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"One can learn from other people's experiences": Latino adults' preferences for peer-based diabetes interventions

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Abstract

Purpose—To assess Latino adults' preferences for peer-based diabetes self-management interventions and the acceptability of the church setting for these interventions

Methods—We partnered with two predominantly Mexican-American churches in Chicago and conducted 6 focus groups with 37 adults who had diabetes or had a family member with diabetes. We assessed participant preferences regarding group education and telephone-based one-to-one peer diabetes self-management interventions. Systematic qualitative methods were used to identify the types of programming preferred by participants in the church setting.

Results—Participants had a mean age of 53±11. All participants were Latino and more than half were born in Mexico (60%). Most participants were female (78%), had finished high school (65%) and had health insurance (57%). Sixty-five percent reported having a diagnosis of diabetes. Many participants believed the group-based and telephone-based one-to-one peer support programs could provide opportunities to share diabetes knowledge. Yet, the majority stated the group education model would offer more opportunity for social interaction and access to people with a range of diabetes experience. Participants noted many concerns regarding the one-to-one intervention, mostly involving the impersonal nature of telephone calls and the inability to form a trusting bond with the telephone partner. However, the telephone-based intervention could be a supplement to the group educational sessions. Participants also stated the church would be a familiar and trusted setting for peer-based diabetes interventions.

Conclusions—Church-based Latinos with diabetes and their family members were interested in peer-based diabetes self-management interventions; however, they preferred group-based to telephone-based one-to-one peer programs.

Peer support interventions are increasingly being used to support self-care among adults with diabetes.[1–3] Through these programs, people with a shared experience can receive emotional support and motivation to improve their diabetes self-efficacy.[2] Common peer support interventions include group-based and telephone-based one-to-one programs.[1, 4–7] Group-based interventions can promote diabetes self-care by inviting enhanced social interactions, encouraging learning from efficacious role models, and providing opportunities for educational activities.[8] One-to-one telephone based peer interventions can also promote

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self-care through social support, protect participant privacy, and reach rural or home-bound populations.[2, 6]

However, despite their theoretical basis, recent reviews have noted little data defining which peer support models are effective in varying settings and populations.[2, 3] Most studies have used group-based interventions but have not explicitly investigated the preferences for different types of peer-based interventions by Latinos.[2, 3] This research gap is particularly important since peer-based interventions may be useful in addressing diabetes disparities, especially among Latinos who face many social stressors and challenges in managing their diabetes. [9–11] Most studies have used group-based interventions or have not explicitly investigated the types of peer-based interventions that Latinos preferred.[5, 7, 12] Additionally, few interventions to improve care of Latinos with diabetes have been set in the church.[3, 7, 12] Peer-based interventions may be particularly effective in churches, since they tend to be the focal points for many Latino communities and are naturally convening places for people with a common culture and shared experiences.[13–19]

Understanding how to tailor peer-based diabetes interventions for Latinos is an important first step in designing effective diabetes interventions for this population.[10, 20] We conducted focus groups with Latinos with diabetes and their family members to elicit preferences for peer-based interventions and to assess the acceptability of the church setting for these interventions.

Methods

Study design

Community-based participatory research (CBPR) is an approach that emphasizes a partnership between community and academic partners in collaborative research projects.[21] This approach uses scientifically rigorous methodology to conduct partnered- research that can lead to research findings that are relevant and applicable to the community. We used a community-based participatory approach to partner with two predominantly Mexican-American, Catholic churches in a Chicago neighborhood.[22] This neighborhood has high diabetes-related mortality and has many risk factors that confer poor health.[23, 24] The research team and community partners decided to speak with parishioners affected by diabetes and their family members to elicit preferences for different types of diabetes interventions in the church setting.

Between February and April 2009, the research team and community partners conducted six focus groups with 37 adults diagnosed with diabetes or who had a family member with diabetes. Five groups were held in Spanish and one in English. The focus groups lasted approximately 90 minutes, were led by a bilingual moderator and were held at partnering churches. The focus group discussions were audio recorded, transcribed, and translated into English as needed. The University of Chicago Institutional Review Board approved all study procedures.

