Parent peer education: Lessons learned from a community-based initiative for teen pregnancy prevention

Heidi Hauser Green, M.S., M.L.I.S.\textsuperscript{a,*}, Patricia I. Documét, M.D., Dr.P.H.\textsuperscript{b}

\textsuperscript{a}Family Health Council, Inc., Pittsburgh, Pennsylvania
\textsuperscript{b}Department of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania

Abstract

Purpose: The Parent Peer Education program addresses a community-identified need to increase parent-child communication about sexuality, teen pregnancy prevention, and related issues. Community members are trained to lead workshops of peers on how to talk with their children about these topics.

Methods: The program was pilot tested in 1997; three waves of workshops were conducted by 35 parent peer educators for 721 community residents between 1999 and 2002. They focused on providing information, increasing participants’ comfort in discussing sexuality, and demonstrating how to use age-appropriate guidebooks. The evaluation used a pre- and post- workshop design. All participants completed a survey before the workshop, and a random sample of 25% responded to a telephone follow-up survey four weeks later. In addition, before the first wave, a random sample telephone survey was conducted of 104 parents in the community. Parent peer educators completed surveys after their training and each workshop.

Results: After the workshop, participants were more likely to feel comfortable talking with their children about sexuality-related issues, talk to their children about these issues, discuss multiple topics, recognize the importance of talking with children at an early age, and use the provided guidebooks. Parent peer educators found their training valuable and enjoyed involvement in the program. Lessons learned include strategies for improving program implementation, improving program evaluation, and involving the community.

Conclusions: This program is a promising, low-cost, community-based method of promoting parent-child communication, an important element of teen pregnancy prevention. © 2005 Society for Adolescent Medicine. All rights reserved.

Keywords: Peer education; Parent-child communication; Community-based education; Teen pregnancy prevention; Health education

Parents play a prominent role in their children’s health decisions, including those related to sexual behaviors. Studies suggest that parental involvement and communication can promote healthy behaviors, thus preventing teen pregnancy, human immunodeficiency virus (HIV), and other sexually transmitted diseases [1–5]. Teens themselves recognize the importance of parental guidance. In response to surveys conducted by the National Campaign to Prevent Teen Pregnancy, teens reported that their parents have more influence on their sexual decision-making than their friends, siblings, educators, or the media [6]. Recent studies suggest that parents may have more impact on adolescents’ sexual behavior than do teen peers [7–9] and that parent-teen communication about sexual issues may have a protective effect that extends into the adolescents’ college years [10,11]. Furthermore, to have the greatest impact on sex-related behavior, parental communication with children about sexuality should take place sooner rather than later [12,13].

Studies also suggest that parents can be taught how to communicate with their children about these subjects [9,14–16]. Worthwhile methods of community-level health

\textsuperscript{*}Address correspondence to: Heidi Green, M.S., M.L.I.S., Family Health Council, 960 Penn Avenue, Suite 600, Pittsburgh, PA 15222.
E-mail: heidigreen100@yahoo.com
education involve community members who receive training and then share health information with other community members [17,18]. Parents, in particular, may be effective peer educators [19]. Bennett et al found that parents can successfully deliver information about teen health, sexual behavior, and HIV prevention to other parents [19].

This article describes findings and lessons learned from a program to train parents as parent peer educators who teach their peers about how to enhance parent-child communication and how to talk with their children about sexuality.

**Purpose**

The Parent Peer Education (PPE) program was developed and tested in Allegheny County, Pennsylvania as part of the Community Coalition Partnerships Program for the Prevention of Teen Pregnancy. It exemplifies a successful collaboration among the hub agency, the Family Health Council (FHC), community members, and service providers to meet a community-identified need to increase parent-child communication on issues related to sexuality and teen pregnancy prevention.

The PPE program was initiated in response to findings from a community-wide needs and assets assessment conducted during Phase One of the Prevention of Teen Pregnancy project. Findings from the assessment were based on key informant interviews with 49 adults from neighborhoods in the community, 16 community service providers, and 12 teen focus groups. These findings indicated that increased parent-child communication was a concern in all neighborhoods and that community members felt that meeting this need could reduce teen pregnancy. Community members also stressed that communication should begin at an early age and continue throughout childhood. The hub agency’s teen pregnancy prevention coalition members identified this program as a priority.

