Developing a Church-Based Diabetes Prevention Program With African Americans: Focus Group Findings

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Purpose

The purpose of this study was to use a community-based participatory research (CBPR) approach to identify resources and barriers to implementing a church-based diabetes prevention program (DPP) in a rural African American church community in Georgia.

Methods

In collaboration with community leaders, researchers conducted 4 focus groups with 22 key informants to discuss their understanding of diabetes and identify key resources and barriers to implementing a DPP in the church. Three researchers analyzed and coded transcripts following a content-driven immersion-crystallization approach.

Results

The participants’ comments on diabetes and prevention covered 5 research domains: illness perceptions, illness concerns, illness prevention, religion and coping, and program recommendations. Program success was deemed contingent on cultural sensitivities, a focus on high-risk persons, use of church resources, and addressing barriers. Barriers identified included individuals’ lack of knowledge of risk and prevention programs, lack of interest, and attendance concerns. Solutions and resources for overcoming barriers were testimonials from persons with illness, using local media to advertise the program, involving the

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food committee of the church, ministering to the healthy and at risk, and acquiring a support buddy.

Conclusions

A CBPR approach engaged church members as partners in developing a church-based DPP. Focus groups generated enthusiasm among church members and provided valuable insights regarding barriers and resources for program implementation. This methodology may prove useful in other church-based chronic disease prevention efforts with at-risk populations.

Diabetes is a significant health problem in the United States that disproportionately affects African Americans. The prevalence of diabetes among African Americans in the United States is estimated to be 12.5%, nearly one third higher than for non-Hispanic whites.\textsuperscript{1,3} Diabetes is on the rise, with the greatest increase occurring among African Americans.\textsuperscript{4,12} Diabetes is a leading cause of many medical complications including nontraumatic amputations, blindness, and end-stage renal disease.\textsuperscript{5-7} It is also evident from recent studies that diabetes can be delayed or prevented with lifestyle modification and use of glucose-lowering agents.\textsuperscript{8-12} In a diabetes prevention program (DPP) in which 3234 persons at high risk for diabetes were randomly assigned to placebo, intensive lifestyle modification, or metformin, both the lifestyle modification group and the metformin group were less likely to develop diabetes compared to controls.\textsuperscript{13} Each of the participants in the DPP was provided with an intensive individualized program delivered by a personal coach as well as material and financial resources (such as exercise shoes, fitness training, etc). Despite the advances in knowledge to prevent diabetes, undiagnosed and undertreated diabetes remains a significant problem for African Americans. In fact, recent studies suggest that nearly one quarter of African Americans with diabetes remain undiagnosed.\textsuperscript{3,14}

African American churches are proven venues for screening and risk factor reduction in cancer and cardiovascular disease.\textsuperscript{15-20} Many studies have demonstrated the benefit of church-based health activities, including smoking cessation, cardiovascular disease risk factor reduction, and breast and cervical cancer screening.\textsuperscript{15-20} African American churches have many characteristics that render them ideal sites for diabetes screening and intervention. They are highly receptive to preventive collaborative activities, have a high rate of persons at high risk for diabetes, and have a tradition of involvement in health promotion activities.\textsuperscript{15-28} To date, however, there are no reports of church-based DPPs that identify persons at high risk for diabetes and seek to prevent or delay its onset, and there is minimal research to guide the development of community-based screening and prevention programs for diabetes. Reasons for this are unclear. It may be that such an intensive program requires resources beyond the reach of most churches. Competing church activities also may hinder diabetes prevention initiatives in such settings, or community leaders may be unaware of the need for diabetes prevention and of the positive outcomes of the DPP.

The objective of this study was to identify key resources for and barriers to successful implementation of a DPP involving lifestyle intervention with diet and exercise in a rural African American church community using a community-based participatory research (CBPR) approach. Based on the findings, the study also presents community recommendations and develops guidelines for program implementation.

