PEER HEALTH STRATEGIES IN HOPE SF COMMUNITIES

An Assessment to Inform the Support and Development of Peer Health Strategies in HOPE SF Communities

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This project would not have been possible without the support of the key partners-- HOPE SF, the San Francisco Department of Public Health and San Francisco State University’s Department of Health Education and Health Equity Institute (HEI). The project Advisory Group provided input and advice about many essential aspects of the assessment. In particular, September Jarrett and Maria X. Martinez provided ongoing and critical guidance, insights and effort that ensured the relevance and focus of the assessment. Laura Mamo, brought her significant expertise to the project and helped ensure the quality of the assessment activities. Emily Weinstein and Uzuri Green provided essential feedback about getting the input of HOPE SF community members and guided this work by sharing their own experiences working in peer health efforts at the Potrero Hill HOPE SF site. Cynthia Gomez, Director of the Health Equity Institute and other HEI staff made the Community Science Dialogue possible. Finally, the people interviewed - resident leaders, program staff and key stakeholders - spent their time and provided the knowledge, opinions and experiences that inform the findings and recommendations. Their work to ensure the health and well-being of HOPE SF communities is humbling and inspiring.
**HOPE SF**

HOPE SF is the nation’s first large-scale public housing revitalization project to invest in high-quality, sustainable housing and broad scale community development *without* displacing current residents. HOPE SF plans to transform eight highly distressed public housing sites in San Francisco into vibrant neighborhoods with over 6,000 new public, affordable and market-rate homes. HOPE SF is led by the San Francisco Mayor’s Office of Housing with dozens of public and private sector partners. Enterprise Community Partners, The San Francisco Foundation and the Mayor’s Office launched the Campaign for HOPE SF with the goal to raise $25 million for a major HOPE SF evaluation as well as programs and services over the next five years. Governed by a Steering Committee and a national Leadership Committee, the Campaign is mobilizing local and national philanthropic investment - and leveraging public dollars -- to ensure that HOPE SF has the resources necessary to create diverse, thriving communities for all residents.

**San Francisco Department of Public Health**

The mission of the San Francisco Department of Public Health (SFDPH) is to protect and promote the health of all San Franciscans. SFDPH realizes its mission through the provision and funding of medical services, Community Health Programs and through the oversight and implementation of Population Health and Prevention activities and programs.

**Health Equity Institute, San Francisco State University**

The Health Equity Institute (HEI) is a trans-disciplinary research institute at San Francisco State University that links science to community practice in the pursuit of health equity and justice. HEI is a multi-disciplinary team pursuing original research on emerging health equity issues and partnering with communities to understand and address critical health equity issues. HEI creates multimedia communication tools that speak the voices of communities and inspire change for health equity.

**Department of Health Education, San Francisco State University**

Housed in the College of Health & Social Sciences, the Department of Health Education currently offers a Bachelor’s of Science degree in health education with emphases in community-based health, holistic health, and school health. At the graduate level, the Department offers a Master’s of Public Health (MPH) degree in community health education. The following students enrolled in the Master of Public Health Program at San Francisco State University and the Health Education course Community Assessment for Change – HED 820/821 in spring and summer 2012. They participated in the Peer Health Strategies in HOPE SF Communities assessment under the guidance of the instructors Jessica Wolin, MPH, MCRP and Paul Rueckhaus, MPH, MA.

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BACKGROUND

In November 2011, HOPE SF, the San Francisco Department of Public Health and, San Francisco State University’s Department of Health Education and Health Equity Institute came together in a collaboration to further the development of peer health strategies in HOPE SF communities. The collaboration is guided by several key recommendations developed by the Campaign for HOPE SF Health Taskforce and focuses in on the clear priority of the Taskforce and HOPE SF of community engagement and resident involvement in promoting community health and well-being.

The collaboration builds on and recognizes the numerous community efforts to improve health that are already underway and the significant research endeavors that have already and continue to take place with HOPE SF communities. This Peer Health Strategies assessment seeks to illuminate how the City of San Francisco and other stakeholders can best support the continued development and implementation of peer health strategies at all of the HOPE SF sites in a manner that honors the uniqueness of each site and recognizes commonalities to ensure a coordinated and thoughtful approach.

