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"TO MOTIVATE MYSELF WITH GOOD SELF-MANAGEMENT"
DEVELOPING AN OPEN-FORMED LOCAL DIABETES COURSE

Degree Programme in Rehabilitation

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The vision of the Finnish Diabetes Association is to overcome diabetes every day. The idea is to place the people with diabetes and their closed ones in priority and support their lives by promoting health and well-being, looking after their interest, and providing peer support. From this ideology also the idea of this thesis was originated. The purpose of this thesis was to develop a local open-formed diabetes course for the Finnish Diabetes Association and its local branches to utilize together. The goal of the course was to support self-management of the people with diabetes and find out what kind of support the local branches need in organizing these kinds of courses.

The development work was done as a project and we used action research as a research method. The time to use for this project was limited and the idea was to develop and implement one course and to gather the data to create guidelines for the future. The diabetes course was planned together with the Porin Seudun Diabeetikot ry. and was organized in Pori. The target group was people with type 2 diabetes in the Pori area. The participants to the diabetes course were adults who were randomly selected from the received applications.

The result of this project was that peer led open-formed local diabetes course can be organized. This course was seen interesting; 37 people applied and 12 people with type 2 diabetes were selected. The participation rate to the course meetings was very high 98%. The participants were satisfied with the course content and implementation. They had realized that they are not alone with this disease and they can influence on their self-management. The guilt because of the diabetes diagnosis had reduced and their perspective towards diabetes had become more positive. Course had influenced on their daily routines by adding physical activity and changes in their diet.

The benefits of the locally organized diabetes course were that we were able to utilize the local branches knowledge and premises, peer support group leaders were amazing, and the course was cost-effective.

This project created information about this kind of co-operation and the guidelines for the future courses are ready to use. The results of this project are going to be used in the future to develop this kind courses together with the Finnish Diabetes Association and the local branches in different parts of the country.

CONTENTS

1 INTRODUCTION

Diabetes is one of the most rapidly increasing diseases in the world. In Finland it has been estimated that 500 000 people have diabetes and the rate is not getting smaller (Ilanne-Parikka, Niskanen, Rönnemaa & Saha 2019, 4; Niskanen & Ilanne-Parikka 2019a, 11-12; Website of the Finnish Diabetes Association 2019).

Diabetes is a chronic disease, a group of metabolic disorders in common with an elevated blood glucose level which can lead to serious health problems affecting heart and blood vessels, eyes, kidneys, nerves, and teeth. Diabetes can be caused by lack of insulin, insulins reduced function or both. Complications due to diabetes can for example lead to reduced vision or blindness, and nerve diseases. Maintaining good level in self-management can delay or prevent diabetes related complications. (Niskanen & Ilanne-Parikka 2019b, 10-11; Website of the International Diabetes Federation 2019.)

Self-management of diabetes is hard work and one's resources can vary between days or life situations. Worries about hypoglycaemia, diabetes-related complications, and diabetes-related distress can influence on self-management and diabetes can sometimes feel overwhelming. People with diabetes need support from people close to them, other people with diabetes, and healthcare professionals to cope with the chronic disease such as diabetes. (Ilanne-Parikka 2019a, 46-47; Website of the Minä voin 2019.)

Most of all people with diabetes need individual guidance, counselling, equipment, and knowledge to boost their care and self-management (Ilanne-Parikka 2019a, 43-44; Koski 2019, 56).

2 BACKROUND FOR THE PROJECT

I work in the Finnish Diabetes Association as an organization coordinator. When the time came to select the topic for my thesis it was clear to me that I would like to do it for my employer. I discussed this with my supervisor, and we talked about few topics. Developing an open-formed diabetes course which is organized locally together with the local branch seemed to be the best choice for me and for the organization. The topic is something that the Finnish Diabetes Association has been thinking of for some years now and the local branches have requested this kind of co-operation, too. For me this topic was very interesting because my daily work includes working with volunteers and I can see the enthusiasm but also the need for support from the central organization. In November 2018 I started to plan the project, got approval from my employer and started to create my thesis plan. The process of the development work; a project to develop open-formed diabetes course is described in this report.

2.1 The Finnish Diabetes Association and the Porin Seudun Diabeetikot ry

The Finnish Diabetes Association (FDA) is a national non-governmental public-health and patient organization of which main activities are supporting people with diabetes, policy advocacy, and enhancing diabetes-related skills. Strategist choices of the FDA are being an attractive community, a promoter of good care, prevention and early support, and a provider of diverse services. The FDA offers information, counselling, support, peer support, and adaptation training courses for people with diabetes and for their immediate family members. One of the FDA's form of adaptation training is AmoS-project which is developing open and diverse formed adaptation training courses in Northern Ostrobothnia for people with long-term illnesses. To diabetes care and patient education, the FDA contributes by offering education for the professionals and contributing to the development work. (Website of the Finnish Diabetes Association 2019.)

The FDA has 53 000 members in about 109 local and national branches. Local and national branches are independent associations who offer for example peer support, activities, lectures, events, courses, and guidance. Together with local and national

branches the FDA works to towards the vision of overcoming diabetes every day. (Website of the Finnish Diabetes Association 2019.)

The model of an open-formed diabetes course was developed together with the Porin Seudun Diabeetikot ry. It is one of the local branches of the FDA. According to websites of the Porin Seudun Diabeetikot ry (2020) they operate in Pori, Harjavalta, Kokemäki, Merikarvia, Nakkila, Noormarkku, Luvia, Pomarkku, and Ulvila. The local branch has about 2000 members. (Websites of the Porin Seudun Diabeetikot ry 2020.) In their operation area lives about 9000 people who had had reimbursements because of diabetes in the end of the year 2018 (Websites of the Kelasto 2020). Unfortunately, we do not have reliable information about how many of the people with diabetes have type 1 or type 2 diabetes.

2.2 Diabetes in Finland

Diabetes is one of the most rapidly increasing diseases in the world. It has been estimated that in 2019 there are 463 million adults living with diabetes and the rate is rising. The estimation for the year 2045 is that the rate of people living with diabetes is 700 million. (Websites of the IDF Diabetes Atlas 2019.) In Finland it has been estimated that 500 000 people have diabetes (Ilanne-Parikka et al. 2019, 4; Website of the Finnish Diabetes Association 2019). Based on the Diabetesbarometri (2019) the number of people living with diabetes has increased by 250 000 people from the year 2000 to the year 2017 (Koski 2019, 10-13). The reason behind the estimation of the number of people living with diabetes is that currently there is no system or register which gathers all the knowledge and numbers of diabetes (Koski 2019, 10-13; Websites of the Terveyden ja hyvinvoinnin laitos 2019).

In ten years (2002-2011) the number of people with diabetes has increased by 70% and at the same time the costs of diabetes have increased by 49% although the costs of diabetes did emerge more moderate than the number of people with diabetes (Koski, Kurkela, Ilanne-Parikka & Rissanen 2018). In the year 2017 every fourth person had at least moderate risk of getting type 2 diabetes (Koski 2019, 25). Genes have an influence on getting type 2 diabetes. The risk of getting type 2 diabetes if another of

one's parents has had it is 40%. If both parents have had type 2 diabetes the risk is 70%. However, also lifestyle has an impact in the process of getting type 2 diabetes. (Websites of the Finnish Diabetes Association 2019.)

Preventing type 2 diabetes can be affected by influencing the whole population in Finland by promoting health through population strategy and by early recognition (Koski 2019, 25). It is more effective to influence on living conditions and things that provide health and well-being in the society than influencing on individuals (Nuutinen 2013). Today the recognition of diabetes has advanced and there is less unrecognizable diabetes. People with diabetes are more in control and in care than in earlier decades. It is vital to point out the meaning of early recognition to continue this good trend in development (Koski 2019, 24-25; Lindström, Jousilahti, Laatikainen, Jula & Peltonen 2018, 67-70; Niskanen & Ilanne-Parikka 2019b, 12.)

Diverse support is more effective than support in just one area in life (Nuutinen 2013). Diabetes care, support for self-management, medicine, technology, and methods are developing which is good for maintaining a good level of self-management and care of diabetes (Koski 2019, 56-57). The development will increase the costs to society, but also the means to better diabetes care and less complications which are most expensive to care (Koski 2019, 56-57; Koski et al. 2018).

3 PLANNING THE PROJECT

The development work was ordered by the FDA. In the FDA, we see that people with diabetes need support in their everyday life. In the questionnaire made in January 2019 by the FDA over half of the respondents pointed out that they did not have enough support in their self-management, about 30% said that they had enough and little over 10% said that they did not need support (Koski, personal communication on 25.2.2019). People with diabetes need individual guidance, counselling, equipment, and knowledge to boost their self-management (Koski 2019, 56).

Planning of the project started in November 2018. After planning the projects structure, the project started when Satakunta University of Applied Sciences and the FDA had approved the project plan at the end of March 2019. Project process started by finding a partner from local branches. We had five candidates Etelä-Pohjanmaan Diabetes ry, Porin Seudun Diabeetikot ry, Puijon Diabetesyhdistys ry, Keski-Suomen Diabtesyhdistys ry, and Lappeenrannan Seudun Diabetesyhdistys ry. After the Porin Seudun Diabeetikot ry. expressed their interest in the development work, the project group was gathered and planning of the course started. Last job in the spring 2019 was to open the application form in the websites.