One moderator led the focus groups that were in Spanish. She had led focus groups previously and was familiar with this research methodology. A second moderator, the principal investigator (AB), led the English speaking focus group and received training from two experienced focus group moderators, including a behavioral psychologist (MQ) and qualitative researcher (RGB), on how to effectively lead focus group discussions. A trained, bilingual research assistant took notes during each focus group session. The principal investigator, research assistant, and moderator convened for fifteen minutes after the end of each focus group in a private room and discussed any new or recurring themes heard in the

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session. For the English focus group, only the research assistant and moderator (AB) debriefed after the session. Focus groups were conducted until there was theme saturation.

Participant recruitment

We recruited participants through posted flyers at churches and church events. Eligible participants included adults 29 years of age or older who had diabetes or had a family member with diabetes. We excluded people who could not give informed consent, were pregnant, or did not speak English or Spanish. We screened 85 participants of whom 77 were eligible and 71 enrolled. All enrolled participants were scheduled for a focus group session. Participants received a mailed letter stating the time, date and location of the focus group. Of the 71 scheduled participants, 37 attended a focus group session. We did not contact people who did not attend the session to assess their reason for missing the group. There was no statistically significant difference in people who did or did not attend the focus group sessions by age, gender, or diagnosis of diabetes. The focus groups on average had 6 participants, ranging from 3 to 12 participants in each group. Study participants received a tote bag and bilingual diabetes literature after attending the focus group.

Interview and Survey Instrument

The bilingual moderator followed a semi-structured questioning guide that was developed iteratively based on discussions with the research team and the community partners. The main objective of the focus groups was to receive feedback on the proposed interventions (self-empowerment groups versus one-to-one peer support). The focus group moderators described both types of proposed interventions to all the focus group participants. Then all focus group participants were asked about their thoughts on both types of intervention.

The group self-empowerment program would be a program where participants with diabetes would meet as a group at the church once a week to learn about diabetes self-management, receive self-empowerment training, and share experiences in a group setting with a set educational curriculum. The one-to one intervention was described as a program where people with diabetes would be paired up with a partner with diabetes and receive training to coach each other on diabetes management. The partners would speak over the phone each week and have the chance to encourage self-management behaviors and share experiences over the phone. The partners could decide if they wanted to meet on their own.

After allowing participants to voice their opinions regarding community strengths and needs, barriers to diabetes self-management, and the role of church in community-based diabetes programs, we explored participants' thoughts on our proposed interventions. Participants were asked about the strengths and weaknesses of each intervention and their overall preference. Participants also had the chance to describe other interventions that they would like to see implemented in their churches.

Participant sociodemographic and self-reported health information was collected via self-administered surveys directly following the focus group sessions.

Analysis

All sessions were audio taped and transcribed verbatim into text files. Focus groups conducted in Spanish were translated by a professional translation service into English. The transcribed text was imported into Hyperresearch 2.8.3 software for analysis (Researchware, 2007, Randolph, MA, http://www.researchware.com/products/hyperresearch.html). Three investigators (AB, CL, RGB) independently reviewed and coded the first focus group transcript. They then met to discuss the coding schema that they independently developed, and created a uniform codebook using grounded theory that would be used to code all the

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interviews. Two reviewers from the research team (AB, CL) then independently coded each transcript and met periodically to compare codes. They revised the codebook using an iterative process where modifications were made to the codes and themes as concepts arose from newly reviewed transcripts.[25] All final codes were agreed upon by both reviewers. Discrepancies were resolved by the third coder (RGB).

Results

Participants had a mean age of 53 years (SD 11). The majority of the participants was female (78%), had finished high school (65%) and had health insurance (57%). All participants were Latino and more than half were born in Mexico (60%). Most participants were of Mexican descent (81%). Sixty-five percent reported having a diagnosis of diabetes, and a majority of them (83%) reported taking medications for their diabetes. Most participants had an immediate family member who had a diagnosis of diabetes (70%).

Benefits to both types of interventions

Group-based intervention—Many participants noted the benefits of a group-based diabetes intervention in the church. (Table 1) Participants felt a group-based intervention would allow community members to share experiences in managing their disease and to motivate one another. Participants were also interested in learning self-empowerment techniques to feel more in control of their disease. The church was seen as an ideal place to have the group since it was a familiar and trusted place in the community.