Methods

Research Design

The researchers used a CBPR approach to engage the church community as consultants and partners in assessing the problem of how to best implement a church-based DPP. In the CBPR framework, “researchers and local people work together on a study that is designed, initiated and managed by the collaborative team.”\textsuperscript{29} The assumption was that researchers often are unaware of all of the relevant issues that need to be considered in community-based studies and that CBPR could serve to “engender greater commitment among all research partners to uncovering social and behavioral determinants of health and to developing innovative, long-term interventions.”\textsuperscript{29} In determining the appropriate way to develop and implement a DPP in a church, researchers recognized that the knowledge, expertise, and resources of the involved community are keys to effective research.\textsuperscript{30}

Sample Design

Focus group methodology was employed to determine background information about diabetes health education and promotion. Focus groups are particularly useful for
obtaining general background information, learning how respondents talk about the phenomenon, and stimulating new ideas and creative concepts. Their value lies mainly in that they create a forum for discussion and brainstorming among the participants regarding the research topic while allowing the moderator to probe in depth for their responses to open-ended questions. In all, 4 focus groups were conducted with a purposeful sample of key informants who were members of a rural African American Baptist church in central Georgia. Key informants are people who can provide informed opinions about the research query by virtue of their special status, knowledge, expertise, access, or communication skills. They can help in the planning of delivery of health interventions by identifying those factors that are unique to a population including community resources and cultural differences that affect health and illness perceptions.

Sample Selection

An initial contact was made with the church pastor to determine his interest in and acquire his endorsement for using his church as the study site. A planning committee composed of 3 researchers, the pastor, and 2 of his handpicked church members was formed in accordance with CBPR practice. This committee also helped to build relationships and develop trust with church members. A snowball sampling strategy was employed to purposely select the key informants. This sampling technique consists of identifying “cases of interest from people who know people who know what cases are information rich.” The planning committee served to identify people active in the church who had knowledge of its workings and programs for participation in the focus groups who could in turn identify other potential participants. All participants identified and selected were adults 18 years of age or older, African American, and church members. A diagnosis of diabetes or a family history of diabetes was considered in the selection of the participants but was not a determinant for inclusion. Consent was obtained from each individual participant, as required by the University Institutional Review Board that approved this study.

A total of 22 church members participated in the 4 focus groups, with 5 to 6 participants per group. The focus groups were conducted at the church over a 4-week period as enough participants per group session were recruited. All participants were uncompensated volunteers. The overall sample was sufficiently homogeneous to allow for candid discussion, as all the participants were African American, most were women, about half had a relative with diabetes, and about one third had diabetes (Table 1). Church membership is slightly more than 400, and three quarters are female. Intragroup composition varied in age, income, education, and diabetes status but not much by gender in all 4 groups or by relatives with diabetes in 2 of the groups. All the participants in 1 group and only 1 of the participants in another group reported having a relative with diabetes, which actually complements the other 2 mixed groups. Study findings are presented as domains under 5 main topics of inquiry: (1) perceptions of illness, (2) illness concerns, (3) illness prevention, (4) religion and illness coping, and (5) program implementation recommendations (Table 2). Although the goal was to elicit recommendations for co-producing a community-based DPP, learning about the participants’ perceptions, concerns, awareness, and beliefs about illness and available resources proved essential to better plan specific health promotion efforts for this community.

Training and Instrument Development

Three African American members of the research team—one of them a primary care physician who is a member of the church—facilitated the focus groups. One acted as the lead moderator and the others as assistants. All the facilitators attended a focus group training workshop that included practical experience and feedback after leading a mock focus group. A moderator’s guide that included 11 open-ended questions was constructed by the research team and reviewed by the planning committee. This research team included a medical anthropologist who trained the moderators and offered qualitative research guidance. The questions were developed through an iterative process and were piloted in the mock session. Examples of these questions are as follows: “What do you think diabetes is?” “How much do you worry that someone you care about may develop diabetes and why?” “In your opinion, what can be done to prevent diabetes?” “What is the role of your faith (or spirituality) in preventing or dealing with illness?” and “How could a diabetes prevention program be implemented effectively in your church?” A facilitator’s manual was developed with the specific questions, group discussion rules, recommendations for probing, a time sequence, and intangibles.

Data Collection

Each focus group had a moderator and an assistant moderator. Only persons who completed the moderator
training served as moderator or assistant moderator. The lead moderator facilitated the discussion while the assistant moderator kept detailed notes. Both worked in tandem to keep the discussion focused on the research question and engaged all the participants in discussion. Focus groups lasted approximately 90 minutes, and all but 1 were audio recorded. The first session was not audio recorded because of technical problems with the audio-recording system. Research assistants took detailed notes in all of the focus groups, particularly in the initial session that could not be audio recorded. Immediately following each focus group, the moderator and the assistant met to review and clarify written notes. All audio recordings were transcribed, and notes were redacted for analysis.

