Peer Support Programs Around the World
Projects of Peers for Progress Investigators
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Introduction

Peers for Progress is a program of the American Academy of Family Physicians Foundation and is dedicated to promoting peer support in health, healthcare and prevention around the world.

With support from the Eli Lilly and Company Foundation, Peers for Progress funded fourteen grants in nine countries on six continents, examining how peer support could be helpful to individuals with diabetes in the day-to-day management of their disease and well-being. Their reports, gathered together here, tell the stories of their work, the challenges they met, and the accomplishments they achieved. As a work-in-progress, this document will be updated in the coming months with additional program descriptions and links to resources.

Managing diabetes is a “24/7” job for the rest of one’s life. Even if someone spends six hours a year in the office of a doctor or other professional, that leaves 8,760 hours per year they are “on your own” to manage their disease – taking medicines as prescribed, measuring blood sugar and adjusting medications accordingly, eating a healthy diet, getting regular physical activity, and avoiding or managing stress and negative emotions. All of this needs to be incorporated into the complex routines of family, workplace, and daily life.

The projects described here show the varied way in which programs arranged peer support to help individuals in their 8,760 hours a year. They included groups and individual contacts, close linkage with clinical care or more of a grounding in communities, communication face-to-face, by phone, and by text, emphases on disease management and on quality of life, varied activities such as group meals to explore healthy versions of culturally traditional meals.

The range of programs was considerable. Together they shared however a template of four key functions of peer support:

- **Assistance in Daily Management** – as one patient put it, “The doctor and nurse help me figure out what I need to do. The peer supporter helps me figure out how to do it.”
- **Social and Emotional Support** – chronic disease management “gets old” and often is accompanied by substantial stress. Peer support can help people stay motivated and help them deal with the stressors that chronic disease, and, too often, life itself may entail.
- **Linkage to Clinical and Community Resources** – peer supporters help individuals recognize when they need to see the doctor or their clinical team and also identify resources in their communities to support healthy lifestyles.
- **Ongoing Support** – diabetes, other chronic diseases, and many of our prevention challenges like maintaining a healthy weight are lifelong, so programs need to address how to provide ongoing support as individuals’ needs and resources change.

These four provided a structure around which programs tailored their activities and services to local needs, resources and communities.

Although the projects described here all focused on diabetes, the approaches they have taken – to healthy diet and physical activity, getting appropriate regular care, adhering to recommended medications, and leading rich and full lives – transfer readily to other diseases and prevention challenges. We hope the stories here will both inspire others and help guide their efforts to harness peer support in promoting healthy and satisfying lives worldwide.

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Bridges To a Better Life/Puentes Hacia una Mejor Vida

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Bridges to a better life/Puentes hacia una mejor vida was a collaborative study between the Institute for Behavioral and Community Health affiliated with San Diego State University Research Foundation and Clínicas de Salud del Pueblo, Inc. (Clínicas), a federally qualified health center. This randomized controlled trial (peer support intervention versus usual care) was designed to research potentially efficacious and disseminable methods for delivering a volunteer-based peer support intervention through community health centers serving a U.S. Latino/Hispanic community on the U.S.-Mexico border in California.

Population & Setting
Mexican/Mexican-American adults randomly selected from the patient rosters of three of Clínicas’ largest health centers located in Brawley, El Centro, and Calexico, CA.

Who Are the Peer Supporters?
Peer leaders (líderes) were required to have previous diabetes education or significant experience helping someone manage their diabetes. Invitation letters were mailed to Clínicas’ patients who had completed the diabetes education program and the study coordinator followed up with a telephone call. Peer leaders were also recruited one-on-one by members of the Department of Programs at Clínicas from among their social networks and clinicians were asked to refer patients they thought would make a good leader. Eligible peer leaders were screened to ensure they, a) could read and speak Spanish, English, or both, b) were living with or had provided extensive care for someone with diabetes, c) were willing to provide support to several patients for at least 12 months, and d) planned to remain in the study area for 12 months. A total of 34 peer leaders were enrolled in the study.

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**Peer Supporter Training**
Peer leaders attended 40-50 hours of training. Each clinic based their training format and structure on what worked best for the peer leaders (e.g., 3 days a week for 6 hours, 4 evenings a week for 4 hours). Training materials included manuals for both trainers and peer leaders, each consisting of 10 lessons on the following topics: building your opportunities as a volunteer, providing support for diabetes, diabetes and nutrition, diabetes and physical activity, diabetes and emotional health, diabetes and medical management, how to conduct a home visit, how to conduct a visit to the clinic, how to conduct a support group, and how to monitor your activities. Two supplementary trainings were developed on how to lead physical activity support groups and cooking support groups.

**Peer Supporter Roles & Responsibilities**
Peer leaders were assigned 5-8 patients each and they were instructed to contact them a minimum of 8 times during the first 6 months and as needed during the subsequent 6 months of the 12-month intervention. Contact was to occur in the following order: a) introductory phone call, b) introductory letter, c) home visit and delivery of a welcome packet that included a business card, a copy of the welcome letter, and a 10-page pamphlet with key pages from the peer leader training manual. Peer leaders had the option of conducting all remaining contact by way of supportive telephone calls, home visits, support groups, or clinic tours depending on the preferences of the peer leader and the patient. Contact was primarily in the form of one-on-one visits and by telephone.

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**TRAINING SUMMARY**

**Duration:** 40-50 hours

**Content:**
- Building your opportunities as a volunteer
- Providing support for diabetes
- Diabetes and nutrition
- Diabetes and physical activity
- Diabetes and emotional health
- Diabetes and medical management
- How to conduct a home visit
- How to conduct a visit to the clinic
- How to conduct a support group
- How to monitor your activities

PLUS two supplementary trainings on how to lead physical activity support groups and cooking support groups

**Approach:** Didactic and interactive components and opportunities to share personal experiences and to practice the skills

**Evaluation:**
- Diabetes knowledge*: post-training, plus 6- and 12-mos post-baseline
- Open-ended questions*: 6- and 12-mos post-baseline
- Satisfaction with training and program support: 6- and 12-mos post-baseline

* Participants who scored <80% on the test were given additional instructions in key areas

**Languages:** English & Spanish
Unique Features or Strengths

The peer support interventions were tailored to address the socio-ecologic perspective. Particularly, peer supporters had the flexibility to help and support diabetes self-management behaviors in multiple contexts (home, community, and clinic).

Major Challenges & How They Were Addressed

- **Reach and engagement**: In the first 6 months an average of only 4 contacts was achieved despite several attempts to contact patients. Peer leaders were encouraged to tell project staff which patients they were having trouble engaging and the patient tracking form was adapted to make it easier to complete. To motivate peer leaders and keep them engaged, 6- and 12-month celebrations were held to strengthen family support for their participation and bi-weekly meetings were held with the Program Coordinator.

- **Travel expenses**: A major barrier for peer leaders in maintaining contact with their assigned patients was out-of-pocket expenses due to inadequate public transportation in this rural community. To compensate, peer leaders were provided gas cards valued at $15 per month at their 6-month anniversaries.

Key Results & Major Accomplishments

Volunteer peer support models compliment paying models and both are essential for community clinics to adequately reach those in rural and resource-poor communities. With intervention participants exhibiting a 0.4% reduction in HbA1c, compared to no change in HbA1c with controls, this volunteer-based intervention significantly improved HbA1c levels. Small improvements in dietary intake of fruits and vegetables and fast food were also observed in the intervention versus control group participants. In addition, participants in both conditions reported greater use of planned health care to support their diabetes, more frequent self-monitoring behaviors, and greater adherence to medication use.
**RESOURCES**
- Lider Training Manual
- **Screening Questionnaire** (English & Spanish)
- Recruitment Letter (English & Spanish)
- Recruitment Script (English & Spanish)
- Application Form (English & Spanish)
- Patient Contact Sheet (English)

**PUBLICATIONS**
- Ayala, GX and Elder, JP. *Qualitative methods to ensure acceptability of behavioral and social interventions to the target population.* *Journal of Public Health Dentistry.* 2011;71 S69-S79.

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A Peer Champion Program for Ugandan Adults with Diabetes

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In Uganda, there is a shortage of health care providers prepared to deliver diabetes care to the estimated 4% of adults with diabetes, so sustaining effective self-management behaviors plays a large role in diabetes treatment. The Peer Champion Program was established in a small rural district hospital diabetes clinic in southern Uganda to test the feasibility and short-term impact of peer support on perceptions of social support, psychological well-being, and glycemic control for adults with type 2 diabetes.