In the fall 2019 it was time to select the participants, do the last corrections to the course model, do a pilot course, and evaluate it. Based on our experiences and the feedback from the pilot course participants, we will write the guidelines to guide organizing these courses in the future. Last phase of the project was reporting it. In the next chapters these phases are explained more thoroughly. The timeline of the project is seen in Figure 1.
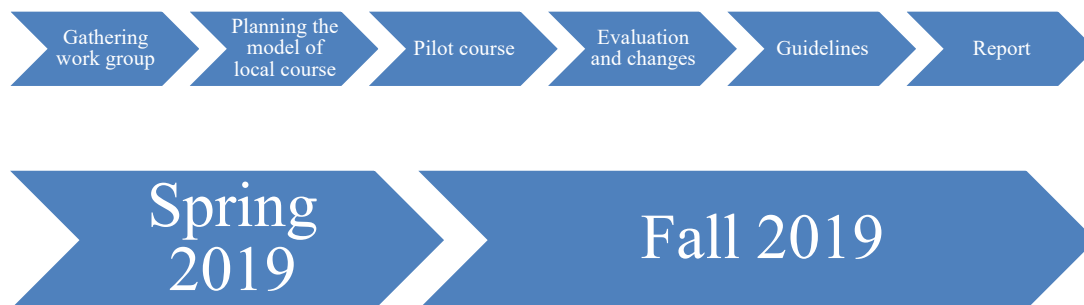
Figure 1. Timeline of the project.

3.1 The goal of the project

Goal of this project was to develop a new service for the people with diabetes offered locally by the FDA and local branches together. The idea was that this course will support self-management of diabetes and can be part of one's rehabilitation process. Self-management is supported by providing keys to people with diabetes to promote their well-being in their everyday life through information and peer support. Central organisation, local branches, and health care can benefit from this service. In the FDA's local branches, we have enthusiastic volunteers who have trained themselves

to be a peer support persons or peer support group leaders and at this point we are lacking a good national model for peer support groups.

The specific goals of this project and how those assessed were explicated as follows:

1. To develop a model of open-formed diabetes course which is directed to people with diabetes, which is local, and which aims at providing support for self-management.
   → Assessed through the feedback questionnaire, project group, and participation rate.
   → Outcome: Pilot course is delivered.
   → Outcome: Information about what to develop in the future.

2. To find out what kind of support local branches need when organizing the course.
   → Assessed through data collected and project group.
   → Outcome: guidelines for the future courses

3. To write guidelines of how to organize open-formed diabetes course in the future.
   → Outcome: guidelines for the future courses are ready to use.

3.2 Action research and collective creativity

We used action research as the method of developing. Action research is a way to product information, develop practices, and is usually used in research and developmental projects that has been limited by time (Heikkinen 2007, 16-17; Lapan 2012, 291-292). Our development work had a specific timeline and was an entity of developing and piloting a diabetes course and that is why it is called a project. Few of the main characteristics of action research are that it is based on practice, it is collaborative and requires people to take responsibility of their actions and focuses on improving learning (McNiff & Whitehead 2009, 17-23; Lapan 2012, 291-292). Action research process contains planning phase, selecting issues and data collection, analyzing results, reflecting, and using the findings to create practice or to revise it (Lapan 2012, 292; Spencer 2017). We followed the simplified circle of action research presented by John Spencer (2017) which is seen in Figure 2.
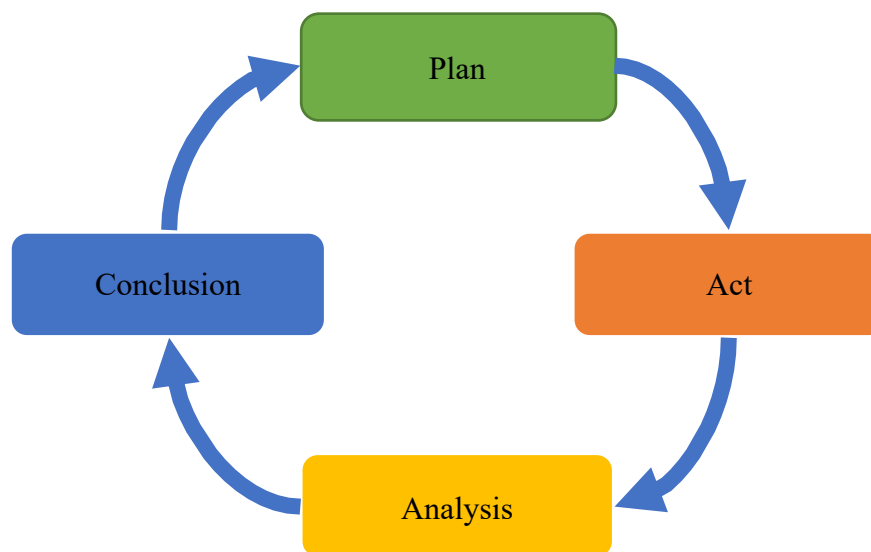
Figure 2. Action research circle by John Spencer (2017).

Research and action research bases on wanting to know something that we did not already know, show what has been found out, how it has been found out and explain it (McNiff & Whitehead 2009, 14-15). It is a process that is combined by time and place, it is participatory, reflective, and intentional process where chain of social actions follows each other in certain way (Heikkinen 2007, 36; Lapan 2012, 291-292.) In this development work the idea was create new service for the FDA and local branches to offer for people with diabetes and action research was a flexible method for that.

Action research is a process where understanding and interpretation increases little by little and the focus is: how things have been and to which way they are evolving. (Heikkinen 2007, 36; Lapan 2012, 291-292). The process of this project started by finding out what has been done before, what are the benefits of the peer support and what people with diabetes need. Using the existing information and project group's knowledge the planning and implementation of the course was seen possible.

The responsibility of the researcher is to make sure that themes and research questions are relevant and in high-level (Koskinen, Ruuska & Suni 2019, 120). Researchers actions are in the center of research. Monitoring one's own actions as a researcher, other people's actions and learning enables the researcher to produce description about what has happened. (Kiviniemi 2010, 70; McNiff & Whitehead 2009, 143-149;

Spencer 2017.) In this project I was the researcher and the project leader. I was responsible about the whole process to proceed towards the goal. The process contained ongoing reflection of my own actions as a project leader and the consequences of them.

Action research's goal is empowerment of participants, hands-on benefit, the role of the researcher is participatory and active on the process, and the point of view is subjective (Heikkinen 2007, 22; Lapan 2012, 297). I thought that if the stakeholders felt good about this co-operation it has more possibilities to continue. The idea was to provide them interesting involvement in the project. Koskinen et al. (2018, 118-123) state that in collective creativity stakeholders provide completing information and understanding from the practices and restrictions in real life. Involving stakeholders requires regular interaction between stakeholders and the researcher which also creates trust towards the research process and its outcomes. (Koskinen et al. 2018, 118-123.)

Our process of developing open-formed local diabetes course based on coworking, sharing ideas, remodeling, and trust between the project group participants. Involving all stakeholders; target group, peer support group leaders, local branch, and professionals to the development process is very important (Heikkinen 2007, 22; Lapan 2012, 297; Spencer 2017). I aimed for equal coworking so that everyone had possibility to express themselves freely in the meetings, asked on every stage the project groups opinions on the matter at hand, kept everyone up to date, and aimed for joint reflection. We had timeframe and schedule what to do and when, but we were communicating with each other in very flexible way.

3.3 Literature review about the topic

Before executing the project, I familiarized myself with the existing knowledge about adaptation training, peer support, self-management of diabetes and what has been done before in the FDA and what were the results of those projects. Although this course was not adaptation training it was important to understand the basis of adaptation training and the experiences of what makes it valuable. Peer support, self-management

of diabetes, and what has been done before offered valuable information to support the planning of this project and its content.

3.3.1 Adaptation training and implementation

Adaptation training is one form of rehabilitation. The aim of rehabilitation is to support rehabilitees daily life at home, in working life and community. Adaptation training is based on group activities and the goal is to empower and help people to carry out their own plans in life. (Ilanne-Parikka 2019c, 48; Peurala 2014, 149-151.) According to Streng & Ruponen (2014) adaptation training has begun from practical needs of people with disabilities. In Finland non-profit organizations have been organizing activity that has had same kind of elements than in adaptation training nowadays. This kind of activity has focused on finding solutions how to cope better with everyday life, social empowerment and peer support, and sharing experiences how disability affects one's life. (Streng & Ruponen 2014, 58.)

In adaptation training the trainee oneself is active and has the best knowledge of one's own life and also the best possibilities to influence it. Learning is based on the combined knowledge of participants and professionals. Peer support is seen as equal process between participants and a process of empowerment in which time one is bound to find one's own capability. The main thing is trust between participants and the sense of community. (Ilanne-Parikka 2019c, 48; Streng 2014, 345.)

One important thing is that adaptation training would be linked to the health care provider. In adaptation training courses people are from all over the country and national advices do not always meet the local possibilities to provide services. (Mäenpää 2014, 304.) In this project we were focusing on using the local knowledge of peer support group leaders and professionals because the course is planned to be local. We were in contact with the local health care to find out the need for this kind of courses and what they think that the course should contain.
The typical feature of adaptation training is that one can explore the meaning of long-term condition or disability in one's life with peers. Important part of this is exploring the knowledge and support from professionals. Knowledge and applying it in to

practice and handling one's emotions and experiences together, increases one's possibilities to find new resources for living everyday life and decisions regarding the future. By dividing knowledge, using functional methods, discussion, and peer support adapting to one's condition or disability can be promoted. (Härkäpää, Buchert, Kippola-Pääkkönen, Martin & Järvikoski 2018, 152; Ilanne-Parikka 2019c, 48.)

In the study that focused on the implementation and significance of adaptation training from the viewpoint of the clients, families, and service providers showed that adult's that had stable life situation, good control in life, and strong psychological resources felt that adaptation training was most beneficial. Client's that had difficulties in life, experienced benefit was lower. (Härkäpää et al. 2018, 5, 154). Changing experiences with peers was felt beneficial in every group. When there was a strong professional output to the group and participants individual needs were met, the expectations were met the best. There were useful situations recorded when participants experiences, peer support and professional knowledge joined together. (Härkäpää et al. 2018, 155-156.)

