An overview of training curricula for diabetes peer educators

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Global community members who experience similar health problems gravitate to each other for information and support. Peers may be more approachable and can relate to the particular living circumstances one experiences. In well-resourced countries, people have opportunities for learning diabetes self-management; however, empathy may be more helpful when practical barriers arise. Little is published in medical literature about how to foster diabetes peer support and what is published is often limited to English language. Among those programs available, commonalities are readily seen. There is significant evidence that well-informed people cope better with adapting their lifestyle to medical regimens. Professionally delivered diabetes education has been well defined, but there may be additional benefit from learning from those who are living the experience everyday regarding how to navigate health care systems, handle finances, deal with natural emotions or family relations. Diabetes is epidemic and worldwide. There will never be sufficient traditional health care services to meet all future patients needs. While we persist in training health care professionals to deliver better diabetes care, we can explore how to mobilize willing volunteers to provide additional ongoing support to people with diabetes, where they live and work. While the characteristics of a peer educator have been defined slightly differently by several programs, there is agreement across programs that they need to be able to communicate clearly, they need to be willing to learn, they need to have confidence and they need to be flexible and dependable.

\textbf{Keywords.} Diabetes, education, support.

Introduction

People have always talked with each other and shared ideas on how to manage their health. This sharing and giving of support has lately come to be called peer education or peer support. In many places, it is becoming more formalized, courses are being developed and certification or accreditation sought. This paper will review some primarily North American programmes that have been developed with a specific emphasis on how the peer educators/trainers/advisors are trained to do the job. In all cases, programmes that focus on helping people with diabetes or other chronic disease to self-manage have been selected. Chronic disease self-management (CDSM) has been defined by Chodosh \textit{et al}.\textsuperscript{1} as ‘a systematic intervention that is targeted towards patients with chronic disease. The intervention should help them actively participate in either or both of the following: self-monitoring (of symptoms or of physiologic processes) or decision making (managing the disease or its impact through self-monitoring)’. Chodosh attempted to define attributes of self-management programmes that result in the best outcomes or how a programme should be designed to ensure the best results. The authors postulated that five design features would be key in self-management programmes: programmes tailored to individual patient needs, group settings, individual feedback, presence of psychological emphasis and care from health care professionals. In their analysis of 53 studies, they could not identify the factors in self-management programmes that were associated with the best outcomes. The programmes reviewed by Chodosh \textit{et al}. were not peer-led programmes, but it may be fair to assume that if key design factors in developing a professionally led self-management programme are unknown, then the best way to design a peer-led programme is also not known. This may be one reason that there are different approaches to curricula...
Peer educator—definition

The term ‘peer educator’ is used in this paper; however, different terms are used throughout the literature. Terms that may be considered synonymous to peer educator for our purposes are community health worker (CHW), promotores de salud, community health advocates, lay health educators/workers and community health outreach workers. Some are volunteers, some paid staff, some focus on diabetes or a specific disease and others on several. It may be premature to differentiate between peer educator, mentor and other terms such as CHW in all parts of the world. While the terms may be clearly defined in the US, they are used with different meanings or interchangeably in other areas and do not necessarily confer a minimal level of education or preparation for the position.

Peer educators have been defined as ‘community workers who work almost exclusively in community settings. They often serve as connectors between health care consumers and providers to promote health among groups that traditionally lacked access to adequate health care’. In order for peer educators to be effective, they have to be accepted by the group as being in a similar situation and perhaps having the same challenges. Acceptance by the group as a leader or in the educational role may be something that occurs naturally or it may be something that can be fostered in the development of the trainer. Potential trainers may need training in communication skills and training behaviour to enhance the likelihood of their being accepted as educators.

Review of peer educator training programmes

The characteristics of the peer educator have been defined differently by several programmes but there is agreement across programmes that they need to be able to communicate clearly, they need to be willing to learn, they need to have confidence and they need to be flexible and dependable. The Centers for Disease Control in Atlanta has sponsored dozens of programmes to demonstrate the usefulness of CHWs or promotores. The CDC states that “CHWs are uniquely qualified as connectors because they live in the communities in which they work, understand what is meaningful to those communities, communicate in the language of the people and recognize and incorporate cultural buffers (e.g. cultural identity, spiritual coping, traditional health practices) to help community members cope with stress and promote health outcomes.”

In 1998, the National Community Health Advisor Study conducted by the University of Arizona and the Annie E. Casey Foundation identified seven core services that could be provided by a CHW or peer educator. The seven services were as follows:

- Bridging cultural mediation between communities and the health care system.
- Providing culturally appropriate and accessible health education and information.
- Assuring that people get the services they need.
- Providing informal counselling and social support.
- Advocating for individuals and communities within the health and social service system.
- Providing direct services such as basic first aid and administering health screening tests.
- Building individual and community capacity.