This 12-month 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. 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 health care providers. 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 health care 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 health care provider by phone before making an arduous journey to the clinic when ill.

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer champions motivated participants to eat healthy foods, take their medication, and be active.

Social/Emotional Support
Peer champions encouraged participants to share their feelings and concerns.

Linkages to Care
Peer Champions and participants were given pre-paid cell phones at no charge to facilitate communication with health care providers about health care needs.

Ongoing Support over Time
Following the intervention, participants were encouraged to continue to support each other and attend the Diabetes Care Clinic for education and medical advice.
The champions were asked to make at least weekly contact with their partners. 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.

Post-measures indicated that the average A1c of participants dropped significantly, as well as diastolic blood pressure. Based on qualitative data, it is likely these positive changes were due to discussion among participants about consistently taking diabetes medication and also encouraging one another to exercise. Participants also found that the Peer Champion Program was helpful in encouraging contact with the clinic, offering helpful advice and encouragement, and providing information about diabetes.

### TRAINING SUMMARY

**Duration:** 2 1/2 hours  
**Content:**  
- Peer Champion Training Booklet  
  - Diabetes self-care goals (healthy eating, being active, taking medication, monitoring, problem solving, reducing risks, healthy coping)  
  - Supportive communication techniques  
  - Instructions on completing diaries  
  - Guidelines for contacting health care providers  
- Peer Partner Training Booklet (English and Luganda)  
- Diabetes self-care questionnaire  
**Approach:** Lectures, skills building, and role playing  
**Evaluation:** 10-item true/false Peer Training Knowledge Test was given to evaluate champions’ ability to differentiate diabetes education from peer support activities  
**Languages:** English & Luganda

### RESOURCES
- Peer Partner Training Booklet (English and Luganda)  
- Diabetes self-care questionnaire

### PUBLICATIONS


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Peer Health Coaching to Improve Glycemic Control in Low-Income Patients with Diabetes

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Peer health coaches offer a potential model for extending the capacity of primary care practices to provide self-management support for patients with diabetes. This randomized controlled trial was conducted to test whether clinic-based peer health coaching, compared with usual care, improves glycemic control for low-income, underserved patients with poorly controlled type 2 diabetes.

Population & Setting
Low-income English- or Spanish-speaking Latino, African American, or White adults with poorly controlled diabetes (HbA1c>8.0%) selected from 6 community safety net clinics in San Francisco, California.

Who Are the Peer Supporters?
Patients with type 2 diabetes and HbA1c levels <8.5% who had a basic knowledge of diabetes self-management and demonstrated supportive and non-judgmental communication skills were recruited to be a part of the study. Eligible peer coaches were screened to ensure they: a) were able to read and write in English or Spanish, b) planned to reside in San Francisco and continue receiving care at 1 of the 6 participating clinics for 12 months, c) had a telephone, d) were willing to attend a 36-hour training program, work with patients, and track encounters for at least 6 months, and e) would attend a monthly coach meeting to discuss patients. A total of 37 patients who met these criteria were enrolled to train as coaches.

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer coaches were trained to help patients read and understand medication instructions, to familiarize them with HbA1c, LDL, and blood pressure readings, to incorporate activity and healthy eating into their daily life, and to share the importance of limiting or quitting alcohol and nicotine

Social/Emotional Support
Peer coaches were trained to recognize “red flags” of depression and guide clients to seek help from trained health care professionals, and also to build a social network by positively engaging family, friends, and care-givers

Linkages to Care
Peer coaches were trained to navigate clinic and community resources

Ongoing Support over Time
Peer coaches were trained to provide ongoing support for clinical visits and interactions with clinicians
Peer Supporter Training and Quality Assurance

Peer coaches attended 36 hours of training at the San Francisco General Hospital led by three study team members. Training was conducted in English and Spanish using a curriculum developed by the study team. Curriculum modules included the basics of diabetes, diabetes medications and medication reconciliation, working collaboratively with patients (e.g., coaches referring to patients as clients), recognizing medical “red flags” such as symptoms of hypoglycemia, and navigating the clinic and accessing community resources. Furthermore, peer coaches were trained to interact with clients using active listening and non-judgmental communication, to help them with diabetes self-management skills, to provide social and emotional support, to assist with lifestyle change, and to facilitate medication understanding and adherence.

After 3 waves of training, a total of 26 coaches who had attended all sessions, demonstrated competency during the training, and passed both written and oral examinations were designated as peer coaches. Trainees were paid $150 for completing the training regardless of whether they passed. The study team held monthly group meetings with peer coaches in order for the coaches to provide support to one another by talking with each other and also to give them the opportunity to discuss with the research team any concerns they had about the study.

Peer Supporter Roles & Responsibilities

Peer health coaches were instructed to:
- interact with clients in-person or by telephone
- call clients every other week
- have 3 face-to-face visits, one preferably during a clinical visit

During the 6-month intervention, the majority of interactions (76.6%) were by telephone. Coaches received $25/month for each client they coached.

Unique Features or Strengths

Peer coach training, materials, and ongoing support were offered in both English and Spanish, the two most commonly spoken languages at participating safety net clinics. Training skills included teaching low-literacy patients about cardiovascular risk reduction, as well as helping them to understand medication instructions and their clinician’s care plans. Furthermore, clients were paired with a coach based on their preference after looking through a booklet containing personal profiles of peer coaches (“baseball cards” for those familiar with the U.S. sport). Profiles included a photo and brief self-description of their background, hobbies, language, and coaching availability.

TRAINING SUMMARY

Duration: 36 hours

Content:
- Working collaboratively with patients (a.k.a. clients)
- Basics of diabetes & self care
- Navigating the clinic
- Accessing community resources
- Coaching techniques, i.e.
  - Active listening and non-judgmental communication
  - Self management implementation
  - Social and emotional support skills
  - Lifestyle change assistance
  - Facilitation of medication understanding and adherence

Evaluation: Need to pass written & oral exams

Languages: English & Spanish
Major Challenges & How They Were Addressed

- **Integration into clinical services:** Conducting the study within safety net clinics was challenging because the study was not a top priority for clinic leadership and personnel. This was reflected in a delay in peer coach recruitment, as well as a disconnect between peer health coaches and the clinical care team (i.e., difficulty for coaches to access a patient’s labs essential for follow-up discussion). Although a member of the clinic was secured to be clinic liaison, in most cases they were unable to connect with the peer coaches due to their busy day-to-day clinical roles and responsibilities. Towards the end of the intervention period, arrangements were made for coaches to receive the HbA1c levels of their clients.

- **Retention of peer coaches:** In some cases when a peer coach dropped out before the end of the study, their clients opted to drop out of the study rather than choose a new coach. To provide support for peer coaches the study team was in contact with them between monthly meetings and they were encouraged to call the Project Director or any of the other coaches with any concerns.

- **Monitoring peer support delivery:** Tracking peer coach interactions was difficult using the paper and pen method. It was important to provide peer coaches with regular support and training to maintain and refresh their skills and motivation.

Key Results & Major Accomplishments

This study showed a statistically significant reduction in HbA1c levels for low-income and underserved patients with poorly controlled type 2 diabetes who received clinic-based peer coaching, compared to those who received usual care. Patients that benefitted most from peer coaching had poorer self-management support and lower levels of medication adherence at baseline. Peer coaches trained for this study not only had in common with their clients the experience of living with type 2 diabetes, but they also faced similar financial, housing, and social issues.

RESOURCES

- [Peer Coach “Baseball Card” Example](#)
- [UCSF Health Coach Training Curriculum](#)
- [Patient Contact Log](#)
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Peer Support, Empowerment, and Remote Communication Linked by Information Technology (PEARL):

A Multi-Component Program to Improve Community-Based Diabetes Care

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The program is also partially supported by Asia Diabetes Foundation and the International Diabetes Federation Centre of Education at the CUHK and PWH.