3.3.2 Peer support and peers as group leaders

Peer support is sharing one's own experiences with others who have been experiencing the same things. It is based on experiential knowledge, listening, equal encounter, and respect. (Website of the Finnish Diabetes Association 2019; Website of the Terveyskylä.fi 2019; Website of the Toimeksi.fi 2019.) It is sometimes easier to share one's feelings and experiences with people who have been through same things than with professionals (Ilanne-Parikka 2019c, 48). In the FDA in addition to face to face peer support that local branches offer, central association offers peer support via internet or telephone (Website of the Finnish Diabetes Association 2019).

In addition to diabetes self-management education patients need psychological support and need to be able to talk with others about their anxiety or unsureness. It has been recommended that multidisciplinary team should give education. (Baksi 2010, i40-i45; Ilanne-Parikka 2019b, 40-43; Ilanne-Parikka 2019a; 44; Ilanne-Parikka 2019c 48-50.) By including trained peer supporter to this team, it would increase available manpower, and this could help to provide locally based education which would make

it be easier to access. (Baksi 2010, i40-i45.) Peer support can offer ongoing support for sustaining diabetes self-management. Peer support consists support in daily management, social and emotional factors for example encouraging and helping patients to cope with their negative feelings, and act as a link to clinical care. In chronic disease such as diabetes the ongoing support is necessary. (Deng, Ren, Luo, Du, Zhang & Zhang 2016, 268; Fisher et al. 2012, 130-131, 133.)

Peer support is seen as a low-cost approach which can be culturally sensitive, and which could improve self-management (Tang, Funnell, Sinco, Spencer & Heisler 2015, 27, 33). Group-based peer support can be offered in low cost demanding minimal effort from general practitioners and it enables them to offer additional support to patients with type 2 diabetes who are willing to be active and make lifestyle changes. An alternative to professionally led interventions could be peer-to-peer motivation. (Johansson, Keller, Winkler, Ostermann, Weitgasser & Sönnichsen 2015, 1-2, 8.)

Peer supporters have time, they have experiences from same kind of situations, and they can provide credible and practical support in initiating and maintaining daily behavioral patterns (Fisher et al. 2012, 134-136; Philis-Tsimikas, Fortmann, Lleva-Ocana, Walker & Gallo 2011, 1927). Study of the Project Dulce suggest that significant public health benefits can be achieved with peer-led diabetes education. By empowering patients could have increased their ability to alert their physicians of critical changes in their clinical indicators. (Philis-Tsimikas et al. 2011, 1928-1930.) Projects reported by Fisher (et al. 2012) were successful in reaching patients, engaging them, improving the quality of life, and changing health behavior. Peer supporters are a natural link to communities, because they are part of them and can engage locally patients to care they need. (Fisher et al. 2012, 134-136.)

Deng et al. (2016) showed that peer support program is effective, increases knowledge of diabetes and self-management and improves glycemic control (Deng et al. 2016, 270-274). Fisher et al. (2012) study showed that peer interventions improved quality of life and three out of four projects also improved clinical outcomes and participants reported that health care from the clinic that they attended had improved (Fisher et al. 2012, 134-136). Attendance rate for education program for people with type 2 diabetes

was 53% despite the fact that peer educators did contact the participants before the course. All attended participants felt positive towards the program, they were pleased that it was in their own language and they had the opportunity to discuss and solve problems together. Participants felt that they had learned about their diabetes and how to self-manage better. However, the study was not able to show clear behavior change in self-management. (Choudhury, Brophy, Fareedi, Zaman, Ahmed & Williams 2008, 40-43.)

3.3.3 Self-management in diabetes

Diabetes is a chronic disease which can lead to serious health problems and complications which can be delayed or prevented by maintaining good level in self-management (Niskanen & Ilanne-Parikka 2019a, 11-12; Websites of the International Diabetes Federation 2019). The basic goal of self-management is good life with diabetes (Ilanne-Parikka 2019b, 46-47). Part of the self-management of diabetes are maintaining healthy lifestyle like good nutrition, physical activity, no smoking and body weight, monitoring blood glucose level, blood pressure, and taking insulin or oral-medication (Ilanne-Parikka & Niskanen 2019, 31).

Self-management is supported by education and counselling provided by the health care professionals and multidisciplinary team. The idea is that professionals ensure that the person with diabetes has the ability, skills, and equipment which are needed in daily care of diabetes. (Ilanne-Parikka 2019a, 43-44.) The care of diabetes is comprehensive care which is planned together with the people with diabetes and the professionals. It is based on self-management and people with diabetes need to make decisions influencing their self-management every day. (Himanen 2015, 43-44; Ilanne-Parikka 2019a, 43-44.) Adapting self-management in different situations is a good thing however, it is important to make self-management as easy as possible. Both of these can improve quality of life. (Ilanne-Parikka 2019a, 47.)

The mental impact of diabetes should be recognized in care and self-management of diabetes (Ilanne-Parikka 2019a; 46; Websites of the Minä voin 2019). Shame related to type 2 diabetes can cause feelings of guilt. Shame can affect one's self-esteem

negatively and lower the ability to take care oneself. (Järvinen 2017.) Worries about hypoglycaemia, diabetes related complications, and diabetes related distress can have influence on self-management and diabetes can sometimes feel overwhelming and exhausting. Self-management of diabetes is hard work and one's resources can vary between days or life situations. (Ilanne-Parikka 2019a; 46; Websites of the Minä voin 2019.)

Self-management can be seen as an instrument which helps one to control one's life and moving towards one's goals regardless of the diabetes diagnosis. There are ups and downs in the way, but it is important to bear in mind that one can influence on things by following one's own daily routines. (Ilanne-Parikka 2019a, 46-47; Ilanne-Parikka 2019c, 53.) Sometimes, people with diabetes can forget that ability to influence on their self-management is a good thing. Knowing one's own diabetes, its care and ability to apply knowledge in to practice, can help to find solutions that work in daily life. (Ilanne-Parikka 2019a; 46-47; Marttila 2015, 46-48; Websites of the Minä voin 2019.) Small changes usually work better because self-management is a big entity and changing it piece by piece helps one to notice the impacts. Noticing the good things and progress can affect positively on one's mind and one can be proud of the accomplishments achieved. (Ilanne-Parikka 2019a, 46-47; Ilanne-Parikka 2019c, 53.)

Although diabetes is a disease that is based on self-management, people with diabetes do not need to be alone. People with diabetes can get support from the professionals, other people with diabetes, and people who are close to them. (Ilanne-Parikka 2019a; 46-47; Marttila 2015, 46-48; Websites of the Minä voin 2019.) Learning from other's experiences is good way to add functionality in one's own routines but it is also important to remember that other's experiences need to be thoughted trough before utilizing them directly (Ilanne-Parikka 2019c, 51).

3.3.4 What has been done before?

The FDA has had projects called DEHKO (2000-2010) and One Life (2012-2017) which have among other things developed peer support and group activities (Website of the Finnish Diabetes Association 2019).

DEHKO developed OMA-groups for people with type 1 diabetes and the idea was to create more coworking between health care and local branches. Challenges in this model were that the health care professionals did not have enough time to work in these groups and they wanted, for example to see some visible changes in people with diabetes glycemic control (HbA1c). Coworking with health care professionals and volunteers and peers from local branches was productive, but there was not enough time in health care to participate in these groups and volunteers felt that they did not have enough knowledge to lead these OMA-groups. The other group activity that was develop, was directed to people with type 2 diabetes and was called ITE-group. The model was from Suomen Sydänliitto and it did not involve health care professionals in leading the groups. ITE-group focused on changes in lifestyle that supported artery health and was led by peers. ITE-groups did work better; they were easier to start and maintain, because it was led only by peers. (Lehto 2010, 13-20.) OMA or ITE- groups have not been active for some time now.

In 2012 started project called One Life together with the FDA, Aivoliitto ry, and Suomen Sydänliitto ry. The aim was equally healthier Finnish people regardless of age, gender, health condition, address, social status or ethnic background. Under this aim placed 15 different programs and one of them was developing peer support. (Website of the Yksi elämä 2019.) During the project One life, 9 trainings to peer support group persons were carried out. In these trainings they focused on establishing peer support group, interaction in group, how to navigate the group, phases of the group, and taking care of oneself as group leader. In total of 110 peer support persons, who had diabetes, were trained during One Life project and in February 2018, 22 peer support persons wanted to act as peer group leaders in the future. One aim was to provide peer support as easy as possible and to find a natural place for it in patient paths of health care. (Yksi elämä loppuarviointi -osahankkeet, 1-14.) There are peer support groups in some of the local branches. They all operate differently, and they are mostly focused on sharing peer support but there is no common structure for these groups.

3.4 Project's roles and responsibilities

When the project was planned, the projects roles and responsibilities were defined by using the FDA's guidebook Projektipokkari (Sampo & Koski 2011). Based on Toikko & Rantanen (2009) actor-based development and Koskinen et al. (2018) collective creativity are based on negotiation and developing together so involved stakeholders feel that they are on the same level, feel as peers and equal with each other's, and are prepared to critically examine one's own ideas and work. (Koskinen et al. 2018, 120, 124; Toikko & Rantanen 2009, 164-165.) In this project we used the idea of actor-based development which is very similar to collective creativity. The plan was to involve all stakeholders, who were somehow connected to this project; professionals, people with diabetes and local branch members, for developing it. When one opens the developmental work to every stakeholder who it does influence on and treats them equally, one can have more perspectives to one's work (Koskinen et al. 2018, 188-121; Toikko & Rantanen 2009, 77-80, 164.) The goal was to understand better what our stakeholders need, learn from each other, critically evaluate how we work, get new perspectives to approach this topic, and create a new system. In this way action research, actor-based development, and collective creativity supported each other.

