



Peers for Progress

Peer Support Around the World

A program of the American Academy of Family Physicians Foundation

Highlights and Developments

Winter-Spring, 2011

Bristol-Myers Squibb Foundation funds Collaboration with National Council of La Raza

In November, 2010, Peers for Progress received a grant as part of the Bristol-Myers Squibb Foundation's new program, *Together on Diabetes, focused on reducing disparities in diabetes care and burden in the United States.*

The Peers for Progress project will be a collaboration with the National Council of La Raza to demonstrate and evaluate the benefits of a peer supporter or *promotora* as a strategy for outreach and patient support from the patient centered medical home.

The National Council of La Raza (NCLR) is the nation's largest Hispanic civil rights and advocacy organization with over 300 constituents around the country. The collaboration will join the experience of NCLR and its constituents in *promotora* programs in many social service and health initiatives, as well as Peers for Progress' experience with diverse approaches to peer support in diabetes and other areas of health promotion around the world.

In addition to their emphasis on the health care team, models of the patient centered medical home

stress the importance of community outreach and addressing the 24/7 lives of patients. As important as these may be, they are difficult to arrange. Those we most want to reach may not be those who participate in community programs and activities. However, peer support interventions can successfully reach and engage high percentages even of those sometimes termed "hard to reach" (reference 9 at end of this document). Also, medical homes can hire peer supporters from the communities they seek to reach, building social network links to priority populations. Thus, peer support can be a useful strategy for reaching and engaging individuals and communities from the patient-centered medical home. This will be a key focus of the demonstration project and its evaluation.



Peer supporters in Uganda – see story on next page

Peers for Progress is dedicated to accelerating peer support in health, health care and prevention around the world. A program of the American Academy of Family Physicians Foundation, it is supported by the Eli Lilly and Company Foundation.

In addition to NCLR, another collaborator in the project will be TransforMED, a subsidiary of the American Academy of Family Physicians focused on practice redesign to enhance patient centered medical homes. TransforMED will help the primary care settings in the project improve their patient centered procedures and practices and link them with the contributions of *promotores*.

The project will be implemented through a NCLR constituent and a cooperating primary care, patient centered medical home. *Promotores* will work with individuals and their families and facilitate other community and social activities, all to support diabetes management and prevention. Evaluation will be broad, including individual clinical measures, quality of life, implementation and scope of activities delivered, costs, as well as organization and system factors related to sustaining the *promotora* program and its close linkage with the patient centered medical home.

In addition to the demonstration project itself, NCLR and Peers for Progress will develop a *National Collaborative Learning Network on Peer Support*. This will link NCLR constituents along with community health centers, primary care organizations, health systems, and other community or health organizations interested in peer support. Through virtual and live networking, it will support information exchange for quality improvement and advocacy to secure peer support recognition and financial underpinnings as a routine part of good health care and prevention.

Project Spotlights

Peer Support for Diabetes in Rural Uganda:

A peer champion program through a cell phone network

In Uganda, there is a shortage of healthcare providers prepared to deliver diabetes care to the estimated 4% of adults who have diabetes. The **Peer Champion Program**, a Peers for Progress grantee project, was established in a small rural district hospital diabetes clinic in southern Uganda to

serve adults with Type 2 diabetes. The surrounding district has a high rate of poverty and has experienced a long standing drought and seasonal food shortages.

This pilot study was conducted by investigators at the University of Wisconsin-Madison School of Nursing in partnership with Mulago Hospital in Kampala, Uganda and the Mityana District Hospital Diabetes Clinic in Mityana, Uganda. It aimed to test the feasibility and short-term impact on perceptions of social support, psychological well-being and glycemic control among participants through engaging participants in diabetes self-care behaviors and fostering linkages to healthcare providers.

Nineteen peer champions who attended the diabetes clinic in Mityana were matched with 27 peer partners in either pairs or triads. All participants attended a one-day training program on diabetes self-care. Education booklets designed for both groups and later translated into Luganda were distributed to all participants. They included information on daily management in seven areas of self-care; supportive communication techniques; instructions on completing diaries; and guidelines for contacting healthcare providers. The champions were asked to make at least weekly contact with their partners. Champions received additional training on supportive communication, such as active listening, asking questions about emotions and feelings, assisting with goal-setting and encouraging the partner to seek healthcare advice when appropriate.

