 1970s (McQuiston et al., 2001; Jackson and Parks, 1997), though Baksi et al. (2008) identify the work of Lorig et al. (1985), who developed the idea of engaging lay tutors in the management of arthritis in the 1980s, as the starting point for the engagement of peers as formal educators.

“Peers as educators have been used as a means of reaching more remote, underserved, and culturally isolated populations, particularly in developing countries” (Taylor et al., 2001: 285).

²¹ The majority of the literature describes one-on-one education initiatives; there is little published literature on peer-led education delivered in group settings.

²² A systematic review of research on lay health advisor programs conducted by Rhodes et al. (2007) found that of the 37 studies meeting their selection criteria, 28 relied exclusively on female lay health advisors.

3.3 The Peer Educator Model Today

The peer educator model is increasingly recognized as an influential strategy for health promotion among traditionally underserved populations (Rhodes et al., 2007; Yu et al., 2007; Paskett et al., 2006; Carr, 2005; Hansen et al., 2005; Parker et al., 1998). The model has been successfully employed in many fields of health care, and in this section the various fields are discussed and examples of successful programs are provided. The review is not exhaustive, but provides evidence for the efficacy of the peer educator model and can provide readers unfamiliar with the model with an indication, through concrete examples, of what peer education entails.

The peer educator model is commonly used in the self-management of chronic disease, largely in the area of diabetes education as a response to the proliferation of diabetes and recognition of the importance of ongoing education (Baksi et al., 2008; Richert et al., 2007):

Education is a cornerstone in diabetes management. Ethnic-specific education, performed by ethnic linkworkers to bridge language and cultural gaps between patient and physician has been advocated (Uitewaal et al., 2004: 359).

Uitewaal et al. (2004) evaluated a diabetes peer educator program for Turkish patients in the Netherlands, in which peer educators were layperson with diabetes, fluent in both Turkish and Dutch languages, and regarded as representatives of the target population. Peer educators provided one-on-one and group counselling education to patients with diabetes in the area of self-care skills and encouraged positive behaviour change. Semi-structured interviews with patients (N=36) revealed that the vast majority (92%) were satisfied with the educators' competence and approach; 86% felt the educators set a 'good example;' and 94% appreciated that the educators were bilingual.

Peer-led breastfeeding counselling and education programs provide information, support, and practical assistance (Rossman, 2007) and have been found effective in increasing the incidence and duration of breastfeeding among new mothers (Agrasada et al., 2005).

An example of an effective peer breastfeeding counsellor program is the *Santa Clara County's Special Supplemental Nutrition Program for Women, Infants and Children (SCCWIC; Mistry et al., 2008)*, in which peer counsellors, who were themselves former breastfeeding mothers of low-income status, provided pre- and post-natal education and support, individually and in groups, to low-income Vietnamese immigrant women. As part of the evaluation of the program, participants were asked to identify the sources of the advice on infant feeding they had received

Project Dulce (Whittier Institute for Diabetes, Scripps Health, San Diego): Launched in 1997 and operating in 17 primary care sites, Project Dulce is a diabetes management program in which diabetes patients who have learned to manage their diabetes provide education and support to culturally-similar patients with diabetes. The peer educators, or promotoras, are a welcome alternative to health professionals, who can be perceived in some cultures as intimidating, and serve as role models, having learned to manage their own diabetes and having dealt with many of the same issues or barriers. Promotoras undergo an extensive 4-month training program, and then teach group classes once per week for eight weeks. Promotoras teach in their native language. Course materials are adapted for Hispanic, African-American, Filipino, and Vietnamese populations. In addition to providing information on diabetes and its management, promotoras conduct demonstrative cooking classes, demonstrate exercises, and share personal stories and fears about diabetes. More information is available online from: http://www.whittier.org/pages/pp_dulce.html

while pregnant, and to identify whether that advice had supported breastfeeding. While physicians ranked as the most predominant source of information generally, peer counsellors ranked second as a source of information and first in terms of being supportive of breastfeeding.

Watkins et al. (1994, cited in Martijn et al., 2004) evaluated a lay health advisor program to encourage Latina farmworker women in the U.S. to visit prenatal care centres and childcare centers. The study found that compared to mothers that did not engage with lay health advisors, those that did demonstrated a greater knowledge of positive infant and child health practices, were more likely to attend the recommended number of prenatal visits, and made significantly more sick-child visits.

A *Community Dental Health Worker* (CDHW) in Vancouver worked with Vietnamese parents of preschool children during immunization visits, providing one-on-one education encouraging positive dental health practices, and placing follow-up calls to reinforce those practices (Harrison and Wong, 2003). An evaluation of the project compared the dental health of the children, as well as mothers' infant feeding and comforting practices, before and after the intervention. Children whose mothers participated in the program had significantly fewer decayed surfaces than at baseline, and their mothers had better reported infant feeding and comforting practices. The evaluation also revealed that the follow-up calls made by the CDHW were a significant source of support, with the calls often turning into lengthy conversations about the challenges of child-rearing. The success of the project is attributed in large to the fact that peer educator shared a cultural and experiential background with the participating mothers. The peer educator spoke the same language and was also a Vietnamese immigrant and a mother of young children.

Evidence of the effectiveness of the peer educator model for health promotion and disease prevention has also been documented in the fields of drug and alcohol awareness, family planning, and smoking cessation (Rhodes et al., 2007); nutrition (Taylor et al., 2001); breast and cervical cancer prevention and screening (Navarro et al., 2007; Paskett et al., 2006); HIV/AIDS prevention²³ (Martijn et al., 2004; Fogarty et al., 2001; McQuiston et al., 2001); cardiovascular disease prevention (Rhodes et al., 2007) and cardiac rehabilitation (Carroll et al., 2007); STD prevention²⁴ (Thomas et al., 2000); and the management of schizophrenia²⁵ (Rummel-Kluge et al., 2008). Peer education is also well established in schools and the youth service (Martijn et al., 2004; Shiner, 1999).

²³ Janz et al. (1996, cited in Martijn et al., 2004) asked coordinators of 37 AIDS prevention projects in the US to identify the most effective strategies for AIDS prevention; lay health advisors ranked third (after small group discussions and the use of outreach workers).

²⁴ Thomas et al. (2000) evaluated a lay health advisor intervention in STD prevention, in which peer advisors distributed information to, and encourage behaviour change among, African-American women in the United States. Twenty-one volunteer advisors participated. The evaluation, conducted 18 months after commencement, revealed substantial improvement in care-seeking behaviours, though this improvement may have resulted from the cumulative effect of multiple levels of intervention.

²⁵ Rummel-Kluge et al. (2008) conducted a pilot study to evaluate the feasibility and acceptability of a peer-counselling program for inpatients with schizophrenia. The peer counsellor had been living with schizophrenia for more than 20 years and had been trained in peer psychoeducation. Peer counselling was offered once per week for about an hour. A total of 88 consultations took place between 2004 and 2006 and of the 71 participants anonymously providing feedback, 96% said they would recommend the program to others, and 4% said they would possibly recommend the program.

3.4 Why does the Peer Educator Model Work?

Peer education is premised on the theory that social networks are effective in communicating behavioural norms, and on the 'diffusion of innovation' theory, which holds that new behaviours (or "innovations") become widespread through social networks and through change agents or "opinion leaders" in particular (Rogers, 1995, cited in Yoshikawa et al., 2003). Opinion leaders are "...influential within social networks, due to characteristics such as slightly higher social status, and greater connection to external systems and sources of information" (Yoshikawa et al., 2003: 151). The peer educator model is premised on the idea that peer educators serve as opinion leaders in their communities, helping "reduce cultural resistance to new ideas or practices" (Lacey et al., 1991: 271).

Peer educators are effective change agents because they are part of the communities they serve; they are "cultural insiders;" ethnically, socioeconomically, and experientially (Rhodes et al., 2007; Giarratano et al., 2005; Yoshikawa et al., 2003; McQuiston et al., 2001). As community members, peer educators "understand what is meaningful to those communities;" because they possess "an intimate understanding of the community's social networks, strengths, and health needs," peer educators can "recognize and incorporate culture (e.g., cultural identity, spiritual coping, traditional health practices) to promote health and health outcomes within their communities" (Rhodes et al., 2007: 418):

...it is not enough, from a practical or ethical standpoint, to simply disseminate health information... For effective disease treatment and prevention and behavior modification, individuals must be motivated and able to access, understand, and use health information in the context of their daily lives. Lay health educators are respected and trusted members of a community who know most of the residents they educate. They help translate health information into culturally meaningful, understandable messages that their neighbours can critically think about and act on... Acting in the spirit of collaboration and mutuality, their work and use of "living room" language embody the principles and best practices of health literacy and relationship-centred care (Auger and Verbiest, 2007: 333).

In addition to knowing their community, peer educators are often trusted members of their community (Rummel-Kluge et al., 2008). Because they are perceived as trustworthy, and because they demonstrate a "unique understanding and empathy for the audience," peer educators, and their health promotion initiatives, are more likely to be embraced by the community (Taylor et al., 2001: 285).

Peer educators are more likely to be trusted when they are perceived as credible, and the credibility of peer educators comes in part from having shared experiences. For example, Rummel-Kluge et al. (2008) describe a peer counselling program for inpatients with schizophrenia and note that:

...the credibility of a peer can be higher than that of a professional team member, especially when it comes to medication. Many consumers say that professionals cannot imagine what it is like to take medication for years. The peer-counsellor, however, having taken medication for many years, can function as a positive role-model here (360).