The programmes reviewed in this paper describe slightly different roles for the peer educator, but all comment on the role as a link to the health care professionals. Most programmes see the peer educator as an adjunct to the health professional, not as a replacement. Some of the activities suggested by the various programmes are as follows:

- Teaching problem-solving skills
- Teaching communication skills
- Teaching decision-making skills
- Finding health care resources
- Developing a plan for the future
- Understanding the management principles of diabetes, healthy eating and activity and medications
- Understanding and managing the psychological response to diabetes.

All programmes using peer educators provide some training to the educators. The education provided varies hugely from many weeks, mentoring and oral examination to 4 hours and observation by professionals in the community. Interestingly, while many programmes have been reported in the literature, few provide details on how they trained the peer educators. Hence in the review of the programmes cited herein, there was access to few curricula. In some cases, programmes simply did not say how the peer educators were trained; in others, the curriculum was available only to those registered in the course. It is likely that the details could be determined with direct communication with the programme designers. The summaries that follow cite curricula where there was one available and in other instances assumptions have been made based on the curriculum the educators would be using once they were conducting the programmes. That is if they had to teach people how to
communicate with health care professionals, then we assumed that this must have been covered in their training programme.

Programmes reviewed—diabetes specific

Peer education programs that are specific to diabetes vary in the training of the peers. While all include information specific to diabetes self-management (to varying degrees) they do not all address the components of how to deliver the material or how to translate the information into use, i.e. decision making skills. It was not possible determine whether screening criteria for the training of new peers selected people who already had those skills, or if they were indeed taught.

- Peer Advisors, Isle of Wight

There are two levels of Peer Advisors in this program. The first level of training takes place over 18 weeks (90 minutes/week) after which there is a written and an oral examination. If successful the Peer Advisors would be expected to provide one-on-one support for others with diabetes, be effective committee members and function as trainers for other advisors. Each Peer Advisor is assigned a health professional mentor and works closely with the mentor (i.e. rehearsals) before setting out to give a lecture. This part of the curriculum was not available.

In order for these Peer Advisors to help people with self-management strategies, there is an additional 6 session training course. This part of the curriculum was available and is very specific to diabetes management at a high level of complexity. In the words of the author, Baksi (2006) “Peer Advisors would then be as effective as specialist health professionals in this field of delivering training for people with diabetes.” Peer advisors are monitored carefully—all consultations must be recorded and reviewed by the monitor before a copy is sent to the general practitioner.

- Project Hope—Mexico. C. Guthereau (email to author August 2, 2007)

The “5 Steps to Self-Care Program” was originally designed to be taught by health care professionals. While in the 5 Steps program participants are expected to be role models and to do “homework assignments” with family and friends. This is part of the grassroots strategy to raise awareness about diabetes within the family and the community at large. Graduates of the 5 Steps program later asked to be able to run it themselves. As well as completing the 5 Steps program potential Peer Educators complete a 50 hour “Lend a Hand” program and 24 hours supervising trainees in the 5 Steps program. Pre and post written testing is done, and it is reported that the peers have done as well as the healthcare professionals in the posttest. Health care professionals observe trainees hosting the 5 Step program and feedback is given on a 10 point scale. Patients also rate the trainees. Details of the Lend a Hand program curriculum are not publicly available.

- Diabetes Association of Jamaica. L. Less (email to author August 10, 2007)

Lay educators are trained by the Diabetes Association to conduct education programs throughout the island. Peer educators were selected based on attainment of secondary level education and being a member of the community. Training consisted of 4 hours of basic diabetes information taught by a physician, chiropodist, nutritionist and a lay diabetes educator. Pre and post testing was done, those attaining more than 90% received a certificate from the Diabetes Association and the Ministry of Health as a Lay Diabetes Facilitator.

- Robert Wood Johnson Foundation Diabetes Initiatives

One of the programs developed as part of the Robert Wood Johnson Foundation Initiatives was at La Clinica de La Raza, a community health centre with 23 sites in California. Community Health Workers (CHWs) who were La Clinica patients were recruited based on having diabetes or having a family member with diabetes, possessing good interpersonal skills, and a willingness to help their community. The program consisted of 10 sessions of general training on group facilitation, decision making, popular education methods, making presentations, communication, and analysis, followed by 30 hours of training in diabetes management and the Transtheoretical Model of Change. Ongoing training consisted of biweekly meetings provided instruction and support on topics requested by the CHWs including 12 hours on depression. Details of the training curriculum have not been published.