Mobile technology was used as an innovative way to connect peer champions and peer partners in this low-resourced rural setting. The program gave cell phones to participants so that they could communicate within a prepaid closed phone network. The use of a prepaid network allowed many participants to experience for the first time the luxury of talking on the phone without worrying about the cost and gave them the ability to contact a healthcare provider by phone before making an arduous journey to the clinic when ill.

In addition to both phone and face-to-face contact between peer champions and peer partners, the Mityana clinic staff also offered educational meetings for the program participants. During these meetings, patients discussed the difficulty they had accessing medications and reading the educational booklet since many had poor vision and a low level of English proficiency.

Post-measures indicated that the average A1C of participants dropped significantly, as well as diastolic blood pressure. Survey items showed changes in dietary behaviors in a positive direction. Participants found that the peer champion program was helpful in encouraging contact with the clinic, offering helpful advice and encouragement, and providing information about diabetes. What was not anticipated at post-test were lower perceptions of support from family and friends and confidence in managing diabetes at post-test. The lessons learned from this pilot study allow for continued efforts to offer peer support programs in this low-resourced setting and other similar settings.

❖ Summary

Roles and Responsibilities of Peer Supporters

- Provide supportive communications, such as active listening, asking questions about emotions and feelings
- Encourage the partner to seek healthcare advice when appropriate.

Key Peer Supporter Training Activities

- Develop two versions of the education booklet: one for the Champions and one for the peer Partners. * Note that the Champion version has more content on supportive communication
- Host a Peer Champion and Peer Partner training day.

Key Peer Support Interventions

- Weekly contact between peers both through phone and face-to-face contact over a period of 4 months
- Interaction and discussions among the program participants occurred during educational meetings provided by the clinic staff

Key Accomplishments

- 100% of the participants reported making peer contact
- 71% increased contact with the clinic
- Significant improvement: healthy eating, blood pressure (DBP), A1C, linkages to care

Lessons Learned

- Peer support was reciprocal, e.g. both provided and received support.
- A cell phone network can enhance management of diabetes; however, economic challenges (e.g., no electricity to keep a phone charged) could impede its value-added.
- Cultural and contextual issues matter-
 - ✓ Without phones, participants preferred being partnered with someone who lived near them over someone of the same gender.
 - ✓ Due to a low level of English proficiency, participants preferred Luganda for written and oral education. However, because of other tribal languages, Luganda did not benefit all participants.
 - ✓ Due to a high rate of poverty, participants required payment for transportation to participate.
 - ✓ Opportunities to learn more about diabetes and to have written information were highly valued benefits of participation.

Program Presentations & Research Publication

- [Peer Support for Diabetes in Rural Uganda: Does it Work?](#) (Oct, 2010 at the 2010 Peers for Progress Global Conference by Linda Baumann, PhD, RN, FAAN)
- [Peer Support for Adults with Diabetes in Rural Uganda: Champions and Partners](#) (Aug, 2010 at the 11th International Congress of Behavioral Medicine by Linda Baumann, PhD, RN, FAAN)
- [Baumann, LC, Nakwagala, F., & Nambuya, A. \(2010\). Peer support for adults with diabetes in rural Uganda: Champions and partners. International Journal of Behavioral Medicine, 17, Supplement 1, p S267.](#)

Program Material

- [Peer Partner Training Booklet in both English and Luganda](#)

Community-Based Peer Support for Diabetes in Anhui, China

A program built upon the strengths of the community and the health system

Promoting and implementing peer support in a particular region or culture has remained a challenge due to variations in settings (e.g., health system, community context) as well as help-seeking and support-giving behaviors across cultures. Therefore, it is pivotal to the success of a peer support program that it is culturally acceptable and built upon the strengths of the community and the health system.



*Anhui Province, China:
Peer support group meeting*

In a collaborative effort to test the effectiveness and applicability of the peer support model within the Chinese context, doctoral candidate Xuefeng Zhong from Mahidol University, along with her advisors Drs. Chanuantong Tanasugarn from Mahidol University and Edwin Fisher from the University of North Carolina at Chapel Hill, conducted a **community randomized control trial** to test the feasibility of a peer support model in the Anhui Province of China.

The demonstration project was a community-based model of peer support that took place in three cities in Anhui: Hefei, Tongling, and Bangbu. Zhong identified subcommunities in each community and recruited 726 eligible participants with type II diabetes. Subcommunities were randomly assigned to intervention and comparison groups, with the

comparison groups receiving standard care with a routine educational component.