Developmental work is a social process and it benefits from social analysis. Simplified social analysis can be called an actor matrix that involves all stakeholders that are related to our developmental work and what is their role, assignment, resource or interest in developing. (Koskinen et al. 2018 124-131; Toikko & Rantanen 2009, 77-80.) The roles and actor matrix are explained in the next chapters. Actor matrix of this project is seen in Table 1.

Table 1. The actor matrix of the project.

Role/actor	Assignment	Resource	Interest
Central association	Funding, support	Employee resource for planning	Organisation imago, new national model of open-formed diabetes course, peer support, support to the self-management of people with diabetes (PWD)
Local branch	Local actor	Local knowledge, premises, part of the project group, experience of living with diabetes	Organisation imago, new service, peer support and support to the self-management of PWD
Peer support persons	Local actor	Part of the project group, group leaders, own experience of living with diabetes	Know-how in to use, give and receive peer support, support to the self-management of PWD
Diabetes nurse (FDA)	Developing	Part of the project group	Organisation imago, new national model of open-formed diabetes course, peer support, support to the self-management of people with diabetes (PWD)
Organisation coordinator (FDA) and project leader	Planning, coordinating the proejct	Employee resource; project leader	Organisation imago, new national model of open-formed diabetes course, peer support, support to the self-management of people with diabetes (PWD), thesis
Project worker from AmoS (FDA)	Developing	Part of the project group	Develop model that differs from AmoS-adaptation training
Local diabetes nurse	Commenting	Ideas compared to Pori's reality	New service for the area, support to the self-management of PWD
Local physician	Lecture	Employee	Support to the self-management of PWD
Local physical professional	Lecture	Employee	Support to the self-management of PWD
Psychologist	Lecture	Employee	Support to the self-management of PWD
Chiropodist	Lecture	Employee	Support to the self-management of PWD

In the FDA, the project roles and responsibilities are divided to projects supervising committee, project group, and project leader (Sampo & Koski 2011, 13). In this project the projects supervising committee was the management team of the FDA. In the FDA's guidebook for project management Projektipokkari it is stated that projects supervising committee will decide on the projects scope, resources, timetable, changes and will supervise its progress, budget, and how it is meeting goals that are set to the project. Supervising committee is present when evaluating the developed model. (Sampo & Koski 2011, 13-25.) Supervising committee has been informed about the progress in the project and the final results will be presented to them after the report is written.

Project group was the group that planned the model for the open-formed diabetes course, modified it during the process and was responsible of evaluating it. Part of the project group also participated to the actual pilot phase. (Sampo & Koski 2011, 13-25). Project group involved:

- two representatives of local branch government Taina Katiskalahti and Virpi Kohtamäki who were volunteering also as peer support group leaders
- professionals from central organization; diabetes nurse Anneli Jylhä and project worker from AmoS-project Kirsi Heinonen
- organization coordinator: me as a project leader

Following the guidelines of the Projektipokkari project leader coordinates the process: plans, implements, follows, and reports the project (Sampo & Koski 2011, 13-25). In this project the I collected the data together before, during and after the diabetes course and analyzed it. Project group members were the ones ideating and giving their experiences in use of developing the course. I was responsible of the coordination of the whole process; communication with the project group, lecturers, local branch, other professionals, and the course participants, about following the timeline, budget, and reporting the project. Peer support leaders were responsible of booking the premises, catering at the course, guiding the course meetings, and keeping the local branch informed. Diabetes nurse and project worker from AmoS-project were responsible of bringing their experience, knowledge, and ideas for to use in the course planning. The whole project group was responsible of making conclusions to develop the course model for the future.

3.5 Budget and resources of the project

The idea of the local open-formed diabetes course was to be cost-effective. The idea was to develop a model that is easy and rather low-cost, but still valid, professional, and offers peer support to the participants. We were looking for this kind of model because we think it has more opportunities to evolve in the future. Preliminary budget was based on the calculation that was done following Allergy, Skin and Asthma Federation's model of open form adaptation training course (Pajunen, personal communication on 18.12.2018).

Resources to the project came from central organization, local branch, and from local professionals. I was working as a project leader as part of my studies and part of the planning was part of my normal work. Budget and resources were calculated by using the key professionals in diabetes care. The real costs after the course can be seen in Table 2. The number of professional's did not change but because of the local planning the professionals were not the ones that were in the preliminary budget.

Table 2. Resources and budget of the project.

Preliminary budget		Real costs after the course	
Professional's	Lecture fee € (recommendation Finnish Diabetes Association)	Real costs of the course €	Notes
Diabetes nurse	255		
Physician	355	355	
Nutritionist	255		
Other lecturers	250		Psychologist, chiropodist…
	-	250	Chiropodist
	-	436,48	Psychologist, including the travel time
	-	250	Lecture of physical exercise
Travel expences	200	25,30	Professionals, peer support group leaders…
Project group expenses			
Diabetes nurse	8 hours (h) = 240	6,5h = 195	Participating on planning

AmoS-project worker	8h = 240	7,5h = 225	Participating on planning
Organisation coordinator (me)	16h = 480	22,45h = 673,5	Project leader, only the hours spend as part of my normal work
Representative from local branch	200	-	Travel expenses
Diabetes course in action			
Rent	250	-	Used local branch's own premises
Coffee and bread	-	241,1	
Organisation coordinator	200	143,10	Travel expenses; support to the local branch and peer group leader
Advertising	200	2h = 60	Making the brochure
All together	*3095 €*	*2854,48 €*	

Nevertheless, the preliminary budget was not exceeded. We had some lucky changes that influenced the budget positively; we did not need to advertise in the local paper because the email and the brochure in local health care attracted enough participants. Also, the local branch had their own premises, so we did not need to pay any rent. Although, the time that I had calculated for leading the project was exceeded, it did not influence the total budget negatively.

3.6 Risk assessment

Recognized risks of this project related to this course being local, to peer support, and funding. With one professional, psychologist, we chose to use the FDA's own professional and this did influence the budget. In this case we were able to do the change within the budget as explained in the chapter 3.5. Using the FDA's professional was justified because the project group did not know any local psychologist who would have had the knowledge about type 2 diabetes. In Table 3. one can see the risk assessment.

Table 3. Risk assessment of the project.

Risk	Risk management	Action
Finding a local branch: Find a local branch which is able and interested to take part in this kind of project.	The FDA has 28 local branches which have over 500 members. One of those is bound to be interested.	Explain accurately what it means to be involved in this project: funding, plan together, support from central organization.
How to find a peer support person as a group leader?	Bigger local branch: more active volunteers.	Support to the peer support person when one is volunteering as a group leader. Opportunity to plan the model together with project group. Equal partnership.
Finding needed professionals.	Professionals are paid to do the work → helps to find professionals. Bigger city: more professionals.	If we cannot find locals, we use our own professionals, but this can influence the budget.
Funding of the pilot course planning and implementation.	The FDA is committed to fund the project.	Follow the budget carefully.

4 PLANNING THE DATA COLLECTION AND ANALYSIS

Key element of action research is which data to use in order to answer the research questions (Lapan 2012, 308). In qualitative research the process of research can be defined into learning process which modifies itself during the research process. The researcher is the human instrument in the research and has to be able to modify the collection of data and the methods if needed. Everything that is happening during the research process can influence the research and its results. (Kiviniemi 2010, 70, 76-78.)

4.1 Data collection methods

The data needed in developing can be gathered through observation, questionnaires, and unofficial material like coffee table conversations and such. The basic thing is how the researcher can capture the phenomenon not the number of methods used.

(Kiviniemi 2010, 70, 76-78; McNiff & Whitehead 2009, 143-149.) In this project I collected the data through project group memos, unofficial communication and conversations, and feedback questionnaire. Unofficial communication and conversation refer to the communication which happened outside the project group meetings with the members of project group, local branch or other professionals from the FDA and health care.

The difference between a questionnaire and interview is that in questionnaire the informants fill the questionnaire at home or in monitored group situation. Interview is done by interviewer. (Kuula 2011, 121-122; Tuomi & Sarajärvi 2018, 76-85.) Questionnaires should be constructed to give answers to goals set up, they should be clear, not misleading, and appropriate questions. Closed questions require less space, but they do not provide information outside the specified area. Open questions are more time consuming, but they also provide diverse and rich material. Questionnaire is good to be piloted to find out if the provided data is what was looked for. (McNiff & Whitehead 2009, 161-163.)

To find out what the course participants feel about the course I had planned to use feedback questionnaire because of the limited timeframe of the project. In the project group we discussed about this and decided to use questionnaire because we thoughted that it suites the course surroundings better than an interview. Questionnaire used in this project was tested by my colleagues in the FDA. Questions for the questionnaire were planned to answer the research questions. Questionnaire contained questions like what the participants thought about the content, how the course influenced on their self-management, and how they would develop the model of open-formed diabetes course and is there something else to add. Feedback questionnaire used in this project is as an Appendix 1.

4.2   Data analysis

Data analysis of the feedback questionnaires answers was done using a qualitative content analysis. When analyzing the data, the first question is why this data has been collected (Eskola 2010, 182)? Qualitative content analysis aims at creating theoretical

entity from the data gathered and it should not be affected by preconception or theories about the phenomenon examined (Tuomi & Sarajärvi 2018, 99-100). It is a systematic procedure where understanding the data is the key. Understanding the data is a process which is interaction between the data and researcher. (Eskola 2010, 180-182; Kiviniemi 2010, 73; Mayring 2014, 21, 31-32.) In this project I tried to focus on analyzing the data as it is, but it is possible that preconception and experiences of leading the project and being part of the development have had an impact on the process.