In type 2 diabetes mellitus (T2DM), team management using protocols with regular feedback improves clinical outcomes, although suboptimal self-management and psychological distress remain significant challenges. This randomized clinical trial investigated whether frequent contacts via a telephone-based peer support program (PEARL) would improve cardiometabolic risk and health outcomes by enhancing psychological well-being and self-care in patients receiving integrated care implemented through a web-based multicomponent quality improvement program, the Joint Asia Diabetes Evaluation (JADE).

Population & Setting
Adult T2DM patients from 3 publicly funded hospital-based diabetes centers in Hong Kong, China.

Who Are the Peer Supporters?
Motivated T2DM patients with good glycemic control (HbA1c<8.0%) were selected by diabetes educators from 13 hospital-based Diabetes Centers in Hong Kong and invited to join the ‘Train the Trainer’ program. Out of the 79 patients invited, 59 completed the training; 33 agreed to become peer supporters.

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer supporters interacted with their patients and shared their experiences of living with diabetes

Social/Emotional Support
Patients were encouraged to call their peer supporters whenever they needed support

Linkages to Care
Patients received reports on their trends of risk factor control and were encouraged to discuss with their health care team or peer supporter any uncertainty or to seek medical advice

Ongoing Support over Time
Peer supporters provided telephone support biweekly for 3 months, monthly for 3 months, every other month for 6 months, plus ad lib meetings and activities by peer supporters and patients
Peer Supporter Training and Quality Assurance

The ‘Train the Trainer’ program consisted of four 8-hour workshops designed by health care professionals and behavioral scientists and run by neurolinguistic consultants, sports scientists, psychologists, nurses, and physicians. The training format included tutorials, case sharing, reflections, role playing, games, and activities with peer supporters receiving tutorial notes and reference materials. Throughout the sessions, the principles of communication and empathic listening were reinforced and participants were encouraged to share positive experiences to assist their peers in managing diabetes on a day-to-day basis.

All participants underwent a before and after evaluation of diabetes knowledge and psychological-behavioral measures. The 33 participants that agreed to become peer supporters attended an additional 3-hour briefing session led by the project team on the rationale, objectives, and protocol of the study. Peer supporters were reminded to advise patients to seek medical advice for uncertain issues.

All peer supporters were given a booklet on resources (e.g., websites and telephone numbers of community centers, lay associations, and hospital diabetes centers and titles of self-help books) and a 3-month checklist to document the discussion items (diet, exercise, self-monitoring of blood glucose, sick day management, foot care, emotional support, resources for information, and clinical care), duration of each call, and relevant remarks. Peer supporters were asked to mail the completed checklist to the Asia Diabetes Foundation project coordinator, who entered the data and sent new checklists and a stipend to the peer supporters. The physicians, nurses, and project coordinators met all peer supporters on 3 occasions for a half-day meeting to facilitate experience sharing, mutual support, and problem-solving.

Peer Supporter Roles & Responsibilities

The peer supporter was first introduced to their assigned 10 peers as a group by the nurse educator who explained the what, why and how of a peer support role.
support program. After exchanging telephone numbers, the peer supporters were instructed to call their assigned peers (with an anticipated 15 minutes per call) at least 12 times during the 12-month intervention as follows:

- biweekly for 3 months
- monthly for 3 months
- every other month for 6 months

Both peer supporters and peers were encouraged to call one another ad lib. Including 15 minutes of documentation after each call, it was estimated that each peer supporter would spend 60 hours calling their 10 assigned peers including documentation time. Although they were happy to volunteer, all peer supporters were offered a $500 stipend at 80% hourly rate (USD 10).

**Unique Features or Strengths**

Peer supporters were asked to call each patient 12 times with an anticipated 15 minutes per call, equaling 180 minutes per patient, but the average number of calls was 19 with a call duration of 300 minutes per patient. This demonstrated the patients’ high appreciation for peer support. The majority of calls were initiated by peer supporters, and the most popular discussion items were related to diet, self-monitoring of blood glucose, emotional support, and drug compliance. Patients who received more telephone calls had greater improvements in medication compliance and diabetes-related literacy, more stable risk scores, greater reductions in body weight, and reduced hospitalization rates, especially those patients who had psychological distress.

**Major Challenges & How They Were Addressed**

- **Patient engagement:** Some patients were reluctant to receive calls from peer supporters, despite having given written informed consent, and due to difficulties in understanding or communication, some elderly patients were initially hesitant to share their experiences of living with diabetes. Nurses contacted these patients to explain the purpose of the calls and sought their willingness to share their experiences with peer supporters. This led to patients being more willing to speak with their peer supporters.

**LESSONS LEARNED**

- It is important that patients attend introductory meetings led by health care professionals and to make sure they are familiar with the nature and details of the intervention protocol.
- To ensure smooth implementation and evaluation, it is helpful to have additional staff to serve as liaisons between doctors, nurses, peer supporters, and patients.

**Key Results & Major Accomplishments**

Peer support did not improve cardiometabolic risks or psychological well-being in patients with T2DM receiving integrated care. However, in an exploratory analysis, benefits of peer support were observed in 20% of patients with elevated levels of emotional distress. The hospitalization rate for such patients was 48% for those who participated in JADE and 17% for those who participated in the JADE+PEARL program. Lower hospitalization rates may be attributed to peer support reducing non-adherence and negative emotions of patients. These results suggest that patients with psychological distress may receive the greatest benefit from peer support.

**RESOURCES**

- Please visit [www.adf.org.hk](http://www.adf.org.hk) and [www.idfce-hk.org](http://www.idfce-hk.org) for more information.
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PUBLICATIONS


The Role of Peers in Optimizing Diabetes Outcomes

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Diabetes education and ongoing support can be effectively provided by health professionals through educational and case management programs, but many organizations are not equipped to manage its implementation. Involving people with diabetes in the education process can address this problem. This randomized controlled trial of peer education and continuing support compared a) a patient diabetes education group to b) a patient education group with peers implementing the diabetes education program as members of the education team and providing continuing peer support.

Six peers were recruited from the Houssay Centre, an organization devoted to the education of people with diabetes and health care team members on the basis of their excellent diabetes control, self-motivation, communication and support skills, and interest. Peer training consisted of a 3-day intensive small-group interactive course that included pedagogic, motivational, communication and group management techniques, as well as basic diabetes control/treatment and evaluation concepts. The health professionals Training Course on Diabetes Education was used as the curriculum. Peers and patients were matched according to their socio-demographic characteristics. During the 12-month intervention, peers met monthly with the study coordinator and members of the education team to share challenges and successes. They also sent quarterly patient progress reports to the patients’ primary care physicians summarizing, in a structured manner, their patient’s progress.

The traditional patient education group attended a five module patient education course that combined diabetes and cardiovascular risk factor education. Conducting the course in groups of no more than 10 patients allowed for effective interaction among educators and participants. It consisted of 4 weekly 1 ½ to 2 hour sessions, with a reinforcement session at 6 months. Family members and spouses were encouraged to attend.

The patient peer education plus peer support group received the same education but with the active participation of peers during the education units (as teachers), plus the addition of post program peer support, which was intended to provide continuing psychological and moral support. It also served as a way for peers to use their own personal experiences to teach patients how to apply what they were learning to their daily lives. Each peer provided support to 15 patients.

**FOUR KEY FUNCTIONS**

**Assistance with Diabetes Management in Daily Living**
Peers reinforced the importance of food selection and following a healthy meal plan

**Social/Emotional Support**
Peers provided psychological support needed to cope with the day-to-day vicissitudes of diabetes self-care

**Linkages to Care**
Peers and patients were given cell phones to facilitate communication by calling, teleconferencing, and/or text messaging

**Ongoing Support over Time**
Peers provided continuing support throughout the intervention via face-to-face meetings and phone
Each educational module of the course included a specific set of activities that the educator-peer shared with patients, such as grocery shopping or eating out. Following the initial education course, face-to-face visits were regularly scheduled every second month to reinforce concepts of food selection, physical activity practices, and to share experiences on following a healthy meal plan. If needed, face-to-face visits could also be arranged outside of the regularly scheduled visits. Telephone communications were performed weekly for the first 6 months, biweekly for the next 3 months, and monthly for the remaining study period. They were based on structured interviews that inquired about the patients’ clinical, metabolic, and psychological progress.