Similarly, Rossman (2007) concludes from a review of recent literature that breastfeeding counsellors are effective in large because they have personal experience with breastfeeding and can relate well to the women they work with. As another example, *Project Early Awareness*, a breast health education program for teenage girls offered by the Howard University Cancer

Center in Washington, D.C., finds that program participants more readily 'buy-in' to the program because they can easily identify with and relate to the spokesperson, who is a young cancer survivor: "They know I'm only a little bit older than them... It makes my experience more real to them" (National Center for Cultural Competence, 2004: 7).

As a member of the community, peer educators have the advantage of understanding the cultural contexts of health, including social norms, which influence health practices and behaviours. For example, peer educators who are members of the ethnocultural community they serve have been found effective because they have an understanding of the norms and values concerning AIDS and sexuality, and therefore know how to discuss sensitive issues in a culturally acceptable manner (Martijn et al., 2004). Yoshikawa et al. (2003) conducted focus groups with front-line HIV prevention peer educators who performed street outreach, distributing HIV information and discussing healthy practices among Asian/Pacific Islander populations. Participants attributed much of the success of the program to the fact that as members of the ethnocultural community, peer educators understood the cultural preferences and customs of their target population and could tailor their health promotion messages accordingly. As another example, understanding the 'mindset' of parents of young children in the UK helped peer educators effectively deliver childhood accident prevention messages; because they understood the community norm that children 'should be hard' and 'independent,' peer educators were able to deliver their health promotion messages in ways that were effective yet respectful of local values (Carr, 2005).

3.5 Lay versus Professional Educators

This review of the literature identified three articles describing research on the quality of education delivered by laypersons compared to that delivered by health care professionals. First, Baksi et al. (2008) conducted a randomized controlled trial comparing the effectiveness and acceptability of the delivery of diabetes patient education by peer advisors (PADs) with that of specialist health professionals (SHPs). The courses ran weekly for six weeks, were interactive, and included problem solving, questions and answers, and the opportunity for participants to raise issues from their own experiences. Participants completed weekly evaluations and an end-of-course assessment form evaluating their confidence in their knowledge related to diabetes, whether they would have preferred to have been taught by SHPs, and whether they were comfortable with the PADs as educators. Results showed no difference in learning outcomes between those taught by PADs and those taught by SHPs. Asked if they were happy to have been taught by peer advisors, the average score was 4.5 out of 5. Asked if they would rather have been taught by a SHP, the average score was 2.2 out of 5. There was no difference in level of attendance between the two groups:

Patients felt that the PADs had a good grasp of the subject, were able to answer questions and had a good understanding of how it felt to be a person with diabetes. These responses indicate clear acceptance of the PADs by their peers as lay educators (Ibid.: 1081).

Secondly, Martijn et al. (2004) describe two studies analyzing the effectiveness of AIDS education by lay health advisors targeting hard-to-reach ethnocultural groups in the Netherlands²⁶. In both studies, students taught by lay educators had higher levels of post-intervention knowledge about AIDS, as indicated by a comparison of their pre-test and post-test questionnaire scores. The first study also revealed a shift in attitude toward condom use

²⁶ Participants in the first study were Turkish and Moroccan male migrants and in the second were male Iraqi refugees.

following the education intervention. The second study was designed to test whether AIDS education delivered by a lay health advisor was more or less effective than that delivered by a health professional facilitated by an interpreter. Participants (N=36) were randomly assigned to the two groups. Results indicated no clear evidence that one type of educator was more effective than the other; the study did find, however, that students of the peer educator were more likely than students of the health care professional to exhibit a positive change in attitude toward condom use.

In the third study, Partridge et al. (2008) tested the hypothesis that with proper training, lay persons could deliver asthma self-management education with results equivalent to nurse-led education. The authors recruited and trained 15 lay persons as peer educators and provided 46 nurses with a refresher course in asthma education. A total of 567 patients with asthma were randomly assigned to the two groups. Results showed that “lay educators were as likely as nurses to recommend meaningful changes to management and patients were as satisfied with care by a lay educator as with care by a nurse” (782).

Together, these findings indicate that peer educators are as effective, and in some cases more effective, in educating members of diverse populations than are health care professionals. Absent from this evidence, however, is an indication of the benefits of the peer education model accrued by participants, their communities, and peer educators themselves. It is this area of inquiry to which we now turn.

4.0 OUTCOMES OF PEER-LED EDUCATION

4.1 Benefits to Participants

According to the literature, peer education benefits participants by delivering culturally relevant knowledge, by influencing social norms leading to positive health behaviour changes, by linking participants to health services, and by providing a source of social support.

Peer-led education initiatives have the potential to impart knowledge that is culturally relevant to the target population. Because peer educators are members of the communities they serve, they are in a unique position to evaluate the cultural relevance of the educational material, and when relevant, students are more likely to embrace the material (Harrison and Wong, 2003). This is not to suggest that certain topics be avoided; rather the peer educator may be better able to identify cultural beliefs and values and modify the course content accordingly. An example from Vancouver's *Community Dental Health Worker* (CDHW) program serving Vietnamese families illustrates how peer educators can be sensitive to students' receptivity to particular ideas and modify the course content accordingly:

For example, it became apparent from comments made by mothers to the CDHW that they resisted diluting milk in their child's bottle because of a concern that 'watering-down' the milk in the bottle would result in watery diarrhea. Mothers also distrusted tap water for dilution, and the cost of bottled water was prohibitive. Therefore, sequential dilution of bottle contents was typically not recommended [in the education sessions] (Ibid.: 398).

In addition to culturally-relevant knowledge transfer, peer education can influence shifts in what participants consider to be normative behaviour (see Section 3.4 on the diffusion of innovation theory and opinion leaders). As peer educators demonstrate desired health behaviours and attitudes in their own lives, they become role models for their students; in group settings, students are also influenced by observing positive health behaviours and attitudes in one another (Plescia et al., 2008). Rhodes et al. (2007) articulate the role of the lay health advisor (LHA) in influencing social norms about condom use among Hispanics / Latinos in the U.S.:

As role models, LHAs imparted skills and guided peers by their own example... They were charged with reframing community expectations and sociocultural norms. For example, although condom use might be affected by access to condoms, information about how to use a condom, and skills to initiate and negotiate use, sociocultural expectations about what it meant to be a man in terms of risk and protective behaviours might be important factors that LHAs were trained to address. As role models, LHAs are in a unique position to reframe negative and to bolster positive sociocultural expectations (424).

A third benefit to participants in peer-led education is the potential for linkages to occur between participants and health care services. Parker et al. (1998) describe a village health worker program, *East Side Village Health Worker Partnership* in Detroit, in which lay health workers provided underserved community members²⁷ with information about, and referrals to, community services. Peer educators need not perform liaison duties, however, to have a positive influence on participants' use of services. For example, Jackson and Parks (1997) report that involvement in peer-led education can lead to greater overall use of the health care system:

²⁷ African American and Latino individuals experiencing poverty.

By having initial health concerns addressed by a trusted community member, African Americans are more likely to accept the information and enter the health care system for necessary care (419).

Individuals having positive experiences in peer-led education programs may be more trusting of the health care system overall and therefore be more likely to utilize additional health care services (Auger and Verbiest, 2007; Taylor et al., 2001).

Social support is a fourth potential benefit to participants in peer-led education. It is well documented that social support is positively correlated with well-being (Preyde, 2007; Kobetz et al., 2005). When peer education is delivered in a group format, opportunities are created for the discussion of shared experiences; newcomers to Canada, for instance, may find the peer education group to be one of their few sources of contact with individuals with similar experiences²⁸. Sharing experiences may facilitate feelings of comfort and trust among members, as well as a sense of belonging (Yoshikawa et al., 2003).

4.2 Benefits to Communities

Benefits of the peer educator model to communities for the most part concern the development of community capacity. Because peer educator programs are developed with community input, are implemented in the community and are led by community members, a sense of ownership of the program can arise, leading community members to feel responsible for meeting their health care needs, and empowered to take action to do so (Plescia et al., 2008):

Empowerment [is a] social action process that promotes participation of people, organizations, and communities in gaining control over their lives in their community and larger society... a process in which community members would learn to make connections with individuals and services in a way that promoted individual and community health (Baker et al., 1997: 506).

When community members participate in the development of peer educator initiatives, it serves to extend the power of the community “to take control of their health destiny. In doing so, it can also serve as a springboard for other areas of community development” (Jackson and Parks, 1997: 420).

Community capacity is further strengthened when students of peer educators themselves become champions of health education (Warrick et al., 1992); with respect to peer breastfeeding counsellors, Rossman (2007) concludes from a review of the literature that:

One of the most promising benefits is that mothers who work with peer counsellors often express an eagerness to share their knowledge and mastery in the art of breastfeeding with others. In this way, they can become role models for others and begin to build a breastfeeding tradition within their community (635).

Similarly, parents participating in peer-led education about childhood accident prevention were observed to become

²⁸ LSIC data show that 13% of new immigrants to Canada cite the absence of support from their home country as a challenge in the early years, and 7% cite the lack of social interactions or lack of new friends in Canada as a challenge (Schellenberg and Maheux, 2007).

...‘champions’ of the accident prevention cause as they were advising friends of the availability of, and process of accessing safety equipment. The number of referrals by the safety advisors and self-referrals by parents rose (Carr, 2005: 176).