At the beginning, the researcher has to decide what is important in this collected data (Eskola 2010, 182-183; Tuomi & Sarajärvi 2018, 97). After that the researcher starts to go through the data and mark the expressions that are important. Marked expressions will be collected together and separated from the other material. The researcher can use for example codes, themes or typologies to make sense of the material. It seems cruel to neglect many interesting things that will arise from the collected data, but the research questions will guide the analysis (Eskola 2010, 182-183; Tuomi & Sarajärvi 2018, 113-117.) When coding the data it is important to remember that codes are inwritten notes and they structure the data in researchers mind, they work as a way to describe the data, they are a way to test the structure and to seek and check expressions from the original text (Tuomi & Sarajärvi 2018, 113-117). From the answers received from feedback questionnaire, the expressions that were important regarding the research questions were marked to structure the data.

After marking the important expressions, I started to categorize the answers. Categorizing is seen the simplest way to organize data. Categories can be inductively developed from the data and they are instruments which help to work through the data (Mayring 2014, 37, 40; Tuomi & Sarajärvi 2018, 97-99). In categorizing you define categories from the data and calculate how many of them are seen in the data. Themes is basically the same thing, but the content of the expression is more important than the number of same themes. In some point the researcher has to make the decision to look for similar or different things from the data. (Tuomi & Sarajärvi 2018, 97-98.) In categorizing the answers, the content of the answers was more important than the number of the same kind of answers. Only in the question related to what you would develop in the content and implementation of the course, the number of the same kind

of answers was important in my mind. If more than one person has noticed the same thing, it has to be important to take into account in the future. However, the other development ideas were taken into account, too.

After categorizing deepening the analysis can be divided in to three phases: reduction, clustering, and abstraction. In reduction phase the data is reduced, and all the irrelevant data is removed, in clustering phase the original data is thoroughly red and looked for similarities or differences. After that, things that mean the same are combined to a cluster and named after the content of that cluster. Last phase is abstraction where the crucial data is formed as theoretical concepts. In content-based analysis researcher combines concepts and this way finds the answer to the research question. It is based on interpretation and reasoning which leads to more abstract vision about the phenomenon. When doing analysis and conclusions the researcher tries to understand the phenomenon from the viewpoint of the examinees. (Tuomi & Sarajärvi 2018, 105-106, 113-117.) When the data was reduced and clustered into clusters with same meaning, it was conceptualized and combined to the phenomenon which answers to the research question. Example about the analysis is in Table 4. The example does not have all the data concerning the question, only few lines to show the idea of the analysis.

Table 4. Example of how the analysis was conducted.

Question 2. What made you to apply to the diabetes course?		
Original data: "To have new and updated knowledge!" "More knowledge and hints to self-management and to have peer support." "To motivate myself better with good self-management."		
Theme, reduction	**Clustering**	**Abstraction**
"To have new and updated knowledge!" "More knowledge	New knowledge Updated knowledge. More knowledge.	Need for knowledge and motivation about the disease, hints for self-management and peer support.
"…and hints to self-management…" "To motivate myself better with good self-management."	Hints to self-management. Motivation for self-management.	
"…and to have peer support."	To have peer support	

Critical conversation between the stakeholders and the researcher is valuable asset that provides information for developing and will provide active participation possibility for all stakeholders. Interpreting the data tentative explanations can be developed. Evaluation is important because of planning further actions and explaining significance of actions that have taken place. (McNiff & Whitehead 2009, 143-150, 155-156.) In the last meeting, we explored the analysed data and the whole process with the project group. We talked about what we had achieved and what needs to be developed. In addition to the answers from the feedback questionnaire the data collected was my own diary, project group's memos, and conversations relating the project. These were used to bring the project group's thoughts into discussion. After analyzing and interpreting the data, the researcher has to connect findings to the theories and earlier studies (Eskola 2010, 197) and in the end write a summary about the topic (Tuomi & Sarajärvi 2018, 97).

4.3 Ethical issues in the project

This chapter is designed to answer to questions regarding ethical issues in this project of developing open-formed diabetes course. This chapter is built by following ethical principles pointed out in TENK "Ethical principles of research in the humanities and social and behavioral sciences and proposals for ethical review" which are respecting the autonomy of the research participants, protecting privacy and data, and avoiding harm. (TENK 2009, 5-13).

Ethical preliminary appraisal about possible risks and disadvantages involves the idea that research path is predictable (Kuula, 2011, 56). For this project the ethical preliminary appraisal was applied from the Human Science Ethics Committee of Satakorkea in June 2019.

4.3.1 Respecting autonomy of the research participants

How and what is told about research to the participants influences on how willingly the participants take part to the research. Also, informing about the research often defines how long the material can be restored and how research material is used. In

this phase it is important to think through: can the same material be used in some other occasion or does it need to be destroyed, for example because of its delicacy, after the research is finished. (Kuula 2011, 101-102.) Participants can make a voluntary decision about taking part only after they have had enough information about the research and what it demands from them as participants. (Kuula 2011, 106-107; Tuomi & Sarajärvi 2018, 145-146.)

TENK (2009, 5-8) principles were followed and in this project the participants of the diabetes course were adults over 18 years old. Attending to the diabetes course was voluntary and was be based on informed consent. Because of the data use in particular study, the consent was specific. The participants to the diabetes course had possibility to withdraw from the project at any stage. The content of this project, participation, and how the data was used and preserved, is explained in information and written consent form which is in Finnish and can be found as an Appendix 2.

4.3.2 Avoiding harm

Following TENK (2009, 8-10) principles, the participants were treated with respect and dignity. Findings were reported in respectful way and privacy and sensitivity of the participants was considered. Confidentiality is important when sharing experiences between the course participants, group leaders, and project group. Matters concerning confidentiality were discussed with all stakeholders.

One source of bias could have been my double role: I was leading the project and I work in the FDA. However, I do not have any access to medical databases used in the organization. The only information I got concerning the participants came from the application form which was asked to fill out when participants were applying to the diabetes course. Application form is attached as an Appendix 3. In the application form things that were asked were name, address, email, phone number, gender, type of diabetes and when it has been diagnosed, age, has the applicant attended in the first knowledge course in Pori, why person is applying to this course, and diet. Type of diabetes was asked because the course was directed for people with type 2 diabetes. The year of diagnosis was asked because the content of the course was planned to

support better people who have had diabetes for some time now, and because in Pori the health care organizes first knowledge courses for people with type 2 diabetes. The reason why to apply to this course was asked to find out are these kinds of courses needed and what motivates people for applying. Diet was asked because of the coffee break catering in the course schedule.

Although I was in charge of the communication with the course participants, the peer support group leaders had the basic information about the course participants: name, phone number, and email address because of the safety of the participants.

4.3.3 Data protection

We paid attention to the data protection and privacy: to confidentiality, preserving data and disposing of the data, and to how the research publications are written. When the advertising of the diabetes course started, it was pointed out that the course is a pilot course which is evaluated, and participants are asked for feedback. To the course participants, we informed more detailed prescription about how the data is going to be collected, how it is used and archived, and that the data will be collected anonymously. Data without identifiers was preserved in the FDAs web location SharePoint, which is protected by password. Me and the project group members who work in the FDA had access to the specific location of the data. Collected data without identifiers was archived in the FDA's SharePoint for secondary use. These things are explained in the informed consent Appendix 2. The data which was not needed any more like applications for the course were destroyed in six months as said in privacy statement which is as an Appendix 4. (TENK 2009, 10-13.)

4.4 Credibility and assessing outcomes

Credibility of the whole project is based on outcomes of the project, all the data gathered during the project and through this report. This report aims at demonstrating the path of the project and giving the keys for doing this kind of courses in the future. When assessing the credibility of the research one must to look through the whole research process where in qualitative research the truth and objectivity rise often to the

conversation (Tuomi & Sarajärvi 2018, 148, 153-155). The reliability and credibility of the research are best met by following good scientific procedures (Kuula 2011, 34). Good research is guided by ethical commitment. Internal consistency in qualitative research defines the quality of the research. Researcher must make sure that every step of the way is done with good quality; selecting the topic, research plan, gathering the data, analyzing the data, and reporting the research. (Tuomi & Sarajärvi 2018, 138, 140-142.) I focused on working with good quality and internal consistency in planning, implementation, and reporting of the project.

To demonstrate validity vibrant data archive is needed to generate strong evidence. Without evidence base knowledge claims are not that trustworthy and may be seen just as an opinion. (McNiff & Whitehead 2009, 171-173.) To this we answered with feedback questionnaire and with documentation of the project group meetings, and with my own diary about the progress of the project. In qualitative research the problem of objectivity can be affected by the reliability of the perceptions and are they bias or not and the fact that the researcher is the one who creates the research setting and interprets the results (Tuomi & Sarajärvi 2018, 149-150). Cooperation and involving other people as co-researchers can help you to make critical, disciplined study. Critical feedback, sharing educational experiences, divided knowledge in research, and co-researching is the right way for validity. (McNiff & Whitehead 2009, 171-173.)

Assessing of the meeting of the goals can be done by assessing the outcome. In Vaikuttavuus ja sen mittaaminen -opas järjestäjälle quidebook the outcome is described as a change that has happened because of actions. Outcome can be determined by comparing situation before and after intervention. Change in situation can be caused by interventions, things that customer does by oneself and events that are happening outside the system. It is also important to measure subjective experiences as a customer and what benefits one experiences.

It is possible that outcomes develop during time and this places challenge for measuring. This requires system that will examine the results in short-term and in the long-term. Short-term follow-up provides information quickly, but the problem may be that it is not reliable enough. Long-term follow-up provides more reliable and

specified information. First the goals of action have to defined, after that indicators can be chosen to assess if the goals are met. (Vaikuttavuus ja sen mittaaminen -opas järjestäjälle.) The goals of the project and the indicators how to measure them were defined in chapter 3.1. Because of the short timeframe we did not have possibility for the long-term follow-up of the course participants although it could have provided good information for us. At present development work of the diabetes course more important was to find out how the course can be done and what participants feel about this kind of model of support.