Following the intervention, both the ‘education alone’ and ‘education plus peer support’ groups had a comparable increase in diabetes knowledge and a significant decrease in diabetes distress indicators related to emotional burden, physician-related distress and regimen-related distress. Although HbA1c levels for each group were close to 7% with no significant changes during the intervention, those in the peer support group decreased their HbA1c to less than 7%. Also, a higher percentage of people from the peer support group controlled their hyperglycemia with a single drug and that percentage increased significantly during the intervention, while for the control group it remained almost constant. Conversely, the use of 2 or 3 drugs showed no significant changes in the peer support group while it significantly increased in the control group. Systolic blood pressure for both groups was within normal range with only the peer support group exhibiting a significant decrease. The peer support group also maintained their level of physical activity, while that of the control group decreased by month 12. And based on structured telephone calls between peer supporters and patients, there was a significant improvement in patients’ well-being and a significant decrease in the number of hypoglycemic episodes.

Altogether, these data suggest that education courses delivered by either professional educators or a combination of these professionals and previously trained peers have a comparable positive impact on clinical, metabolic, and psychological indicators. Consequently, efficient diabetes education courses taught by previously trained peers could be implemented in places where professional educators or funds for hiring educators are not available.

**TRAINING SUMMARY**

- **Duration:** 3 days
- **Curriculum:** Training Course on Diabetes Education, Houssay Centre
- **Approach:** Pedagogic, motivational, communication and group management techniques, and evaluation concepts
- **Language:** Spanish

**PUBLICATIONS**


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Peer-Led Self-Management Support in “Real-World” Clinical Settings

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Improvements achieved through diabetes self-management education (DSME) are short-lived without ongoing diabetes self-management support (DSMS). This randomized controlled trial compared a more intensive peer leader DSMS intervention with a less intensive community health worker (CHW) DSMS intervention conducted at a federally qualified health center as two possible approaches to maintain over a 12-month period health-related gains achieved through an evidence-based, CHW-led, 6-month DSME program.

Population & Setting
Spanish- and English-speaking Latino adults in Southwest Detroit, MI with type 2 diabetes.

Who Are the Peer Supporters?
Peer leader candidates had to: a) have type 2 diabetes, b) be a resident of the southwest Detroit community, c) be ≥ 21 years old, d) be bilingual in Spanish and English, e) be a graduate of Journey to Health, an evidence-based, CHW-led, 6-month DSME program, f) have transportation to attend training, and g) be willing to commit to 3 months of training. A total of 8 peer leaders were recruited for training.

Peer Supporter Training and Quality Assurance
Peer leaders underwent a 46-hr training program over 12 weeks. The training consisted of 3 main components: review of basic diabetes information; communication, facilitation, and behavior modification skills; and practice applying skills in experiential learning scenarios. Specifically, peer leaders were trained to help patients build motivational interviewing skills, apply empowerment-based facilitation strategies, set goals, develop action plans, and problem solve. To graduate successfully, candidates had to meet the pre-established competency criteria for four domains: diabetes

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer leaders helped patients set goals for a self-identified issue, then develop & execute an action plan

Social/Emotional Support
Peer leaders listened to patients and provided support for psychosocial issues

Linkages to Care
Peer leaders helped patients develop strategies for navigating the health care system

Ongoing Support over Time
Peer leaders provided continued self-management support through weekly drop-in sessions or telephone calls.
knowledge, active listening, empowerment-based facilitation, and self-efficacy. Seven of the 8 peer leaders recruited for training completed the training program and achieved the criteria for all four competency domains. To keep up morale and engagement, monthly peer wellness sessions led by CHWs with a meal were held. For any questions or issues, peer leaders were encouraged to contact the CHW assigned to support them, the CHW supervisor, or the Principal Investigator.

**Peer Supporter Roles & Responsibilities**

Peer leaders provided support through weekly group-based sessions and follow-up telephone calls. They helped patients set goals using the following 5-step goal-setting model:

- exploring a participant-identified problem
- discussing the emotional impact of the problem
- selecting a self-management goal
- developing an action plan
- executing and evaluating the action plan

Peer leaders also provided support to patients by discussing psychosocial concerns, identifying facilitators and barriers to behavior change, taking inventory of support sources, and developing strategies to navigate the health care system. To ensure regular contact with each patient, peer leaders made a telephone support call to any patient who had not attended a DSMS session for over 3 consecutive weeks. During the support calls, peer leaders facilitated a conversation that closely mirrored support activities conducted in the group setting.

**Unique Features or Strengths**

Peer leaders had progressive leadership responsibilities. Initially, they met participants and observed some of the CHW-led activities during the 6-month DSME program led by CHWs. They then assumed primary leadership for the 12-month self-management support component of the project seeking to maintain gains from the CHW program. This allowed the CHWs to serve as mentors for the peer leaders in the areas of clinical content, educational methods, and group facilitation skills, as well as provide additional opportunities for the peer leaders to obtain the skills and confidence needed to be effective. The CHW was also available to the peer leaders for any questions or concerns, and oversaw monthly ‘booster’ sessions among participating peer leaders to allow discussion among peer leaders, help sustain morale, and provide training as needed in facilitation skills.
Major Challenges & How They Were Addressed

- **Peer leader retention:** To minimize the risk of peer leader attrition, monthly peer leader wellness groups were conducted. During these group meetings, peer leaders had the opportunity to discuss difficult cases, receive booster training on communication and facilitation skills, and receive emotional support from fellow peer leaders. Peer leaders were also encouraged to contact their CHW supervisor, as well as the Principal Investigator, to discuss any issues raised during the intervention. We had 100% retention of the peer leaders over the 12 months of the intervention.

- **Peer leader availability:** To accommodate patients’ differing schedules, morning and evening groups were offered. Pairs of peer leaders led each group session.

- **Communication modality:** The core support mechanism was intended to be group support sessions, but all peer leaders reported having substantially more telephone support contact with patients than group-based face-to-face contact. In fact, for some patients it took great effort to attend the group sessions as they had to take two different bus lines to reach the clinic, and for other patients child care and/or employment opportunities took precedence over attending the group sessions. Consequently, with telephone outreach as the primary support mechanism for both interventions, 2 different delivery modalities were not able to be tested, but 2 different types of interventionists (peer leader vs CHW) conducting telephone outreach were still able to be compared.

Key Results & Major Accomplishments

Adults with diabetes often need DSMS following effective DSME to help improve their diabetes outcomes. Both of the maintenance programs sustained key gains from the 6-month CHW-led DSMS program. At the 18-month follow-up, both groups maintained improvements in waist circumference, diabetes support, and diabetes distress. Only the peer leader group maintained statistically significant improvements achieved in A1c and blood pressure but these were not statistically significant from gains achieved in these outcomes in the CHW-led maintenance group. The key take-home message is that both approaches were quite effective and can be used in low-resource settings to maintain gains from short-term DSMS and that CHWs can effectively mentor and support volunteer peer leaders in a maintenance program.

LESSONS LEARNED

- Monthly wellness meetings with peer leaders are beneficial for minimizing peer leader attrition
- Participants may opt for telephone support over face-to-face group meetings due to transportation difficulties or life priorities (e.g., child care, employment opportunities, etc.)
- More effective and sustainable yet low-cost approaches to keeping participants engaged need to be explored (i.e., providing paid taxis, conducting assessments at participants’ homes, etc.)

RESOURCES

- Recruitment Flyer
- Recruitment Interview Protocol
- Training Manual
- Encounter Note #1
- Encounter Note #2: 5-Step Behavioral Goal-Setting Model
- Encounter Note #3
- Peer Leader Evaluation Packet


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Peer Mentoring Interventions in Older Patients with Diabetes: The Care Companions Program

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Diabetes is a complex illness to manage for both patients and physicians. Experience has shown that it can be difficult for patients to make necessary lifestyle changes on their own and while physicians and other health care providers can help educate patients about changes in lifestyle, they often lack the time for extended interactions or knowledge of the patients’ home and community environments to provide substantial assistance in these areas. This randomized controlled trial examined the impact of a peer to peer mentoring program on the health outcomes and behaviors of senior patients already receiving comprehensive diabetes care by implementing a peer-to-peer mentoring program at 15 practices that are part of a large medical group (WellMed) specializing in senior healthcare in San Antonio, TX.

Population & Setting
English- and Spanish-speaking, middle-class Caucasian and Hispanic older adults (50-80+) with diabetes who are patients at one of the 15 practices in WellMed participating in the intervention.