**Data Analysis**

Three researchers—2 primary care physicians and 1 medical anthropologist—analyzed the data following a content-driven, immersion-crystallization approach. This approach consists of a systematic iterative process of text interpretation and categorization in which the analysts identify relevant statements, make inferences, and establish patterns of significance. First, the analysts reviewed each transcript separately, searching for meaningful units of information related to the research queries. Then, the analysts discussed their independent preliminary findings for each to establish coding categories through consensus. Codes were constructed based on the frequency, intensity, and consistency of their supporting statements and were labeled in reference to their most representative example or a common theme. Minority opinions were included in the findings insofar as they were deemed significant and did not conflict with the general categories. Interpretive disagreements were resolved by debating and reconciling the existing supporting evidence. Consensus was achieved in establishing all the codes. Last, as a measure of trustworthiness, the analysts reviewed the transcripts over again in search of overlooked data and evidence contradictory to the findings. Researchers also discussed the findings with the church intervention group for further planning.

**Table 1**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
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<tbody>
<tr>
<td>African American</td>
<td>22</td>
<td>100</td>
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<tr>
<td>Have diabetes</td>
<td>8</td>
<td>36</td>
</tr>
<tr>
<td>Female gender</td>
<td>18</td>
<td>82</td>
</tr>
<tr>
<td>Have a relative with diabetes</td>
<td>12</td>
<td>55</td>
</tr>
<tr>
<td>Education</td>
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<td></td>
</tr>
<tr>
<td>&lt;High school</td>
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<td>9.1</td>
</tr>
<tr>
<td>≥High school</td>
<td>9</td>
<td>40.9</td>
</tr>
<tr>
<td>≥College</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Age, y</td>
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<td></td>
</tr>
<tr>
<td>30-39</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>40-49</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>50-59</td>
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<td>18.2</td>
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<tr>
<td>60-69</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>≥70</td>
<td>4</td>
<td>18.2</td>
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**Table 2**

<table>
<thead>
<tr>
<th>Topic</th>
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<tr>
<td>Illness perceptions</td>
<td>Behavioral, Biomedical, Symptomatic, Outcome based</td>
</tr>
<tr>
<td>Illness concerns</td>
<td>Destiny, Denial, Stigma</td>
</tr>
<tr>
<td>Illness prevention</td>
<td>Lifestyle modification, Office-based patient education, Spiritual conditions, Church-based social support</td>
</tr>
<tr>
<td>Religion and illness coping</td>
<td>Spiritual healing, Faith and medicine</td>
</tr>
<tr>
<td>Program implementation</td>
<td>Presentation, Participation, Resources, Barriers, Integration</td>
</tr>
</tbody>
</table>
Results

Several findings overlap and are interrelated. What follows is a narrative of the findings.

Perceptions of illness. Participants’ definitions of diabetes fell into 4 categories: behavioral, biomedical, symptomatic, and outcome based. Respondents who offered behavioral references described it as an illness caused by stress and anxiety, dietary choices, lack of physical activity, and other social determinants. For example, 1 respondent stated that “stress can raise your [sugar] level.” Another respondent stated, “It comes from fried foods, eating too much sugar, drinking too much sweets.” Another participant responded that diabetes is related to inactivity: “They just can’t go sit down and watch TV.” Others described diabetes in biomedical terms, emphasizing physiological problems such as the body’s inability to regulate blood sugar levels and genetic factors. As one respondent noted, “Something isn’t regulating the blood sugar level in the body.” Another said, “It’s in your blood...diabetes goes from one generation to the next.” Symptomatic definitions used to describe diabetes included experiences of weight loss, thirst, and increased urination. Last, several participants defined diabetes in terms of negative health consequences, stating, “Diabetes is very bad...causes strokes, heart attacks, blindness” and “they found out he had diabetes so bad they had to amputate both his legs.”

