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The Impact of Being a Peer Sexual Health Educator: Lessons Learned from Mobilizing African American Adolescents Against HIV in Flint, Michigan

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The Impact of Being a Peer Sexual Health Educator: Lessons Learned from Mobilizing African American Adolescents Against HIV in Flint, Michigan

Q17 Charles Senteio[a], Deborah Yoon[a], Yiwei Wang[a], Swetha Jinka[a], Terrance Campbell[b], and Palena Elizabeth[a]

[a]Rutgers School of Communication and Information, New Brunswick, NJ, USA; [b]YOUR Center, Flint, MI, USA

ABSTRACT

Although peer-led health education is common, the long-term impact of being a peer educator is under-studied. The purpose of this qualitative study is to investigate the long-term impact of being a peer sexual health educator. The sample consists of African American young adults who had served in this role. Being a peer sexual health educator had perceptual, cognitive, and relational impacts. This study has implications for the design and evaluation of sexual health programs.

KEYWORDS

Peer sexual education; peer sexual health mentors; adolescent health education; youth sexual education; health education

Background

Peers can have a dramatic influence on adolescent and young adults' general health behavior (Aladağ & Tezer, 2009). Peer education for adolescent sexual health is defined as, "the teaching or sharing of health information, values and behaviors by members of similar age or status groups" (Sriranganathan et al., 2012). Peer education programs focused on adolescent healthy relationship awareness and/or sexual health behavior have been used since the early 1980s for three key reasons (Sawyer, Pinciaro, & Bedwell, 1997). First, adolescents use peers as sources of health information and their behavior is influenced by them (Edelstein & Gonyer, 1993). Consequently, educated peers mitigate the risk of sourcing critical health information from ill-informed peers. Further, evidence suggests that adolescents are more likely to adopt recommended, healthy sexual behavior in interventions that use peer educators (Divecha, Divney, Ickovics, & Kershaw, 2012; Mahat, Scoloveno, De Leon, & Frenkel, 2008; Maria, Guilamo-Ramos, Jemmott, Derouin, & Villarruel, 2017). Second, peer education is particularly well-suited for highly sensitive topics and health

CONTACT Charles Senteio, PhD, MBA, LMSW Charles.senteio@rutgers.edu Department of Library and Information Science, Rutgers School of Communication and Information, 4 Huntington Street, New Brunswick, NJ 08901, USA.

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behaviors (Jennings, Howard, & Perotte, 2014). When compared to traditional didactic educational delivery methods, personal health topics are more effectively addressed through peer-led health promotion activities (Edelstein & Gonyer, 1993). Third, peers are more cost-effective than certified health education practitioners, and cost is an important consideration for many agencies that deliver sexual health programs (Sawyer et al., 1997).

Considerable racial disparities persist in sexually transmitted infections (STIs) especially in HIV infection. When compared to White youth, African American youth experience a higher rate of STI and HIV infections. In Michigan, African Americans make up 14% of the state's population, but they represent 55 percent of all individuals in Michigan living with HIV, and of all Michigan teens diagnosed with HIV between 2009––2014, 82% are African American (Michigan Department of Community Health, 2014).

STI incidence and prevalence among young adults are associated with a complex combination of psychosocial, cultural, and individual factors (DiClemente, Salazar, Crosby, & Rosenthal, 2005). Consequently, culturally appropriate intervention designs are recommended to promote sexual health education among young African Americans (Veinot, Campbell, Kruger, & Grodzinski, 2013). However, there is a gap in the literature "giving voice" to young African Americans concerning sexual health education (Kimmel et al., 2013).

Investigating the long-term impact of being a peer sexual health educator––by listening to African Americans who served in this role––broadens the lens of program evaluation. This is valuable to help articulate the effect these programs have on the peers themselves; after all, peers are subsets of the target populations. Further, understanding that impact beyond the conclusion of the peer sexual health educator role helps contribute to understanding any lasting impact of the peer educator experience from the perspective of the peer educator.

Despite the use of peer education to provide health education for adolescents and young adults, very few of these programs evaluate long-term impact on the peers' perspectives and behaviors (Cramer, Ross, McLeod, & Jones, 2015; Heys & Wawrzynski, 2013; Sawyer et al., 1997). Describing the long-term impact on the peer educators themselves is invariably challenging because it is difficult to assess the attitudes, perceptions, and behaviors over time. In fact, most peer health education interventions last for relatively short periods of time, many over just one session over the course of a few hours. Consequently, process evaluation measures (i.e., delivery) are most readily obtained at the conclusion of the particular intervention, which is appropriate. But outcome evaluations (i.e., impact) may be administered either directly after, or in several months following the intervention,

and follow up time varies considerably (Sriranganathan et al., 2012). Given the persistent STI/HIV racial disparities, there is a considerable imperative to understand the long-term impact on African American peer educators, beyond the immediate conclusion of serving in the peer educator role.

Objectives

The purpose of this study is to examine any long-term impact of being a peer sexual health educator. We explored the perspectives of the African American peer sexual health educators in the HOPE project (**H**IV/STI **O**utreach, **P**revention, and **E**ducation), a Michigan based sexual health education program. We contacted peer educators between 3 and 5 years after their engagement in the HOPE project.

The HOPE project was a CDC-funded (Centers for Disease Control and Prevention), STI-reduction program that ran from 2009– 014 throughout Genesee County, where Flint is located, and Saginaw County, Michigan. The HOPE project was developed and conducted through a community-academic partnership between the YOUR Center, a faith-based nonprofit in Flint, and the Prevention Research Center of Michigan at the University of Michigan School of Public Health (Prevention Research Center - Michigan, 2017a). The HOPE project aimed to assess the efficacy of integrating peer sexual health education and technology into an established evidence-based prevention program for STI awareness and prevention, with an emphasis on HIV, among youth ages 18–24. Several peer-reviewed journal articles describe the HOPE project and its outcomes (Kimmel et al., 2013; Unertl et al., 2016; Veinot et al., 2011, 2013). For example, Kimmel et al. (2013) describe how young people perceive school and community-based sexual health education. Veinot et al. (2013) further detail perspectives in the context of the use of information and communication technology (ICTs). To the best of our knowledge, this is the first study to examine the impact of sexual health education programs from the perspective of the peers themselves.

Methods

We conducted a qualitative study for this exploratory investigation. We used individual semistructured interviews to elicit perceptions by probing specific aspects of impact, informed by peer sexual health education literature and expert practitioners. The interview guide emerged from discussions with personnel who helped train and worked closely with the peer mentors, and have maintained contact with them since their role. The questions were refined after reviewing literature on how impact is assessed for STI/HIV programs. We conducted interviews via phone, as some of

these former Michigan-based peer sexual health educators are now dispersed throughout the United States. The Rutgers University Institutional Review Board (IRB) approved the study protocol, which included consent procedures (IRB # 17-684M). The study was explained to the participants by the principal investigator (CS), who led each interview. The consent was read, and the participants provided their verbal consent at the start of the interview recording. We did not offer financial compensation to participants.