Who Are the Peer Supporters?
Patients with diabetes were referred to an 8-week Diabetes 101 course led by certified diabetes educators. The course, which will eventually be led by peer mentors, focused on teaching about diabetes and diabetes self-management skills. Throughout the course, instructors looked for individuals who showed high levels of engagement and natural leadership skills and were likely to make good “mentors” or peer supporters for the program. A total of 51 participants were invited to train as mentors.

Peer Supporter Training and Quality Assurance
Peer mentors completed a structured, 4-day, 16-hour mentor training course that included lessons on communication skills, social support, diabetes self-management, motivational interviewing, documentation of visits, self-care, conflict resolution, and confidentiality. The initial training was

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer mentors helped mentees implement lifestyle and self-care recommendations from diabetes self-management training programs, health educators and their physicians, or other health care providers

Social/Emotional Support
Peer mentors were trained to share their own experiences with diabetes and engage mentees in conversations about shared challenges in managing diabetes

Linkages to Care
Peer mentors help mentees schedule and follow through with health care visits and coached them in ways to communicate with their clinicians about health concerns

Ongoing Support over Time
Peer mentors provided support as long as the mentee desired; peer mentors continued to make monthly check-in phone calls with patients even when they were no longer actively participating
conducted by Latino Health Access, developer of the peer mentoring program being adapted for use by WellMed. Later trainings were conducted by nurse educators assigned full time to the peer mentoring program. As mentors provided support to their mentees, they completed and submitted individual contact sheets for all communication with mentees. They then reviewed and discussed these with the nurse educator during a monthly support and supervision session. The nurse educators were also available between sessions when needed. Any concerns a peer mentor had regarding a mentee were addressed with the nurse educator. For additional guidance, the nurse educator contacted the health coach and/or physician.

**Peer Supporter Roles & Responsibilities**

Peer mentors were paired up with individuals who wanted a mentor to work with during and following the Diabetes 101 classes. While the original model called for home and community visits, because participants were elderly and experienced mobility issues, mentee-mentor visits were conducted at the practice during monthly small group “booster” sessions. These sessions included peer to peer support and mentoring, continuing education about diabetes, and celebrations of progress. The small groups were initially run by the nurse educator. Over time as a consistent group of peer mentors is developed, peer mentors will co-lead the sessions with the nurse educators. Mentees shared successes and opportunities for improvement with the group, and through interactive dialogue and encouragement, each was encouraged to set a goal or define an existing goal. Follow-up was conducted at subsequent meetings or when mentees experienced specific issues. Spontaneous one-on-one support between meetings took place via telephone. Each peer mentor had approximately 1 to 3 mentees and provided support as long as the mentee desired; the average duration was 6 months.

**Unique Features or Strengths**

A key component of the program was use of a paper-based personal health record (PHR) called the Carpeta Roja, or red notebook. This PHR is the basis of empowerment and training for the mentees, helping them organize their health information, track their health care visits, and trend and track their progress in terms of HbA1c values, blood sugar levels, etc. Through learning to use this PHR with the help of their mentors and nurse educator, the patients became “owners” of their own health and health information. The PHR also served as an “expert system” for the mentors, helping focus their attention on the important issues the mentees should be learning about and managing. The mentors learned how to help their mentees use the Carpeta Roja. To track their mentees’ progress, mentors maintained their own version called the Carpeta Azule, or blue notebook.
LESSONS LEARNED

➢ Locating peer mentoring programs in healthcare organizations rather than the community has some benefits, but can make it difficult to move peers into leadership positions in the program

➢ It is important to involve the entire clinical team (administration, health coach, clinic staff, and provider) as early and as often as possible throughout the implementation process

➢ Including information on peer mentoring in the electronic health record facilitates recruitment and communication between peer mentors, clinicians, and the health care team

Major Challenges & How They Were Addressed

➢ Reach and engagement: Since a number of mentees attended numerous doctor appointments during the week or month, there was great interest in differentiating the typical “medical appointment” visit from the monthly support group meeting by creating a special environment. Therefore, monthly meetings were designed to include a “social” or “fiesta” type atmosphere including music, food and lively conversation. Educational topics for each session were based on suggestions from the seniors during the previous event. Topics presented were interactive and focused on problem-solving. This outcome-centered forum helped individuals identify patterns for coping and other factors that can contribute to behavior change and disease management. It also provided a rich environment for participants to share and integrate their own personal experiences for the learning process and promote active participant engagement in the process.

➢ Recruitment: In an effort to boost recruitment, peer mentors began making calls to potential mentees, rather than clinical or front office staff, and WellMed’s electronic health record system was used to encourage referral to the program by providing a point of care reminder to physicians and health coaches regarding patients’ eligibility.

➢ Co-leadership by peers: While most peer programs are community-based, this program was located within a healthcare organization. This resulted in access to helpful resources such as meeting places, easy access to health data, and staff support. However it also created some challenges as health care professionals found it difficult to transfer leadership of the training sessions and small groups to peers. This was addressed through training provided to the nurse educators and selection of a program director who recognized the competence of peers, the centrality of the empowerment model to the intervention, and understood how to help realize this within the program.

Key Results & Major Accomplishments

Although clinical indicators (weight, BMI, HbA1c, and systolic blood pressure) for all patients, both intervention and control, improved over time, peer mentored patients’ HbA1c values improved slightly more rapidly than their non-intervention controls. Improvements were statistically significant with a decrease in their HbA1c levels from 6.34 at baseline to 6.13 at 6-10 months following the program. Individuals participating in the intervention showed an increase in knowledge about diabetes from pre- to 6 month post-intervention, as well as increases in desired health management behaviors. They reported understanding what HbA1c is and how it relates to their health, knew their own HbA1c levels, reported improvements in their nutritional behaviors, and increased monitoring of their blood glucose.

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A Controlled Evaluation of the Australasian Peers for Progress Diabetes Program (PfP-DP) and Its Transferability to Other Countries

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The Australasian Peers for Progress Diabetes Program aims to deliver peer support in a community-based group support model. This cluster randomized controlled trial was designed to evaluate the effects of a peer-led program on improving daily management, social and emotional support, and linkage to clinical care for people with type 2 diabetes.

Population & Setting
English-speaking adults with type 2 diabetes living in 1 of 36 specified postcode (zip code) locations in Victoria, Australia.

Who Are the Peer Supporters?
The National Diabetes Services Scheme (NDSS), administered by Diabetes Australia on behalf of the Australian Government, is a national database of Australians diagnosed with diabetes. The NDSS, through Diabetes Australia-Vic (DA-Vic) was used to identify individuals who: a) had been enrolled in the database for more than 12 months, b) indicated a willingness to be contacted for research purposes, c) resided in one of the selected locations, and d) was between the ages of 25 and 75. Potential participants were invited by mail to contact the project team if interested in receiving more information about participating in the study as a peer supporter or as a group member. General Practitioners, community health centres, pharmacies, diabetes clinics, podiatrists, optometrists and any active DA-Vic community network group, or other

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Peer leaders encouraged group activities, such as walking and exercise classes; a password protected website offered vignettes from self-management education sessions

Social/Emotional Support
Peer leaders provided support outside of meetings via telephone, email, or face-to-face

Linkages to Care
Peer leaders organized group meetings with health care professionals; meetings were driven by group needs

Ongoing Support over Time
Several peer support groups will continue meeting past the intervention period and have established close integration and support from local community health services
community-based groups within the selected locations were also targeted with posters and brochures to increase study exposure. A total of 285 participants were selected to participate in the study and were randomized by their neighbourhood to a peer support intervention or usual care. Eighteen peer leaders were successfully trained for the intervention.

**Peer Supporter Training and Quality Assurance**

Peer leaders were given a resource manual and trained over two and a half days by a credentialed diabetes nurse educator experienced in group facilitation training. Training aimed to equip leaders with communication and group facilitation skills so they could help their group members share their stories, set goals, problem solve, increase awareness and linkages with the available health system, optimize self-management behaviours (including glucose monitoring, dietary changes and physical activity), and also provide emotional support. Peer leaders were supported during the intervention period through weekly teleconferences with the project staff, including diabetes educators, dieticians and psychologists. They also received a weekly informational e-newsletter. Peer leaders were asked to attend at least one supportive peer group teleconference with the project staff each month for organizational and informational support, and also as an opportunity for peer leaders to provide experiential, emotional and social support to each other.