In the intervention, groups consisted of 10 to 15 individuals who lived within close proximity and were led by a peer supporter nominated by the Community Health Service Center (CHSC). The peer supporters were usually retired members of the community who had lived with diabetes for a relatively long time and were in compliance with medical advice. After training, they were tasked with facilitating discussions on issues of interest and promoting better self-care in the lives of participants. In contrast to many peer support programs, 16 of the 19 peer group leaders were men.

A key feature of the program took advantage of the fact that the participants lived near each other and all knew each other. As a result, smaller, informal groups emerged from the formal group settings, and participants began to shop together, exercise together, and even fish together. Interviews with participants indicated that these informal group activities were an important source of support for participants.

Preliminary findings of the study indicate that the peer support model is both applicable and effective within the Chinese context. Both support providers and receivers received tangible benefits, including increased knowledge and awareness, improved diet and physical activity levels, and better glucose monitoring.



*Anhui Province, China:
Peer supporter training activity*

The testimonials from participants reinforce the benefits of peer support demonstrated by the study and, in particular, the importance of social and emotional support. A 61 year old woman commented,

“...I became sick two years ago, and when I found out I had diabetes, I felt upset, and thought that my life was meaningless. When I joined the peer support group, I discovered that many people had the same illness as me, and some people in our group had been living with diabetes for more than 20 years. They lived very well, and now they are more than 80 years old, so it encouraged me to believe that I too can live a long and healthy life if I can control my blood sugar and manage my life suitably.”

Kate Lorig's Chronic Disease Self Management Program has been adopted in several settings in China. However, to our knowledge, this study is the first in China to emphasize peer support outside of formal group meetings and through individual contacts with the peer group leaders and the informal activities emerging from the groups. Amidst reticence to burden one's family, the contacts with peers appeared to provide a more acceptable outlet for sharing emotions and concerns regarding diabetes. Due to Zhong's role as a professional in the Anhui province Chinese Centers for Disease Control, the program was able to recruit resources both from the CDC and the government health service. Following the demonstration project, the "peer support group" approach has been integrated as a routine component of the community chronic disease management in these three communities. Zhong hopes to expand upon these findings beyond these communities and use the positive results as a means of promoting peer support into standard care.

Live, Learn and Share

Diabetes Peer Support Group Project for
the Black Caribbean Community
Toronto, ON, Canada



Live, Learn, and Share: Graduation Day

The Black Creek Community Health Centre (BCCHC) serves a catchment area in Toronto, Canada made up of neighborhoods with some of the highest rates of diabetes in the city, according to a 2007 report by the Institute for Clinical and Evaluative Sciences (ICES). The region consists of a diverse community - Asian, South Asian, African-Caribbean, and Latin-Hispanic populations- which has traditionally lacked access to culturally appropriate care.

The BCCHC addressed this issue through a dynamic collaboration with the local community. Known as the *Live, Learn and Share Community Project*, its first initiative had two main goals: 1) to create a culturally relevant guide for developing diabetes peer support groups, and 2) to train members of the community to be peer support facilitators. As the community contained a large Black Caribbean population, *Live, Learn and Share* directed its initial efforts towards this population. The project used a strengths-based approach, focusing on the assets and capacities of the community and the individuals within the community living with diabetes, in working towards these two goals.

To ensure active community input in development of the guide, the Project engaged the help of local residents and community organizations through regular meetings. An advisory group provided an outline for the guide, and multiple actors within the community including residents and literacy groups worked to ensure its appropriateness for the Black Caribbean community. The completed guide, made by the community and made for the community, can be found at

http://www.bcchc.com/LLS/Diabetes_Support_Guide_web.pdf

The second goal of *Live, Learn and Share*, to train community members to be facilitators for peer support groups, was accomplished through the recruitment and training of 16 Black Caribbean community residents with diabetes. They attended a four month series of weekly workshops aimed at providing them with an understanding of both the peer support model and knowledge about diabetes. Participants continue to meet on their own and have successfully started and maintained their own Diabetes Peer Support Group, which meets monthly. Utilizing both a culturally sensitive and engaging approach, this project overcame the taboo among many Caribbean cultures against speaking freely on issues pertaining to diabetes and mental health. The lessons learned from the project can be used by

organizations as they create and manage their own peer support programs for distinct populations. Moving forward, *Live, Learn and Share* is hoping to train residents from the Somali, South Asian (Urdu-speaking), Spanish, and Vietnamese communities to become Diabetes Peer Support Group facilitators, and translate the guide into these four languages.