An additional benefit to communities of peer education is the opportunity that is created for the communication of the health needs and preferences of diverse ethnocultural communities to mainstream health services (Bronner et al., 2001; Parker et al., 1998). Working with peers, educators may become more familiar with the health-related values, beliefs, preferences and practices, as well as health-related needs of the participants and of the broader community, and may convey this knowledge to the health care organization through informal communication and/or more formally at the time of program evaluation. An example is provided by Rhodes et al. (2007) in the context of lay health advisors working with American Hispanic and Latino populations:

With intimate appreciation of their communities, including needs, expectations, and norms, LHAs served as community advocates to educate and raise the consciousness of providers, practitioners, and researchers to contribute to ensuring that interventions and services were culturally appropriate, responsive, and effective (424).

Notably, opportunities for underserved communities to influence the delivery of health care also arise from their involvement in developing, implementing and evaluating peer education initiatives (Fischer et al., 2007). Community involvement further creates opportunities for mainstream systems to identify barriers to care contributing to the underutilization of services, and to address those barriers (Ibid.).

4.3 Benefits to Peer Educators

Benefits of working as a peer educator are well documented in the literature and generally pertain to employment/career development and to the intrinsic benefits of increased self-esteem, personal empowerment, and satisfaction from ‘making a difference.’

First, the training and experience peer educators receive can enhance their ability to pursue subsequent employment (Taylor et al., 2001; Jackson and Parks, 1997). In the words of Rossman (2007):

External recognition and valuation of the peer counsellor’s knowledge and skills, particularly by health care professionals, often serve as a catalyst for engaging in other related activities by participating in advanced training programs, furthering their education, or finding employment. This last element is critical, because many of the peer counsellors come from the same low-income communities as the mothers they serve (635).

Peer educators may also be inspired to pursue careers in health care; this benefits the individual, but also creates opportunities to build a health care workforce that is more representative of the populations it serves (Auger and Verbiest, 2007).

Secondly, peer educators may benefit in terms of increased self-confidence and self-esteem, increased status in the community and greater personal empowerment, and personal satisfaction (Ibid.):

Benefits for the peer counsellors include increased community status and enhanced self-esteem and empowerment through recognition, by themselves and others, of their social usefulness (Rossman, 2007: 635).

Numerous studies document these benefits to peer educators; for example, lay health advisors participating in the *Charlotte Racial and Ethnic Approaches to Community Health (REACH) 2010* project²⁹:

...expressed pride in their knowledge about health issues and the sense of authority that this knowledge provides. There was a strong theme of having made a difference in the lives of others and being successful in bringing about change (Plescia et al., 2008: 438).

Similarly, lay health tutors participating in the *Chronic Disease Self Management Course (CDSMC)* report increased self-confidence, a sense of satisfaction having added value to the lives of their students, and greater acceptance of their own chronic condition (Barlow et al., 2005). Finally, promotoras working with low-income Mexican and Mexican-American women in a community prenatal education program ("*Un Comienzo Sano*," or "A Healthy Beginning") cited their role as a source of great pride:

The promotora experienced unbounded pride in their new knowledge and visible role in the community. Initially their reaction was similar to the women they taught, fascination with the new information. With repetition and integration of the learning, they began to see themselves as legitimate experts and they made specific requests of project staff for additional training, particularly on newborn care and parenting skills. All promotoras described the importance of their relationship of teacher and friend to the families. This interpersonal commitment to the participants, an extension of the informal helping relationships that were already part of their social networks, was viewed by the promotoras as a critical component of their role. They promotoras' stature in the community was also enhanced, as demonstrated by the fact that they were frequently approached by phone or on the street for health care advice by non-participant families (Warrick et al., 1992: 23).

We have reviewed the main benefits of the peer educator model to participants, communities, and peer educators themselves. This, combined with an overview of the peer educator model (Section 3.0) has provided an understanding of and appreciation for the peer educator model. We turn in the remainder of the report to the 'logistics' of peer education, including program development, peer educator recruitment and training, and peer educator program evaluation.

²⁹ *REACH* is a federal initiative in the U.S. intended to reduce disparities in the health and wellbeing of racial and ethnic minorities; the *Charlotte REACH* project was designed to reduce health disparities among individuals with cardiovascular disease and diabetes living in a predominantly African American community in North Carolina (Plescia et al., 2008).

5.0 PROGRAM DEVELOPMENT

Peer educator program development involves not only recruiting and training peer educators (discussed in subsequent sections), but requires consideration of the role of the target community in program development and implementation (and evaluation; see Section 8.0), as well as consideration of the curriculum/course content, of the responsibilities of peer educators, of remuneration, and consideration of factors that will influence peer educator job satisfaction. Each is discussed, in turn, in this section.

5.1 Community Collaboration

It is recommended in the literature that members and leaders of the target community be involved in the development of peer educator programs as a way of ensuring programs meet the needs of the local community (Taylor et al., 2001; Baker et al., 1997) and to cultivate a sense of investment and ownership within the community, leading, in theory, to greater program sustainability (Parker et al., 1998).

Based on findings from an evaluation of an HIV/AIDS lay health advisor program (*Protegiendo Nuestra Comunidad*) for recent Mexican immigrants to the United States, McQuiston et al.(2001) recommend using a ‘collaborative inquiry’ approach to the development and implementation of peer educator programs. This approach is premised on the belief that the input of the community is as valuable and legitimate as the input of members of the organization. In essence the approach ‘levels the playing field’ by involving community members as equal stakeholders. In doing so, the program gains, from “cultural and community experts,” the necessary knowledge to design an effective program; and marginalized groups gain “a voice and a role as decision makers in program development” (276).

In developing the community dental health workers project in Vancouver, Harrison and Wong (2003) report that members of the target population, Vietnamese mothers of young children, were invited to join the planning committee. Despite arranging for a translator and child care, community members were reluctant to participate; they felt shy sharing their opinions with the larger group, but were quite willing to discuss the program with individual committee members with whom they felt comfortable.

5.2 Curriculum Development

There is scant literature on the development of peer educator curricula. To the extent that it is addressed, the literature tends to centre on the importance of community needs assessment to ensure the relevance of the course content (McQuiston et al., 2001). For example, during the development of the *Community Dental Health Workers* program in Vancouver, a convenience sample of the target population, Vietnamese mothers of young children, was interviewed about feeding practices, comforting practices, and beliefs about dental health, and the findings helped guide the focus of the peer education intervention (Harrison and Wong, 2003). Similarly, in the development of *La Cocina Saludable*, a nutrition education program for Hispanic mothers of preschool children in Colorado, focus groups with members of the target community provided insight into the learning needs of the community which informed the development of the program content (Taylor et al., 2001).

A few authors cite the importance of ensuring the course content is written and delivered at a literacy level that is appropriate for the target audience. While peer education is generally

delivered in the first language of participants (or in English with a bilingual peer educator who can translate as necessary), and therefore English-language proficiency may not be a concern, it is important to recognize that students will have different levels of literacy in their first language, and materials should use simple words and sentences and should not use jargon or technical language (McQuiston et al., 2001).

Students will also have different levels of health literacy, and materials should be appropriate for the level of *functional literacy* of the group, or the ability to read and write; the level of *interactive literacy*, or the ability to communicate effectively with others about health needs; and the level of *critical literacy*, or the level of ability to critically appraise health information (see Arnold and de Peuter, 2008).

It should also be recognized that peer educators themselves will have varying levels of literacy, as was discovered in the development of training materials for peer educators participating in *La Cocina Saludable*, a peer educator program for Hispanic mothers of preschool children. Because peer educators had a relatively low level of literacy, the Resource Guide for peer educators was written at a sixth-grade level (Taylor et al., 2001).

5.3 Responsibilities of Peer Educators

When developing a peer educator program it is important to consider the appropriate responsibilities of the peer educator. This review did not identify articles specifically addressing this issue, but several program evaluations documented in the literature do lend insight into some of the issues that can arise with respect to responsibilities. The main sources of difficulty seem to arise from assigning peer educators the responsibilities of student recruitment and coordinating or arranging the classes.

It is not uncommon for peer educators to be given the responsibility for recruiting participants. For example, promotoras were responsible for recruiting participants and helping overcome students' barriers to attending classes in *Comienzo Sano*, a prenatal program for low-income Hispanic women in migrant and seasonal farmworker communities in Arizona (Meister et al., 1992), and health advisors or *consejeras* similarly recruited participants to a Latino community health advisor program described by Navarro et al. (2007).

However, these 'administrative' responsibilities can be a source of strain and dissatisfaction for peer educators, as an evaluation of *La Cocina Saludable*, a classroom-based peer education program on nutrition for Hispanic mothers of preschool children reveals. In this program,

The abuela educators were given the responsibilities of recruiting participants, organizing the class details, and teaching the classes. They were given basic guidelines they needed to follow but were allowed to determine the best schedule, class size, class length, location, child care arrangements, and transportation arrangements on their own. The purpose of providing a few guidelines and leaving logistical details up to each abuela educator was to allow the educator to overcome the obstacles unique to each class group in an attempt to accommodate the largest number of class participants (Taylor et al., 2001: 286).

When interviewed, 39% of *abuelas* (n=25) cited recruitment of participants as a significant challenge, 25% cited coordinating or arranging the classes, and 14% cited student retention as most significant. Just 7% indicated that teaching the classes was challenging and none indicated that learning the material they needed to teach was a challenge. These findings suggest that program organizers use caution in 'overloading' peer educators with administrative

tasks; while it is important that courses be offered at times and in locations that are convenient, it appears assigning peer educators to administrative roles can create a source of dissatisfaction and frustration.

5.4 Remuneration

The majority of published studies on peer educator programs include mention of whether the peer educators were paid or volunteer, but few address the outcomes and benefits/drawbacks of engaging volunteer versus paid peer educators.