**Peer Supporter Roles & Responsibilities**

One or two peer leaders met once a month with groups ranging from 7-14 participants for a period of 12 months. Meetings were 90 minutes in length and took place within a local community setting. Additional contact in between meetings was encouraged; some groups participated in routine walks, group tai chi classes, or met for coffee. Peer leaders actively followed up with participants who did not attend the monthly meeting.

**Unique Features or Strengths**

Prior to randomization, all study participants and peer leaders received 1 day of basic diabetes education to account for a lack of basic diabetes knowledge and self-management principles among a number of participants. A dedicated education program was developed in association with credentialed diabetes educators from DA-Vic and delivered to as many participants as possible. The 7-hour program covered basic disease information, good self-management practice including diet and physical activity, disease complications and medications, and included a project-specific education manual. A DVD incorporating video excerpts from the education day along with additional

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**TRAINING SUMMARY**

**Duration:** 2½ days

**Content:**
- Setting the scene
- PFP support groups
- Story telling & communication skills
- Goal-setting
- Review goals & problem solving
- Linkage to clinical care
- Group facilitation
- Ethics & self-care
- Peer leader roles & responsibilities
- Putting it all together
- Working with the research group

**Approach:** Knowledge acquisition, skills building, & role playing

**Evaluation:** Peer supporters’ suitability further assessed during the interactive sessions by training facilitator

**Language:** English
information and key messages was developed and provided to all participants who were unable to attend a formal education session in-person.

**Major Challenges & How They Were Addressed**

- **Reach and engagement:** Soon after support groups began meeting it became clear that getting accurate information from group leaders could be problematic. To accurately and effectively measure what happened during group meetings, the intervention was adapted to a real-world setting with more focus on supporting peer leaders through teleconferences, providing group meeting report templates for simply recording group meeting activities, and sending a weekly e-newsletter with a reminder about reporting. This approach aimed to engage the leaders more supportively and enabled the research team to record teleconferences in order to hear how the group was connecting. The peer leaders also “met” regularly every month via a conference call to review their progress and to problem solve issues that were identified by each of the participants; these calls were supported by the project team, however, the agenda and input for the majority of the calls were provided mainly by the participants.

- **Basic diabetes education:** During pilot training of the peer leader program, it was noted that basic diabetes education and knowledge of diabetes self-management principles were lacking among many participants. In order for intervention groups to provide support, rather than focus on filling the wide knowledge gap, participants received 1 day of basic diabetes education. Those who were unable to attend the face-to-face meeting were sent the education manual and a DVD resource featuring footage from the actual education session supplemented with visual material to reinforce diabetes self-management education messages.

**Key Results & Major Accomplishments**

Eleven of the 12 planned intervention groups continued for the entire trial period. The majority of recruited participants were already quite well controlled with a mean HbA1c of 7.2% at baseline. The main hypothesized outcome of a significant reduction in CVD risk in the intervention arm, using the UKPDS risk score, compared to the usual care arm, was not observed. Significant differences between the intervention and usual care arms for clinical and anthropometric measures (HbA1c, lipids, weight, BMI etc.) were also not observed in the intervention condition compared to control participants. Whilst clinically significant findings were not demonstrated in this study, daily management of diabetes by group members were significantly enhanced in the intervention group with intervention participants reporting increased frequency of daily self-care activities, increased intake of >5 servings of fruit and vegetables, more frequent BGL testing and monitoring as well as some improvements in physical activity intensity and frequency. Recipients of peer support also reported improved medication adherence. They reported increased satisfaction with the support
they were receiving from their health care team, suggesting improved linkages with the clinical care team and/or better understanding of the role of clinical care providers in diabetes self-management. Five of the eleven groups still continue to meet by themselves, most of which are in rural/regional areas. Rural participants also reported higher costs and lower accessibility to both clinical and allied health services associated with ongoing diabetes management. This study demonstrates the feasibility of providing self-directed community-based diabetes support groups; however, we also note the value and requirement for extensive peer leader support to ensure the initiation, strong establishment and long term sustainability of these kinds of groups. The clinical benefits of this kind of program in Australia have not been clearly demonstrated in this study that recruited people with relatively well controlled diabetes; however, it could also be the case be that the intervention and follow-up period may have been too short to detect any significant clinical improvements and/or the prevention of diabetes complications.

**RESOURCES**
- Peer Support Recruitment Brochure
- Peer Leader Interview Scorecard
- Facilitator Handbook
- Peer Leader Manual and Participant Workbook
- Sample Newsletter
- Group & Individual Contact Notes

**PUBLICATIONS**

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Diabetes Buddies Program in South Africa

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As the diabetes epidemic continues to rise in South Africa, the country’s health system faces many challenges in meeting the needs of people with diabetes. The Diabetes Buddies program was a pilot program designed to promote a healthy lifestyle and better management of diabetes through reciprocal support among women in the Mfuleni Township surrounding Cape Town, South Africa.

The study was conducted by Dr. Mary Jane Rotheram-Borus and her colleagues at the University of California in Los Angeles (UCLA) and to ensure that the program was tailored to the cultural needs of the women in South Africa was advised by a local organization called Women for Peace. The intervention had three components: a) a series of 12 psycho-educational group sessions that addressed improving one’s lifestyle of eating, moving, and abstaining from alcohol and drugs; b) mobile phone probes about daily lifestyle; and c) text messages to support lifestyle changes.

Eligible participants were Xhosa women with diabetes who were able to read. A total of 22 women were recruited from the local health clinic and paired with a “buddy”. The Diabetes Buddies were then trained by 2 Peer Mentors (women with diabetes who were trained at UCLA) using the following 12-week curriculum: a) Introduction, b) Using the cell phone, c) Understanding our feelings, d) Healthy eating, e) Physical activity, f) Healthy cooking, g) Diabetes overview, h) Talking to your doctor, i) Healthy families, j) Eating healthy portions, k) Stress & relaxation, and l) Looking to the future. Outside of weekly group sessions, women were able to contact each other through use of a mobile phone network, which allowed ongoing support between buddies.

Women were also encouraged to share their successes and challenges in adopting new and healthier lifestyles. As part of the mobile phone component, one message, or probe, was sent daily to each participant with the goal of helping the women gather information to use in the management of their disease.

FOUR KEY FUNCTIONS

Assistance with Diabetes Management in Daily Living
Diabetes Buddies used mobile phones to contact their peers and answer daily “probes” about self-management.

Social/Emotional Support
Diabetes Buddies reached out to each other through a mobile phone support system and also found training meetings to be good forums for social and emotional support.

Linkages to Care
Diabetes Buddies met with nurses from the local health clinic for assessments of biomarkers of diabetes.

Ongoing Support over Time
A year after program completion, the original group of women recruited more participants and continued to meet.
In addition to baseline assessments, the program also conducted a 3- and 6-month assessment following the intervention. Evaluation measures included: biomarkers of diabetes; self-reports of lifestyle, coping styles and mental health symptoms; and support measures. In pre-post comparisons at 3 months, there were increases in sleep time, blood checks by a health care provider, positive coping styles, and level of social support.

The Diabetes Buddy program has provided a long-term model for sustained behavior change, which is evidenced by the continuation of the program one year post evaluation. Programatically, having an infrastructure in place is critical for a sustainable peer support model. Also, in terms of developing interventions, the use of the mobile phone is beneficial in resource-poor settings.

**TRAINING SUMMARY**

**Duration:** 12 weeks  
**Content:**  
- Introduction  
- Using the cell phone  
- Understanding our feelings  
- Healthy eating  
- Physical activity  
- Healthy cooking  
- Diabetes overview  
- Talking to your doctor  
- Healthy families  
- Eating healthy portions  
- Stress & relaxation  
- Looking to the future

**Approach:** Group sessions  
**Language:** English and Xhosa

| RESOURCES | ➢ Appointment card  
|           | ➢ Overview of 12 group sessions  
|           | ➢ Baseline and follow-up assessment  
|           | ➢ Recruitment script |


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Diabetes is highly prevalent in the South and rural residents have a higher incidence of negative outcomes. This cluster randomized trial was conducted to determine if volunteer peer support added to diabetes education is superior to education alone in improving diabetes outcomes.

**Population & Setting**
Rural residents with diabetes living in low resource communities in Alabama’s Black Belt, where 80% of residents are African Americans.