Illness concerns. Participants expressed various concerns about diabetes when asked how much they worry about themselves or a relative developing the illness and why. Although all of the participants believed it to be a serious illness, many downplayed their worries because of destiny or risk denial, and some expressed worry specifically about the stigma attached to the diagnosis. For example, many of the participants believed that illnesses such as diabetes are God’s will and therefore would accept what they deemed their inevitable destiny. According to one respondent, “I do not worry...I read the Bible. Don’t worry today about what tomorrow will bring...Trust in God. He’ll take care of it whatever you have.” Another person stated, “Don’t start worrying about things that could happen...When that happens, I say ‘Lord, help me out of this mess...I’m in your care.’” On the other hand, some in the group felt that what happens in life is God’s fate and must be accepted as His will: “Medicine is important...but my faith in God is more important to me than anything.” Several participants expressed some confidence that they were not at risk of developing diabetes because of their good health status or health behaviors or plainly denied that it could happen to them. For example, one person asserted, “It’s a disease that I can’t get,” while another stated, “I declare myself healthy even though I know there are things I need to do.” Some participants stoically declared that there are other more serious illnesses to worry about such as cancer, and several were less concerned about their own risk of developing diabetes than about their relatives’ risk. Moreover, some respondents seemed more concerned about the stigma of being diagnosed with diabetes than about the health implications. According to one of these respondents, “It’s somewhat [of] a stigma attached to [diabetes]...people wonder why you’re not partaking of certain foods or drink if they don’t know you have diabetes, and if they know you have diabetes, they say things like ‘You can’t eat that with your sugar.’” Another respondent described her reluctance to identify herself as having diabetes while on a cruise because of her fear of embarrassment.

Illness prevention. Regarding knowledge of diabetes prevention, participants’ responses fell into 4 categories: lifestyle modification, office-based patient education, spiritual conditions, and church-based support. Several participants displayed a general knowledge that obesity, diet, and exercise are all related to developing diabetes, and some noted changes in lifestyle as behaviors that could help prevent diabetes. As they proclaimed, “We need a good diet and exercise period” and “You have to be concerned with weight and portion [size].” Several participants also reported that patients obtain office-based preventive information about diabetes from physicians through patient education material or direct advice. For some people, their annual office visit was the only thing deemed necessary for prevention, as evidenced by one participant’s declaration that “when I do my yearly check-up...that’s it for me until next year.” However, some noted that physicians tend to provide little if any information or screening to patients concerning diabetes before a diagnosis of diabetes is made. According to 2 respondents, “[The doctor] didn’t tell you how to keep from getting diabetes,” and “you have to ask the doctor for screening.” Several participants agreed that, unfortunately, many people learn about diabetes only after they contract the disease. Their point was that while information may be available at the physicians’ offices, brochures did not describe how to prevent the illness, and most physicians
do not regularly focus on prevention. Still others noted that although physicians may advise about prevention, some people do not follow the recommendations.

The participants discussed several spiritual aspects related to diabetes and disease prevention. These included faith in God, the Bible as a source of guidance, and prayer together with common sense. Overall, participants believed that God has a purpose for each person’s life, and through faith, one could follow God’s direction to maintain good health. The participants stated that their faith in God helps them to prevent diabetes and other illnesses. When asked how faith worked, one participant shared, “I don’t know how to explain it...you can’t tease that out.” For some participants, having faith was of itself sufficient for prevention, and they did not need to do anything else; as one respondent said, “Jesus is going to fix it, there’s no need to listen to doctors.” The importance of the Bible in diabetes prevention was summarized by one participant: “The Bible gives us good information about what God intended for us to eat.” Prayer was also described by the participants as a tool to prevent disease, as in pleading, “Lord, protect me from all hurt, harm, or danger,” and “Father bless this food and the hands that prepared it that it may be used to nourish.” Many participants felt that spiritual aspects should not exclude using common sense to prevent diabetes and disease. “I think we should do everything possible to prevent and treat, believing all the while that God has the same power...I believe that He expects us to be as intelligent as we can about everything and to use whatever resources are available for a particular thing.”