One-to-one peer intervention—Similarly, many participants felt that a telephone-based one-to-one peer intervention would provide an opportunity to receive advice, share ideas on diabetes management, and receive emotional support. The one-to-one intervention would also provide companionship and friendship to the participants, especially those who had no family nearby. Most of the participants were not concerned about partner incompatibility; however, if there were conflict, one would simply change partners. Additionally, the telephone calls would be convenient since busy schedules could preclude people from attending group meetings.

Areas of concern

Group-based intervention—While participants were overall interested in the group-based intervention, they did have some concerns about the time commitment to attend group sessions. (Table 2) They also emphasized that the groups needed to be well-organized and led by a person who was well-trained and knowledgeable about community resources.

One-to-one peer intervention—Participants had several concerns about a telephone-based one-to-one program. The impersonal nature of telephone calls, the lack of face to face meetings, and the inability to interact with people who had a range of diabetes experience hampered the participants' enthusiasm for this type of program.

General preference for group-based intervention

Once asked to balance the benefits and concerns of these two interventions, some participants liked both interventions.

> To me it is the same when it comes to sharing with one person or with everyone.

However, while participants found value in the telephone-based intervention, an overwhelming majority of participants were interested in the group-based intervention.

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> So the idea of having a friend is a good one; of mutually calling one another over the phone. But this group that you mention with people, to like for example, meet every, week and bring all the experience you have listened to and heard in groups that you've had, is much better because this way, one can also learn from other people's experience.

Tailoring strategies for the proposed intervention

Group-based intervention—Participants had suggestions for tailoring the church-based programs for their community, such as by inviting families to be a part of the group, coupling the adults programs with ongoing youth programs at the church, providing child care, and continuing the groups after the set curriculum ended.(Table 3)

> Sometimes it would be better if the family comes, because that way they can take responsibility.

> There's also, there's also another thing like you have the boy scouts here. But maybe while they drop off their child in one of the, another program that they have here…So something, while there's a function for the youth, maybe there could be another function also for the adult.

Participants also had many suggestions regarding who should lead the class, where the class should take place, and how to involve local professions. While participants preferred professionals, they agreed that a knowledgeable peer could lead and facilitate the groups

One-to-one peer intervention—Many saw the one-to-one peer intervention as a natural outgrowth of the group-based program. Participants wanted to form trusting relationships with peers in a group program before choosing a telephone partner.

> Work in a group first, about two or three sessions and from there you can maybe pick a person that you trust the most.

Others mentioned that a benefit to having a partner within the group could be to learn what happened in the group session.

> So if you and I are partners, I can, I come and I provide you the information, and if another time I can't, you come and you provide me the information.

Discussion

We found that Latinos with diabetes preferred a group-based diabetes intervention compared to a telephone-based one-to-one peer support program. Both interventions would provide opportunities to share knowledge regarding diabetes, but the group education model was perceived to offer more opportunity to engage with community members and learn from people with a range of experience with diabetes. Participants noted many grievances regarding the one-to-one intervention, such as the impersonal nature of telephone calls and wanting to interact with peers with a range of diabetes experience. However, participants believed the peer intervention could be a natural outgrowth of the group meetings.

Despite the recent increase in use of peer-based interventions, we found that not all types of interventions were acceptable to our participants. Most of our participants had concerns about a telephone-based one-to-one peer intervention. While Latinos have a high rate of cellular telephone use, many participants mentioned the difficulty of calling and getting in touch with participants due to busy schedules and competing interests.[26] Additionally, contrary to other studies that support the use of telephone-based programs to provide participants with privacy and help them overcome geographic barriers, our participants

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desired face-to-face contact. The impersonal nature of telephone conversations impeded them from forming a trusting bond with their partner, especially with someone whom they have never met before. The idea of “simpatía,” an emphasis on the need for pleasant social relationships, and “personalismo,” a desire for a formal friendliness with others, may have impacted their preference for face-to-face contact with peers.[27] Even when recruiting participants for our study, we found that we had more success through direct contact with people than through posted flyers.[28] Additionally, geographic distance may not have been a significant barrier in connecting peers in our study population due to the density of Mexican-Americans in the neighborhood we recruited our sample from.[24]

Other studies have noted the success of collective learning, but our study is the first to elicit preferences for group education compared to one-to-one peer interventions among Latinos.[7, 29] Despite concerns about competing time commitments affecting attendance, our participants suggested that the groups provided opportunities to discuss shared experiences, learn how others solved problems that arose in diabetes self-management, provide each other motivation, and interact with others who had a range of diabetes experience. The preference for group learning may also reflect their shared sense of community. Many participants had leadership roles in the community and enjoyed interacting with their fellow community members. This desire to interact with community members may have extended into their preferences for group-based diabetes interventions. However, this may only be a partial explanation for our findings, since some participants were socially isolated and wanted to find companionship in their community through this group interaction.