The collaboration is engaging in activities to position HOPE SF to be able to support effective, sustainable peer health strategies across the HOPE SF sites. A key aspect of the collaboration is that it is designed to result in meaningful products for HOPE SF, the San Francisco Department of Public Health and stakeholders as well as serve as a practice-based learning opportunity for San Francisco State University Master of Public Health (MPH) Students. San Francisco State University MPH students implemented many of the key activities of the Peer Health Strategies assessment, guided by the assessment’s Advisory Group.

Commitment to Health Equity and Meeting Immediate Urgent Health Needs

This collaboration and the Peer Health Strategies assessment stems from the partners’ commitment to health equity and the urgent need to address the health issues facing the HOPE SF communities today. Actions at all levels – the individual, interpersonal, community and societal levels – are needed to address health inequities in the HOPE SF communities. Peer health strategies are, by their nature, interpersonal and can have a significant impact on individual health, but they can also play a critical role in community and societal level approaches to address health inequities. This collaboration seeks to balance a commitment to both long term changes in social determinants and the more immediate individual, interpersonal and community changes that have an impact on health.
Purpose and Key Questions

Purpose

The purpose of the HOPE SF Health Strategies in HOPE SF Communities assessment is to examine the opportunities for, and barriers to, the implementation of peer health strategies at HOPE SF sites.

Key Questions

**Background and Current Activities**
- What peer health strategies have been implemented at Bay Area public housing sites and what activities are in place now at the HOPE SF sites?

**The Model**
- What defines success of peer health strategies and what outcomes are likely to be achieved?
- What are the strengths of peer health strategies and what are the limitations of this approach?
- To what extent should peer leaders be trained and focus on community organizing and advocacy efforts vs. individual and interpersonal behavior change?

**Success Factors**
- What structures, systems, supports, program activities and other elements are needed to make peer health strategies at HOPE SF sites effective and sustainable?
- Who can most effectively serve as a peer leader at HOPE SF sites and how should they be selected to ensure fairness, program success and desired outcomes?
- How should peer health strategies implemented at HOPE SF sites be connected to other health and social advocacy and service activities of the community, local organizations and government agencies?

**Challenges**
- What are the challenges to the development, implementation and sustainability of peer health strategies in HOPE SF sites?

**Desired Approaches**
- What would be the ideal peer health strategies implemented at HOPE SF sites – including how they should be structured and what health issues they should address?
ASSESSMENT METHODS

The following methods were used to conduct the Peer Health Strategies assessment. SF State MPH students conducted many of these methods as part of their work in the Health Education class entitled Community Assessment for Change – HED 820/821/822. The course instructors provided ongoing support and guidance to the students and the advisory group to the assessment provided input throughout the development and implementation of the project.

Peer to Peer Health Assessment Advisory Group

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Key Assessment Activities

Literature Review (February – April 2012)

20 MPH students and the SF State instructors conducted a comprehensive review of the literature, including examination of literature regarding both peer health strategies in public housing and peer health strategies in other relevant contexts.

Community-Science Dialogue (March 2012)

Community-Science Dialogues are forums hosted by San Francisco State’s Health Equity Institute that bring together researchers with policy makers, local government, community organization staff and other community stakeholders to discuss cutting edge issues at the nexus of science and practice. On Thursday, March 29th, the Health Equity Institute hosted its 3rd Community-Science Dialogue which was focused on Peer Health Strategies in HOPE SF Communities. The Community-Science Dialogue was an important opportunity for key stakeholders in HOPE SF to discuss the challenges and opportunities of peer health strategies and identify critical areas for future research and practice.
In-depth and Key Stakeholder Interviews (April – July 2012)

20 MPH students and the SF State instructors conducted a total of 50 interviews over the course of three months. Potential interviewees were identified by the assessment Advisory Group and through snowball sampling methods by asking assessment participants if they knew of other potential people to interview. Data analysis took place over the course of a month and was done by coding all interview data and identifying key themes which were developed into findings and recommendations.

- 13 in-depth interviews with resident leaders representing four of the HOPE SF sites – Sunnydale, Alice Griffith, Potrero and Hunter’s View were conducted. 62% of those interviewed were African American while other participants identified themselves as being biracial, white, Samoan, Latino/a and Russian. The average time participants had lived in the community was 16 years while the average time participants had spent working in their community was 11 years. The average age of interviewees was 47 years old and 85% were identified as female.