More information can be found at
<http://www.bcchc.com/BCCHC/Live, Learn and Share.html>

Response to Negative Results in British Medical Journal

Disappointing results of a peer support study were contained in a recent paper posted online by the *British Medical Journal*. We wanted to bring this to your attention and also to share with you the substance of a rejoinder to the paper that we have posted on the BMJ website. Our rejoinder can be found at:

http://www.bmj.com/content/342/bmj.d715.abstract/eply#bmj_el_250926

The paper, “Peer support for patients with type 2 diabetes: cluster randomized controlled trial”¹ is impressive in many ways, a cluster randomized design that followed 395 patients (192 in the peer support condition) recruited through 20 general practices in the Republic of Ireland. The intervention was comprised of nine group meetings led by trained peers and spaced over a two-year period. Outcome indicators included metabolic control (hemoglobin A1c), systolic blood pressure, total cholesterol and a measure of well being. There were no statistically significant differences between groups indicating an advantage to the peer support. The prominence of the report and its conclusion that “the results do not support the widespread adoption of peer support” raise concerns for the field. However, details of the intervention point up important differences from widely endorsed features of peer support and call into question the generality of these null findings.

A vast amount of evidence links social support to health and well being. Primates derive great advantage from the support of parents, kin and familiars.² Social support is strongly related to

numerous health indicators³ and its absence, social isolation, has been estimated to be as lethal as smoking a pack of cigarettes per day.⁴⁻⁵ Reviews indicate widespread benefits⁶ and promising results of peer support interventions within important areas like diabetes management.⁷ Individual controlled studies indicate substantial benefits of specific peer support interventions, such as with “Lady Health Workers” reducing by half prevalence of post-partum depression in Pakistan⁸ or “Asthma Coaches” reducing rehospitalization for asthma by half among children with very low income, single mothers in the U.S.⁹ Peer support programs are numerous around the world, but are often poorly evaluated, reported, and disseminated. Thus, how to organize and deploy peer support remains elusive.

The paper by Smith and colleagues¹ shows null results in a cluster randomized evaluation of periodic diabetes information groups led by peers plus enhancements of clinical care, compared to enhanced clinical care alone. A number of features of the study may have accounted for the disappointing results. At entry, the clinical status of participants was not remarkable (e.g., mean HbA_{1c} = 7.2%), making demonstration of improvement difficult. Additionally, the enhancement of clinical care common to both conditions appears to have been appreciable, e.g., reduction of systolic blood pressure from 144 to 137 mm Hg in controls.

Most important, however, is the particular approach taken to operationalizing peer support in this study. The intervention itself focused on nine peer support group meetings spaced over two years. Based on the description of “Specific topics discussed in the peer support meetings” posted at BMJ.com, meetings addressed varied topics of interest to those with diabetes (e.g., heart and vascular disease, blood sugar levels, healthy eating, exercise, medications, foot care). “In general, the groups followed and discussed the planned topics” p. 5,¹ However, meetings appeared not to include a focus on individualized plans for behavior change and follow up of these plans, a feature commonly observed to be important in achieving improvements in self management of diabetes and other chronic diseases.¹⁰⁻¹² The description of the “Peer supporter training,” also posted at BMJ.com, indicates there were two, 90-minute training sessions for the peer supporters. Communication skills and role play of them were covered only in the second session, which also addressed lifestyle and medication issues, confidentiality, and support for the peer supporters. From the report, there appears to have been no contact with participants outside the

group meetings. Those who failed to attend the meetings were contacted by study nurses and the study manager but apparently not by the peer supporters themselves.p. 5,¹

Was peer support achieved? Average attendance was only five of the nine meetings schedule over two years. Eighteen percent attended none. If an intervention was intended to provide peer support but was only modestly attended, one might question whether peer support has been provided sufficiently to be tested.