Participants acknowledged the various types of church-based support in preventing the onset of diabetes. They believed that church involvement in prevention activities was a good idea and that securing outside or local help to prevent diabetes was important. They wanted the church to be mindful of activities that could be conducted at church to prevent diabetes, such as screening and workshops. In addition, participants suggested that their church’s menu plans could be assessed with health in mind and that exercise plans could be developed to be carried out in church. At times, the church was noted to have a negative impact on health by promoting overeating and the consumption of unhealthy foods. Various participants stated, “In this church we eat so much. There is nothing that a diabetic can eat,” and “We are having a big picnic on the 4th and it is going to be all kind of crazy stuff and it’s not good for us.” Others observed, “It’s tradition, you just can’t stop doing it when they have been doing it...how long? 160 years.” Some also suggested that it would be helpful if they had to be accountable to other people such as fellow churchgoers who were also interested in preventing diabetes. However, some participants still viewed prevention efforts as futile for some people because of their denial or stoicism or the perceived role of genetics as an inevitable determinant rather than propensity.

**Religion and illness coping.** Responses to the role of faith in illness coping are categorized into 2 main themes: spiritual healing and faith and medicine. Participants for the most part viewed illness and health through a spiritual prism. Several participants believed that one should always take good care of the human body because it is a “temple” where God and the Holy Spirit reside. Furthermore, God was viewed as a healer who acts on behalf of persons who pray and exercise faith. Participants viewed personal spirituality as an important component not only of preventing illness and maintaining physical health but also in the treatment of and coping with illness. Prayer and faith were frequently mentioned as tools for confronting illness, and the Bible was viewed as a guidebook to health. As one participant stated, “I always pray a lot...and read my Bible. People may have faith in dealing with their illness, but it shows up when a person gets sick.” Furthermore, the church as a group was believed to have a role in responding to illness among the members, visiting and praying for the sick. The church’s Health Committee, composed mostly of active and retired nurses, was regarded as an important tool to that end.

In addition to the theme of personal spirituality as an important component in illness prevention and coping with illness, another consistent theme was the linking of faith with receiving care from health care providers. According to one participant, “God works through doctors.” Faith, medical care, and personal responsibility were viewed as integral parts of pursuing health. As one participant stated, “I take advantage of every medicine that’s available. ... My spiritual base allows me to take the medicine. ... God works through doctors...my scriptures...I read them every day...I eat good and take my medicine.” Interestingly, some participants reported that for some church members, participating in medical treatment demonstrated a lack of spiritual faith. As one participant with childhood diabetes described, her mother believed that in praying and not seeking treatment, she was demonstrating her faith in God.

**Program implementation.** Participants identified 5 key areas needed to facilitate implementation of a faith-based
DPP at their church: (1) program presentation, (2) participation, (3) resources, (4) barriers, and (5) integration. Program success was deemed to depend in part on its being presented in a linguistically and culturally appropriate manner. Participants recommended small-group workshops with hands-on learning activities, testimonials from persons with diabetes, prevention literature, video presentations, and gospel aerobics classes. To help increase program participation, respondents suggested that focus should be made on high-risk persons and those who avoid doctors. Participants should be held to some degree of accountability (“we do better being accountable to other people”), and youth should be included for long-term impact (“start with young kids . . . utilize the children in innovative ways”). A support system for participants was considered useful (“some people would be motivated . . . if they had some kind of support system”). One specific suggestion was for individuals to identify a buddy. Moreover, church community resources were recognized as essential ingredients for program development. Examples of these resources include persons with diabetes acting as peer coaches for those with prediabetes (“what better people to get involved than those people that already have diabetes?”). Another resource identified by participants was the church’s health ministry. One participant observed that the health ministry already visits the sick, and perhaps fellow parishioners should start ministering to the healthy before they get sick.

Participants also cautioned researchers about potential barriers that should be considered for successful program implementation. These included individuals’ (1) lack of awareness of their risk factors, (2) lack of knowledge of church-based prevention programs, (3) lack of interest and motivation, and (4) difficulty in maintaining regular participation throughout the course. Detailed participant suggestions for overcoming these barriers are summarized in Table 3. Finally, participants discussed the advantages of integrating the ways of the medical community with their faith and church traditions, as noted in the role of religion in illness coping. Participants’ statements included, “We do need an exercise program in the church,” “Have a fellowship [teach] that there are foods you should eat and foods you shouldn’t eat,” and “Start this program from God almighty.”