In the PPE program, members of the community are trained as parent peer educators to lead interactive workshops with parents and caregivers in their neighborhood on how to talk with their children about sexuality with the use of age-appropriate guidebooks for factual reference. This program sought to apply peer education strategies to promote parent-child communication and prevent teen pregnancy. Specifically, the PPE program had the following goals:

- Provide community members with skills to conduct parent communication workshops on sexuality and sexual decision-making.
- Provide parents and caregivers with skills and materials to help them communicate more comfortably with their children about sexuality and sexual decision-making.
- Encourage parents and caregivers to begin communication about sexuality-related issues well before their children reach puberty.

**Methods**

**Sample**

The program was pilot-tested in 1997 (Table 1). During pilot testing, 119 parents and caregivers participated in nine workshops. Because of substantial differences in the evaluation protocol, data from the pilot test have not been included in our analysis. However, findings from the pilot test did inform the development of the program and are included, on a limited basis, in the Discussion section of this article.

Between May 1999 and April 2002, some 602 parents and caregivers participated in three waves of community workshops conducted by 26 parent peer educators. Both the parent peer educators and the workshop participants were recruited from seven low-income communities of Allegheny County, Pennsylvania. Criteria for inclusion in the PPE program as either a parent peer educator or a workshop participant were being an adult, being a parent or caregiver, and residing in a program community. From 1997 through 2000, four communities were identified as “program communities.” As a result of the strong interest in the program among coalition members and community members, three additional communities were added during Wave 3 in 2002. Because parent peer educators would enlist workshop participants through their social networks, they were recruited to represent a broad range of people in the communities and varied on characteristics such as age, age of their children, education, and socioeconomic status. Most of the workshop participants (82.9%) were female.

Both parent peer educators and community workshop participants received compensation for participating in the PPE program. Parent peer educators received cash stipends or mall gift certificates for their training and for each workshop they conducted. Workshop participants received gift vouchers for a grocery store chain and a set of *Family Connections* guidebooks.

**Program design**

The Institutional Review Board at the University of Pittsburgh approved the protocol and questionnaires.

Before the first wave of workshops, a baseline community assessment was conducted with a random sample of approximately 3% of the parents and caregivers with children aged 18 years or younger who lived in the targeted community. This survey was intended to examine the extent to which the workshop participants might differ systematically from community members with respect to concern and willingness to talk about issues related to teen pregnancy.
This survey was not repeated before subsequent waves of workshops.

During the pilot testing of the PPE program, with endorsement of the project’s central community coalition and with IRB approval, the hub agency partnered with a countrywide service provider, the Health Education Center. In this partnership, the Center’s lay health advisor approach to providing community education was combined with the FHC’s previously developed set of guidebooks for helping parents talk to their children about sexuality issues. Residents of the communities that the Center serves were recruited and trained to work in educational programs teaching healthy lifestyle skills to their neighbors.

The guidebooks, *Family Connections*, comprise a series of three parent-friendly resources developed by the staff of the FHC’s Center for Adolescent Pregnancy Prevention under the guidance of a community-based advisory committee representing schools, media, youth, civic groups, and government. Each guidebook is tailored to meet the specific needs of parents raising children at different developmental stages, from birth to seven years old, from eight to 13 years old, and from 14 to 18 years old. Before the PPE program, the guidebooks had been publicized through a media campaign and made available to parents and service providers at no cost. In this program, parent peer educators used the *Family Connections* guides to assist parents in talking with their children of all ages about sexuality.

During Waves 2 and 3 of the project, FHC was primarily responsible for the recruitment and training of parent peer educators. Community partnerships, with both residents and service providers, remained important to this process. Coalition members provided support and encouragement for expanding the PPE program into additional neighborhoods. Local service providers assisted in recruiting parent peer educators and provided space for workshops. Community members’ involvement as parent peer educators was essential to program implementation, both in facilitating workshops and in conducting outreach.