- Border Health Strategic Initiative Border Health SI

This program was one of those funded by the Center for Disease Control. Two community health centers worked with the local hospitals to build a community program. The hospitals provided a Certified Diabetes Educator (CDE) to facilitate
classes and train the promotoras in diabetes care and work individually with the participants. Classes were taught by either the CDE or a promotora depending on language fluency. A non-fluent CDE supervised the teaching of the promotora. Promotoras provided ongoing support and follow up. The curriculum for training the promotoras is not available.

- **Diabetes Empowerment Education Program, Midwest Latino Research and Training Center**

  This program was modeled on a Latino Health Access (LHA), Inc. program that used trained community health workers as diabetes educators. The Midwest Latino Health Research, Training and Policy Center developed partnerships with local hospitals and community health centers. The Diabetes Empowerment Education Program (DEEP) consists of 2 parts, a *Train the Trainers Program* and *The Diabetes Patient Education Program*. Train the trainers is a 20 hour workshop “that stresses the development of skills and knowledge related to diabetes by using interactive group activities and adult education methodologies recommended in the curriculum.” The program is now being implemented across the US, in Puerto Rico, Peru and along the US Mexican border in partnership with PAHO. A detailed, scripted manual is used in the Patient Education program and is available on the web site, the curriculum for the Train the Trainers program is not available on the web site.

- **Stanford Self-Management Programmes**

  This program is primarily for self-management of any chronic disease, not specifically diabetes. However additional diabetes specific training has been added and several diabetes self-management programs have been completed and outcomes published. Training for Master trainers is 4 ½ days with the option of 1 extra day on positive Self-Management. Master Trainers train the Leaders of the Self-Management Programs. This curriculum is not publicly available. Leaders or Peer educators receive 28 hours of training. A course manual gives the educators the course content and process for all activities they will do in the program for patients. As part of the training they discuss how to handle difficult classroom situations and practice teaching different aspects of the course. Disease specific training is available as an add on to the basic course. This is one of the oldest most well regarded peer programs. The claim is made in the Leader’s manual that participants in their training will be able to:

  - Conduct the Chronic Disease Self-Management (CDSM) Workshop with one other trained co leader.
  - Utilize the *Chronic Disease Self Management (CDSM) Workshop Leader's Manual* and accompanying book, *Living a Healthy Life with Chronic Conditions*.
  - Understand the concept of self-efficacy and the strategies to enhance self-efficacy.
  - Use the four efficacy-enhancing strategies with their groups: skills mastery through making an action plan, sharing and feedback, modeling, reinterpretation of symptoms and persuasion.
  - Utilize the following training techniques: lecture with discussion, brainstorming, demonstration, practice, feedback, problem-solving and making action plans.
  - Handle problems that arise in the group learning situation.
  - Ask for and use assistance as needed.
  - Provide constructive feedback about both the content and process of the workshop to the program coordinator in your facility or area.
  - Utilize other course leaders as resource people and/or for assistance as necessary and appropriate.
  - Understand and maintain the evaluation requirements of the workshop as determined by your agency or organization.

**Programmes which are not diabetes specific**

- **NHS/UK**

  The Expert Patient Programme is a lay-led self-management program specifically for people living with chronic disease. The basis of the program is to develop confidence and motivation in the patient to use their own skills, information and professional services to take control of their lives. Lay educators offer a structured course over 6 weeks (2.5 hours/week). They are given a detailed leader’s manual. Core self-management skills taught are problem solving, decision making, resource utilization, formation of the patient-professional partnership and taking action. It appears that this program is not disease specific and there is no training for the lay educators on diabetes self-management. How one becomes a Lay educator is not published, although the web site does state that the program is developed based on the Chronic Disease Self-Management Program developed at Stanford University.

- **SONRISA, Southwest center for Community Health Promotion, University of Arizona**
This program builds on diabetes support by focusing on mental health issues of people with diabetes, although the manual states that it could be used with other chronic conditions as well. The detailed training manual is available and is 157 pages of handouts, slides, notes to the community health workers. The community health workers are expected to address both the physical and mental/emotional well-being of their clients. They are “trusted bridges between the community and the healthcare system and providers.” With additional training they are able to explain the relationship between depression and diabetes.

The training manual does not cover medical issues around diabetes other than mental health issues. The manual does not indicate how long it would take to complete, or whether it is a self-study program or there are formal training programs offered.

- Community Voices Miami (Community Voices Miami, Collins Center for Public Policy, personal communication)

A very comprehensive lesson plan/curriculum identifies 30 hours of training for community health workers in the Community Voices Miami program. The focus is on healthy lifestyle and mental health issues.