- 18 in-depth interviews with SF Bay Area program staff that have experience developing and implementing peer health programs were conducted. Interviewing program staff whose work specifically focuses on public housing residents was prioritized. However, due to the small number of programs with public housing as its discrete focus, many assessment participants were program staff from organizations that implement peer health programs that may include public housing residents along with other community members or work with populations with similar characteristics. Interviews were done with representatives from the following organizations,

  - Anka Behavioral Health Inc.
  - Bridge Housing Corporation
  - Enterprise Community Partners
  - Instituto Familiar de la Raza
  - Homeless Prenatal Program
  - Learning for Action
  - Mercy Housing
  - Mission Graduates
  - Ravenswood Family Health Center
  - Richmond Area Multi-Services
  - SF Breastfeeding Peer Counseling Program
  - SF Department of Public Health
  - SF Housing Authority
  - SF Education Fund
  - Urban Strategies Inc.
  - Youth Leadership Institute
• 16 key informant interviews with key stakeholders including individuals in leadership roles in organizations that are involved in HOPE SF were conducted. Interviews were done with representatives from the following organizations,

  - YMCA
  - SF Department of Children Youth and Families
  - Bayview Hunters Point Foundation
  - SF Unified School District
  - 3rd Street Youth Clinic
  - SF Mayor’s Office
  - Center for Youth Wellness
  - First Five San Francisco
  - POWER
  - SF Housing Authority
  - SF Department of Public Health
  - Coleman Advocates for Children & Youth
  - University of San Francisco
  - Youth Leadership Institute

• In-depth interviews with national and local experts representing the following organizations were conducted.

  - Boston University’s Partners in Health and Housing Prevention Research Center which is funded by the US Centers for Disease Control and Prevention (CDC)
  - Housing and Urban Development (HUD)
  - University of California, San Francisco

**Definition of Peer Health Strategies**

For the purpose of this project the following definition of peer health strategies is used: Peer health strategies involve community residents working to address community health issues by serving as a source of health information, bridge to services, advocate for community health needs, facilitator of community action, and organizer of community health promotion activities. They reside in the community and serve the community. In order to simplify language and remain consistent over the course of this assessment, the term “peer leader” is used to describe anyone that is doing peer health work regardless of the model or approach used or scope of their work.

**Definition of Health**

This assessment uses the definition of health provided by the World Health Organization: Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
LITERATURE REVIEW

Methods
An essential element of the Peer Health Strategies in HOPE SF Communities assessment is a comprehensive review of the literature regarding the implementation of peer health strategies in public housing settings. Prior to making contact with interviewees for the assessment, the class of 20 graduate public health students reviewed 125 articles and reports with the purpose of better understanding the essential qualities of peer leaders in peer health programs, the patterns of successful peer health programs and notable challenges such programs encounter across the country.

To review the literature of peer health promotion strategies in public housing settings, the class of 20 graduate students worked in five teams of four students. Four of the teams focused on particular health issues in the peer health program context, including:
- chronic diseases (i.e., nutrition, physical activity, obesity, diabetes, heart disease, cancer)
- mental health and substance abuse issues
- environmental hazards (e.g., asthma-related hazards, lead, pollution)
- infectious diseases (e.g., HIV/AIDS, Tuberculosis, sexually transmitted diseases, injection drug use).

The fifth team focused on different models of peer health strategies including: advocacy and community organizing models; community health worker models (e.g., Promotoras, lay health workers, peer leaders); and peer support models (e.g., rap groups, 12-step, and support groups).

Each literature review team used a variety of databases available through the San Francisco State Library server including: PubMed, ERIC, Web of Science, Academic Search Complete as well as Google Scholar.

Lessons Learned from Literature on Peer Health Strategies in Public Housing

Defining the Peer Leader
Peer health strategies involve community residents who work to address community health issues by serving as a source of health information, bridge to services, advocate for community health needs and organizer of community health promotion activities. The articles reviewed used a variety of terms to describe the role of the peer support person such as advocate, educator, mentor, community health worker, navigator, promotora, lay health worker and so on. We will use the term peer leader to generically describe all of these possible support roles. Peer leaders are from the community and serve the community. They function as trusted sources of information, health and life coaches, and role models for other community members. In addition to simply being from the
community, the literature identified patterns of qualities that are often found in peer leaders such as:

**Established Credibility**: The literature indicated that peer leaders in established peer health programs were often already functioning as leaders, confidants or role models in their communities. The programs formalized their leadership roles by providing training and material support to execute the interventions with adequate resources and accurate information. While peer leaders were usually similar in age to the target population, intergenerational approaches to peer strategies were also found in the literature. One remarkably effective asthma control program paired lay-trained seniors who had asthma with children who had asthma, attributing the success, at least in part, to the intergenerational aspect of the peer dynamic (see Reddy, et al., 2007). While peer leaders typically had a high level of trust and credibility in their communities, this was not universal. Even successful studies reported varying degrees of reluctance and mistrust by community members as a barrier to participation. Furthermore, public housing environments often posed real and perceived barriers to privacy, which can further compromise trust and reliability. For example, an intervention that required peer leaders to conduct home visits with the aim of controlling indoor environmental hazards were perceived to be intrusive and ensued mistrust and reluctance to participate (see Jordan, et. al., 2003).

**Natural Leadership**: Very different strategies to identify leadership in peer educators were at play in the literature. In one instance, public housing residents were asked to list the names of five women they trusted and respected to identify the peer leaders (see Sikkema, 2005). Natural leadership, however, was not only contingent on community trust, but on an intrinsic desire to improve the conditions of the communities in which the peer educators lived. In another example, the housing project was canvassed with flyers which promoted volunteer opportunities as peer leaders in which the peer educators were entirely self-nominated. In most cases, peer leaders came to their position vis-à-vis a combination of community vetting and self-referral (see Davey-Rothwell, et al., 2011).

**Cultural Flexibility**: Peer leaders act as navigators, advocates and a bridge of sorts between formal, professional arenas such as health care, social services and urban planning, and the target community in which they live. Because of their formal training in the salient health issues and their insider status in the community, they also promote health literacy and self-advocacy among community members. As insiders, they explain health information in a relatable, culturally appropriate way and help community members problem solve in ways that professionals are not able to (see Ayala, 2011; Findley, et al., 2011; Baksis, 2010; Turner & Shepherd, 1999). Peer leaders are often thought of as being culturally competent liaisons to deliver services, however, they often served as not only educators to the community but advocates on behalf of the community to the extent that they were involved in
decision making process such as planning and problem identification (see Andrews, et al., 2011).

**Role Models:** In addition to these qualities, peer leaders often acted as role models in the community. As they modeled health care utilization, exercise, food preparation, communication and a variety of other skills, peer leaders were *living* what they were teaching. Because of this role-modeling function, peer leaders, themselves, often made notable improvements in their health as we discuss in the outcomes section (see (Ayala, 2011; Brownstein et al., 2005; Plescia et al., 2008).

**Outcomes of Peer Health Strategies**

**Learning 1: Health Improvements**

Peer health programs in public housing demonstrated measurable health improvements in many objective health outcomes. Reduction of Emergency Room visits and admissions for asthma (see Krieger, et al., 2002; Kreiger et al., 2010; Takaro, et al., 2004) and other manageable conditions (e.g., diabetes, hypertension) (see Brownstein, et al., 2005; Carrillo Zuniga, et al., 2011; Edgren, et al., 2005; Horowitz, et al., 2011); Tuberculosis treatment adherence and Influenza vaccination (see Klein, 1995; Krieger, et al., 2000; Tulsky, Hahn, Long, Chambers, Robertson, Chesney, & Moss, 2004); and decreased waist circumference and improved blood pressure (see Ayala, 2011) are some examples of these positive outcomes. Indeed, peer health programs have proven several times throughout the reviewed literature to improve discrete, measurable health outcomes in short-term studies (3-12 months). The literature also indicated improvements in behavioral and self-reported outcomes such as smoking cessation (see Andrews, et al., 2011), increased physical activity (see Ayala, 2011), and increased consumption of fruits & vegetables (see Larkey, 2006). These changes were often directly connected to the intervention (e.g., smoking cessation group, exercise groups, nutritional counseling).

**Learning 2: Influencing the Lives of Peer Leaders**

Significant positive outcomes for peer leaders resulted from their involvement in peer-to-peer health programs. Positive outcomes not only included changes in peer leader's knowledge, attitudes and beliefs but in their own health status as well. Leading exercise groups, conducting nutrition education, counseling peers on safer sex influenced the behavior and positive health outcomes of peer leaders. In some cases, working as a peer leader served as a professional development opportunity for community members and promoted empowerment, community engagement and self-efficacy (see Condon, et al., 2007; Plescia, et al., 2008; Brown N., Vaughn N.A., Lin A.J., Browne R., White M, & Smith P., 2011).