In each community that received the intervention, six to 10 residents were recruited to be parent peer educators through local service providers, flyers, and word of mouth. They received eight hours of training from FHC staff on topics such as puberty, contraceptives, communication, decision-making, and how to use *Family Connections* guidebooks as a teaching and reference aid.

After completing the training, the parent peer educators arranged and conducted workshops in their communities. They invited friends, neighbors, and other acquaintances to participate in two- to three-hour parent peer workshops. Some recruited workshop attendees through flyers distributed in the communities. Workshops typically included between six and 12 participants. The workshops focused on providing information, increasing participants’ comfort discussing sexuality, and using the guidebooks.
Evaluation instruments

Baseline community assessment
As discussed in the Methods section, before the first wave of workshops, a random telephone survey was conducted of 104 parents and caregivers with children aged 18 years or younger in the targeted community. The survey document was similar to the pre-workshop survey completed by workshop participants, described below.

Workshop participant evaluation
The evaluation used a pre- and post-workshop design. All workshop participants completed a survey before the beginning of the workshop, and a random sample responded to a telephone follow-up survey four to six weeks later. Owing to budget constraints, the sample size of the post-workshop survey was limited to approximately 25% of participants.

The questionnaires were designed to collect information about participants’ perceptions of health issues related to youth, their ability to communicate with their children about health topics, and their familiarity with the Family Connections guidebooks. Demographic data such as zip code, gender, and ages of children were collected. Contact information was collected on the workshop sign-in sheets. All participants signed informed consent forms before completing the questionnaires.

Pre-workshop survey
The 19-item pre-workshop survey focused mainly on the participants’ past communication about health issues with their children and included their perceptions of the seriousness of health issues affecting children and teens. For comparison, questions were also asked about their ability to discuss smoking with their children. To elicit information that might be helpful in future program planning, an open-ended question was included: “What do you think would make it easier for people to talk with their children about sexuality-related issues?”

Post-workshop survey
The 26-item post-workshop survey was administered by phone to a random sample of workshop participants. In addition to items from the pre-workshop survey, it included items about respondents’ communication with their children and use of the Family Connections guidebooks since attending the workshop. Additional open-ended questions asked respondents about the helpfulness of the workshop and the guidebooks.

Parent peer educator evaluations
Parent peer educators completed surveys after their training and the workshops they conducted. These surveys, initiated in Wave 2 and continued in Wave 3, were designed to evaluate their training, assess feelings of preparedness, and gather information relevant to program improvement.

Post-training survey
The 15-item, post-training survey included questions about the elements of the training and respondents’ feelings of preparedness to talk about training topics. Additional questions assessed general satisfaction with the training and collected information to assist in program improvements.

Post-workshop surveys
A 12-item survey was completed after the parent peer educator’s first workshop. It collected feedback about the workshop, as well as the participants’ feelings of preparedness, and measured how well they felt their training had prepared them to conduct a workshop. A 13-item survey completed by the parent peer educators after a second or subsequent workshop collected information such as level of discussion and engagement of participants in the workshop.

Informal assessment
The program was also informally assessed during debriefing sessions. Program and evaluation staff met to reflect on program progress and evaluation. In addition, program staff met with parent peer educators regularly to assess and respond to their concerns about the program. Feedback and additional resources were provided on an as-needed basis.

Data analysis
Data were entered, transformed, and analyzed with use of the Statistical Package for the Social Sciences (SPSS; SPSS Inc., Chicago, IL). Results of statistical tests were considered significant if the $p$ value was $< .05$. Chi-square tests of homogeneity were used to compare responses from the community sample with those of participants pre-workshop. A $t$-test was used to find out whether there was a difference between community members and participants at pre-workshop in the number of issues discussed during their last conversation about sexuality-related issues.

McNemar chi-square was used to compare program participants’ paired data from the pre-workshop and post-workshop surveys. Data from Waves 1, 2, and 3 of the program were pooled, yielding a total of 136 matched pairs. Pooling the data posed some challenges, as the wording of three questions was changed between waves of the program. One question was removed from analysis because the change proved to be significant. The remaining two questions, about level of comfort in talking with children about sexuality-related issues, used a four-point scale in the first wave of the program and a five-point scale in subsequent waves. Results from these questions were dichotomized for analysis.