Validity of the research is based on the fact that has the research been researching what it was assigned to do and reliability if the research can be repeated (Tuomi & Sarajärvi 2018, 150). Validity and reliability were in our minds all the time because we were all the time thinking is this what we are now doing answering to the goals and I kept in mind how this project can be reported in a way that this model can be understood and repeated by someone who has not been involved.

5 ACTING IN THE PROJECT

Our project group met three times. Communication plan helped to understand what kind of communication is needed in different stages of the project and with the stakeholders (Koskinen et al. 2018, 130-131). Communication plan is seen in Table 5. Meetings of the project group were held in Pori. Peer support group leaders and I were present in Pori. The diabetes nurse and the AmoS-project worker from the FDA attended by Teams web meeting. In addition to the meetings the project group talked via email. Peer support group leaders and I were communicating in regular basis through WhatsApp or email.

I was involving stakeholders in every step of the project. To communication between the project group and supervising committee was used FDA's SharePoint, email, Teams, WhatsApp, and telephone calls. All stakeholders were not able to use SharePoint or Teams. When communicating with local branch, peer support group leaders, and professionals who were involved in the developing or lecturing in the

diabetes course I used email, WhatsApp, telephone calls or text messages as seen in the communication plan in Table 5.

Table 5. The communication plan of the project.

Communication channel	Who	Why
SharePoint	Project supervising committee, project group (employees from the FDA), other professionals in the FDA	Share information, to keep everyone informed
Teams	Project supervising committee, professionals in the FDA, project group	Local branch was far away from the office of FDA. Web meetings were required to stay in budget and save some time
Email	All stakeholders	To schedule meetings, inform rapid change.
WhatsApp	Peer support group leaders and project leader (me)	For quick interaction and support
Telephone calls and text messages	Professionals keeping the lectures and project leader (me)	To plan the schedule of lectures

5.1 Developing the course

After getting the project plan approved and project group was gathered, we started the development work. The idea was that this model will promote realization of diabetes self-management by offering information and peer support. Our base for developing was the model of open-formed adaptation training course of the Allergy, Skin and Asthma Federation, the experiences of the FDAs diabetes courses, and previous projects.

The basic frame of Allergy, Skin and Asthma Federations open-formed adaptation training course is:

- The content of adaptation training course is planned to meet local needs
- Training course involves 4 group meetings
- Every meeting is from 2 to 3 hours
- Training course is led by local professional

- In every meeting they have different agenda depending on what is the topic and goal of training course
- Professional speaker in every session
- Local branch organizes training course in practice
- Federation supports local branch as much that they need and also is responsible from the selection of participants (12) to the training course
- Federation will look after that the training course will meet the goals of adaptation training
- Federation provides funding of the training course

(Pajunen, personal communication on 18.12.2018.)

Based on the model of the Allergy, Skin and Asthma Federation, project group decided that the new service is open-formed local diabetes course which contains four meetings and our goal is to find 12 participants to the course. Project group talked also about bigger number of participants but based on experiences of the representatives of the FDA and the Allergy, Skin and Astma Federation, we decided on 12 participants. Local branch, Porin Seudun Diabeetikot ry, wanted to provide the course for the people with type 2 diabetes, because the they did not have too much to offer for this target group. Project group planned the schedule of the course, place of the course, and the topics of the lectures. The course was scheduled to be every Thursday from 26.9. to 17.10. all together four times. Every meeting lasted 2-2,75 hours. Because the course was open-formed and on a weekday, we wanted to keep the length of the meetings as short as possible, but long enough so that there would be time to talk about the topic at hand.

The basic structure in the meetings was:

17.00 Welcome! Discussion in small groups

17.15 Lecture about the day's topic

18.15 Coffee break, open discussion

19.00 Discussion in small groups

19.20 Back in to own seats and closing the meeting

19.30 Thank you all and have a nice way home. See you next week!

The most fundamental professionals in diabetes care are the physician and the diabetes nurse. Other members of multidisciplinary team are for example chiropodist, nutritionist, psychologist, physiotherapist, and dental care professionals. (Ilanne-Parikka 2019a, 43-44; Koski 2019, 34.) First the planned topics and the professionals for the lectures were based on the viewpoint of project group of the basic need of counselling for people with type 2 diabetes: physician, diabetes nurse, chiropodist, and nutritionist. After talking with the diabetes nurse in the Pori area the topics and professionals defined to psychologist, physical information, chiropodist, and physician (Mäkelä, personal communication 21.5.2019). Talking with the diabetes nurse in Pori area clarified what kind of services they offer and based on that our topics were modified. The order of the topics and lectures were planned by using the experiences of the project groups representatives of the FDA; psychologist at the beginning to motivate participants and to support them in grouping together, and the physician last because then she would be able to answer the questions raised during the meetings before. However, we could not keep the planned order of topics because of the schedule difficulties. The schedule before and what really happened is seen as an Appendix 5.

Project group decided that I as a project leader will make a specific guideline for every meeting to help maintain the planned schedule. The specific guideline for every meeting is as an Appendix 6. The questions for small group discussions were decided in advance and laminated so that questions could be passed out to the groups to help them to keep the topic of the conversation in mind. The questions in the beginning at the first meeting related to getting to know each other and the next three times they were relating to the last times topic. Questions were: 1) What changed in your daily routine? 2) What did not change? 3) What would you do differently? Questions for the small group discussion in the end of the meeting were the same every time and the group remained the same during the one meeting. Questions at the end of the meeting were: what have you learned today and what are you going to take with you into our own daily routines? Reason behind the small group discussions was that through them all the participants had possibility to talk about the topic and think how things heard last time or the current meeting could be applied in daily routine. Questions are in the Appendix 6 and Appendix 10.

Project group decided that it would be best to fill in the feedback questionnaire at the last meeting and peer support group leaders to send filled forms by mail to the project leader afterwards, this way we could ensure getting the feedback. Feedback questionnaire is as Appendix 1. We decided not to gather personal goals or clinical information from the participants because the course being so short; only four meetings and few hours per meeting, also the timeframe was too tight to do long-term follow up.

Project group decided that the course is going to be advertised in the websites of the Porin Seudun Diabeetikot ry and the FDA, local diabetes leaflet, sent by email to the members of the local branch who are in the target group of the course, and if needed it would be advertised in the local newspaper. Advertisement of the course was sent to the diabetes nurses and to those who are in charge of the care equipment distribution in the Pori area. People had little over two months' time to apply to the course. We decided not to advertise in the local newspaper because of the good turnout of the applicants. Advertisement is as an Appendix 7.

5.2   Selection of the participants

We used cluster sampling and the basic criteria for the course selections were based on the goal of the course. Participants needed to be people who had type 2 diabetes, adults and from the Pori area or nearby to meet the idea of a local course. There were 37 applicants for the course. Before anything was done for selection of the participants the project leader did remove the personal identifiers from the applications and numbered the applicants. From the 37 applicants the project group excluded five persons who did not have type 2 diabetes or did not have possibility to attend on every session. The idea of this course was that it is a package where all the parts link to each other and that's why it was important for the baseline to be able to take part in every meeting.

In the planning phase of the project we decided to use random selection. Cluster sampling was chosen because using it every one of the populations can have the same opportunity to be chosen to attend (Website of the QuestionPro 2019). In this project

the population were people who had type 2 diabetes in the Pori area. They had possibility to apply to the diabetes course, because it was open to everyone who had type 2 diabetes and was advertised quite widely. Information about the selection methods was in the fact sheet which was in the course advertisement text in the websites of the Porin Seudun Diabeetikot ry. The fact sheet is the Appendix 8 and the text in the websites is seen as an Appendix 9.

In cluster sampling every participant has the same possibility to be selected. The researcher will define the cluster and how many clusters to have by planning a clustering frame. In each cluster should have the same number of members. (Websites of the KvantiMOTV 2019; Websites of QuestionPro 2019). After exclusion there were 32 applicants left who I divided in to two categories under and over 65 years of age, both categories had 16 people. Dividing applicants for these categories guaranteed that there would be participants from different life situations and age groups and due to that more diversity on participants.

From these two categories 12 participants were selected by using lottery method, six (6) from both categories. Lottery method means that the participants are numbered, and the researcher will pick up the numbers randomly (Websites of the ThoughtGo 2019). Every participant had own number and the numbers were in two baskets based on which group they belonged to. The FDAs member secretary lifted up the numbers. From both groups two people did cancel their participation and the FDAs member secretary lifted new applicants to replace the ones who cancelled. The selection of participants can be seen in Figure 3.

```
┌─────────────────────────────┐
│        37 applicants        │
└─────────────────────────────┘
                │
┌─────────────────────────────┐
│ 5 exluded: 3 not people with│
│ type 2 diabetes, 2 not able │
│ to participate in every     │
│ session: 32 applicants      │
└─────────────────────────────┘
```
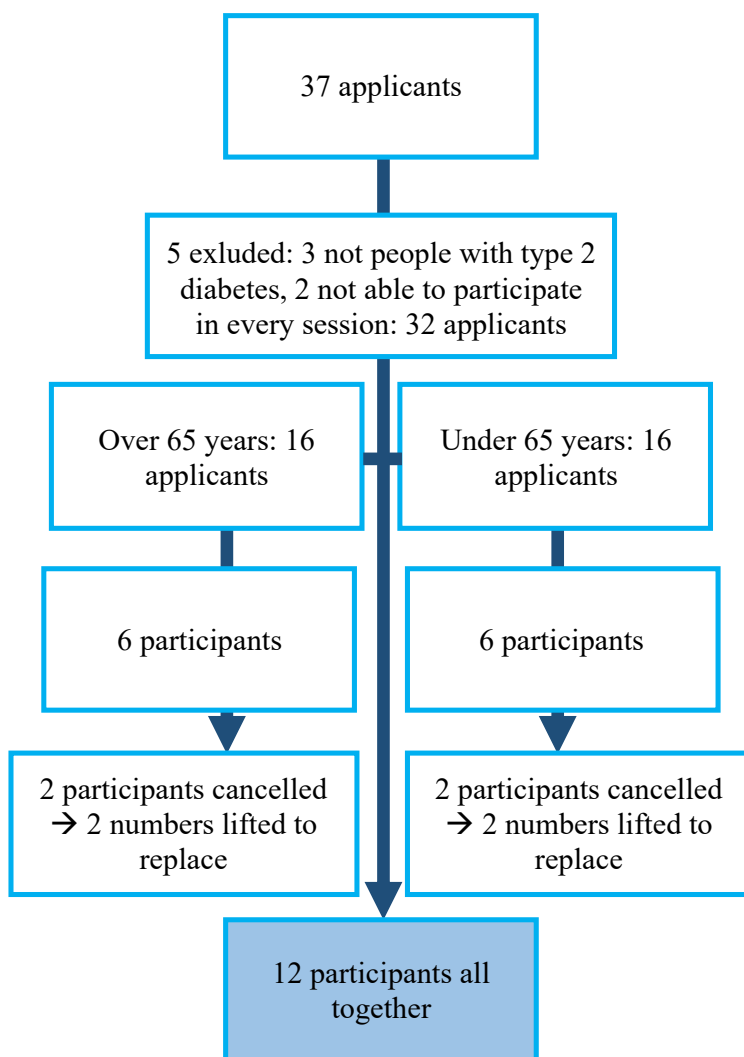
Figure 3. Selection of the participants.