We recruited 11 participants using existing professional and social networks of YOUR Center personnel, specifically those involved in recruiting and training various participants involved in the HOPE project, specifically the YOUR Center Founder, Co-Founder, and Director. These individuals maintain contact and relationships with the former SeXperts ("X" is capitalized because the peer mentors wanted the "SeX" initial syllable to be conspicuous) and PHIMs (peer health information mentors). The study team collaborated with YOUR Center personnel to identify study participants based on peer educator role and diversity of academic and professional experience since their role as peer sexual health educators. Participants were called to arrange phone interviews at a mutually agreed upon time. Three coauthors (CS, YW, SJ) participated in the interviews.

Participants

Our sample consisted of participants from each of the two, distinct peer sexual health educator roles used for the HOPE project: SeXperts and PHIMs. The SeXperts were part of Your Blessed Health (YBH), a YOUR Center STI/HIV education project. The PHIMs were part of a health improvement grant awarded to the Flint Urban League, in collaboration with the YOUR Center and the Prevention Research Center at the University of Michigan School of Public Health. The SeXperts and PHIMs were recruited in Flint via newspaper and radio advertisements and word of mouth throughout area churches, youth organizations, and youth serving organizations.

SeXperts

The HOPE project included a total of 60 SeXperts who worked in a variety of venues across Genesee County. Their ages ranged from 12–18 at the time of starting to serve as peer educators. The SeXperts assisted with: (a) HIV/STI workshops; (b) web radio talk shows; (c) educational theatre (i.e., skits and mime performances); (d) an annual Women and Girls Reproductive Health Conference; and (e) an annual World AIDS Day event.

PHIMs

There were 20 PHIMs, ages 18–24, who worked with the HOPE project. PHIMs increased access and use of sexual health information resources among their peers and enhanced online information literacy to support their peers to be more informed health information consumers (Prevention Research Center - Michigan, 2017b).

Sampling Plan

We used convenience and purposive sampling of former HOPE project peer sexual health educators to include males and females of various ages and levels of participation.

Measures

We developed a semistructured interview guide based on consulting with experts with extensive experience working with African American sexual health education and reviewing literature on the influence of peer-led sexual health education (Aladağ & Tezer, 2009; Badura, Millard, Peluso, & Ortman, 2000; Cramer et al., 2015; Heys & Wawrzynski, 2013; Sawyer et al., 1997). Studies that aim to assess impact of peer-led sexual health programs have measured impact across a number of *personal dimensions*. Some have focused on perceptions and beliefs concerning healthy relationships, including self-esteem in the context of dating, peer, and intimate relationships (Cramer et al., 2015). Others have measured self-esteem, personal development, and changes in sexual behavior (e.g., Sawyer et al., 1997). Further, researchers have measured specific interpersonal skills, such as communication, awareness of diversity, and empathy (Aladağ & Tezer, 2009; Sawyer et al., 1997). We are unaware of measures that incorporate educational and/or career goals. However, our research team and community-based collaborators indicated that we should investigate impact in these areas, as those individuals are experienced in various dimensions of African American youth sexual health. This expert-led insight helped to inform our semi-structured interview guide (Harden et al., 2001). Consequently, our interview guide probed general impact, impact on personal development (i.e., self-esteem, health behavior, social network composition), impact on the participants' educational goals (i.e., programs of study, pursuit of college degrees/certifications), and career pursuits (i.e., working in health education field, working as a clinician or healthcare provider, etc.). See Appendix A for the semistructured interview guide.

Analysis

We used the Rigorous and Accelerated Data Reduction (RADaR) technique to code, summarize, and condense the interview data collected because

(a) it is well-suited for analysis of different types of qualitative data, specifically interviews; and (b) it is appropriate for small datasets (Watkins, 2017). This technique enabled us to extract the most relevant data, which facilitated us incorporating it into a cohesive presentation of study findings.

RADaR Preparation and Preliminary Analysis

Since the RADaR technique cannot be implemented without preliminary analysis, we meticulously prepared the data sets (Fernald & Duclos, 2005; Guest & MacQueen, 2008; Watkins, 2012, 2017; Watkins & Gioia, 2015). To prepare, each transcript was reviewed by listening to the audio recording of each interview to ensure that all interviews were transcribed thoroughly and accurately. Next, we compiled the responses into a spreadsheet that included pertinent information (e.g., Participant ID, Interview Section, Time Stamp, Response, etc.), the RADaR *All Inclusive Data Table*. This process enabled easy access to most important information collected. In addition, we created the preliminary code book using in vivo codes to preserve participants' meanings and experiences to support the analysis process (Glaser, 1978). The code book included code definitions and representative quotes, which helped guide the analysis. See Appendix B for the code book.

RADaR Methodology

Once preparation was complete, we deleted responses that were not relevant to our research question. The most relevant information was extracted from the *All Inclusive Data Table* according to the specific interview question being answered, confirming pertinence as it related to the overall research question; any other information that was not pertinent was removed completely. Three members of the research team (YW, SJ, EP) collaborated to develop the *Phase Two Data Table*, each of whom was assigned to one-third of the data. After each team member produced a data table individually, we reviewed the table collectively to ensure that only the relevant data were included in the table. While we worked through and reduced the data, we refined our preliminary coding by highlighting the key portions that may be used as codes, and added notes in a dedicated column in the table. We also continued to refine the code book to encompass the reduced content through research team conversations held both face-to-face and remotely, in order to interpret the data comprehensively. This resulted in the *Phase Two Data Table*. Then, we once again completed a process of inclusion and exclusion by further interpretation of the data. Similar to the previous phase, each team member first worked individually to truncate and code the data for the portions they analyzed previously in

order to develop a deeper interpretation of the data––which resulted in the *Phase Three Data Table*. We then reviewed the data table and collectively resolved disagreements concerning the codes. At this stage, only the pertinent data remained. We (CS, DY, YW) analyzed the data considering the assigned codes, and discussed consolidation of codes, which resulted in the *Phase Four Data Table*. We then discussed meanings of each concept that emerged from the codes as they became more concrete over the course of this process––which resulted in the *Final Phase Data Table*. Individual interpretations were discussed during team meetings to make collective decisions about how to condense or expand relevant preliminary themes, using specific quotes extracted from the initial interview data. Each of these overarching themes were categorized to include quotes along with participant identification numbers and timestamps as part of the *Final Phase Data Table*. As a result, team decisions were the foundation for the *Final Themes*, which represented each overarching theme deduced from the data.