Pilot test data were descriptive and were used to inform subsequent program and evaluation planning. Likewise, parent peer educator evaluation data were descriptive and were used primarily for program development.
Results of the community survey at baseline show that workshop participants at the pre-workshop survey were more concerned about teen pregnancy than parents in the community at large (Table 2). However, they were not more comfortable answering questions from or holding conversations with their children about issues related to sexuality or teen pregnancy. By comparison, the participants did not differ from the general community regarding concern about smoking, another important health issue facing teens.

Comparison of results from the pre- and post-workshop surveys indicates that the PPE program effectively met its stated objectives (Table 3). After attending a workshop, participants were significantly more likely to feel comfortable talking with their children about sexuality-related issues. Almost 90% reported being comfortable answering their children’s questions related to sexuality, an increase of nearly 25% over the pre-workshop survey (67.0%). In addition, they were significantly more likely to have talked to their children about these issues and to have discussed multiple sexuality-related topics when they did. Nearly 64% of participants reported having talked to their children about these issues, and about three-quarters of those reported having addressed multiple issues. Parents who attended the workshop were significantly more likely to have used the Family Connections guidebooks. About 85% of parents reported having used the guidebooks when surveyed four to six weeks after attending the workshop, compared with about 28% before the workshop.

Findings from the post-training and post-workshop surveys completed by the parent peer educators showed that they felt they benefited from the training they received. They believed that it was valuable and that it met their expectations. This positive feedback continued even after they conducted a workshop, with nearly all reporting feeling “very well” or “well” prepared. Most felt that their workshops were successful and that the participants were concerned about the issues. In addition, they reported being glad to learn how to conduct the workshops and having enjoyed doing it. Their participation made

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Comparison between community members’ and participants’ responses at preworkshop, wave 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic</td>
<td>Community (%)</td>
</tr>
<tr>
<td>Spontaneously mentioned smoking as one of the five first serious issues</td>
<td>14.4</td>
</tr>
<tr>
<td>Spontaneously mentioned teen pregnancy as one of the five first serious issues</td>
<td>8.7</td>
</tr>
<tr>
<td>Very comfortable/comfortable in answering questions about it</td>
<td>91.2</td>
</tr>
<tr>
<td>Very comfortable/comfortable in initiating conversations about it</td>
<td>83.2</td>
</tr>
<tr>
<td>Has the parent initiated a discussion teen pregnancy?</td>
<td>67.0</td>
</tr>
<tr>
<td>Three or more issues were talked about the last time they discussed teen pregnancy</td>
<td>22.1</td>
</tr>
</tbody>
</table>

* Indicates a statistically significant difference ($p < .05$) in chi-square test of homogeneity, with one degree of freedom.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Combined results of waves 1, 2, and 3 of PPE program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of matched pairs</td>
<td>Preworkshop (%)</td>
</tr>
<tr>
<td>Seriousness of teen pregnancy</td>
<td></td>
</tr>
<tr>
<td>Spontaneously mentioned it as one of the five most serious health problems facing teens in the community</td>
<td>136</td>
</tr>
<tr>
<td>Consider it to be a “very serious” problem</td>
<td>132</td>
</tr>
<tr>
<td>Comfort talking about sexuality-related issues</td>
<td></td>
</tr>
<tr>
<td>Very comfortable/comfortable answering questions</td>
<td>114</td>
</tr>
<tr>
<td>Very comfortable/comfortable initiating conversations</td>
<td>115</td>
</tr>
<tr>
<td>Talking about sexuality-related issues</td>
<td></td>
</tr>
<tr>
<td>Has ever discussed sexuality-related issues with the child</td>
<td>127</td>
</tr>
<tr>
<td>Parent considers child too young for questions about sexuality to be answered</td>
<td>131</td>
</tr>
<tr>
<td>Two or more issues talked about last time they had a conversation about sexuality-related issues</td>
<td>136</td>
</tr>
<tr>
<td>Use of Family Connections guidebooks</td>
<td></td>
</tr>
<tr>
<td>Has used the Family Connections guidebooks</td>
<td>136</td>
</tr>
</tbody>
</table>

* Indicates a statistically significant difference ($p < .05$) in McNemar chi-square test, with one degree of freedom.

b Comfort scales were not exactly the same. In wave 1, a 4-point scale was used; in waves 2 and 3, a 5-point scale was used.
them feel proud and helpful. Several expressed their interest in acting as parent peer educators again, and some expressed concern about other health issues affecting their communities.