One article describes the process a planning committee went through in making the decision to provide compensation to lay health advisors. According to Plescia et al. (2008), individuals involved in the development of the *Charlotte REACH* project, an American lay health advisor program serving predominantly African American adults with cardiovascular disease and diabetes, were divided on whether to engage lay health advisors as volunteers or paid staff members:

There were mixed views on compensation versus volunteerism. Some coalition members voiced concerns about paying volunteers and believed compensation would inhibit capacity building, empowerment and sustainability efforts, and compromise the community's perception of the "natural helper." Others believed that LHAs should be paid due to the importance of their position, dangers associated with outreach work, and the belief that persons in low-income areas would benefit from additional employment opportunities. Many coalition members felt that a stipend alone would not suffice to reimburse their LHAs for their time, talents, and service to their neighbourhoods. Consensus was eventually reached on the present policy, although some controversy still persists about whether LHAs should receive a benefits package (438).

In other literature the decision to compensate peer educators appears to be contingent, in part, on the extent to which the role of the educator is formalized. For example, Jackson and Parks (1997) conducted a review of published articles on lay health advisors serving the African American population in the US, and found that more than half of the programs provided remuneration or other forms of compensation, such as transportation reimbursement, and that payment was more common among programs in which lay health advisors worked regular hours or had a formal work schedule. Eng et al. (1997) articulate a similar sentiment with respect to lay health advisors serving hard to reach, at-risk communities including racial minorities and migrant farmworkers in the U.S.:

At the formal end of the continuum is the paraprofessional LHA intervention strategy. These LHAs are extenders of the service delivery system, performing tasks that would normally be carried out by practitioners. Hence, paraprofessionals must meet minimal qualifications (e.g., literacy level, bilingual, driver's license) and at the completion of training must demonstrate an acceptable level of standardized competencies to become a certified LHA. Since these LHAs are fulfilling a set of professional responsibilities, they are often paid by an agency and required to complete time sheets and reimbursement forms for expenses, such as mileage (415).

Remuneration may signify the status of peer educators as professionals or paraprofessionals, and for the peer educator, it also communicates "a clear message that a project values the time of its peer workers" (Shiner, 1999: 561). Providing remuneration and treating the peer educator as professional or paraprofessional more generally can also give the peer educator credibility in

the community and among health care professionals (Baker et al., 1997); Giarratano et al. (2005) report that by paying lay health educators working with Latino immigrants in the field of cervical and breast cancer screening, educators were recognized as legitimate health experts in their own right, and were then more highly respected by community members they served, as Latinas traditionally respect those in positions of authority.

5.5 Peer Educator Job Satisfaction

There are few published studies on the experiences of peer educators and a virtual absence of literature on the topic of peer educator job satisfaction in particular. An exception is a commentary about lay health educators, in which Auger and Verbiest (2007) acknowledge the importance of job satisfaction:

Lay health educator programs must consider ways to respect the contribution of time and expertise of LHE's as well as ways to keep them engaged over time. Cash compensation is one obvious incentive. Increased access to services, training opportunities, respect from their peers, and a deep sense of knowing they have helped their community are other ways that LHEs benefit from their labour (334).

Baker et al. (1997) also touch on the issue of job satisfaction in their discussion of the importance of respectful communication between lay health advisors and program coordinators:

The lay health advisors needed to learn to voice their opinions even when they differed from those of individuals with more credentials. Alternately, those with more credentials needed to learn to listen and make changes in the program as appropriate (507).

In addition to determining which methods of compensation will be most effective in generating positive job satisfaction among peer educators, then, program organizers might also consider the extent to which peer educators will feel comfortable voicing their opinions or concerns, and if necessary, develop deliberate channels of communication in which peer educators are made to feel, and are treated as, respected equals.

Finally, Giblin (1989, cited in Bronner et al., 2001) identify sources of job dissatisfaction in the context of peer counsellors working in clinical settings alongside health care professionals. According to Giblin, sources of dissatisfaction may include poorly defined job descriptions, inadequate training and supervision, lack of input into defining program goals and objectives, poor rapport among peer counsellors, health care staff and clients, and limited funding for peer counselling programs. Because these barriers were identified in the context of peer counsellors working alongside health care professionals in a clinical setting, the extent to which they arise in peer educator programs of different formats is not known.

However, it can be inferred that clear job descriptions, adequate training and supervision, opportunities for discussing concerns as they arise, and ensuring peer educator programs are adequately funded can positively affect peer educator job satisfaction. Job descriptions can delineate the extent to which peer educators are responsible for dealing with issues that arise that are not directly related to the education initiative (this is further discussed in Section 7.0, below, on peer educator training), and program coordinators can consult with peer educators from time to time to identify any issues that may be contributing to poor job satisfaction more generally.

While there is not an abundance of literature addressing the development of peer educator programs, the preceding discussion lends insight into some of the key variables that require consideration in program development. Two additional areas of program development, peer educator recruitment and training, receive greater attention in the literature, and are discussed, separately, in the following two sections (Sections 6.0 and 7.0).

6.0 RECRUITMENT OF PEER EDUCATORS

The characteristics and qualifications of peer educators recruited for existing programs can help inform recruiting decisions in the development of new peer educator programs. In this section we review such qualities, and then consider methods of recruitment of peer educators.

6.1 Characteristics and Qualifications of Peer Educators

Peer educators have been recruited on the basis of having had experiences similar to the target population. For example, peer educators in the area of diabetes self-management education have been required to either have diabetes or be at risk for diabetes, or have a family member with diabetes (Richert et al., 2007); lay health advisors working in the area of prenatal education have been required to have children of their own (Meister et al., 1992). Having shared experiences enables students to better relate to the educator and facilitates the development of rapport and relationships of trust.

Many peer educator programs recruit educators who can model the desired outcome behaviour for students. For example, educators recruited for a diabetes self-management education program were required to have an understanding of the importance of, and be committed to engaging in, physical activity (Richert et al., 2007).

The extent to which candidates are considered able to become effective teachers is important in recruiting decisions, but Giblin (cited in Taylor, 2001) argues that personal characteristics are as important as teaching skills, and Yu et al. (2007) argue that peer educators can be taught how to teach, but when recruited should have a demonstrated enthusiasm for helping others.

Candidates with existing ties to and knowledge of the target community and those with a reputation in the community as a 'natural helper' are also considered good candidates for peer educator positions (Jackson and Parks, 1997). In addition to being active in their community and having an interest in helping others, recruits for the *East Side Village Health Worker Partnership* in Detroit were required to be individuals whom others already turned to for advice about women's and children's health issues (Parker et al., 1998). In short, good candidates for peer educator positions are individuals who "embody the combination of social, cultural, ethnic, environmental, and communication values, norms and beliefs of the target population" (Jackson and Parks, 1997: 420).

Finally, with the exception of a few programs requiring a high school diploma (Yu et al., 2007; Jackson and Parks, 1997), none of the peer educator programs identified in this review required formal credentials of peer educators. Programs designed for diverse linguistic communities generally do require peer educators to be bilingual (Yu et al., 2007), and good communication skills are also generally required (Jackson and Parks, 1997).

Lacey et al. (1991) describe the development and outcomes of a program in which lay health educators promoted smoking cessation among African American women in an underprivileged urban community. Lay educators were recruited from the target population and were similar to the target population in terms of age, race, educational level, income, and place of residence. Candidates were required to have a good knowledge of the community, the ability to establish rapport with the target population, and, in order to model the desired health behaviour, were required to be non-smokers.

6.2 Recruitment Methods

Peer educators have been recruited through advertisements in local media, through word of mouth, through the distribution of fliers by community organizations, and by asking previously trained peer educators for recommendations (Richert et al., 2007; Yu et al., 2007; Jackson and Parks, 1997).

Importantly, the literature recommends drawing on the knowledge and resources of target communities themselves in the recruitment of peer educators. Jackson and Parks (1997) articulate the reason for avoiding traditional recruitment and selection techniques:

Many of these methods may not be conducive to the identification of true lay advisors... many of the methods employed fail to consider the fact that it is the community, not experts, who are best qualified to identify the natural leaders among them. Thus, methods that rely solely on the judgement of professionals or predetermined program criteria may be considered faulty... LHAs must be chosen from and by the communities they will serve (424).

The authors recommend partnering with community leaders to establish selection criteria, asking community leaders to recommend candidates, and inviting community leaders to participate in the final selection process.

This principle is embodied in what Parker et al. (1998) describe as the “reputational” method of recruitment. Under this method, community leaders or representatives of community agencies may be asked “Who do people in this community turn to for help and assistance?” Individuals whose names appear on more than one agency list may be invited to apply for the position of peer educator.

This method has proven effective in several projects; lay health workers were recruited to the *Comienzo Sano* program³⁰ in Arizona by gathering names from contacts in the community (Meister et al., 1992); lay health advisors were recruited to the *Charlotte REACH* project in North Carolina by asking for recommendations from neighbourhood associations (Plescia et al., 2008). In the recruitment of lay health educators for a smoking cessation program, the involvement of community leaders in developing the selection criteria, recruiting candidates, and making the final selection decisions not only resulted in the recruitment of effective lay educators, but also helped to raise the profile of and secure support for the program in the community (Lacey et al., 1991).

³⁰ Designed to facilitate prenatal education among low-income Hispanic women in migrant and seasonal farmworker communities.

7.0 TRAINING

This review did not identify the existence of standards or recommendations concerning the training of peer educators³¹. Several issues related to training however were identified in the literature, and are discussed in this section. They include the need to consider the objectives of the training, factors to consider in choosing or developing training materials and formats, the importance of training evaluations, and the benefits of ongoing training.

