

Shape Up For Life: peer-led lifestyle modification based on preventive self-management

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Introduction: Obesity prevalence is higher in rural Australia than in urban centres and a population health study provided evidence to show rates of abdominal obesity alarmingly high in a rural city but without a corresponding higher rate of diabetes diagnosis when compared nationally. These findings were interpreted as predictive of a spike in diabetes cases locally if no action was taken. Local government and non-government organisations partnered with UniSA Whyalla campus to apply for a Healthy Communities Initiative grant to address the identified needs and were successful.

Shape Up For Life was first developed in 2006 and delivered to this rural community as the intervention phase of a randomised controlled trial successfully reducing the symptoms of metabolic syndrome, a recognised precursor to diabetes. The program has been re-developed as a peer education led, lifestyle modification program based on the principles of self-management.

Methods: A process of building community capacity was undertaken in the lead up to program implementation. Peer Educators were recruited who were already skilled in specific self-management skills via the Stanford Chronic Disease Self-Management program. They were trained in the lifestyle education modules and the delivery mode via interactive power point presentations weekly over eight weeks. Eight of the nine trained delivered at least one complete eight week course over the length of the project to a collective cohort of 290 people.

Baseline measures taken prior to the education phase were: height, weight, waist, hips, blood pressure, HbA1c, Albumin/Creatine ratio (ACR) and lipid panel. Demographics, lifestyle behaviours and knowledge were collected via questionnaire. Risk factor self-management scores were collected via the Flinders University Living Well Scale™. Measures were repeated immediately following the eight week education intensive and then at the end of the study period following three, monthly group sessions. Qualitative feedback was also collected via focus groups.

Results: Interim results have shown clinical measures improved following the intensive education phase and dropped off slightly by the end of the study as engagement diminished. This is reflected as common in the literature based on similar lifestyle modification programs. This suggests that a program delivered via peer education is at least as effective as others taught by experts in the field. Community engagement and feedback was overwhelmingly positive with participants wishing to remain in an ongoing program based in the community.

Conclusion: Lifestyle modification programs can be safely delivered via peer education and are inexpensive to deliver to rural communities and should be strongly considered as part of the overall health service delivery model. Further population health measures need to be undertaken to ascertain the level of impact this intervention has had on preventing diabetes in this rural community.