**Who Are the Peer Supporters?**
Peer advisors were individuals who were either living with diabetes or had experience helping a close friend or family member with their daily diabetes self-care. Eligible peer advisors: a) wanted to help others, b) were willing to work with 3-6 participants over 12 months, c) attended a 2-day training session, and d) attended participant enrollment days. A total of 68 peer advisors were recruited for training.

**Peer Supporter Training and Quality Assurance**
Peer advisor training occurred in venues within Alabama’s Black Belt on 2 consecutive Saturdays and included interactive didactic sessions and hands-on practical training. The training manual contained chapters on diabetes basics, taking medicines, healthy eating, physical activity, stress management/mental health, getting the most out of doctor’s visits, communicating with clients and goal setting, problem solving and overcoming barriers, community resources, protocols, research and ethics, and safety in the community. Activities during the first day of training included role-playing to teach motivational interviewing skills and goal setting, lunch as an opportunity to model healthy eating, and exercising together to familiarize peers with the study’s exercise DVD. On the second day of training, peers were certified using a checklist of rudimentary mastery of skills related to assistance with diabetes management in daily living, social/emotional support, and linkages to care. Peer advisors provided support weekly by telephone for a length of time optimal for the peer-client pair, then monthly thereafter.

**Assistance with Diabetes Management in Daily Living**
Peer advisors used motivational interviewing skills to set realistic, achievable goals with the client and identify a monitoring plan to track progress.

**Social/Emotional Support**
Peer advisors encouraged and motivated clients by modeling positive attitudes, beliefs, and behaviors.

**Linkages to Care**
Peer advisors were trained to recognize situations that required input from the health care team, which included a physician, nurse, and pharmacist.

**Ongoing Support over Time**
Peer advisors provided support weekly by telephone for a length of time optimal for the peer-client pair, then monthly thereafter.
to supportive listening, motivational interviewing, and realistic goal setting; 28 peers were certified. Of the remaining 40, 18 opted to participate in remediation training, after which 13 additional peers were certified for a total of 41 peer advisors. During the first 4 weeks of the intervention, continuing education and support were provided through weekly conference calls with monthly calls thereafter. Community coordinators held monthly in-person meetings to give peer advisors an opportunity to share experiences and troubleshoot problems. In addition, community coordinators and peer advisors contacted each other at least biweekly, which was helpful for bringing to attention any issues or problems related to peers and/or clients that needed to be addressed.

**Peer Supporter Roles & Responsibilities**

Each peer advisor worked with 5-8 clients according to the following protocol:

- an initial 45-60 minute baseline needs assessment conducted face-to-face in the week following Enrollment Day
- weekly telephone calls for approximately 8-12 weeks, depending on what was optimal for the peer-client pair
- monthly telephone calls for the remainder of the 12-month intervention

In addition, peer advisors made a special telephone call to clients prior to each doctor visit to help prepare them for the visit. They also made a post-visit call.

**Unique Features or Strengths**

Although initial meetings with peer advisors and clients were fairly structured with a “get to know you” segment and selecting an initial focus of coaching sessions, follow-up sessions were quite unstructured. Focus areas were highly individualized with the client choosing which aspect of self-care they wanted to work on for improvement. Session content was also highly individualized because topic areas were not predefined, except for the session designed to occur shortly prior to a doctor visit. Peer advisors used that time to prep clients for getting the most out of doctor visits by using a concept developed for this study called “Raise the Bar” – Be prepared; Ask and learn; Reflect and reach out.

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**TRAINING SUMMARY**

**Duration:** 2 days, 6 hrs each

**Content:**
- Diabetes basics
- Taking medicine
- Healthy eating
- Exercise and active living
- Stress management and mental health
- Getting the most out of your doctor visit
- Communication and goal setting
- Problem solving and overcoming barriers
- Knowing your limitation, tapping into your community resources, asset mapping, and community empowerment
- Research and ethics

**Focus on:**
- Interactive discussions
- Principles of motivational interviewing
- SMART goals

**Approach:** Based on adult learning theory – Interactive sessions & role-playing

**Evaluation:** Certification with an opportunity for remediation training and re-certification
- Working knowledge of diabetes basics (open-book quiz)
- Coaching skills – Use collaborative, client-centered approach; Help set SMART goal (observed role play)

**Language:** English
Major Challenges & How They Were Addressed

- **Peer advisor selection:** Partnering communities had a high level of functional illiteracy. A longer time horizon might have permitted the training of functionally illiterate individuals as peers, but due to the short timeframe of the study a literacy screen was included early in the recruitment process.

- **Peer advisor certification:** Many potential peer advisors did not become certified after training due to an inability to demonstrate rudimentary proficiency with goal setting or motivational interviewing skills, or an inability to read well. Remediation training, which included sessions over the phone with university study staff and also community coordinators, was offered to any peer who remained interested in becoming a certified peer advisor.

- **Reach and engagement:** Client contact forms were designed to help peer advisors keep track of each client’s goals and to remind them of what they learned during training. To confirm that the recorded information actually reflected the content of the sessions, a video tool was created to assess key features of peer training, including supportive listening and realistic goal setting.

- **Peer retention:** The close relationship between community coordinators and peer advisors resulted in early notification that a peer may need to drop out of the program, permitting time to plan for how to handle the peer’s clients.

- **Participant retention:** The study experienced relatively low retention at follow-up and switched to an option for in-home data collection to maximize retention. Although 85% retention was achieved, this came at the expense of a longer time than one year between baseline and follow-up for many participants. As a result, the study’s main analysis utilized generalized additive mixed models which reflected intervention effects over time.

Key Results & Major Accomplishments

Culturally adapted diabetes education resulted in improved diabetes knowledge and health behaviors. Participants in both study arms ate more fruits and vegetables and reported better adherence to a medication regimen. Compared to control arm participants, intervention arm participants lost more weight and had improvements in blood pressure, quality of life, and activation, but similar HbA1c and cholesterol. These effects varied over time.

Lessons Learned

- Community engaged research tends to attract participants who may not meet the study’s guidelines; in-home data collection is better for reaching the target population
- To enhance acceptability of randomization and control group membership, providing a one-hour diabetes education program to both trial arms is beneficial
- Incentive programs are helpful for getting peer advisors to fill out their contact records and hand them in
### RESOURCES
- Training Curriculum
- Peer Advisor Training Evaluation Form
- Recruitment Flyer
- Peer Advisor Interest Talking Point.Screening Form
- Client Contact Log

### PUBLICATIONS

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Peer Support for Sustainable Self-care and Enhancing Quality of Life Among Diabetes Mellitus Type 2 Patients in Thailand

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Diabetes mellitus (DM) is highly prevalent in Thailand’s northeastern province of Nakorn Rajasima and central province of Supan Buri. The aim of this pilot study was to enhance the capacity of Village Health Volunteers (VHVs) to provide peer support that motivates DM type 2 patients to develop and maintain diabetes management behaviors by applying an ecological approach. Functioning as a crucial link between communities and frontline health care providers, VHVs provided health education, supported & motivated self-care management, and assured accessibility of necessary services and resources related to diabetes care. In each province, 2 districts were selected based on their similarities in terms of socio-economic and demographic characteristics; 1 was randomly assigned into the experimental arm (peer support interventions) and the other into the comparison.

Ten VHVs were recruited from the experimental district and 10 from the comparison in each province using the following selection criteria: a) had at least 3 DM patients in their areas of responsibility, b) were able to read and write in Thai, c) were willing to participate in the project, and d) were able to complete the training. During a 4-day training program, VHVs learned critical knowledge and skills through a comprehensive training module, which covered topics including: early signs and symptoms of diabetes complications and how to address them, proper diet and exercise for diabetes patients, motivation and support techniques for encouraging and regulating patients’ desirable behaviors, and collaborative goal setting and action plans. Lecture and practice sessions were alternately carried out to reinforce participants’ self-efficacy. Toward the end of the training, VHVs developed activity plans based on the cultures and lifestyles in their community settings detailing objectives and activities to be carried out, time schedules, and resources needed to support patients.