**Success Factors for Peer Health Programs**

In addition to reporting measurable and anecdotal outcomes, the literature revealed key characteristics and program tactics that led to successful peer health promotion outcomes.
Learning 3: Training Peer Leaders

Despite being trusted leaders in their communities, peer leaders often required training to execute the interventions. Peer health programs that invested in training of peer leaders and engaged them in providing concrete, actionable health information, such as how to address asthma triggers in the home; delivering specific health services, such as blood pressure screening; or facilitating access to health behavior change opportunities, such as leading walking clubs, showed significant improvements in salient health outcomes for community program participants.

Learning 4: Incentives

Financial incentives were essential to the recruitment and retention of peer leaders and the success of peer health programs in public housing settings. The coalition of one project struggled to determine whether compensating peer leaders would compromise the role of “natural helper” or provide an important employment opportunity (see Plescia et al., 2008). Other studies found that not hiring volunteers after the initial training period, or failure to provide supportive resources (such as childcare for trainees), negatively impacted the program’s length and effectiveness (Brownstein et al., 2005; Krieger et al., 2009).

Learning 5: Community Engagement

Literature describing a community based participatory research (CBPR) process, explicitly attributed successful outcomes to the planning processes (see Shelley, et al., 2010; Kreiger, et al., 2009; Rorie, et al. 2007). Programs that engaged the community in problem identification and intervention strategy not only reported desired outcomes but were enduring and dynamic programs—lasting years instead of months. For example, the study of the Sister-to-Sister smoking cessation support program authored by Andrews, et al. (2011) described a ten year process of problem identification, developing community advisory boards and proliferating a peer-based smoking cessation program for African American women in fourteen public housing communities.

Learning 6: Collaboration

Collaboration among institutional stakeholders was essential to the success of peer health programs in public housing. Multi-agency collaboration helped advocacy efforts to improve building maintenance and management (see Condon, et al., 2007; Wolff, et al., 2004). Collaborations among public, academic and nonprofit partners were essential made it possible to leverage material support to finance resource intensive interventions that may require the purchase of air filters, dust covers and cleaning supplies, which were provided as incentives in some environmentally focused programs (Krieger, et al, 2002; Wolff et al., 2004; Wechsberg et al., 1992).

Challenges

Learning 7: Lack of Life-Work Separation

Living and working in the same environment proved to be a challenge for many peer leaders as they were working with individuals who were also potentially involved in other aspects of their lives. Confidentiality and trust related issues between the peer worker and
residents created conflict. In some cases, trainings to strengthen communication and conflict resolution skills were needed to help address this (see Davidson, Chinman, Kloos, Weingarten, Stayner, & Tebes, 2006). Peer leaders, belonging to the same community they served, faced similar stressors to those faced by other residents, at times leaving them without the peer support that they might need. The peer leader role risked encroaching on normal life. (see Plescia, 2008; Davidson, et al, 2006). Meister, et al. (1992) illustrated this sense of encroachment into personal life in their study of a prenatal support program in which peer leaders were, at times, called upon in emergency situations during their personal time.

**Learning 8: Funding and long-term planning**

Lack of resources and piecemeal programmatic funding was cited continuously throughout the literature as a major challenge to successful implementation of peer health interventions. While peer-to-peer strategies have the potential to be both more cost-effective and culturally adept than clinical approaches, stipends, incentives and training are still costly and not reimbursable services. In the absence of adequate, reliable long-term funding, programs simply cannot sustain themselves.

**Gaps in the Literature**

**Gap 1:** Long-term examination of peer health interventions in public housing and low-income communities was largely missing from the scientific literature. Brief program periods (rarely lasting over three years) make it difficult to ascertain how peer-to-peer interventions shape health status in public housing communities over time.

**Gap 2:** Outcomes of peer health programs were, for the most part, narrowly framed to focus on measurable health outcomes. In addition, it is important to acknowledge that violence was not included as focus of literature review as it requires its own comprehensive review. The peer approach was often noted as a preferred strategy for interventions because of its ability to promote social cohesion and build on community strengths. Yet, community-level outcomes such as social cohesion and collective efficacy were not measured despite the acknowledgment of these being positive side effects of peer health strategies.