Discussion

The data obtained during the PPE program show that it is a promising means of promoting parent-child communication about issues related to sexuality and teen pregnancy. Compared with other community members, workshop participants reported more concern about teen pregnancy, but no more comfort answering questions from or holding conversations with their children about these issues. This indicates that participants, although more interested than other community members, still needed programs that promote parent-child communication through enhancing skills and providing resources.

Significantly more participants reported feeling comfortable answering questions from and initiating conversations with their children about these issues after attending a PPE workshop than before. Parents who are more comfortable talking with their children about these issues may be more likely to do so. Significantly more participants also reported having ever discussed these issues with their children after attending the workshop. These results indicate that the parents’ comfort increased as a result of the skills and resources they gained during their workshops. It may also indicate that they were more motivated to carry on such discussions at home as a result of participating in the workshops.

Overall, the number of parents who reported that their child was too young for information about sexuality-related issues decreased after attending a workshop, but the change was not significant. However, there was a significant change reported in data for Wave 2. During that wave of the PPE program, the issue of “when it is appropriate to talk to your child” received much discussion, and parent peer educators stressed the importance of talking to children of all ages about these topics. After the workshop, significantly more parents also reported discussing multiple topics related to sexuality during their most recent conversation with their child about these issues. These findings suggest that parents were better able to make connections between the topics and to discuss sexuality-related issues more holistically. Given that parents reported feeling more comfortable talking with their children and using the guidebooks after they had attended the workshops, it is not surprising that they talked with their children about these topics more often.

On the pre-workshop survey, many of the participants reported that they had used the Family Connections guidebooks in the past. They may have obtained the guidebooks as a result of the earlier media campaign. It is also possible that such “use” included casual references to them at FHC medical offices or elsewhere, such as at a large women’s hospital that makes the guidebooks available in its Women’s Resource Center. The survey findings suggest that some workshop participants knew about the guidebooks, that they wanted to enhance their knowledge about these topics, and that they benefited from receiving copies of the guidebooks and instruction in how to use them. When surveyed four weeks after the workshop, the vast majority of the participants reported having used the guidebooks.

The program’s positive impact on the parent peer educators, as indicated through their feedback, is also important. The program is capacity-building for the parent peer educators through both the training they receive and the experience they gain conducting workshops. The parent peer educators gain valuable skills that help them in their community. In addition, they continue to be “goodwill ambassadors” about the program and the hub agency in their communities. As mentioned, several participants expressed a willingness to conduct additional PPE programs or to take part in additional health education programs in the future.

Lessons learned

We learned several valuable lessons about strategies for improving the PPE program and its evaluation. These lessons, in addition to enhancing future generations of our own PPE program, might be applicable to other parent education programs.

Make the most of community partnerships

The involvement of the coalition was a critical element of program implementation. FHC’s collaboration with community members and service providers encouraged us to develop the PPE program by combining our existing guidebooks with other community resources. It was owing to the feedback of community members during the needs assessment process, as well as at the great interest of the coalition members, that this program was conducted. During the annual planning meeting each year, coalition members continued to identify parent-child communication as a top priority and decided to continue and expand the PPE program. The support and guidance provided by the coalition, local service providers, and community members enabled us to improve the program during its five years.

Stay focused

Emphasize the most important points not only in the first wave of the program, but in all subsequent waves. For example, we felt that it was important to convey that communication between parents and their children should occur at all ages. However, because of staffing changes and lack of oversight, this message was not stressed as strongly in all waves of the program. It is essential that program staff members identify the program’s primary messages and address those messages every time the program occurs.