7.1 Training Objectives

The bulk of the literature on peer educator training focuses on developing the peer educators' knowledge of the subject matter; Jackson and Parks (1997) for example surveyed 87 African American lay health advisor programs in the US and found the training provided to lay health advisors emphasized disease-specific content, with little emphasis on interpersonal communication skills.

Notably, among programs providing interpersonal communication training, Jackson and Parks (1997) found that some attempted to cultivate "appropriate behaviour" and "professional etiquette" among peer educators. The authors caution against "professional imperialism" or efforts to 'professionalize' peer educators, because peer educators are effective precisely because they can interact with members of diverse communities in ways that are comfortable and familiar:

...the overall purpose of training is not to change LHAs or to have them "mimic" professionals. Rather, the training program should be designed to enhance LHAs' role of helping and advising others (422).

Alternatively, interpersonal skills training might focus on raising awareness of cultural diversity. Yu et al. (2007) report that lay health advisors working in the field of cancer screening with Asian Americans received cultural competency training because they were going to be working with clients of diverse backgrounds. Including cultural diversity training in peer educator training acknowledges the fact that even when students are of the same ethnocultural community, or when they have shared the experience of being an immigrant or refugee for example, they will not be a homogeneous group. Training in cultural competency can help peer educators become aware of the diversity that may exist in terms of health values, beliefs and practices within the student group.

Additional objectives of peer educator training may include behaviour change techniques and advocacy skills (Plescia et al., 2008). It is also important that peer educators be informed of the expectations concerning their role. For example, peer educators may receive training in how to manage questions and requests from students that are beyond the scope of the peer educator's role or that the educator feels uncomfortable or ill-equipped to address. For example, writing about *Comienzo Sano*, a peer educator program in prenatal care for low-income Hispanic women in migrant and seasonal farmworker communities in the U.S., Meister et al. (1992) found that:

³¹ An exception is the recommendations made by the World Health Organization for the training of breastfeeding counsellors (specifying that training should be at least 18 hours with an additional 3 hours of clinical experience; Rossman, 2007).

As teachers, the promotoras were often presented with problems for which they were not prepared. These primarily involved medical emergencies and access to prenatal care. When medical issues arose the promotoras were instructed to discuss the problem with the field coordinator before offering advice. The coordinator reminded the promotoras that they were neither physicians nor nurses and were not expected to have all the answers, especially answers to technical or clinical questions. Rather, they had access to clinical and technical expertise through the cooperating health professionals in the area (44).

The literature also suggests that the role of the peer educator often extends beyond teaching, as illustrated in the *Latino Health Advocacy Program* which:

...was designed to take a holistic and ecological approach to improving access to and utilization of health and human services. The Latino health advocates found this to be particularly important because they noted that the factors that affected individuals' lives were interconnected. Many community members needed a variety of services and resources, and lack of access to certain resources (e.g., phones and transportation) often affected access to and proper utilization of other resources (e.g., primary health care)... Moreover, access to and utilization of services required that agencies provide consistent and clear messages about the services they provide (Baker et al., 1997: 507).

The expectation that the peer educator will support students in various facets of their lives should be discussed, and if anticipated, peer educators should be prepared for this role during training (e.g. peer educators may be provided with information about resources etc.). Peer educators should also be prepared for a role beyond teaching that may emerge even if not part of the job description. Meister et al. (1992) for example found that lay health workers or promotoras who provided prenatal education to low-income Hispanic women living in migrant communities in Arizona became “lifelines” for participants:

Because of the extent of need of the participants and the commitment of the promotoras, it also became a family support system, focused on but not limited to issues of pregnancy and infancy. It is not surprising that the families of participants typically had multiple needs. The promotoras became a “lifeline” to many of the participants (43).

In short, peer educator training provides an opportunity to discuss the roles of the peer educator and to provide the necessary preparation for these roles. Though not an issue raised in the literature, peer educator training may also constitute a forum in which differences between role expectations held by program organizers and those held by peer educators can be discussed and negotiated.

7.2 Training Materials

As members of the ethnocultural communities they serve, peer educators often share culturally-embedded beliefs and values concerning health and health care. It is suggested in the literature that peer educator training materials, like the materials peer educators will deliver, should be culturally sensitive (Yu et al., 2007). Because peer educators often share the educational background common to the communities they serve, training materials should be linguistically appropriate, written at an appropriate literacy level, and avoid the use of medical terminology (Ibid.).

Who trains peer educators? Jackson and Parks (1997) reviewed the literature and found the primary trainers to be nurses, health educators, and program coordinators.

Training materials should be concise, given that peer educators likely have limited time (with other life obligations), and should be rich in content but easily comprehensible (for example, objectives and major points should be clearly highlighted; *Ibid.*).

Finally, it may be useful to have lay persons of the target community review and provide comments on the training materials, to ensure they are comprehensible for community members who will be trained as peer educators (*Ibid.*).

7.3 Training Formats

Multiple formats are often engaged in the training of peer educators; Yu et al. (2007) document the use of a combination of classroom and self-study methods, and Rhodes et al. (2007) reviewed a number of lay health advisor programs and found that:

[t]raining included increasing LHA level of knowledge using didactic techniques, skills practice through role playing, and ongoing evaluation and reinforcement to ensure adherence to the intervention. Training models included completing the entire training prior to beginning their work as LHAs... to ongoing training, further skills development, and booster sessions (419).

Baksi et al. (2008) recommend using the lesson plans that will be used by peer educators to structure the training. In this format, peer educators practice their delivery of the material and receive feedback from the trainer and fellow peer educators. Having peer educators work with the material they will be delivering to students has the added benefit of enabling peer educators to provide feedback on the material, such as the cultural relevance of the content (*Ibid.*).

7.4 Training Evaluation

It can be useful for program organizers to plan to evaluate the effectiveness of their peer educator training program; for example a pretest may be used to test peer educators' knowledge before the training and the results compared to those of a posttest conducted at the conclusion of the training (Yu et al., 2007). In addition to providing an indication of the effectiveness of the training for increasing peer educators' knowledge, evaluations can provide insight into the successes and challenges of the training program from the perspectives of peer educators themselves (*Ibid.*).

7.5 Ongoing Training

Many programs routinely offer seminars and workshops to peer educators (Yu et al., 2007; Jackson and Parks, 1997). The *Move More Diabetes Program*³² for example provides peer educators with optional monthly training sessions which provide an opportunity for additional skills development, but also provide peer educators with a support system (Richert et al., 2007). The *East Side Village Health Worker Partnership* in Detroit similarly provides lay health advisors with ongoing training and monthly meetings in which advisors gain additional knowledge but also share experiences and assist one another (Parker et al., 1998). Ongoing training and networking sessions can enhance morale and "should be a structured component of any [lay health advisor] program" (Plescia et al., 2008: 438).

³² This lay health educator program was designed to encourage persons with type 2 diabetes in a rural, economically depressed community in Maine, U.S. to increase their level of physical activity and improve their self-management skills (Richert et al., 2007).

Continuing education and support for peer educators may also help peer educators as they strive to model the positive health behaviors encouraged in the program. Plescia et al. (2008) found that lay health educators involved with the *Charlotte REACH* project (designed to create positive changes in attitudes and behaviours among mostly African American adults with cardiovascular disease and diabetes) were more effective as agents of change once they had internalized the health promotion messages themselves. In their words,

This experience suggests that the development of LHA programs should include efforts to initiate and support individual behaviour change among these important community change agents (438).

Continuing education opportunities, as well as individual support, may help facilitate and support peer educator behaviour change.

As mentioned, there is not an abundance of literature specifically addressing training for peer educators. However, the insights presented above may prove useful in designing the training component of peer educator programs. Another important component, program evaluation, is discussed next.

8.0 PROGRAM EVALUATION

8.1 Introduction

When appropriately designed, an evaluation can provide evidence of a program's effectiveness, facilitating program improvement and helping ensure funding and sustainability; an evaluation can also provide opportunities to build community capacity and may facilitate the sharing of information with organizers of similar programs (Schmid et al., 2006).

There is an extensive literature on evaluation and assessment in the field of health promotion; however, there are few proposals in the literature for the evaluation of health promotion initiatives targeting diverse populations, and fewer yet for eliciting feedback from culturally and linguistically diverse program participants. There is also a lack of consideration of evaluation methodologies within the peer educator literature itself; to the extent that evaluation is mentioned, it is often in the context of providing descriptions of evaluation techniques used to measure the efficacy of individual programs, without critical consideration of the effectiveness and appropriateness of the methods used.

A further limitation of the literature on peer educator program evaluation is the bias in current program evaluation toward quantifiable outcome measures and the use of 'traditional' qualitative methods (limited largely to focus groups and interviews) to garner feedback from program participants, neither of which may be optimal for evaluating programs that serve culturally and linguistically diverse populations (Cathexis Consulting, 2006). As a result, there are few documented examples of innovative evaluation approaches in the literature.

In this section, we examine various evaluation methods, including, to the extent available, methods considered to be particularly innovative, and summarize the recommendations provided by the literature for developing effective evaluation approaches for diverse populations. Because of the limitations of the literature this review is informed by publications in a variety of fields, including peer education, health promotion more broadly, and health and mental health literacy.

8.2 Common Evaluation Approaches

Three of the most common methods of evaluation identified in the peer educator literature are quantifiable outcome measurement, participation satisfaction measures, and feedback from peer educators. Each is discussed in this section, following which we explore some of the more innovative approaches in the evaluation literature.