Discussion

This CBPR study brought together an African American church and primary care clinician researchers to investigate the potential barriers and resources to implementing a faith-based DPP in the rural South. African American churches have been used for recruiting persons with diabetes into treatment trials and for implementing weight loss programs for African Americans. Spirituality is an important aspect in general health and disease management for many African Americans. However, there have been no studies on the effectiveness of early risk factor reduction in the church setting for the prevention of diabetes and its complications. This study explored via focus groups the key resources and potential barriers for developing a DPP for at-risk members of a rural African American church and presented recommendations. In addition, the focus groups contributed by building and strengthening relationships and trust between church members and the research team, provided information about the health beliefs of the program’s target group, identified links between church members’ spiritual beliefs and practices and potential program components, and generated enthusiasm for the program among focus group participants and their friends and families. The barriers identified and the proposed solutions could serve as a guide for developing other church-based health promotion programs.

The Centers for Disease Control and Prevention and the Institute of Medicine have recognized the value of community health workers (CHWs) in health promotion interventions within a CBPR framework. Focus group participants in this project also suggested that people with diabetes in their community could function in this capacity, serving as teachers to others in light of their knowledge and experiences managing and coping with this chronic illness. Many members of African American churches may have significant experience dealing with diabetes as patients or caregivers to relatives and friends. The potential for developing church-based CHWs who devote their time to diabetes prevention and management remains virtually untapped and is a potential future offshoot of this DPP effort. The idea of having the church health ministry educate and support at-risk and healthy individuals and not just pray for the sick is consistent with the CHW model.

Limitations

This report has a few limitations. First, focus groups in this study were performed in only 1 rural African American church. Therefore, information gleaned regarding church resources that could be used to promote a DPP-type program and barriers to conducting such a program may be
unique to the particular members of this church community. Second, most of the focus group participants were women. This is likely because most of this church’s members are women and most of the participants in planning and implementing church activities are women. If men are to be included in DPP-type activities, special efforts may need to be made to recruit them for planning and participation in program activities. Third, a large percentage of focus group attendees had at least some college education. It is unknown whether level of education is a factor that could influence study or program participation.

**Conclusions**

Successful implementation of a program to prevent diabetes in an African American church requires careful attention to programmatic and spiritual components. A CBPR approach using focus groups proved to be a valuable step in the implementation of this project by generating enthusiasm among church members for beginning the project while at the same time identifying lay perceptions and concerns about diabetes and barriers and resources for DPP implementation. This methodology may prove useful in other church-based disease prevention or health promotion efforts.

**References**


2. Centers for Disease Control and Prevention. Prevalence of overweight and obesity among adults with diagnosed diabetes—United

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**Table 3**

**Barriers and Solutions to Attending a Diabetes Prevention Program**

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Solutions/Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of knowledge of risk</td>
<td>Testimonials from persons with illness</td>
</tr>
<tr>
<td></td>
<td>Distribute literature on diabetes</td>
</tr>
<tr>
<td></td>
<td>Education on diabetes preventive measures</td>
</tr>
<tr>
<td>Lack of knowledge of program in church</td>
<td>Announcement during Sunday services</td>
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<tr>
<td></td>
<td>Announcement in Sunday bulletin</td>
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<tr>
<td></td>
<td>Use posters and the bulletin board</td>
</tr>
<tr>
<td></td>
<td>Use local media/newspaper and radio to advertise program</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>Pastoral endorsement is important in creating interest</td>
</tr>
<tr>
<td></td>
<td>Involve the food committee</td>
</tr>
<tr>
<td></td>
<td>Talk to them about spiritual as well as physical</td>
</tr>
<tr>
<td></td>
<td>Do not leave people out</td>
</tr>
<tr>
<td>Maintaining attendance throughout the program</td>
<td>Create a gospel aerobics class</td>
</tr>
<tr>
<td></td>
<td>Create an interest</td>
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<tr>
<td></td>
<td>Use times that are convenient, not Sundays</td>
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<tr>
<td></td>
<td>Develop peer support</td>
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<tr>
<td></td>
<td>Include the children</td>
</tr>
<tr>
<td></td>
<td>Acquire a support buddy</td>
</tr>
<tr>
<td></td>
<td>Make sessions hands-on and interesting</td>
</tr>
<tr>
<td></td>
<td>Avoid starts and stops</td>
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<tr>
<td></td>
<td>Keep sessions to one hour</td>
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<tr>
<td></td>
<td>Use faith to keep them motivated</td>
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