Use what you learn

Each wave of the program built on our findings from the previous one(s). For example, during the initial pilot test of
the program, we learned the importance of providing workshop participants with on-site child care. Lacking short-term child care, participants often brought their children to the workshops, and their presence negatively affected group discussion. Consequently, program staff arranged child care services during workshops. The program itself continued and expanded in large part because both the pilot test and pre-workshop survey results confirmed that there was strong community interest. Many survey respondents said that “information” and “programs and groups” would help them to communicate with their children about sexuality-related issues.

**Be interactive**

Both training and workshop participants said they felt interactive, role-playing activities were a particularly helpful method of teaching them about sexuality-related issues. Accordingly, role-playing activities were emphasized during training and included in workshops.

**Provide supportive materials**

It is not possible to cover all issues related to parent-child communication and sexuality during the course of a parent education program. Even if it were possible, workshop participants might still be at a loss when facing a particular issue in their own relationships with their children. The PPE program does not try to provide parents with a full curriculum of everything there is to know about puberty, sexuality, youth development, and communication. Instead, it seeks to provide parents with a general understanding of the issues, strategies for talking with their children, and resources for finding additional information when they need it. The *Family Connections* guidebooks are not only a valuable teaching device during the workshops, but also a helpful reference tool for parents to consult later.

**Develop a strong relationship between program and evaluation staff**

We found that the PPE program worked best when our program and evaluation staff worked closely together. Benefits came when lines of communication were open, when debriefing sessions occurred regularly, when data were reviewed quickly, and when feedback came in a timely fashion.

**Limitations**

There are several limitations of this study. First, there are design limitations. An evaluation of the effectiveness of the program in improving parent-child communication and reducing adolescent sexual risk behavior would ideally incorporate control communities, measure child outcomes, measure parent and child outcomes across a longer follow-up period, and measure outcomes for all participants rather than just a sample.

There was a self-selection and/or recruitment bias that could be considered a limitation. Participants self-selected to attend the workshops, or they were solicited to attend the workshops as a result of a personal relationship with the parent peer educators. Self-selection, however, is a realistic strategy for recruitment in a community-based PPE program. Notably, although participants had more interest in the topics than did other community members, they were not more comfortable discussing the topics before they attended the workshops.

Other limitations related to the participant data were the lack of extensive demographic information obtained from workshop participants and the small sample size (e.g., just 22 matched pairs in the first wave and 40 in the second). Because of the predominance of female participants (82.9%), our findings cannot be applied to a male population. Also, the small sample size prevents comparison of improvements in communication between parents of younger children and parents of teens.

There is also an issue of accuracy with regard to self-reported data on parent-child communication about issues related to sexuality. We believe, however, that the overall questionnaire results are not invalidated by this inaccuracy and that the flaw is probably similar in other comparable studies.

The evaluation instruments were modified slightly between Waves 2 and 3 in response to concerns of program staff. The revised questions improved overall completion rates and reduced respondent confusion. Themes remained consistent, and responses were still comparable with earlier versions of the surveys.

**Future directions**

Our findings suggest that the PPE program may be useful in reducing adolescent sexual risk behavior. We learned some valuable lessons regarding strategies for improving the evaluation process, ensuring that adequate outcome measures are obtained, and involving the community in a parent education program. Still, more extensive, controlled evaluation research on this program is needed.

The PPE program received additional state funding to continue the workshops throughout Allegheny County during the summer and fall of 2002. FHC staff members have developed a replication manual detailing both parent peer educator trainings and parent workshops, and parent-serving groups and community organizations can use it to implement the program. Additional data collected during PPE replication would be valuable in learning more about the program’s effectiveness.

**Conclusion**

The Parent Peer Education program builds on community assets such as cooperation and existence of relationships as well as the support of concerned service providers. The program provides a promising, low-cost, community-based method of promoting parent-teen communication, a
behavior that is valued by the community and can contribute to teen pregnancy prevention.

Acknowledgment

This study was supported in part by grant #U88CCU312381 from the Centers for Disease Control and Prevention. The views stated in this report do not necessarily reflect those of the funding agency.

References