To attend to the course 12 participants were selected, they were 49-85 years old, 10 females and two (2) males. Participants had been diagnosed with type 2 diabetes 1-19 years ago and no-one had attended on the first knowledge course. Most of the participants lived in Pori and two of them lived in nearby municipalities.

To the course participants the I sent an email first in the beginning of September 2019 to announce about the selections and get confirmation about attending. Because of the course entity it was important to get confirmation about attending from the selected participants. Few weeks before the first meeting I sent another email to confirm the schedule, meeting place and other practicalities. All emails were sent to participants as blind carbon copies because of personal data protection.

5.3 Course in action

Course meetings took place in the premises of the Porin Seudun Diabeetikot ry. Course schedule was Thursday 26.9. from 5 p.m. to 7.45 p.m. physician lecture, Thursday 3.10. from 5 p.m. to 7.30 p.m. physical activity lecture, Thursday 10.10. from 5 p.m. to 7.30 p.m. psychologist lecture and Thursday 17.10. from 5 p.m. to 7.45 p.m. chiropodists lecture. The first and last meeting were 15 minutes longer because of the introduction about the project at the first meeting and the feedback at the last meeting. The course schedule is as an Appendix 5.

About week before every meeting I sent a text message, called or send an email to the lecturer to inform about the course participants age distribution, sex, how long the participants have had type 2 diabetes, and the specific schedule of the meeting.

In the first meeting (26.9.) of the group we used more time in getting to know each other, there was introduction about the project, and reading and signing the informed consent for the thesis. At the beginning small group discussion focused on getting to know each other by dividing participants into three groups of four people by using funny family cards. In these groups, participants were told to find four common things relating to their daily activities, hobbies, and things which interests them. They were told not to talk about their diseases because the idea was to get to know each other's as persons and not through their condition. After discussion in groups, participants came back to their seats and told to the others what they had found in common. I was leading this meeting. In addition to the topics planned, the participants pointed out that they wanted to know something about the nutrition as well. Peer support group leaders took this seriously and decided to talk about this in the local branches' governments meeting.

The next three meetings were led by the peer support group leaders. The structure remained the same. The small group discussions in the beginning were in different groups every time. The participants were divided into groups differently every time; dividing them by numbers, using marked nametags, and last time they chose the groups themselves. I was present at the last meeting until the coffee break because of the feedback questionnaires and giving a lift home for the lecturer. Feedback questionnaire

was filled after the coffee break, but I introduced the questions if there were something that someone needed to clarify. After every meeting of the open-formed diabetes course, peer support group leaders had an opportunity to call, email or send WhatsApp to talk with me about the course. The idea was that if something is not working or there are challenges with something, we can think together how to address the situation and what to do. We exchanged thoughts and ideas after every meeting; everything was going on as planned and there was no need to changes. The specific guideline for the meetings is seen as an Appendix 6.

In addition to these four meetings that were planned content of the course, the local branch Porin Seudun Diabeetikot ry. decided to offer nutrition lecture for the participants in the end of the October. This meeting is not discussed more widely in this report, because it was not part of the course, but it is mentioned because it was something that this course provoked.

6 ANALYZING THE DEVELOPMENT WORK

In the analyzing phase of the action research I analyzed the feedback from the course participants and together with the project group we analyzed how did the development work proceed, where did we succeed, and what needed to be changed. These thoughts are presented in the next chapters.

6.1 Course, participation and feedback

The feedback questionnaire was filled in the end of the last meeting and the privacy statement and informed consent were printed out for participants to read if needed. One of the participants could not take part in the last meeting so he/she filled out the feedback questionnaire in the internet. Peer support group leaders sent the feedback questionnaires to me after the last meeting. I typed all of the filled questionnaires to the Webropol form by using the same website link, so it was not possible to find out who had written what. Feedback questionnaire and the answers were in Finnish and

the citations used in this chapter were translated from Finnish to English as accurately as possible.

Course was seen interesting from the point of view of the people with type 2 diabetes. This conclusion is based on the fact that there were 37 applicants for the course. Because lack of the system or register which gathers all the knowledge and numbers of diabetes (Koski 2019, 10-13; Websites of the Terveyden ja hyvinvoinnin laitos 2019) it is not possible to calculate percentage of applicants in relation to how many people have type 2 diabetes in the Pori area. The number of applicants was accomplished by advertising widely. From the course participants 84% had found out about the diabetes course via email, 8% from one's health care and 8% from the local diabetes bulletin.

The reasons why the participants had applied in this course were related to themes like knowledge about diabetes, self-management, and peer support. Mainly participants applied because they wanted to have basic knowledge about diabetes, update and find the current and newest information. Participants wanted to have more motivation to self-management, hints, and peer support. Also, the fact that the course was directed to people with type 2 diabetes and the content was interesting and important were reasons which attracted participants to apply.

"To have new and updated knowledge!"

"More knowledge and hints to self-management and to have peer support."

"To motivate myself with good self-management."

The participation rate to the course was 98% which was very good. Although, we informed the selected participants that it would be desirable that they would attend on every meeting, there still could have been sick leaves or something and there was possibility to drop out from the course whenever the participant felt like it, but no-one dropped out.

The questions related to the content and implementation of the diabetes course were in the matrix and there were 11 claims about the content and implementation. All 12 participants answered this matrix question. There were four choices totally agree,

partly agree, partly disagree, and totally disagree. For the 11 claims no-one answered totally disagree. The claims and the number of answers is seen in Table 6.

Table 6. Answers to the matrix question about the content and implementation about the diabetes course.

Answer to the claims about the diabetes courses content and implementation. 12 answerers				
Claim	Totally agree	Partly agree	Partly disagree	Totally disagree
1. The content of this course was what I expected	8	3	1	0
2. The number of meetings was appropriate	9	2	1	0
3. The length of the meetings was appropriate	9	3	0	0
4. I got information to back up self-management	12	0	0	0
5. I learned how to apply information	6	5	1	0
6. I think that this course has affected on my attitude towards diabetes	9	3	0	0
7. Atmosphere of conversation felt safe	11	1	0	0
8. I had opportunity to change experiences with other participants	10	2	0	0
9. I got peer support	8	4	0	0
10. This course has increased my welfare	6	4	2	0
11. Entity correlated with my expectations	7	4	1	0

To this matrix question 95% of the answers were either totally agree or partly agree. The participants of the course did agree the most to the claim "4. I got information to back up my self-management", all of them answered totally agree. For the claim "7. Atmosphere of conversation felt safe" 11 out of 12 participants answered totally agree and for the claim "8. I had opportunity to change experiences with other participants" 10 out of 12 participants answered totally agree, though for the claim "9. I got peer support" 8 out of 12 participants answered totally agree.

The biggest variation between answers (Table 6.) were in the claim "10. This course has increased my welfare". The second biggest variation was seen in claims 1., 2., 5.

and 11. The second biggest variation between answers was seen in the claim "5. I learned how to apply information" in this claim 6 participants answered totally agree, 5 partly agree and 1 partly disagree. When the variation between the matrix answers was compared to the open-ended questions it was seen that the participants who were the most critical in the matrix answers were not negative in the open-ended answers and had gained knowledge and ideas for themselves.

When asked about the most important epiphany during the course, participants pointed out that realizing that this disease is not one's own fault that both genetics and lifestyle choices have an impact on type 2 diabetes, the guilt had eased, and that self-management acquires practicing, constant self-monitoring, strength, and confidence. Knowledge, social support, guidance, and peer support are important in living and managing with diabetes.

"I am not alone with my disease, peer support and care are available and I don't suffer from guilt because of diabetes anymore."

"That I haven't caused this myself and that it is in my genes."

"Maybe the process of self-management still demands practicing and thinking over and adapting to the practice."

"I have been on the 'right track' all the time and now I got more encouragement for that."

Diabetes course had influenced on participants self-management by adding physical activity and influenced on their daily rhythm and diet. Participants were more aware of the meaning of self-management and its regularity. Also, making changes bit by bit was seen important. Through this course the viewpoint to diabetes had become more positive. Acknowledging the influences of one's own choices had strengthened, and the received knowledge had eased the stress caused by diabetes.

"I have changed my diet, increased the amount of physical exercise and reduced the stress caused by diagnosis."

"My approach has changed to more positive after getting more knowledge and means to self-management of diabetes."