Analytical Framework

We developed a framework to analyze the themes that emerged from the RADaR methodology informed by two distinct, but connected, areas of literature: (a) systematic reviews of HIV/AIDS interventions focused on youth (Kaaya, Mukoma, Flisher, & Klepp, 2002; Paul-Ebhohimhen, Poobalan, & van Teijlingen, 2008; Sani, Abraham, Denford, & Ball, 2016), and (b) impact assessments for programs designed to improve various health and wellness measures for individuals and populations. USAID impact assessment tools were especially useful for generating our framework for impact assessment (Chen, 1997; Cohen et al., 2005).The framework consists of three dimensions of impact: perceptual (attitudes), cognitive (information and awareness), and relational (relationships enabled through conversations).

Results

Sample

The sample consisted of 11 participants ($n = 11$), who were interviewed between August and October, 2017. We conducted interviews until we reached saturation of thematic diversity (Corbin & Strauss, 2007; Guest, Bunce, & Johnson, 2006; Ogedegbe, Mancuso, Allegrante, & Charlson, 2003). After participants provided verbal consent, we collected demographic information at the start of each interview. See Table 1 for demographic information of the entire sample. Six participants are former SeXperts (out of a total of 60 SeXperts) while the remaining five are former PHIMs (out of a total of

Table 1. Demographic Information––Entire Sample.

Age as Peer Mentor	Total No.	PHIMs	SeXperts
14–17	6	0	6
18–22	4	4	0
23 and older	1	1	0
Current Age			
20–23	6	0	6
24–27	4	4	0
28 and older	1	1	0
Gender			
Male	2	1	1
Female	9	4	5
Race			
African American	11	5	6
Years as Peer Mentor			
0–2	7	5	1
2+	4	0	5
Sexual Orientation			
Bisexual	1	0	1
Heterosexual	8	4	4
Homosexual	2	1	1
Role			
SeXpert	6	–	–
PHIM	5	–	–
Year of becoming a mentor			
2009–2010	3	1	2
2011–2012	7	2	5
2012+	1	1	0

Note. Total number of participants ($n = 11$)

20 PHIMs). Participants are between 3–5 years removed from their role as peer educators. Their current age ranged from 20–30. All of them are African American and the majority ($n = 9$) are female (identified), which reflects patterns of many peer education programs, in which the majority of peer educators are female (Beshers, 2008). Participants had been peer sexual health educators for two and half years on average, ranging from six months to four years.

Participants report their time as a peer sexual health educator was life-changing. They remain deeply influenced by their experience, not just in terms of sexual information awareness, but also in their lives in general. They describe the impact experience as all–encompassing, because they regard sexual health as holistic, integrated with their emotional, spiritual, and physical health, "Whether it is doing this interview or trying different sexual acts … It's all about really just taking care of yourself at the end of the day" (P05, SeXpert). Some express how the experience continues to help motivate them in general, inspiring them to excel beyond their circumstances, "I didn't wanna be no statistic [sic]. I didn't wanna be that. I didn't wanna be that kid, a statistic. I didn't wanna be that. I refused to be that" (P11, PHIM). Several state that they believe that the information they learned and conveyed to others via various HOPE project activities may have saved lives, "(sexual health) information could possibly save a life" (P01, SeXpert). They state that the experience continues to be

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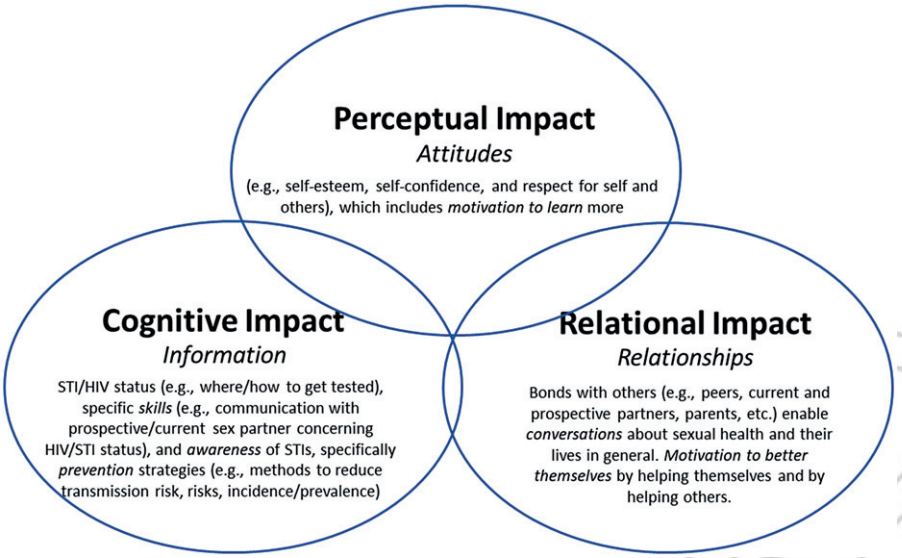

Q15 **Figure 1.**

transformative, and for some it may have *saved their own life*, "everything that I learned … you can save a life. You can save many lives. It saved my life" (P06, SeXpert).

Three impact themes emerged from our analysis: perceptual impact, cognitive impact, and relational impact. See Figure 1 "Impact Themes." Perceptual impact concerns attitudes like self-esteem, self-confidence, and self-respect. This theme also includes motivation to learn more about sexual health, or just learning in general. Cognitive impact concerns information about STIs, including HIV, which include prevention strategies. Last, relational impact concerns interactions and connections with others: peers current or protective partners, parents, etc. Forging and nurturing these relationships are enabled through conversations they are better able to have as a result of their work as peer sexual health educators. These relationships contribute to their motivation, to help themselves and to help others.