**Conclusion**

Training and supporting peer leaders who are accessible to a given population has improved health outcomes in a number of public housing sites and other low-income communities across the country. Peer health strategies build on community strengths and bring community members together for reasons beyond the intended health intervention. The notable health outcomes through peer health strategies are reliant on factors such as: character strengths of the peer leader, the recruitment and retention of peer leaders, sustained funding, and implementation of a community-based planning process. Gaps still remain unaddressed by the literature and have to do with sustainability and longitudinal investigation of peer-to-peer strategies over time as well as measurement of the social benefits and consequences of implementing a peer health promotion program.
INTERVIEW FINDINGS

The following findings were developed by the MPH students who conducted the in-depth and key stakeholder interviews and transcribed, coded and analyzed the interviews in collaboration with the course instructors who conducted the expert interviews and guided the data analysis process. The findings reflect themes that were found in the interviews with residents, key stakeholders, program managers and national experts and highlight those areas of agreement across these groups. In addition, specific important issues raised by interviewees from only one group of interviews are presented.

Current Peer-to-Peer Health Activities at HOPE SF Sites

Finding 1: HOPE SF residents establish and use informal or community supported peer strategies and social support systems to address health concerns and improve quality of life for residents. These peer health activities are often not well connected across HOPE SF sites and may not be linked to existing social service and health systems. There was widespread agreement that peer-to-peer programs are most effective when built on pre-existing activities and networks.

Health and Community Outcomes

Finding 2: Peer health strategies focused on behavior change (i.e. walking clubs, promotoras) can also foster community advocacy and organizing through training and discussions that support peer leaders and community members as they share experiences in their lives, gain skills and develop a vision for action from which to make change.

Finding 3: Peer health strategies can promote social cohesion and building of relationships between people who share similar experiences. Currently, there is often significant lack of trust amongst community residents. However, residents felt that there is a strong desire for their community to be more connected. There was also widespread agreement that role modeling is one of the most critical aspects of peer-to-peer programs.

Finding 4: Mental health and substance abuse are primary health concerns for HOPE SF residents and should be a priority focus of health strategies. Furthermore, these health issues are significant barriers to some residents being able to serve as peer leaders or participate in community building programs.
Outcomes for Peer Leaders

Finding 5: Job attainment is a key priority for HOPE SF site residents and peer health programs are viewed as an opportunity to further the professional development and provide work opportunities to community members. Access to regular, paid work either through employment in the peer health program itself or as an outcome of serving as a peer leader is viewed as a meaningful and critical aspect of successful peer health programs at HOPE SF sites. However, there is also a need to create job opportunities for peer leaders when they are ready to transition to other work opportunities.

Success Factors

Finding 6: Essential to peer health program success, and strongly desired by current HOPE SF residents, is significant resident engagement in health issue identification, program development, implementation and evaluation. Lack of trust of local government, developers and community based organizations is a significant obstacle facing any program or service focused on HOPE SF sites. Resident “ownership” of programs is seen as critical to program success and sustainability while community engagement efforts must avoid elevating the views of only a few residents.

Finding 7: Training of peer leaders is a critical component of successful peer health programs. Training peer leaders is an ongoing process that should support peers and respond to their needs expressed through feedback. Training needs to acknowledge different skill levels and promote skills that enable peers to implement their ideas for solutions. Retraining and refresher training modules are important for sustainability of peer health programs.

Finding 8: Successful peer health programs provide supervision and structures that support peer leaders and recognize the real and daily health, financial and social issues they may face. Skilled staff who are dedicated to supporting the development of peer leaders are essential and burnout of both peer leaders and staff is an ongoing challenge.

Finding 9: Financial incentives (i.e. stipend, salary, scholarships, gift cards, rent reduction, support to get in school, school credit) of peer leaders is an essential form of support and critical to recruitment and retention of peer leaders. Residents expressed appreciation of the value of volunteerism as part of community engagement. However, they believe that incentives, ranging from monetary compensation to logistical support for participation, to skills training, is necessary for most residents to overcome participation barriers.