8.2.1 Quantifiable outcome measures

One of the most common methods for evaluating health promotion initiatives, and peer educator programs in particular, is the use of a pre-test/post-test design measuring quantifiable changes in health status, health behaviours, and health knowledge (Gelmon et al., 2005; Taylor et al., 2000). Contento et al. (2002) for example surveyed the literature on nutrition education initiatives evaluated between 1980 and 1999, and found that the majority measured program success by changes in health status (serum lipids, blood pressure and physical fitness). Similarly, an evaluation of the *Community Dental Health Worker* program used the reduction in

dental caries in participating children, measured through a comparison of pre-intervention and post-intervention oral examinations, as an indicator of program success (Harrison and Wong, 2003).

8.2.2 Participant satisfaction measures

Health promotion program evaluation also frequently includes measures of participant satisfaction. Data is commonly garnered through focus groups, interviews or satisfaction questionnaires. However, because “clients can be satisfied with ineffective programs that are not meeting their goals” (Saunders et al., 1998: 294), measures of satisfaction should not be the sole method of program evaluation. Satisfaction ratings garnered through traditional methods of focus groups, interviews and questionnaires may also not be most appropriate for evaluating programs that serve diverse populations, as cultural norms of withholding criticism, particularly in such ‘public’ contexts as the focus group, may reduce the likelihood that these measures will capture honest or genuine perceptions of the program:

There is much evidence for the “yes-saying” tendencies in many ethnic groups, including Hispanics. It has been suggested that this tendency comes from a desire to show respect to people perceived as being in positions of authority. Included in this concept is the desire to show that the participant is behaving in the way they know the perceived authority wants them to behave (Taylor et al., 2000: 259).

8.2.3 Feedback from educators

Peer educator programs have been evaluated by soliciting feedback from peer educators. Yoshikawa et al. (2003) for example conducted focus groups with front-line HIV prevention peer educators in which participants were asked to share “success stories” as a method of determining ‘what worked’ and what did not. Again, however, the “yes-saying” effect may prevail, leading peer educators to emphasize the strengths of the program and the positive experiences of being a peer educator (Taylor et al., 2000).

8.3 Innovations in Program Evaluation

In addition to the evaluation methods already discussed, a small number of more innovative methods are identified in the literature and may prove promising for evaluating peer educator programs.

8.3.1 Creative approaches to knowledge testing

While evidence of knowledge change can provide an indication of the effectiveness of a peer educator program, the conventional method of pencil and paper testing before and after a program can be undesirable to culturally and linguistically diverse program participants. An evaluation of the *La Cocina Saludable* nutrition education program, for example, found that:

Many participants stated that they loved the classes, but hated the tests at the beginning and end. Their past educational experiences created a negative connotation for anything resembling a test (Taylor et al., 2000: 260).

In addition to having negative past experiences, conventional testing may be inappropriate for participations with low literacy. The participants of *La Cocina Saludable* suggested some innovative alternative approaches to conventional testing, including “discussing what they had

learned rather than taking a test on it, playing games to demonstrate what they had learned, or taking a “practical” cooking or meal preparation test” (Ibid). While these methods would not produce readily quantifiable data, by providing an opportunity for participant interaction and discussion, they may potentially provide a rich source of insight not only into what participants have learned, but into their overall program experience and possibly, areas in which further education is necessary or desired.

8.3.2 Reflective journaling

As a program evaluation approach, reflective journaling can “provide an opportunity for individuals to document their personal perspective on program activities, which may offer insights not likely to be captured by other methods” (Gelmon et al., 2005: 66). Both peer educators and program participants can participate in this method, recording personal reflections and observations on a regular basis, either ‘free-style’ or in response to general guided questions (Ibid.).

The reflective journaling method may be well suited for use by culturally and linguistically diverse program participants, as the method does not require literacy skills; reflections may be recorded with audio-recorders or digital video recorders and later transcribed³³. In addition, because participants are encouraged to record their perceptions on a regular basis, this method does not suffer from the recall bias that is typical of approaches that garner feedback at the completion of a program (Baker et al., 1997). Further, reflective journaling can take place at times and in locations that are comfortable for participants, which may enhance the likelihood that participants will feel comfortable providing both positive and negative feedback; the frequency and repetitive nature of this method may also facilitate participants’ level of comfort in providing feedback.

Gelmon et al.(2005) suggests journals be analyzed by evaluators for thematic content upon completion of the program; it could also be suggested that the authors of the journals participate in the evaluation/summary phase, reviewing their own collections of reflections and stories for pertinent insight into the quality of the program and suggesting recommendations for improvement. Whether analyzed by external evaluators or the ‘authors’ themselves, this method of evaluation may convey the message to participants that their input is valued, and may provide a ‘release’ for frustrations or difficulties encountered during the education sessions (Baker et al., 1997).

A sample of reflective journaling guidelines is provided in Appendix A.

8.3.3 Reflexive photo-participation

Various ‘reflexive photo-participation’ methods have been used in research with vulnerable populations, including photovoice³⁴, photo-narratives and photo-novella (Prosser and Loxley, 2008; Hurworth et al., 2005). Reflexive photo-participation involves showing participants photos that have been selected by the evaluators or researchers to provoke a response (photo-

³³ Lay health advisors in the *Latino Health Advocacy Program* in Massachusetts participated in the ongoing evaluation of the program by keeping written progress notes. When advisors found written notes too time-consuming, they were provided with tape recorders; oral notes were made immediately after and between teaching sessions and were transcribed and analyzed for concerns, successes and challenges (Baker et al, 1997).

³⁴ Photovoice was coined by Caroline Wang (University of Michigan School of Public Health) and Mary Ann Burris (Ford Foundation) and “is essentially a mode of inquiry that has as its primary objective the generation of social change through community action informed by research evidence” (Prosser and Loxley, 2008; no pagination).

elicitation method), or providing participants with disposable or digital cameras to take pictures illustrating their experiences. In either case, the photographs and participants' responses to them (positive and negative) as well as their meanings and interpretations serve as the basis for subsequent interview discussions (Hurworth et al., 2005).

Reflexive photo-participation is not well documented for use with program evaluation; however, the method was used in an educational program evaluation conducted by Tucker and Dempsey (1991, cited in Hurworth et al., 2005); evaluators took photographs of the education session every 20 minutes, and at the end of the session learners were shown the pictures and asked to provide comments. The photographs served as a useful launching point for discussing the learning experience.

One advantage of reflexive photo-participation as an evaluation method is that it can be highly participatory, and hence empowering, particularly when participants themselves are the photographers. As the photographers, participants are empowered to create narratives about experiences which *they* have found personally meaningful (Hurworth et al., 2005); when used as the basis for discussion in an interview, participants, rather than the evaluator, become the 'authorities' in the interview encounter (Prosser and Loxley, 2008). This approach is also advantageous because it uses a combination of visual and verbal languages, thereby reducing reliance on linguistic skills and potentially negating the need for written literacy skills altogether (Prosser and Loxley, 2008; Hurworth et al., 2005). The approach is further believed to facilitate the development of trust and rapport between participants and evaluators and, compared to conventional interview methods, can promote longer and more detailed interviews (Hurworth et al., 2005).

8.4 Additional Recommendations

8.4.1 Triangulation of data

The triangulation of data, or the use of multiple evaluation methods, contributes to the validity and credibility of the evaluation (Schmid et al., 2006), provides rich data, for example by ensuring a variety of perspectives are captured (Yoshikawa et al., 2003), and helps to ensure that the evaluation captures the complexity of the program under review (Canadian Public Health Association, 2004). With respect to the latter, for example, it is noted in the literature that adult literacy education is often evaluated with the use of participant attendance and drop-out rates, which fail to capture the lived experiences of participants:

Literacy programs are devalued when attendance drops. Although this is categorized as a motivational issue, the major factors affecting attendance are socioeconomic. Funding programs are not recognizing the complex issues surrounding the determinants of health. Literacy programs are not opposed to assessment and evaluation, but the criteria are not working. Evaluations should support the complexities of the work and the partnerships (Canadian Public Health Association, 2004: 23).

8.4.2 Participatory evaluation methods

The literature recommends the use of participatory methods when evaluating programs delivered to culturally and linguistically diverse populations (Canadian Alliance on Mental Illness and Mental Health; 2008; Akerman et al., 2007; Schmid et al., 2006; Yoshikawa et al., 2003; Naylor et al., 2002). Involving program participants as well as community stakeholders in the evaluation process can help ensure that they "feel respected, involved and treated as people

who do bring practical experience to the table” (Canadian Public Health Association, 2001: 38). Moreover, participant and stakeholder involvement enhances ‘ownership’ of the evaluation and hence the program, helps ensure that evaluations are culturally and linguistically appropriate (discussed below), and helps ensure that the interests of all stakeholders are addressed (Akerman et al., 2007; Schmid et al., 2006). Finally, participatory evaluation methods facilitate a more equitable distribution of power and knowledge between evaluators and participants (Prosser and Loxley, 2008).