Perceptual Impact

I am ultimately in control … to live my life in a more fluent way that is safer. (P03)

The peer sexual health educator experience enhanced participants' general perceptions of sexual health, and of themselves; it enhanced their autonomy, "I definitely found that in knowing more, I gained more self-esteem and more awareness and security in myself … to be sexually healthy is to be on top of everything, and to really take care of your body" (P05, SeXpert). Another participant specifically mentioned influence on their

self-esteem, "[being a PHIM] essentially taught me how to have better self-esteem and how to protect myself more" (P08, PHIM). As P08 alludes to in this comment, several participants describe how the experience empowered them, to take control of their lives, specifically their bodies,

> [Being] knowledgeable in this area, knowing about STIs and HIV [enabled me to] have control over my safer sex practices … knowing that I am ultimately in control, and no one else is in control of my life, of my body. [It] helped me with my confidence because it's ultimately my life and I have control over it. (P02, SeXpert)

This ardent empowerment is illustrated in what one participant describes as "owning" their sexuality. P05 describes how the peer educator experience helped them process and put into context other sexual health information focused on the consequences of having sex, and this context was crucial to their empowerment for their *own* sexuality:

> Owning your sexuality too is another thing that I appreciated, because as teenagers, we're taught to stay away from [sex]. But it becomes like a consequence, or something that has a negative effect. Like if you have sex, you'll get a disease; or if you have sex, you'll immediately get pregnant. (P05, SeXpert)

This information gained through the peer sexual health educator role helped to reinforce that they had choices. They recognized authorship for their own futures. This participant articulates his/her experience as a sexually active teen, and recalled his/her experience favorably as he/she reflects on the experience of their peers who may not have been as aware as he/she was:

> Man … honesty, having been sexually active from a young age … You're just trying to be so in with the in-crowd. Just because such-and-such is doing it, you wanna do it, but you could be putting yourself at risk trying to be with the in-crowd. It [being a SeXpert] made me cautious, I could be just like another vulnerable [kid] out here … A [prospective/current partner] could be like, "Oh, no, I'm only with you," all that pillow talk. I could fall for it and become one step closer to being infected with a STI or HIV. (P01, SeXpert)

These perceptions were particularly vital as an adolescent, a critical developmental time in their lives, " … and it was just a lot of information that was given to me at a young age that helped me learn how to deviate and learn how to live my life in a more fluent way that is safer" (P03, SeXpert). One former PHIM (P10) reflects upon the person he/she was as a young adult, and how the experience changed him/her as a person, "I was the type that … I didn't care about what I messed around with. I didn't care if they was ugly, fat, Black, White, whatever race … whatever. I didn't care. It actually changed me. I will try to stay with one [person] instead of trying to be with two, three at a time. It changed a lot of stuff that I used to do".

As a peer sexual health educator, they believe that they had something tangible to offer, and they perceive that their role was so vital that they

consider it life-saving; they believe that the information that they provided to their peers helped to save lives, "Health is just important. We used to always say that we save lives. We work towards saving a life. One life. It's a matter of teaching and it's a matter of gaining knowledge, but it's also a matter of saving the lives of others" (P05, SeXpert).

Participants emphatically express how this experience *continues* to be a positive influence in their lives. This participant describes how the training and work as a peer educator changed him/her, made him/her more confident, "My self-esteem was so shot, [prior to becoming a SeXpert] it was so low, I don't even think I would be in the same mindset. The person that I was is a shell, a shadow of the person that I am today. I'm shining so bright, like a diamond, it's ridiculous" (P03, SeXpert).

Two participants in particular express intense perceptions of influence on their self-esteem, on their lives based on the challenges they faced at this critical juncture in their development. They were peer sexual health educators when life altering decisions are made, and when life altering experiences can be confronted. P05 expresses how his/her experience as a SeXpert buoyed his/her confidence to make the decision to leave home state of Michigan to attend a four year university away from friends and family, "I appreciated it for bringing me out of my shell and giving me the confidence that I needed to go to (named university) … just being more sure of myself in a totally foreign place, that's definitely something that the SeXperts helped me with. So I'm forever grateful. I am." Another participant describes how being a peer sexual health educator helped him/her process his/her own experience with sexual abuse. P06 articulates how the experience as a SeXpert helped him/her stop blaming herself, and how he/she resolved to ensure that his/her daughter will not have to face the experiences that he/she faced:

> It influenced me a lot. It helped me say, "Don't feel bad." [Because of] my childhood and things that I've been through … it made me feel like, "Why me, why did this have to happen to me and why did I have to go through this?" And I just felt like a bad person. But me being a SeXpert, it made me [pause] it's a feeling that I can't, I can't really explain. It made me feel good about myself and it also taught me that it wasn't my fault [pause] what I went through. It wasn't my fault, 'cause I blamed myself for so long. I'm not ashamed anymore. I don't feel bad anymore about what I've been through. And I know it's not my fault. I'm comfortable with telling other people about it. I just try my hardest to do any and everything to make sure my [own children] would never be in that type of predicament.

Cognitive Impact

> *I learned so much. I learned how to protect yourself.* (P01)

During peer sexual health educator training, participants acquired information about various aspects of sexual health, they also acquired information

working in the peer educator role, and they continue applying this knowledge 3–5 years after the role. Participants recount specific information about various STIs and particular prevention techniques to reduce STI transmission risk. This knowledge persists some years removed from their roles, "We learned about a lot of stuff, different diseases [some I] didn't know even existed … HIV, gonorrhea, [were] the main STIs" (P07, PHIM). Another participant speaks to specific information about spikes in incidence, "I learned about a lot of STIs that I didn't know about [and] the percentage of young people or certain areas where outbreaks [occur]. We learned about how the outbreaks have grown, numbers of times each year, in different areas" (P09, PHIM). A former SeXpert (P06) also speaks of learning about information concerning STI incidence and prevalence, and their effect on individuals and families, "Starting off I didn't know how sexually transmitted infections was [sic] spreading, how serious it was, how many people in my city that I lived in, actually have sexually transmitted infections … how serious STIs were, and also what can they do to you. How can it affect your life, how can it affect your family's life, how can it affect you as far as having kids or anything like that." Also, discussion and confrontation of sexual and racial stigma had a cognitive impact on participants. Participants shared how they became more open, and less judgmental, concerning sexual orientation, sexual behavior, and perceptions of those living with HIV/STIs, which was particularly germane to them as African Americans.

Learning about sexual health and exposure to sexual health information helped to transform them. Participants share how their experience as peer sexual health educators exposed them to issues beyond just sexual health, but mental and physical health. This participant speaks to how trauma can influence health behavior, "I've learned a lot about abuse, as far as mental abuse, physical abuse, and emotional abuse; and that they're all on one level, that one is not greater than the other, and that they really do affect people. So, I would say before [being a] SeXpert, I didn't believe that other forms of abuse could really have an effect on a person" (P05, SeXpert).

Information Influences Self-Reported Behavior. Participants reported how the information gained profound impacts their own sexual health behavior, "There is no more unprotected sex, and there is no more multiple partners. There is getting tested" (P08, PHIM).