Sixty patients were recruited into the experimental and the comparison arms, respectively. The patients in the experimental arm received support from their respective VHVs. This 6-month intervention was implemented differently in the 2 provinces due to respective lifestyles and cultures of the provinces. In urban Nakorn Rajasima, participants receiving peer support met

**FOUR KEY FUNCTIONS**

**Assistance with Diabetes Management in Daily Living**
Village Health Volunteers had face-to-face discussions with patients about diet and exercise

**Social/Emotional Support**
Village Health Volunteers visited patients at home and encouraged their involvement in group activities

**Linkages to Care**
Village Health Volunteers bridged the gap between the community and primary care by being closely linked with the health staff

**Ongoing Support over Time**
Village Health Volunteers were trained to encourage and motivate chronic patients to manage their sugar level more effectively and sustainably
every Tuesday for small group discussions, and VHV s conducted home visits with patients once a week. In addition, health staff and VHVs visited each patient at least once a month. In rural Supan Buri, health staff routinely joined group discussions and diet and exercise demonstrations with patients and VHVs. VHVs visited patients every 2 weeks or as needed and group exercise among VHVs and patients was organized every day at the home of a VHV. Each month, a meeting among patients, VHVs, health staff and the research team allowed discussion about experiences, problems, and obstacles of diabetes self-management.

The patients in the comparison arm received usual care which consisted of health education at the clinic, and periodic home visits from health staff.

Overall, both experimental and control arms had a good retention rate. Specifically, 6 months after implementation, patients in the peer support arm had only decreased by 2 (1 died in a car accident and 1 moved from the area), while 1 comparison group in Nakorn Rajasima province moved to another district due to property damage caused by severe flooding. As a result, there were 58 and 30 patients retained in the experimental and comparison groups respectively.

Patients who received support from VHVs had a significant increase in their DM knowledge and perceived susceptibility to complications. They also exhibited a decrease in HbA1c (from 8.23% to 7.6%) and BMI (from 26.5 kg/m² to 24.9 kg/m²), while both of those were increased in the comparison group. Although frequency of exercise decreased from 5.2 to 3.4 times/week among the VHV group, duration of exercise increased from 22.5 to 24.4 minutes. The peer support group also increased their average quality of life score from 38.5 to 44.3 (out of a total score of 54), while that of the comparison group remained the same at 41.4. Both groups, following the intervention, better understood the benefits of glycemic control through exercise, diet, and emotional control and perceived higher self-efficacy in controlling blood sugar levels.

This project demonstrates the effectiveness of VHVs in supporting DM type 2 patients to gain more knowledge about DM and how to live with it, increase their self-efficacy in controlling blood sugar levels, decrease their HbA1c and BMI, and have a better quality of life. VHVs can also strengthen the 2-way referral system from community to primary and higher care levels to facilitate the continuity of care for the patients.

**TRAINING SUMMARY**

**Duration:** 4 days

**Content:**
- Diabetes knowledge & management
- Early signs & symptoms of complications and how to address them
- Proper diet & exercise
- Foot care & changing lifestyles
- Patient assessment
- Patient classification
- Collaborative goal setting & action plans
- Social support and networking

**Approach:** Alternating lectures and practice sessions to reinforce participant’s self-efficacy

**Languages:** English & Thai

**RESOURCES**
- Focus group discussion guides


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RAPSID: Can Peer Support, Delivered as a Group or Individual Intervention, Enable People with Diabetes and Improve their Health? (RAndomised controlled trial of Peer Support In type 2 Diabetes)

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People with type 2 diabetes face various psycho-social, self-management and clinical care issues and evidence is mixed whether peer support can help. This randomized controlled trial was designed to test the efficacy of peer support delivered through a peer support facilitator (PSF) as a 1:1 approach, a group approach, a combined 1:1 and group approach, or a control group (no peer support).

**Population & Setting**
Adults with type 2 diabetes living in rural Cambridgeshire, England.

**Who Are the Peer Supporters?**
Patients with type 2 diabetes from 62 general practices were asked if they would like to volunteer to be a PSF. Those who expressed an interest were selected if they: a) were not flagged as unsuitable by their general practice team b) passed a criminal record check c) attended a pre-trial education session d) appeared flexible, adaptable and non-judgmental at the measurement, education and training sessions. A total of 1163 patients expressed an interest in being a PSF; 245 were invited to training, 167 completed training, and 136 became active in the role.

**Peer Supporter Training and Quality Assurance**
Prior to training, PSFs attended a diabetes-specific education session, during which they received a basic diabetes educational booklet about the fundamental aspects of diabetes.

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**FOUR KEY FUNCTIONS**

**Assistance with Diabetes Management in Daily Living**
Peer support facilitators were trained to help patients implement good self-management techniques and practices

**Social/Emotional Support**
Peer support facilitators were taught active listening skills, emphasizing the importance of engaging with patients’ narratives in positive ways, both visually and verbally

**Linkages to Care**
Monthly meetings with the RAPSID nurse provided an opportunity for peer support facilitators to discuss issues that might require clinical services

**Ongoing Support over Time**
Peer support facilitators were taught to help patients develop personal support networks when necessary or appropriate
Each then completed a 2-day training course that included:

a) introduction to the trial

b) session exploring the role of the peer supporter

c) role-plays to practice boundary-setting, effective listening, dealing with difficult situations such as depression or alcoholism, and the limitations of the role

d) strategies to overcome personal barriers to diabetes care

**Enabling Peer Support**

PSFs and patients were introduced during an education session held for all participants and asked to arrange their first peer support meeting.

PSFs were provided with diaries to record their experiences, mobile phones to facilitate contacts with patients and also a resource booklet that contained a number of activities and ideas for stimulating supportive discussion (along with study documentation).

The study team’s research nurse held monthly support meetings with the PSFs to discuss the roles they were playing, as well as challenges they were facing. The nurse also provided them with a telephone number which they could call during set hours if they had pressing concerns.

**Peer Supporter Roles & Responsibilities**

PSFs met monthly with patients for 8-12 months. 456 peers attended a session, given a PSF:peer ‘ever attended’ ratio of 1:3.4. Intervention arms included meeting 1:1, as a group, or 1:1 and group meetings combined. PSFs were encouraged to find local venues in which to meet and were offered help to do this by the study team. It was advised that 1:1 meetings would last 1 hr and group meetings last up to 1.5 hrs. PSFs in the combined intervention arm were encouraged to offer 1:1 and/or group peer support, allowing patients to choose between them or participate in both. During the intervention, PSFs were asked to keep records of the telephone contacts they had with their peers, the number of meetings they held (and with whom), and to write brief reports on the content of those meetings.

**Unique Features or Strengths**

Intervention arms included not only individual and group peer support, but also a combination of individual and group support to compare the efficacy of all 3 methods. Patients in the combined approach had the opportunity to try both. Individual interactions often mimicked a counselling style, whereas group settings allowed PSFs to draw on the experiences and narratives shared by others. Another distinctive feature included training in how to overcome barriers to diabetes care along with the provision of local data from eligible participants on the barriers they faced, facilitating discussions on these issues.
**Major Challenges & How They Were Addressed**

- **PSF recruitment:** Recruitment processes required the completion of health and safety and background criminal checks all delaying the commencement of the intervention.

- **Basic diabetes education:** The level of diabetes knowledge found in participants was considerably lower than expected. To account for this, the study team adjusted the education session to a suitable level, targeting the more fundamental aspects of diabetes.

- **PSF retention:** An ongoing concern was retaining PSFs. The RAPSID research nurse provided social and emotional support to mitigate the risk of them dropping out.

**Key Results & Major Accomplishments**

The trial is now complete and the main findings under peer review. Also currently underway is an analysis of which factors are associated with PSF engagement in terms of the number of meetings held, and effectiveness in terms of the changes they elicit in the peers they have seen. Previous analysis suggested those who volunteered to be PSFs were more positive about several aspects of self-care. Ongoing analysis suggests that factors associated with PSF engagement are female gender, non-married status, having a university degree, and having a professional occupation.

**Publications**


- Simmons D, Graffy J, Holman D. *Potential to reduce hyperglycaemia through peer support in RAPSID: RAndomised controlled trial of Peer Support In Diabetes.* American Diabetes Association Chicago June 2013.


**Lessons Learned**

- Diabetes education sessions are important to ensure participants have a basic grasp of the fundamentals of diabetes.

- Level of support provided by a research nurse is greatest during recruitment and initial phases of the intervention.

- Social and emotional support is important for retaining peer support facilitators.
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