8.4.3 Culturally and linguistically sensitive and appropriate feedback mechanisms

Perhaps most importantly, feedback from program participants and community stakeholders should be garnered using methods that are culturally and linguistically appropriate (Gelmon et al., 2005). The following recommendations are provided in the literature for enhancing the cultural and linguistic congruence of feedback mechanisms:

- Feedback from participants and/or community stakeholders should be solicited using methods that are congruent with the cultural values and preferences of participants (Gelmon et al., 2005); conducting focus groups for example may be inappropriate for some cultural groups, particularly when ‘public’ expression of emotion or negative opinion is considered culturally inappropriate (Cathexis Consulting, 2006).
- Communication styles should be congruent with those preferred by participants; for example, some cultural groups are more comfortable with oral communication than with written communication (Gelmon et al., 2005).
- To facilitate effective communication and enhance the comfort of participations, evaluations should be conducted in the first language of the participants; when this is not possible, participants should be provided with the services of a professional interpreter (Cathexis Consulting, 2006).
- Methods should be congruent with the literacy level of participants; the language of print or written materials used for garnering feedback should be kept simple and clear, sentences should be short, the use of jargon should be avoided, and illustrations should accompany print material (Cathexis Consulting, 2006; Atkinson, 2003; Contento et al., 2002). Evaluators should show respect for persons with limited literacy, and should look for clues that the participant may be having difficulty understanding because of limited literacy; when low literacy is suspected or known, evaluators should rely on face-to-face and oral methods of communication (Canadian Council on Learning, 2006).
- Individuals conducting the evaluation should be persons with whom program participants feel comfortable and feel they can share personal information (Gelmon et al., 2005).
- To help overcome the ‘yes-saying’ tendency of some cultural groups, it is suggested that questions intended to garner feedback be constructed so that the intent of the question is more subtle (e.g. avoid direct questioning; Taylor et al., 2000).

8.5 Program Evaluation as a Measure of Organizational Diversity Competence

Though not stated in the peer educator literature, an earlier literature review conducted for Alberta Health Services - Calgary identified the importance of program evaluation in measuring organizational cultural competency (Arnold and de Peuter, 2008). It can be argued that evaluations of specific initiatives meant to contribute to the cultural competency of a health care organization, such as a peer educator initiative, when combined with evaluations of other

programs, can serve as an indicator of the overall cultural competency of the organization. Evaluations of peer educator programs, therefore, might be designed, in part, around the following areas of inquiry:

- To what extent has the program contributed to a reduction of health disparities among the target population?
- How did participants perceive the attitudes of peer educators and other members of the health care team, and the environment? To what extent were the attitudes and environments welcoming and respectful of diversity?
- To what extent was the program developed, implemented and evaluated in consultation or collaboration with key stakeholders, including members of the target community?
- To what extent were health education and promotion materials appropriate for, relevant to, and accessible by the target population?

In this way, evaluations of individual programs can contribute to the overall measure of the organization's cultural competency.

The literature reviewed to this point has provided a description of the peer educator model and an explanation for its effectiveness, has described the outcomes of peer education, and has provided insight into the development, implementation and evaluation of peer educator programs. Before concluding the report and presenting recommendations, we briefly identify, in the next section, some of the challenges associated with the peer educator model.

9.0 CHALLENGES

9.1 Staying True to the Sociocultural Model

One of the reasons the peer educator model is effective is because it is based on what Meister et al. (1992) refer to as a sociocultural model and as such, constitutes an alternative to the biomedical model of health and health care. There is a danger, however, that the peer-led intervention may over time come to reflect the biomedical model, as was the case with the *Comienzo Sano* program:

When the demonstration ended and the project was integrated into the county health department, both the philosophy and curriculum of Comienzo Sano were directed more toward the biomedical model of prenatal risk assessment and medical intervention. This resulted in conflict. While the promotoras expressed concern that the curriculum was becoming less relevant to the program participants, they themselves felt empowered by their control of new medical information. And with increased value placed on the medical model, resentment developed among some staff over having lay teachers rather than nurses presenting the information... A major lesson learned from the project is that continuous oversight is necessary to preserve the uniqueness of the sociocultural approach as well as to preserve program elements, such as advocacy, that are non-medical or extra-medical in nature. Programs designed to be culturally sensitive require administrative environments that will nurture and protect these program goals (Ibid.: 48-49).

Auger and Verbiest (2007) make a similar point about preserving the sociocultural qualities of peer-led education:

Lay health educators' primary allegiance is to their communities and social networks. This is a critical element and must be both respected and maintained by programs (334).

Awareness of the potential for peer educator programs to lose their sociocultural advantages should be cultivated among organizers, particularly as programs become well-accepted and well-integrated into the system of health care delivery.

9.2 The Professionalization of Peer Educators

Just as the peer educator model may be at risk for assimilation into the mainstream, biomedical model of health care, so too are peer educators at risk for losing some of the essential qualities that make peer-led education so successful. Taylor et al. (2001) describe this as the paradox of the peer educator model. Simply put, peer educators are effective because they have an authentic relationship with the community served; at the same time, as the peer educator becomes more skilled and gains status in the community and develops stronger ties with the sponsoring organization, he or she may become isolated from their community. In the words of Taylor et al. (2001):

Empowerment can be defined as the degree to which the peer educator is given responsibility and authority to perform his or her duties in the program. Strict guidelines placed on the educators may limit the important advantages of the relationship to the target audience. Less strict guidelines offer benefits of greater use of the peers understanding of the target population but may pose other problems. For example, in a program involving

prenatal education for migrant farm workers, it was found that empowerment of lay educators had benefits of increased self-esteem and sense of efficacy. The educators began to see themselves as experts in the topic areas and wanted to learn more information. The downside of empowerment included isolation from the targeted audiences now that they had increased their own standing in the community and strengthened their ties to the sponsoring agency (285).

Neither challenge discussed in this section has been 'resolved' in the literature, but by being aware of the importance of preserving the essential components of the peer educator model and the essential qualities of peer educators, program organizers can perhaps intervene when either appears to be threatened.

10.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

10.1 Summary and Conclusions

10.1.1 Summary

The population served by Alberta Health Services - Calgary is ethnically and culturally diverse, necessitating the development, implementation and evaluation of innovative health strategies. Health disparities among newcomers to Canada, as well as negative post-immigration experiences and barriers to health care, further contribute to the need for culturally-appropriate health strategies.

In this paper we examined one such strategy: the peer educator model of health promotion. We reviewed variants of the peer educator model, the scope of duties of peer educators, and the applications of the model in historical and current contexts. The effectiveness of the model was examined and attributed to the embeddedness of peer educator programs in the cultural and social networks of target communities and the efficacy of peer educators was attributed to their being 'cultural insiders,' and trusted, respected and credible members of their community. Research evidence was presented supporting the premise that peer educators are as effective as professional health care workers in delivering educational material to diverse, and often underserved, populations.

Benefits of peer education to participants were found to include the acquisition of culturally-relevant health-related information and potentially a shift toward acceptance of more positive social norms; increased linkages to health services; and potentially, social support and a sense of belonging. Benefits to communities were identified as increased community capacity and the ability to influence the provision of health care that is culturally sensitive and appropriate. Benefits to peer educators were found to include skill development and experience that can facilitate future employment, and intrinsic rewards of increased self-confidence, personal empowerment, and a sense of satisfaction.

The report then shifted to an examination of the literature on the 'logistics' of the peer educator model. Specifically, we looked at program development, and found recommendations for including members of the target community in the planning and implementation of peer educator programs, for conducting community needs assessment in the development of the course content, and ensuring course materials are congruent with the literacy, and health literacy, levels of the participants. The literature suggested the importance of delineating the responsibilities of peer educators, and ensuring that peer educators are not 'overloaded' with administrative responsibilities. It was found that peer educators with more formalized roles are more likely to receive remuneration, and that remuneration can communicate the message that peer educators are valued and can help raise the status of the peer educator in the community. Job satisfaction of peer educators was identified as an under-researched area, though some studies acknowledge its importance and emphasize the need for peer educators and program organizers to communicate honestly and as equals.

Recruitment and training issues were discussed in subsequent sections. With respect to recruitment, desired characteristics of peer educators were identified as including shared experiences, the ability to model the desired behaviour, personal characteristics such as an enthusiasm for helping others, and ties to and knowledge of the target community. Methods of

recruitment were discussed, with an emphasis on the reputational model of recruitment. Issues identified in the literature on peer educator training included the danger of 'professional imperialism' and the benefits of providing peer educators with cultural competency training, as well as other skills training, such as behaviour change techniques and advocacy skills. Training sessions were also identified as an appropriate forum for discussing role expectations and ensuring peer educators are equipped to manage requests for assistance that transcend role boundaries. Qualities of effective training materials and formats as well as the need to conduct evaluations of peer educator training were discussed, and the section concluded with the recommendation that peer educators be provided with opportunities for continuing education and networking.

In the section on program 'logistics,' we identified characteristics of strong evaluation tools, and reviewed common methods of evaluating the effectiveness of peer educator programs, including measures of behaviour and knowledge change and participant satisfaction. The importance of garnering feedback from peer educators and methods of doing so were presented, and the section concluded with a look at how the evaluation of the peer educator program can contribute to the overall measure of the organization's cultural competency.

The paper concluded with a brief look at two of the challenges facing the peer educator model: losing the essence of the sociocultural model as the program becomes more closely aligned with mainstream health care services and the biomedical model of health; and the professionalization of the peer educator and the paradox this presents.

10.1.2 Conclusions

From this review it is possible to conclude that the peer educator model exemplifies many of the characteristics associated with 'best practices' in diversity or culturally competent health care³⁵.

Specifically, implementing and adequately supporting peer education signifies that the organization understands and appreciates the importance of providing health promotion that is appropriate and effective for diverse populations, and signifies a commitment on behalf of the organization to reduce health disparities among underserved populations. By implementing the peer educator model, the organization demonstrates its commitment to the idea that consumers, key stakeholders, and diverse communities should be involved in developing programs, a key principle of diversity competency. By employing community members as peer educators, the organization shows its commitment to developing a workforce that is representative of the populations it serves.

The peer educator model also embodies a number of diversity competence best practices at the level of service delivery, including the provision of an environment that is inclusive and welcoming of diverse populations, and one that reflects the values and beliefs of the communities served; the reduction of language barriers through the engagement of language-congruent peer educators; the provision of health promotion materials that are aligned with the norms of the target population; and the empowerment of clients through their active participation in their health care.