Embracing Diversity/Dealing with Stigma. In addition to information concerning STI incidence, prevalence, and prevention strategies, they also gained important perspectives on difference and stigma, and understanding diversity. They describe how self-confidence was associated with being non-judgmental, "One thing that I felt was that someone who's a little more comfortable and more confident in their skin are a little more open to

being nonjudgmental, and not having negative perceptions about other people" (P05, SeXpert). P05 elaborates on how being nonjudgmental influenced her thinking beyond sexual identity, to various aspects of identity:

> So really my perception of everything, I feel, have [sic] changed in terms of relationships and just being more open and not viewing a certain sexual orientation or a certain sexual act as something that's negative or something that's against what's being normal. 'Cause what's normal? I learned that there's no cookie cutter shape for who we are, and who we love, and who we decide to have relations with. I think I just learned to not really have a perception, if that make [sic] sense, and then kinda from what I learned through experience, and to not stereotype, I guess. To not have preconceived notions about certain things.

Participants describe general stigma, and how it can lead to an individual lacking respect for another, "Stigmas need to be washed away. I learned that the respect for [another] person's body is not as high as it should be" (P08, PHIM). This awareness of diversity helped them recognize the negative effects of stigmas, which enabled them to approach their peer-educator work in a nonjudgmental way. This appeared to be a key tenet of their work. One former SeXpert (P04) describes how important it was to not just approach their peer-education work free from judgment but also how doing so in his/her own life benefits him/her:

> We were always taught never to judge someone's situation, what they have been through. You come across so many different people, going through so many different walks of life that could be potentially different from yours. They have different beliefs from yours. I am a heterosexual and someone comes to me who is a homosexual, you know we have different beliefs … [different] preference, so I can't be like I am not going to help this person because they are homosexual and I am not. You have to take those beliefs out of it and recognize that this is just another human being that is seeking help. We live in such a judgmental society.

Participants believe that their experiences enable them to examine their own sexuality devoid of stigma, especially critical during sexual identity development as an adolescent and as a young adult. One former SeXpert (P05) shares, "I've always lived a life that was based on being heterosexual. But I think one thing that being a SeXpert helped me with was just not being afraid of being open to other possibilities. If there was a time when I felt that I wanted to experiment or kinda step out of my own persona to try different things, then that was fine; but just to do it in a manner that was still protecting myself and still being aware." Another specific stigma addressed concerns those individuals living with an STI. One former SeXpert (P06) describes how their experience with the HOPE project included participating in educational events with people living with STIs, who shared their experience with the peer sexual health educators and program participants:

> It helped me a lot. It helped me to don't just judge people. Because we did meet people that had sexually transmitted infections and me just growing up not knowing anything, I thought people with sexually transmitted infections were nasty, they did something wrong. I just thought it was just the nastiest thing in the world. But you never know that unless you have that information. When I first learnt [sic] about it I thought that it was gonna have them depressed and have them down but these people were living their lives. They didn't let that [STI] stop them. They taught us … to not just judge someone off of their infections.

Some participants specifically address stigma that they assert is unique to their African American communities. They suggest how low-resourced communities, such as the communities they came from, are vulnerable to stigma, and how support is needed to address persistent stigmas, "I learned that we need a lot of help, a lot of help. And I'm not just saying Flint. I'm saying the Black community. We need a lot of help. [Because] a lot of stuff is stigmatized" (P08, PHIM).

Filled a Void. As P08 alludes to in the previous quote, the sexual health information participants acquired impacted them because it filled what they perceive to be a void in their education. A former SeXpert (P03) states how prior to their experience as a peer sexual health educator, television, and media were the sources of sexual health information, and the peer educator role helped them broaden their perspective of what 'sex' was, "I learned that sex was so much more than just the act of sex, because everything I learned previous to being a SeXpert was based off of television, was based off of media. But I learned of my sexuality as a whole." Being a peer educator enabled them to answer their unanswered questions. They learned what they perceived to be important information, which they did not have access to at home, in school, or in church.

Several participants mentioned how schools specifically do not adequately address sexual health education. A former SeXpert, who shared that he/she attended a predominantly White high school, describes the lack of sexual health education in school in terms of *how* their school approached sexual health education; it was abstinence-based which they perceived as judgmental:

> The high school that I went to was not within the city (Flint). It's actually a predominantly White institution; and sexual education there was more like abstinence-based. And I felt, I was unable to get a lot of my unanswered questions answered, and [I was unable to] just talk about things that I didn't really wanna necessarily talk about with my parents or other peers. So, I felt that it was good to come to a place where everybody was just so open to what was being said, and what was being asked. It seemed to be sexual education in a way that was free, fun, and nonjudgmental. (P05, SeXpert)

Another SeXpert referred to sexual health education not being offered in schools, "I don't think schools nowadays, [have] that much [sexual health]

information" (P06, SeXpert). This former SeXpert also described the imperative of peer sexual health education by referring to the lack of sexual health education in school and the lack of sexual education at home:

> It's something (sexual health education) that I feel like the upcoming generations need. Because like so many kids are having sex at such a young age, and I really feel like they aren't educated and knowing what they are actually doing … well the kids I worked with, they were not getting that (sexual health education) at home. They were not even getting the homework support they need at home. (P04, SeXpert)

Another former SeXpert (P02) also suggests that the lack of sexual health education is amplified by the convergence of cultural difference and low-resourced communities, "It's just not really taught to younger individuals, especially in urban neighborhoods. I know a lot of high schools, they don't really have sex education anymore. And I know my school in particular did not have sex education. I don't think parents really talk to their kids about things like that. That's a topic that parents just doesn't discuss with their kids." A former PHIM (P08) describes how African American families and the African American community in general are reticent to discuss sexual health issues, because the very topic remains stigmatized. This perspective helps them illustrate the need for sexual health education in African American communities:

> (For African Americans) sex isn't talked about at home, and sex isn't talked about [at all]. And when we did programs with adolescents from different races they would say, "Oh yeah sex was talked about in our household, we had the talk with our parents." African American kids didn't have that so, they felt more comfortable speaking with us. I feel like sex is kind of crossed out in our community, I just feel like they don't talk about it. I just feel like – as far as mental health and sex and all that stuff – it's completely (nonexistent), "We don't talk about this in this household." (We may) pray about it, you know, the rituals we'll do, we'll do something else besides actually sit down and discuss it. That's how I feel about the African American community.

Advancing Education and Career Goals. Participants detail how the experience had a dramatic influence on their educational and career goals. Participants share specific career goals and programs of study which the role helped spark, or for some it helped to nurture nascent goals, "At the time, when I was 15 … I always wanted to help people. And now I major in social work" (P04, SeXpert). Two participants describe how the specific information helped them prepare for clinical training, "Actually I am going to school to be a CNA (Certified Nurse Assistant) right now. I already wanted to be one [prior to being a PHIM] and it just helped me out more … I'm learning all the diseases and stuff that I already know [about], so it definitely helped me out" (P09, PHIM). A former SeXpert (P06) is a CNA, and his/her experience as a peer sexual health educator helps him/her relate to his/her patients, "It helped me, because right now, I am a

certified nurse assistant and I am a dialysis technician. Yes, I am. [Being a SeXpert] helped me to use the knowledge that I got then, even now in the field that I'm in now [nephrology], to help me to influence people. Not just about sexually transmitted infections, because dialysis [is for] kidney failure. But it helped me influence people and give people knowledge about their health as well."