Although participants had concerns about one-to-one peer telephone interventions, they were not opposed to interventions that utilized peers. Participants wanted community members who had expertise in medicine, nursing, and community health to be involved and lead group sessions. Additionally, participants believed the believed the group based-program could naturally lead to a one-to-one program. Once people became acquainted in the groups, they could break off into dyads. The one-to-one program could be a supplement to group-based program and provide motivation and support to participants in between group sessions.[2] Lastly, while most supported the idea of having these interventions in the familiar setting of a church, we found that many people did not specifically say how these programs would be different in the church versus other community settings. Thus, these preferences for programming may be applicable to settings outside of the church as well.

Our study has several limitations. Our findings may not be generalizable to all Latino persons with diabetes since our focus groups were conducted with mostly Mexican Americans from Catholic churches in one Midwestern city. However, Mexican-Americans represent the largest population of Latinos in the United States, and most Latinos in the U.S. are Catholic.[16, 30] Additionally, the participants’ preferences for group-based interventions may have been a reflection of their satisfaction with their involvement in groups in and out of the church. However, not all the participants in our focus groups were actively engaged in their communities or in the church. Our participants also had a higher level of education, income, and health insurance than national averages for Latinos, although the barriers they listed in receipt of care were similar to other studies with Latinos.[9] Our participants may have given socially desirable answers during the focus group discussions, and some participants may have been more vocal than others. Yet, we found that the respondents repeated similar stories across the focus groups, reassuring us that we did capture the most common responses as well as a wide range of beliefs.

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Conclusions and Implications

Peer-based diabetes interventions need to be culturally-tailored to specific populations to be effective. In our study, the majority of Latinos with diabetes and their family members preferred a group-based peer intervention as opposed to a lone telephone-based one-to-one program. Furthermore, participants agreed that the church would be a familiar and trusted setting for these types of interventions. The next step is to use these findings to design peer-based diabetes interventions for Latinos in the church setting and evaluate their impact on diabetes outcomes.

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Table 1

Perceived benefits of group-based and telephone-based one-to-one peer diabetes interventions

	Themes	Example quotations
Group intervention	Common culture may facilitate understanding	With the group, it'll build trust because they're from my community, they're from my neighborhood so, you know, they understand what I'm going through. So that'll give more people an opportunity to come in and be a part of that group.
	Have mutual interest in learning about diabetes	I sometimes tell my friends, 'Ay, I feel like this and like that,' and sometimes I feel as if I'm bothering them because they don't share my disease…So if we're in a group… we all want to know what to do to, in order to ease that load.
	Receiving advice and sharing ideas	Because in these support groups, one learns something. We learn from the others, things that I may not think of.
	Learning about self-empowerment	So, in other words, it's not like ok, well, I need to wait till the doctor tells me what I have to do. Here with empowerment and going to these classes, they are now putting it in your hands, so you're the one who controls how your diabetes is. It's either diabetes is gonna control you or you're gonna control your diabetes
	Provides motivation to improve self-management	I think that when one starts to come to the meetings, one starts getting more motivated.
	Prefer the groups be held at church because it is a familiar place	I think it would have to be here at the church because it's a central location…if all the information is coming out of this church then this would be a good location for people that come. And I think they feel a bit more comfortable because it's, you know, it's church.
	May lead to one-on-one peer program	So you feel more comfortable with that person and then little by little you get to know the person and from there you start, you start your own little buddy system.
Telephone-based one-to-one	Getting advice/sharing ideas	Yes, and find out what works for one. Perhaps someone drinks a tea and feels good and tells the other, "Well, I drank that tea. You should drink it." In other words, share ideas, exactly.
	For companionship/friendship	Once or twice [contact per week], yes, because for one who lives alone, that doesn't have any relatives or anything. I also don't have any more relatives, my kids and I, and well… Yes, one is always in need of more friends.
	To receive and give motivation and emotional support	Well, it's good because, for example, there are a lot of people that are like the lady, alone, that don't have any goals, or similar, right? So then, if one has somebody's phone number and calls them, "Hi, how do you feel today? How are you? Is your sugar high? Do you feel sad?" or "go out, get up, go for a walk, do something…" Right? It's providing support to the other person, and that seems like a good idea, to have someone like a partner or someone else that one can call each day or one day a week early in the morning, or invite to go out. "Come on, let's go out. We're going for a walk or for coffee."
	The convenience of speaking on telephone	Many times, when the climate is too cold, imagine having to leave the house. It's better over the phone. "And how have you been? How's your sugar? What have you done? What's fun?" "Well I started watching the soap opera." "Why the soap opera?" [Laughter]
	As a way to know what happened in class if unable to attend	So if you and I are buddies, I can, I come and I provide you the information, and if another time I can't, you come and you provide me the information, ok. That's how it would be, well yes.
	Partner incompatibility not a concern	Yes, well I think that talking with someone is a friendship. I don't think there would be problems, right? I don't think so, since there are many cases, since sometimes one says, you think that, but it's only as friends, to talk to each other as friends. I believe that there wouldn't be a reason to clash there, I believe, but if it were to happen, I would also get rid of them.