- National Cancer Institute, Body & Soul

This program is run by African American churches across the United States to encourage the consumption of fruits and vegetables. The focus of the training is on listening, reflecting, asking open-ended questions and summarizing thoughts. Counselors are to help people overcome their own barriers and find their own motivations for change.

- California Healthcare Foundation

Two peer training programs are described in this publication, one for chronic kidney disease peers another for those with heart failure. The National Kidney Foundation offers 8-24 hours training for volunteer peer mentors. Content of training includes communication skills, empathetic listening, values clarification life goals, problem solving and assertiveness. Mentors learn how to support others and not assume the role of provider. They also learn about grief and loss, sexuality and relationships, plus how to work with health care providers. The focus in this program is on mentoring.

In the Self Care of Heart Failure program topics included are:

- Diet and fluid management, medications, activity, smoking, alcohol
- How to integrate the diet and medication regimen into ones lifestyle
- Recognizing and managing symptoms
- Acting quickly
- How to communicate with the physician

Professional curricula

The International Diabetes Federation published The International Curriculum for Diabetes Healthcare Professional Education in 2002. As the title states this curriculum is for the education of health care professionals. However, it could be used as a model for the development of a Peer Educator Programme. The IDF Curriculum contains goals, learning objectives, teaching strategies and suggested evaluation strategies, all components required in a curriculum.

From 2003 to the present, the American Association of Diabetes Educators (AADE) has identified self-care behaviour groupings that are minimal, essential and should guide educational programmes. These have been validated in various patient populations. Training in these behaviours could and should form the basis of any self-management programme curriculum. Studies can be found at the AADE website (www.aadenet.org). The skills needed are as follows: healthy eating, being active, monitoring, taking medication, problem solving, healthy coping and reducing risks.

The American Diabetes Association (ADA) certifies US Diabetes Education Centers of Excellence. A recent evidence-based version of the Standards of Diabetes Education was published in 2007. One standard describes the general curriculum that professional educators should be able to provide. The topics are as follows:

- Describing the diabetes disease process and treatment options,
- Incorporating physical activity into lifestyle,
- Using medication safely and for maximum therapeutic effectiveness,
- Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making,
- Preventing, detecting and treating acute complications,
- Preventing, detecting and treating chronic complications,
- Developing personal strategies to address psychosocial issues and concerns,
- Developing person strategies to promote health and behaviour change.

The AADE and ADA documents are consistent with each other but have different perspectives.
Content could be used along with other examples of professionally delivered content to construct a simplified peer curriculum.

Standardized training for peer educators

In 2007, Kash et al.\(^1\) looked at CHW training and certification programmes in the US. All the programmes reported that the use of CHW’s had developed in answer to unmet needs in the community and a lack of access to health care services. Training programmes were developed in response to the lack of standardized training and skill development of CHWs. Some states had programmes at the community college level and others at the direct care agency level. Community college programmes were more likely to receive state funding and to offer standardized training and certification; however, this was not standard across all programmes. Kash et al. reported six outcomes of their review that should be considered in the development of future education programmes for the non-professional health care worker. Training at the community college level provided career advancement opportunities, with many of the graduates moving onto professional schools such as nursing. Training and especially certification enhanced the earning capacity of the CHWs. It was reported that agencies that provided on-the-job-specialized training enhanced retention and that CHWs were less likely to leave for the ‘better’ job. On-the-job-specialized training at agencies also improved the standards of care, health outcomes reliance on the CHW and their competencies. Certification where available, improved the status of the CHW and their earnings. Certification also improved the self-esteem and the CHWs’ own feelings of self-worth.

Summary

There are many models for training of the non-health care professional educator in use today. No one model has been shown to be superior to any other. Curricula appear to have been developed based on the content and programmes the peer educator will be expected to deliver. Key issues are that the peer educator works with and supports the medical community. Peer educators help people access and use the available medical services to their best ability. Most programmes have included some training on how to train, dealing with classroom situations and communication strategies. Research has shown that development of the peer educator training within the context of a recognizable institution with a link to a diabetes agency for specialized training would enhance the recognition of the educator and thereby increase the likelihood of retention in the position.

Moving forward it will be important to clearly define the role and nomenclature of the peer educator. To set a framework for a curriculum that could be used to train peer educators worldwide will require discussion on the role, how it may be the same or different in different countries, how peers will be recognized, whether there could be levels of peer educators, certification or a diploma of sorts, standardization of training and if so to what degree? Many questions remain to be asked. Informal communications indicate that there are many more examples of peer education in developing countries that have not been published but that have been helping people live with chronic disease. It will be beneficial to elicit details of the successful efforts worldwide and publicize their processes for others to follow.

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References

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