From this important and well designed study, one can conclude that spending time in an intervention led by a peer is not magic. Offering adults with diabetes the opportunity to meet in occasional groups led by a peer to discuss issues of common interest appears insufficient to effect improvements in clinical status or well being. However, features of peer support recognized in the field as important may not be well appraised by this study. In particular, focus on adjusting management plans to the specifics of individuals' lives, social and emotional support, linkage to clinical care, individualized contact, ongoing support, and other features common to successful peer support interventions¹³⁻¹⁶ do not appear to have been emphasized in the intervention reported by Smith and colleagues. Perhaps most important, the apparent limitation of contacts with the peer supporters to the nine structured meetings appears to have eliminated the easy availability of peer support often emphasized as a strength of social support interventions.¹⁷

It is surely correct that the results of the study of Smith and colleagues "do not [in and of themselves] support the widespread adoption of peer support".(abstract) However, it would be a tortured interpretation of null findings to extend this observation to all of peer support. As indicated above, there are many reasons to believe that peer support is indeed highly effective. Rather than overwhelming that evidence, the present results point to the challenges in developing ways to deliver peer support that is responsive to the complex and dynamic set of emotional, practical, and social needs of people with diabetes. Peers for Progress (peersforprogress.org), a program of the American Academy of Family Physicians Foundation, is dedicated to promoting global exchange to identify effective and feasible peer support interventions. Surely the field needs the "future research" for which Smith and colleagues call, but the failure of this particular study should neither discourage that

research nor efforts to find effective and efficient ways to bring peer support to the many who may benefit from it.

Edwin B. Fisher, Ph.D., and Renée I. Boothroyd, Ph.D., M.A., M.P.H., C.H.E.S., Peers for Progress of the American Academy of Family Physicians Foundation and Gillings School of Global Public Health, University of North Carolina at Chapel Hill

References:

1. Smith SM, Paul G, Kelly A, Whitford DL, O'Shea E, O'Dowd T. Peer support for patients with type 2 diabetes: cluster randomised controlled trial. *BMJ* 2011;342:d715.
2. Harlow HF. The nature of love. *American Psychologist* 1958;13:673-85.
3. Uchino BN. Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *J Behav Med* 2006;29(4):377-87.
4. House JS, Landis KR, Umberson D. Social relationships and health. *Science* 1988;241:540-44.
5. Holt-Lunstad J, Smith TB, Layton JB. Social relationships and mortality risk: a meta-analytic review. *PLoS Med* 2010;7(7):e1000316.
6. Swider SM. Outcome effectiveness of community health workers: an integrative literature review. *Public Health Nursing* 2002;19:11-20.
7. Norris SL, Chowdhury FM, Van Let K, Horsley T, Brownstein JN, Zhang X, et al. Effectiveness of community health workers in the care of persons with diabetes. *Diabetic Medicine* 2006;23:544-56.
8. Rahman A, Malik A, Sikander S, Roberts C, Creed F. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *Lancet* 2008;372(9642):902-9.
9. Fisher EB, Strunk RC, Highstein GR, Kelley-Sykes R, Tarr KL, Trinkaus K, et al. A randomized controlled evaluation of the effect of community health workers on hospitalization for asthma: the asthma coach. *Arch Pediatr Adolesc Med* 2009;163(3):225-32.
10. Bodenheimer T, Davis C, Holman H. Helping Patients Adopt Healthier Behaviors. *Clinical Diabetes* 2007;25:66-70.

11. Bodenheimer T, Handley MA. Goal-setting for behavior change in primary care: an exploration and status report. *Patient Educ Couns* 2009;76(2):174-80.
12. Funnell MM, Brown TL, Childs BP, Haas LB, Hosey GM, Jensen B, et al. National Standards for diabetes self-management education. *Diabetes Care* 2011;34 Suppl 1:S89-96.
13. World Health Organization. Peer Support Programmes in Diabetes: Report of a WHO Consultation 5-7 November 2007. Geneva, 2008.
14. Boothroyd RI, Fisher EB. Peers for progress: promoting peer support for health around the world. *Fam Pract* 2010;27 Suppl 1:i62-8.
15. Funnell MM. Peer-based behavioural strategies to improve chronic disease self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Fam Pract* 2010;27 Suppl 1:i17-22.
16. Heisler M. Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: evidence, logistics, evaluation considerations and needs for future research. *Fam Pract* 2010;27 Suppl 1:i23-32.
17. Fisher EB, Jr. Two approaches to social support in smoking cessation: Commodity Model and Nondirective Support. *Addictive Behaviors* 1997;22:819-33.



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