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Table 2

Concerns about group-based and telephone-based one-to-one peer support interventions

	Themes	Example Quotations
Group intervention	Time commitment	Well yes, it would be a little difficult [to attend the groups] because once people start working, it's a little difficult for others.
	Classes must be well-organized	Cause if I go and then it's not prepared or anything, I'm gonna tell you, you know what, I went and it's not worth it.
Telephone-based one-to-one	People have busy schedules	Yes, I feel that sometimes there are days one is busy. So, one has to schedule that day, "I can't for this reason, well…"
	Impersonal and lack of trust	For me, I don't like over the phone either. It is like… especially now that people also have cell phones, it's like you wouldn't take it seriously. If someone calls you and you're at the store, are you going to answer the phone and talk about diabetes in the store? So then, it's like you wouldn't think it is important. I wouldn't like the phone thing. And then comes, like she said, the opinion of the lady that says, like that, face to face, there is more trust. And over the phone, you don't know if the other person is making faces at you or "This person is already bothering again…" Or you can say "You know what? I will call you right back because I'm going to eat" or "I'm going out." And it's a very… very diplomatic way of saying, "You know what, I don't want to talk to you."
	Wanting partner with more diabetes experience	Because there's different stages of diabetes. So you could ask one person, you know, if she's not on insulin, she is and I want to know more about insulin so I have the choice I could call her and the following week or day, whatever, I have a different question which I know that she'll be able to answer better. Because, it doesn't necessarily have to be just one person. Well, little by little, more people will join the circle, right? For example, I don't like having a conversation with just one person; I like to talk with everyone.
	Mixing genders may be problematic	Since I have my husband, I have to ask him if he wants, I have to tell him "Do you want to meet the person?" I have to tell him.

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Table 3

Ways to tailor group-based and telephone-based one-to-one peer support interventions

		Example quotations
Group intervention	• Utilize local experts for classes • Instructor can be trained peer or professional • Genders can be combined or separated • Visit other facilities (e.g. hospitals, YMCA) • Desire to continue monthly meetings after program ends • Bringing family to the groups • Provide childcare	For example, I see in other countries that they look for a person that is more trained or knows a little more about the topic being discussed, for example, about AIDS or about other diseases so that person is the one that facilitates the conferences. You also have people in the community who are nurses, doctors, dieticians, and you can have them come in and say, you know, can you do just this talk for this week, and then have somebody else for another week
Telephone-based one-to-one	• Can be a natural outgrowth of group intervention • Face to face meetings with the partner desired • Some preferred a partner with more experience or different partners for different concerns • Frequency of phone calls depends on need of partners	Work in a group first, about two or three sessions and from there you can maybe pick a person that you trust the most. I like to chat with people that have diabetes because I learn something about what experiences they have had. Almost always, when I find someone and we begin to talk, I say, “What do you do to control it?” And that, I think is very good to share. But by phone, I think it’s sort of impersonal. I want to meet the person first. Well, I also think that it doesn’t matter, but I would like someone with more experience. Perhaps it can start as once a week, depending on what one needs.