In addition to specific career goals, participants also describe how the experience was a factor in their general pursuit of education. One former PHIM (P08) describes how the experience helped them discover how much they enjoyed working with adolescents, "It (being a PHIM) made me wanna continue, go further [with my education], I wanted to do something to have some kind of influence on adolescents … to make sure that adolescents understand the risk they take, the health factors and the issues that can come from being promiscuous and not being sexually protected. It's opened my eyes to a lot of what was going on in the city and in the world basically." A former SeXpert (P03) shares how it sparked their passion for working with others:

> I [found out that I] loved sex education, it was just my niche. I loved talking about it, and I loved talking in front of people. That's how I learned that I love talking in front of people, because all of the various things we did, I found that it was something that I really wanted to continue to do, and educate people as well. It's really turned my life upside down and turned it into something that I think it definitely would not have been had I not been a SeXpert. It has definitely influenced me in so many ways.

Relational Impact

> *Just knowing that I had peers around my age to talk to. I looked at them as family … it wasn't like my friends or my other peers.* (P06)

The third theme is relational impact. The experience enabled them to forge and nurture important and distinctive relationships with others. They were able to communicate with prospective or current sex partners, and family and friends, which participants recount could be especially challenging as an adolescent. This challenge is exacerbated by a lack of information, or lack of a shared experience, and as peers they perceive that they could relate to each other in ways that were unique, and important.

Talking to prospective/current partners. The former peer sexual health educators share how the experience enabled them to speak more openly with their current or prospective sexual partners. Clearly, they perceive that their work with facilitating and participating in "uncomfortable" conversations in their peer roles, enabled them to have these conversations in their personal lives, "It made me feel comfortable having a conversation with a

sexual partner, how to actually have the talk with a partner" (P01, SeXpert). Another participant expressed specifically how the role helped them to have specific conversations with their prospective partners,

> Everything I learned, I definitely practice what I preach. And the sexual partners I encountered after [being a] SeXpert, and even during, I would constantly ask questions, "Have you been tested? What is your status? Let's talk about this. I would appreciate if we both were just more aware of our status, and just being smarter about the sexual decisions that we make." [I'm not] afraid to confront my partner, let them know, this is something I'm comfortable doing, this is something I'm not comfortable doing. I learned … to just be open, and to always ask questions, just always be an open book. And I think being young, in the younger generation, it's hard for us to do that. (P05, SeXpert)

Another participant discussed the challenges of having these conversations with prospective sex partners, "It helped me towards my personal life cause … [I learned that] a lot of males don't like to go and get tested. Males, do not go to the doctor at all, like at all. So it showed me in my personal life … the guys that I talk to, [for] one of our dates, we would just go get checked out together, do you know what I'm saying? To walk in and get checked out together cause guys don't do it, you know what I'm saying? If you [sic] confident enough to go get tested with me, then [I] can take our relationship further. But if a guy don't wanna go to get tested, that should tell you something" (P09, PHIM). One participant shares how he/she is very direct with these conversations with his/her prospective partners, in ways that he/she probably would not be able to if he/she had not had this experience, "[If I was never a PHIM] I probably wouldn't [be as] straightforward like I am now. Like I'm being blunt with it, ain't no sugar-coating or beating around the bush with it. No, I wouldn't be saying like, "What you be doing?" like that. I want to know, "How many partners, and who you screwing?" and all that. I'll ask. I want to know, "Do you use protection? Do you have multiple partners? When the last time you been tested?" Hmm … I ask a lot" (P07, PHIM). A former SeXpert (P01) shares that the ability to even have a conversation is a way to further protect themselves, "It made me literally ask those questions [prospective partner's STI/HIV status]. And if that answer wasn't what I was looking for, [I] would just walk away, it wasn't worth it."

Forged and Nurtured Relationships. The peer sexual health educators were tasked with discussing topics that were familiar, but generally were not discussed with individuals beyond one's very close social network, if they were discussed at all. This unfamiliarity actually appeared to breed cohesion and a sense of intimacy among the program participants. The peer educators were tasked with recruiting their peers to events where these topics were discussed, which participants state could be uncomfortable at times, but that initial discomfort would quickly subside, "Yea sometimes it

do be [sic] uncomfortable [sexual health topics]. But, I mean you take your friends with you (HOPE project events) and you blend right in with them. One person gets talking and you comfortable replying to the conversation. Like it's not uncomfortable at all … especially when it's considering your health" (P07, PHIM). The peer educators were able to have these "uncomfortable conversations," and one former SeXpert (P05) describes how they were able to do this:

> We (SeXperts) normalized the conversation of sexual health. I feel that that's the biggest takeaway … having it be just a part of everyday life, not something that you have to avoid. We basically just opened up the whole world of sexual health, and made it a little more easier [sic] for people to live with … it's not something that's normally talked about and I think we just kind of gave it a voice and kind of gave it a platform.

In an earnest way the peer sexual health educators, through their conversations and work at HOPE project events, forged bonds with participants. The relationships that developed were unique, and valuable, "Just knowing that I had peers around my age to talk to. I looked at them as family. We talked to each other, we laughed, we had a good time, and we shared information with one another. It wasn't like [talking to] my friends or my boss or other peers" (P06, SeXpert). These warm relationships extended beyond peers and other participants, but to staff as well, "I liked how everyone that worked together grew as like a family, I would say. While we were working together, we really bonded with each other. And even people in the office at YOUR Center took the time out to really bond with us, even though we were, you know, just kids. [chuckle] They really took the time out to bond with us, and get to know us, and so I enjoyed just having those connections" (P02, SeXpert).

One former PHIM stated the importance of shared experience. Being African American, and being from the same community, was critically important to relating to African American adolescents and young adults concerning sexual health, "How can you tell African American adolescents about high sex rate, high STI rate in an urban community if you don't live in the urban community? Or you've never experienced stuff. You can't relate to them in all honesty" (P08, PHIM). For the participants who share their direct experience with trauma, they relate how participation actually helped them relate to other participants.