The peer educator model also has the potential to contribute to the cultivation of diversity or cultural competency within the health care organization. For instance, as a link between the

³⁵ For a review of best practices in diversity competent health care the reader is referred to Arnold and de Peuter (2008).

health care organization and the community, the peer educator has the potential to educate the organization about the community's perspectives on health and health care.

The current literature on the peer educator model, in conclusion, clearly demonstrates the benefits and effectiveness of the model, and is beginning to articulate recommendations with respect to program development, implementation and evaluation. Despite gaps in the existing literature, it is possible to conclude that the peer education model should be considered by health care organizations as a culturally appropriate method of health promotion in diverse ethnocultural communities.

10.2 Recommendations

The insights generated by this review of literature may serve as a basis for recommendations for the development, implementation and evaluation of peer educator initiatives. Recommendations are provided below in the areas of program development, peer educator recruitment and training, and program evaluation.

10.2.1 Recommendations for program development

1. The literature recommends peer educator programs be developed, implemented and evaluated in collaboration with the target community. During the initial stages of developing a peer educator program for refugees for example organizers would be encouraged to request the participation of representatives of community based refugee-serving agencies. A 'snowball' technique could then be used in which representatives identify other members of the community who would be well positioned to contribute to the development of a culturally and linguistically appropriate peer educator program.
2. Course content should be driven by the needs of the target population; content should include that deemed necessary and appropriate by health care professionals, but also by members of the target community. Community representatives participating in the development of the program (identified above) will likely have knowledge of the learning needs of the target population and should be invited to provide input to course content. In addition, organizers may wish to conduct interviews or focus groups with additional community members who would serve as 'key informants,' and once selected, the peer educator should also be invited to review the course content as a further 'check' on the relevancy of the material.
3. Course content should also be culturally appropriate. Again, representatives of the community, including organizers, key informants, and the peer educator should be provided opportunities to review the material to ensure it is congruent with the cultural norms and values of the target group.
4. Peer education is normally delivered in the first language of participants. Course materials should be developed in the language of the target community and if participants will be from diverse language backgrounds written materials in a variety of languages should be available. If English language materials are used, they should be professionally translated into the first language of participants and validated through review by members of the target community.
5. Materials delivered in written and oral formats should be designed at low literacy and health literacy levels, avoiding long sentences, using simple language, and making

generous use of illustrations. Materials developed for use by the peer educator (e.g. curriculum guide) should also be written at a low literacy and health literacy level.

6. Program development should include consideration of the roles and responsibilities of the peer educator. Organizers will need to decide, for example, whether the peer educator will be responsible for recruiting participants, keeping track of participation and drop-out rates, and so on. The literature identifies 'overloading' peer educators with administrative duties as a factor contributing to poor job satisfaction, and organizers should therefore keep administrative responsibilities to a minimum. A written statement of roles and responsibilities should be created and reviewed with the peer educator.
7. Remuneration conveys the value of the peer educator and contributes to the peer educator's credibility in the community and among health care professionals. Peer educators should be considered health care paraprofessionals and compensated accordingly. Additional 'perks' such as access to services or invitations to participate in training opportunities of interest can further facilitate peer educator job satisfaction and should be considered during the development of the program.
8. Poor rapport between peer educators and health care staff is documented in the literature as a source of job dissatisfaction among peer educators. It is recommended that peer educators and the staff with whom they will work be provided with opportunities to work together during the development of the program, with staff members being mindful of the importance of respecting and valuing the contributions of the peer educator. Viewing the peer educator as an 'expert' on the target population will help ensure that their input is sought and valued.
9. During the development of the program consideration should be given to the available and appropriate channels of communication through which the peer educator may express any concerns or problems during the course of their work. It should not be assumed that the peer educator will feel comfortable discussing problems or concerns with persons of authority (e.g. those overseeing the program). It may be more appropriate to designate a community member participating in the development of the program to act as a 'liaison.'

10.2.2 Recommendations for recruitment of peer educators

1. The criteria used for selecting a peer educator should reflect the qualities that are considered important for a peer educator to be effective. These include the following:
 - a. The candidate should have existing ties to the target population and be knowledgeable about the population's health beliefs and practices;
 - b. The candidate should be experientially similar to the target population. For example, a peer educator working with refugees should herself be a refugee; a peer educator working in the area of parent education should herself be a parent;
 - c. The candidate should model the desired outcome behaviours. For example, an educator in the field of tobacco reduction should be a non-smoker;
 - d. The candidate should demonstrate enthusiasm for helping others and if possible should have a reputation in the community as a 'natural helper;' and
 - e. The candidate should be bilingual and demonstrate strong communication skills.

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2. The literature recommends partnering with community leaders to develop the selection criteria (keeping in mind the recommendations for selection criteria above), asking community leaders to recommend candidates (e.g. by asking “Who do people in this community turn to for help and assistance?”), and inviting community leaders to participate in the final selection process.
 3. Additional recruitment methods may include advertisements in local media, word of mouth, and distribution of flyers by community organizations, and asking previously trained peer educators for recommendations.

10.2.3 Recommendations for peer educator training

1. Broadly, training should emphasize developing the peer educator’s knowledge of the subject matter over the cultivation of teaching skills. It is important that the peer educator interact with participants in ways that are comfortable and familiar, and an overemphasis on teaching skills runs the risk of ‘professionalizing’ the educator to the extent that they are less able to interact ‘authentically’ with participants.
2. In addition to knowledge of the subject matter, training should provide peer educators with an opportunity to cultivate cultural awareness; such training can sensitize the peer educator to the diversity that may exist in terms of health values, beliefs and practices within the student group and will help minimize the risk that the educator will make assumptions based on generalizations or stereotypes.
3. Peer educators should receive training in how to manage questions and requests from students that are beyond the scope of the peer educator’s role or that the educator feels uncomfortable or ill-equipped to address. They should also be informed of the scope of their responsibility for dealing with such issues (as identified in the written statement of roles and responsibilities, above), and should receive information on the available channels of communication for garnering assistance with difficult issues.
4. Peer educator training may also include information on additional services and supports available to program participants, so that this information may be communicated to students as needs arise.
5. The materials used in the training session should be culturally appropriate and may be reviewed by key informants in the community for appropriateness prior to their use.
6. The materials used in the training session should be written at a low literacy and health literacy level, avoiding the use of long sentences, using clear language, and incorporating illustrations.
7. Training materials should be concise, rich in content but easily comprehensible; for example, learning objectives and major points should be clearly highlighted.
8. Training should be structured around the course curriculum and peer educators should be provided with opportunities to practice their delivery of the material and receive feedback from the trainer and fellow peer educators. Having peer educators work with the material they will be delivering to students has the added benefit of enabling peer educators to provide feedback on the material, such as the cultural relevance of the content (Ibid.).

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9. Peer educators should have an opportunity to provide feedback about the training and feedback should be used to improve future training sessions.
 10. Ongoing training and support should be made available to peer educators.

10.2.4 Recommendations for program evaluation

1. To gauge the success of the peer educator program in improving students' knowledge of the topic at hand, it is recommended that conventional testing methods (e.g. multiple choice pre- and post-tests) be replaced by methods that are more comfortable and familiar to students, such as exercises in which students demonstrate their knowledge or group discussions about what students have learned.
2. Direct questioning of students and educators about their experiences with the program is subject to a 'yes-saying' tendency. Rather than ask students and peer educators for feedback through conventional means (focus groups; interviews) it is recommended that indirect methods of garnering feedback be used, such as reflective journaling or reflexive photo-participation.
3. Program evaluations should use multiple methods and gain insight into the experiences of multiple stakeholders, including students, peer educators, program organizers, and community members.
4. Program evaluation should be participatory, involving stakeholders (students, peer educators, program organizers and community members) in the evaluation development, delivery and analysis.
5. Evaluations should be conducted in the first language of participants and should use written and oral materials that are culturally congruent and designed for low literacy and low health literacy populations.
6. Evaluations should be conducted to individuals with whom program participants and peer educators feel comfortable sharing personal information. While the literature does not provide guidance regarding whether peer educators themselves should conduct evaluations, having an individual or individuals not closely associated with the program conduct the evaluation might be preferred, as this can minimize the tendency of participants providing only positive feedback for fear of offending those with a generous stake in the success of the program.

APPENDIX A: REFLECTIVE JOURNALING GUIDELINES SAMPLE

(Source: Gelmon et al., 2005: 67)

Reflective Journaling Guidelines for the WIN Nursing Transition Program

Reflective journaling provides a way for you to record your thoughts, feelings and reactions to your learning. It will also be a valuable piece of your clinical experience later on. Reflective journaling gives you an opportunity to share your thoughts, concerns, successes, and frustrations with your instructor and receive feedback on a regular basis.

Guidelines for Journaling

- Journaling will be done weekly.
- Journals are due to the instructor at 2 pm on Wednesdays and will be returned to you at 7pm on Thursdays.
- Journals may be handwritten, typed or e-mailed.
- Journals will only be read by your instructors.

Contents of Journal Entries

1. What has been the most valuable learning for you in the past week?
2. What has caused you confusion or been difficult to understand? What can/did you do to get clarification?
3. Describe a personal strength or something that you feel you are doing well now related to the WIN Nursing Transition Program.
4. What are you struggling with most right now (personally or related to learning)? What can/did you do about this?
5. Describe your level of comfort with the classroom discussions. (This may include your understanding of English, your instructors' or classmates' speech, your ability to communicate the way you would like in English, etc.)

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