Challenges

Finding 10: Selecting or supporting emerging peer leaders requires that program staff understand existing social relationships, while peer leaders need to be able to manage their
own conditions in order to ensure their effectiveness and buy-in from community members. Challenges with recruiting, selecting and retaining peer leaders for HOPE SF sites may include,

- lack of qualifications
- behavior that may be viewed as unprofessional
- poor health
- lack of trust of between residents
- legal barriers to credentialed participation, such as criminal records and immigration status
- difficulty with time commitment
- fear of losing disability benefits or other public assistance due to financial compensation
- difficulty maintaining confidentiality and appropriate boundaries due to living and working in the same environment
- burn-out

**Finding 11:** The inclusion of mixed income housing at the HOPE SF sites poses both potential strengths and challenges to peer-to-peer program development and implementation. Peer health programs offer opportunities for residents across income levels to exchange strengths, resource, skills and perspectives. However, the mixed income housing strategy poses the challenge of establishing trust between public housing residents and higher income residents due to historical racial oppression and institutional classism.

**Sustainability**

**Finding 12:** Securing both short and long term programmatic funding is one of the biggest challenges facing peer health programs. At the same time, community engagement efforts require program infrastructure that is legitimized by partnership and support from credible organizations. Ongoing support and links to trusted services is viewed as key to peer-to-peer health program sustainability and more wide-scale impact.
RECOMMENDATIONS

The following recommendations were developed solely by the MPH students and the SF State course instructors who conducted the Peer Health Strategies assessment. They do not represent the views or opinions of the assessment Advisory Group or any specific participant in the assessment. The recommendations are based on the findings from the assessment and lessons learned from the literature and incorporate the perspectives of both the students and the instructors.

Community Engagement & Trust

Recommendation 1: Support community building, foster social cohesion and address priority health issues at the HOPE SF sites through peer health strategies as part of the overall social service and health strategy of the City and the Campaign for HOPE. Invest in community engagement and ownership of programs and services for HOPE SF site residents, including peer health strategies, in all stages including, problem identification, program design, implementation and evaluation.

Recommendation 2: A consistent system of communication, collaboration and the sharing of resources between trusted agencies and residents should be prioritized and fostered. Tensions between potential collaborators (peer leaders, residents, government agencies, etc.) should be identified and addressed throughout the entire process of the development and implementation of any peer to peer program.

Workforce Development

Recommendation 3: Support workforce development at HOPE SF sites through peer health strategies that offer strong training, professional skill attainment and a specific promotional track for resident leaders. Create an ongoing cycle of peer engagement and professional development by providing residents with opportunities to become peer leaders, move into roles that involve mentorship, training other peers, and gain leadership within the organization. Create partnerships between local employers and peer to peer programs that can establish pathways to stable employment.

Support

Recommendation 4: Peer health programs should include policies and practices that support the work and well-being of peer leaders. Programs should offer peer leaders incentives and logistical supports to serve in their role. Programs need to provide structure and mechanisms that enable peer leaders to address their own health and social concerns while also maintaining confidentiality of residents and appropriate boundaries.
**Recommendation 5:** Peer health programs should provide ongoing training in professional skills and health related content and expertise. At the same time, programs should promote skills that enable peer leaders to work with community residents to implement their own ideas for health promoting activities and community change.

**Evaluation and Sustainability**

**Recommendation 6:** HOPE SF, funders and the City should take a long-term approach for investing in and understanding community change. Funding should be provided for the long term and the impact and outcomes of peer health strategies should be evaluated over time. The impact of peer to peer strategies on peer leaders themselves should be valued and measurements of changes in their emotional and physical well-being should be considered as part of any evaluation activities. More broadly, partnerships between residents, academic institutions, city and local agencies should be developed to create a community driven research approach for HOPE SF and broaden opportunities for funding of health strategies for these communities.

**Models**

**Recommendation 7:** Boston University’s Partners in Health and Housing Prevention Research Center which is funded by the US Centers for Disease Control and Prevention (CDC) and was established in 2001 provides a compelling model for partnership between community members, public agencies and researchers to support peer-to-peer strategies. The Center’s mission is to improve the health and well-being of the residents of Boston’s public housing, and reduce health disparities, by engaging residents in community-centered research efforts and prevention activities. Over the past 10 years the Center’s Resident Health Advocate program has trained over 150 community members to provide support, health education and to serve as a bridge to health services for public housing residents. Further examination of this model of an overarching mechanism to support peer to peer health strategies that encompasses all of the HOPE SF sites is warranted.
BIBLIOGRAPHY


Rice, V., & Stead, L. (2009). Nursing interventions for smoking cessation. *Cochrane Database of*


Planning Association, 72(1), 100-108.