> It kinda helped some people because I talk about it [trauma]. It happened repeatedly and repeatedly to the point where I was scared to tell anyone. So as a kid you scared because you don't wanna tell people [sic]. [pause] It's a million kids out there just like that right now. They parents don't even know [sic]. And that's the fucked-up thing about it because these kids are so scared to be able to tell their parents [pause]. So, I had to tell people. Yeah, I would tell people because I want people to get to know me, "I come from where y'all come from. I come from the bottom just like

y'all come from the bottom. I done went through some things just like y'all done went through some things. I done experienced some things just like y'all done experienced some things." (P11, PHIM)

Discussion

This paper helps to expand the literature describing the impact of sexual health education programs. We describe how peer sexual health educators are impacted across three specific areas: perceptual, cognitive, and relational. We describe the lasting impact, some years removed from the peer educator role. Clearly these impact outcomes persist as the adolescents and young adults acutely describe how their participation continues to impact their lives. These findings should be considered with how outcomes are defined and evaluated for similar peer sexual health programs.

We explicate both the nature and extent of impact. Interestingly, female participants express confidence and authorship over their bodies in the context of negotiating STI/HIV status and protective practices with current and prospective partners. They "own" their sexuality. Female participants expressed how they are empowered to have very direct conversations with male prospective sex partners about various topics, such as STI/HIV status and what they are comfortable with. They also expressed a keen awareness of how these conversations can be difficult. We take particular note of this. This impact is considerable given the literature on how adolescent females and young adults can face challenges in negotiating these issues with male current/prospective partners. For example, for women across age groups, conversations concerning sex in general can be avoided because these conversations are masculinized, and carry gendered roles (Montemurro, Bartasavich, & Wintermute, 2015; Wang, 2013). The impacts presented through other peer education programs describe how female adolescents are taught to love themselves and their body ultimately reducing their thoughts about negative body image can help to empower them to make better decisions about their sexual health (Crosby et al., 2000).

In addition to offering an in-depth understanding of the long-term impact of being a peer sexual health educator, this study also adds to our existing body of knowledge in the following areas. First, they are important in the context of the considerable literature describing sexual perceptions and behaviors based on communication within familial relationships (Averett & Estelle, 2013; Widman, Choukas-Bradley, Helms, Golin, & Prinstein, 2014). Parents play a role in various areas of adolescent development, including sexual behavior. In many cases, parents take on significant roles in fostering sexual literacy and sexual health information (Shtarkshall, Santelli, & Hirsch, 2007). Level and type of parental supervision and

monitoring influences adolescent sexual expression (Romer et al., 1994). Parents can impart information about sexual literacy and sexual health according to particular social, cultural, and religious views, and parental influences are particularly noteworthy in mother-daughter relationships (Hutchinson, 2002). Second, findings contribute to the burgeoning literature concerning sexual health communication within African American families (Crosby et al., 2002; Miller, Kotchick, Dorsey, Forehand, & Ham, 1998; Usher-Seriki, Smith Bynum, & Callands, 2008). In addition, these findings are pertinent to researchers and practitioners focused on gender-based intimate partner relationships, especially among African Americans.

Findings offer practice implications for sexual health education programs. Despite their overwhelming praise for its impact, participants suggest opportunities to improve sexual health programs. Improvement opportunities center on expansion by reaching more people. These former peer members were keenly aware of the persistent information need that they sought to fill. They wish that the program could impact even more people, especially given the importance of the topics and the dearth of sexual health information available to adolescents and young adults. Although the sample is entirely African American, and the HOPE project focused on African American communities, former peer sexual health educators express the desire for diversity, across many dimensions. While participants expressed strongly held opinions that being from similar backgrounds enabled them to relate to their peers in meaningful ways, but they suggest that more racial, socio-economic and gender inclusion would make the program even more impactful.

Last, we offer a framework for health educators and practitioners to use in developing and evaluating outcomes for sexual health programs. The "three impact themes" analytical framework is informed by extensive literature on measuring impact, the majority of which are informed by health behavior theoretical frameworks. The "three impact themes" framework offers a platform to help facilitate ideas for articulating outcomes for community-academic collaborations focused on sexual health, which can be used to enhance how programs are structured and evaluated, critical to support efforts to secure funding.

Limitations

Since the sample of both former sexual health educator roles was recruited via individuals who helped administer and direct the HOPE project, the sample may be skewed toward positive experiences. Any former peer mentors who may not have been impacted at all, or were impacted negatively, may not have been contacted or may not have agreed to participate. Further, it follows that the former peer educators remain in contact with key individuals that they have an affinity for, and accordingly an affinity

for the peer educator experience itself. Nevertheless, since this is an assessment of impact on the peers, we situate our results in the context of how participation as a peer educator *could impact* adolescent and young adult peers. Just as participation did not result in uniform impact in our sample, it is reasonable to conclude that all HOPE project peer sexual health educators will not share the same experience, and our sample may be skewed toward those who perceive positive impact.

Conclusion

The effect of being a sexual health peer educator is rarely examined. This novel study offers a unique viewpoint from African American peer sexual health educators years removed from their role. Being a peer sexual health educator had perceptual, cognitive, and relational impacts that were important several years after the role had ended. The effects of sexual health programs on peer educators should be considered when routine program evaluations are planned.

Paper Contributors

All authors contributed to this paper in various forms. CS and TC initiated the project. CS designed the study, collected data, worked on data analysis and interpretation, and drafted and revised the paper. DY worked on data analysis and interpretation, and secondarily drafted and, with CS, led the paper revisions. YW worked on creating code book, data analysis, and interpretation, and provided help in writing a section of the paper. SJ and EP, worked on analyses and interpretation of data, and collection of literature.

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ORCID

Charles Senteio http://orcid.org/0000-0002-0254-3127

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Appendix A

Semistructured Interview Guide—Former SeXperts/PHIMs

Impact *of participating as a peer educator in an HIV/STI program*

We are specifically interested in understanding the impact that serving as a peer educator has had 3–5 years after participation in an HIV/STI health education program ("HOPE Project").

1. Demographics: Age? Racial Identity? Gender Identity? Sexual Orientation? Location and Timeframe for participating as a peer educator (age at time of participation)?
2. Role and Motivation: What was your specific role: SeXpert or PHIM (Peer Health Information Mentor)? Why did you decide to be a peer health mentor? What did you learn in becoming a peer health mentor? What did you do as peer health mentor (who did you help educate, what did you educate them on)? What did you learn in your role as a peer health mentor? What was your compensation? What did you like about it? What would you change?
3. Impact––General: How did being a peer health mentor impact you? What would be different about you if you never were a peer health mentor?
4. Impact––3 Areas: How did being a peer health mentor impact you in these 3 areas:
   a. Education: How did participation influence your educational goals? Educational choices (i.e., post-high school training, other training/certification)?
   b. Career: How did participation influence your career goals? Career choices?
   c. Personal: How did participation influence your personal life? Your personal habits/sexual behaviors? Your skills (interpersonal, awareness of diversity, empathy)? Your perceptions (healthy relationships, self-esteem)? Your decisions of how to contribute to others (financial contributions, volunteering, serving on boards, etc.)?
5. Impact––Benefits: If you were attempting to convince a potential peer educator to participate in a similar peer education sexual health program, what would you tell them?
6. Impact––Health Information Seeking (HISB): Recall a recent time when you looked for information about sexual health (or health in general), where did you look 1st, and why?
   a. Categories: Internet (General search [via Google], or a specific site); Family and Friend/Coworker, Healthcare professional, Traditional media (books, brochures, magazine, library)
   b. Sharing: Have you shared what you found with anyone else? If so, who? If not, why and who would you share this information with?
7. Is there anything else you'd like to tell me about how your experience as a peer health mentor has impacted you?

Appendix B

Q16 Impact of Being a Peer Sexual Health Educator Data Codebook

Code No.	Codes	Description/Examples
1	Things learned in becoming a SeXpert	What did a participant learn in becoming a SeXpert?
1.1	Learn to feel comfortable having a conversation with a sexual partner	*It helps to have a conversation… To make you feel comfortable having a conversation with a sexual partner.* [Psex01, 06:57]
1.2	Learn to feel comfortable having a sexual conversation in general	*Psex05: [21:16]Well, 'I've learned that the topic of sex is definitely not something that we are gonna be able to sweep under the rug forever… having it become more regulated and more of a normalized conversation.* *Psex05: [22:08] in 'society's norms, 'it's not something 'that's normally talked about. 'It's not a conversation to be had at the table. And I think we just kind of gave it a voice and kind of gave it a platform, to kinda sum it up.*
1.3	Learn new knowledge (e.g., sexual health, community statistics)	Learning new knowledge about sexual health such as how to practice safe sex, etc. *Psex04: [7:23] Just about the STI, STD, and it made me more aware of my surroundings with them giving you the statistics on the community and how many people are affected and things of that nature.*
1.4	Learn to be aware and to protect oneself	Learning to be aware and cautious about one's actions. For example, *I would say that knowledge is power and I 'don't think you learning about something encourages you to engage in that activity. It just makes you more conscious and aware of what could happen if you were to do those activities.* [Psex02, 12:23]
1.5	Learn to decompartmentalize when talking to people	*And my only job is to help you and I cannot help you if 'I'm judging you. So for me, personally, professionally, it helped me in every form or fashion. Personally, professionally and anything in between, every single time I'm having a conversation with somebody, 'I've learned to de-compartmentalize because my job is to assist you and I cannot assist you if 'I'm thinking from a one biased viewpoint, standpoint of everything. I cannot do that. So 'it's definitely assisted me in every form or fashion.* [Psex03, 43:35]
1.6	Learn to be truthful	*It is best to be truthful with each other. This stuff 'that's come out anyway. So You have a good if you want to have a friend or a good partner.* [Psex10, 36:11]
2	General impact of being a SeXpert	How did being a SeXpert impact a participant? What would be different if they never were SeXperts? For example, *If I never been a "sexpert" I wouldn't have made the relationships I made with other people, and I 'wouldn't be knowledgeable…* [Psex02, 29:48]
3	Impact in education/knowledge	
3.1	Impact in educational goals	How did participation influence a participant's educational goals? For example, *Actually I am a CNA so I kinda… 'I'm going to school for it right now. So 'it's like, 'I'm learning all the diseases and stuff that I already knew from the book, so it definitely helped me out in the long run.* [Psex09, 16:34]
3.2	Impact in educational choices	How did participation influence a participant's educational choices?
4	Impact in career	
4.1	Impact in career goals	How did participation influence a participant's career goals?
4.2	Impact in career choices	How did participation influence a participant's career choices? For example, *So 'that's one thing that I definitely enjoyed about Sexperts that continued into my career choice because directing, being able to take on a different persona, but still get a word of… A message out there to go reach people in a form of a play or a skit 'that's still giving information is something that I'd definitely continue…* [Psex05, 34:17]

(*continued*)

Continued.

Code No.	Codes	Description/Examples
5	Impact in personal life	
5.1	Impact in habits/sexual behaviors	How did participation influence a participant's habits/sexual behaviors? For example, *It was basically about not endangering yourself because of the diseases and stuff that's going on.* [Psex07, 11:37]
5.1.1	Motivation to learn more (not just sexual health information)	*It made you wanna learn more. Not even just about sexual stuff, it made you wanna learn more about everything. It made you wanna dig deeper because a lot of this stuff…* [Psex01, 18:55]
5.2	Impact in skills	How did participation influence a participant's skills (interpersonal, awareness of diversity, empathy, etc.)? For example, *'I've known how to express, "Well, we need to get tested," or,"We need to have protection"…* [Psex03, 37:52]
5.3	Impact in perceptions	How did participation influence a participant's perceptions of healthy relationships, self-esteem, etc.? For example, *As far as self-esteem, I definitely found that in knowing more, I gained more self-esteem and more awareness and security in myself.* [Psex05, 41:24]
5.4	Impact in decisions of contributing to others	How did participation influence a participant's decisions of how to contribute to others (financial contributions, volunteering, serving on boards, etc.)? Learn the necessity to inform and educate other people. For example, *I would always make sure I was signed up for different volunteer opportunities, because 'it's something that I learned from Sexperts and wanted to bring over with me into adulthood…* [Psex05, 31:18]
5.5	Helpful in the process of coming out	*Well, being a sexpert helped me in the process of coming out because, prior to being a sexpert, I was very lackful of most education in anything concerning sexuality.* [Psex03, 6:55]
5.6	Making new connections and friends	*They really took the time out to bond with us, and get to know us, and so I enjoyed just having those connections. And I saw Tamara… 'Let's see… I saw her, like, a few months ago and it was still like, "Oh, I 'haven't saw you in so long." 'It's still like that bond was still there.* [Psex02, 21:24]
6	Benefits	How did a participant benefit from participation? How would a participant convince another person to be a peer educator? For example, *'it's a matter of teaching and 'it's a matter of gaining knowledge, but it's also a matter of saving the lives of others.* [Psex05, 45:48]
7	Value of knowledge [Empowerment through knowledge]	Major importance of what was learned was repeated as value of the information in real life for everyone *Psex03: [4:43] I was just enthralled by the conversation, I was getting so much education about it… I felt like it was such a need for youth to be able to talk to people and bridge that gap between the sexual communication for people to understand better about their health. I understood that.*
8	Washing away stigmas	A lot of stuff is stigmatized, and those stigmas need to be washed away. I learned that the respect for a person's body is not as high as it should be. [Psex08, 20:49]
9	Realizing the knowledge that should be taught in schools [Decreasing void of sexual information]	I don't think schools nowadays, period, accept that much information. [Psex06, 14:48]