Participants had ideas how to develop the course. Participants would develop the content by adding information about nutrition, some practical tips for food recipes,

weight control, and exercises like foot gymnastic exercises or little walk together, and some concrete videos could have been helpful. In addition, they were interested in diabetes-related complications, and on courses organized by FDA. Furthermore, they were eager to have more time for free conversation during the course. In this question the table is used to show the main themes which raised from the development ideas, number of themes is seen in Table 7.

Table 7. The course participants ideas of how to develop the course.

How would you develop the content and implementation of the diabetes course? 11 answerers	
Theme	**How many times mentioned?**
Information relating nutrition	7
Practical instructions	6
Information about complications	2
Information about the FDA activities	1
Free conversation around some theme	1

For the question: "Would you like to add something?" there were 6 answerers. The ones who answered to this question wanted to thank the lecturers, peer support group leaders, the ones organizing this course and they own peers from the course. Course was seen productive, interesting, and as the source of useful information. They felt that course had positive atmosphere and possibility to have social support.

"The course was productive and interesting."

"The course had good and positive atmosphere."

6.2 Project group's perspectives to the development process

In this chapter the viewpoints of the project group and me regarding the development process are presented. This chapter is based on the meetings and memos of the project group, and other communication between the project group. As a project leader I did this development work partly as part of my current job as an organization coordinator and partly on my own time as part of my studies. In the project's planning phase, it was easy to exchange ideas with professionals and my supervisor in the FDA because it was natural part of my job. In addition, getting in touch with the local branches was easy because I had had some contact with them all before this project.

Project group worked actively through the development phase of the open-formed diabetes course. As the whole, the development project was seen fruitful and needed. The participation rate and feedback from the course tells about the good motivation of participants and that there is need for this kind of activity in Pori area. Moreover, the peer support group leaders saw that the course participants were actively participating into the discussion and interested about the topics during the meetings. One of the biggest outcomes of this course was that the guilt, felt by the participants because the diabetes diagnosis, had reduced. Almost all the lecturers did deal with this issue and it seemingly had an impact on the participants.

The topics and schedule of the topics changed from the original plan, but peer support group leaders saw that the physicians lecture in the beginning of the course created a solid ground for the course. The chiropodist lecture can be more interactive and maybe it could contain some concrete examples of the insoles and foot gymnastic exercises. The clearest wish from the course participants was more information about nutrition which is very important part of type 2 diabetes care. One of the biggest benefits of working with the local branch was that the local branch was quick to react on the need of the participants to know more about nutrition and organized the lecture for them outside this course.

The actual implementation of the course should be as easy as possible for the local branch and to the peer support group leaders. The volunteers from the local branch would not have had the time to find and settle lectures, change the schedule, create the course content, advertise, and so on, but they were enthusiastic to participate on planning and to the actual course. One meeting with catering and other preparation takes about 4 hours and in the beginning of the project this whole process seemed overwhelming through the eyes of the local branch. When the peer support group leaders found out what this really means for them that they did not have to make written reports more than phone call or email to me, they got more enthusiastic. There were many people applying to the course, the content was planned, and the whole course started to seem real, hence, we all started to wait the beginning of the course. After every meeting the peer support group leaders started to wait the next meeting. Moreover, this course was rewarding for them, they learned new things, met new people, and got to know each other better.

The roles in the process of developing this course and in the diabetes course group were clear. The roles and responsibilities of the project group were talked through with every member of the project group. Roles of the peer support group leaders and I were talked through with the course participants in the first meeting. It was agreed that I will be in charge of the communication with the participants for example the absence notifications were directed to me and I informed the group leaders. Group leaders did feel that it was good that the structure of the meetings was the same every time, but the small groups changed every time; this way the participants got to know each other better. It was a good thing that the small group questions were written in advance in small, laminated piece of paper so that they could be distributed to the groups. The structure of the course written in detailed way helped the peer support group leaders to guide the group (Appendix 6). The openness between the group increased towards the last meeting.

Project group discussed that it was good that central association was in charge of the application process. In the application phase, it could be more specifically told that the baseline of participating is that one can attend on every meeting. It has to be noted that the schedule has to be in order at that point and selection criteria more specifically explained. Albeit the life situations can change before the course actually happening and of course people have the right to drop out if needed but these things clearly said ahead can ease the disappointment if not selected to the course. About the selection criteria the project group talked that diabetes type is the main thing. Even the need for the course can be difficult to define from the applications because we ca not use medical data to help us do the selections. Age is not necessarily a good criterion because the age difference did not come up in the feedback. Also, the experiences from the FDA's other courses suggest that age is not necessarily the main criteria in adult courses.

From my viewpoint as a project leader working with the project group was easy and rewarding. All stakeholders were enthusiastic and took part to the development work. In the spring 2019 we had some difficulties with finding common time with the professionals from the FDA because the calendar does fill in several months ahead. In addition, the diabetes nurse in Pori had the busiest time in the spring when I tried to

contact her but getting in contact succeeded. It was important to talk with her to find out the practicalities in type 2 diabetes care in the Pori area.

7 CONCLUSIONS BASED ON THE RESULTS AND PROCESS

In this project we used action research as a method and followed the four stages of the development process presented by Spencer (2017) planning, acting, analysis, and conclusions. We are now at the phase of conclusions where I am gathering the results of the development process together. The goal of this project was to develop a model of an open-formed local diabetes course for people with diabetes, find out what kind of support the local branch needs and to write guidelines for the future. The goal of the diabetes course was to provide keys to the people with diabetes to promote well-being in their everyday life and to provide support for self-management by combining peer support and professional knowledge.

For measuring the outcomes and achievement of the goals we used feedback questionnaire, my diary, memos, communication of the project group, the turnout rate of participants, and how did they participate in the meetings. From the feedback questionnaire we did find answers for how the course served the participants from the viewpoint of the set goals. Questionnaire is in Finnish and can be found as Appendix 1. Finding out the what kind of support the local branch needs demanded an open mind and honest communication with the local branch and its representatives. It would have been interesting and valid to do long-term follow-up questionnaire for the participants but because of the tight timeframe of the project we did not have that opportunity.

It was important for the course to succeed that we had two professionals from the FDA in the project group who had wide experience in planning and working in different kind of diabetes courses. Also, it was important to have contact with the local diabetes nurse in health care to find out about their practicalities, ideas, and needs for the course. Through the data collected we were able to develop the course structure and write the guidelines for the future courses. The whole process is seen in Figure 4.
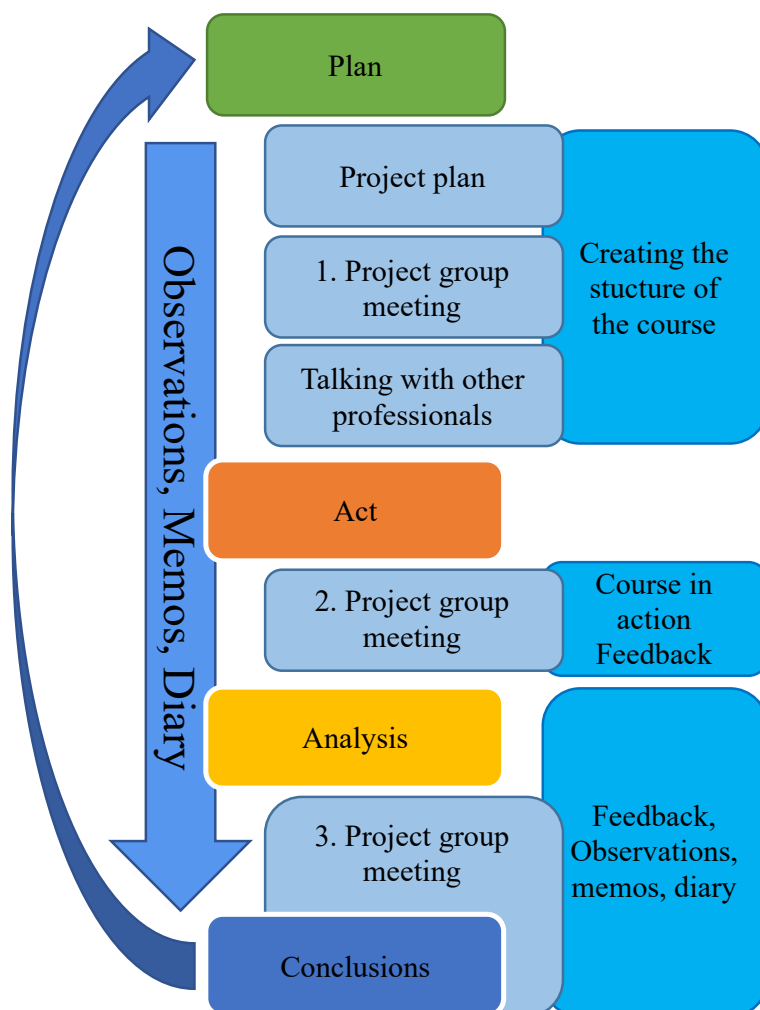
Figure 4. Process of developing open-formed local diabetes course.

7.1 The open-formed local diabetes course model

We succeeded on creating a model of open-formed local diabetes course led by peer support group leaders. We were able to implement the plan which we had drawn up and get the experiences we needed for the future. Albeit we did not get data regarding wider access to the course even though it could have come up in the open-ended question about "What made you to apply to this course?". One of our base assumptions was that when we offer local course it can attract people who are not able to access national courses, but for this we cannot reply.

People with type 2 diabetes were interested about the course; 12 out of 37 applicants were selected to attend and the participation rate to the course meetings was 98%. The participants were motivated to take part in meetings, to small group discussions and

conversation during the meeting. Participants mostly attended because they wanted to have knowledge to support their self-management and all of the participants felt that they had had it, but in applying the information into everyday life had variation in the answers and this is something that we need to develop. Participants ideas about the concrete examples, videos, and practical hints might help in applying the information to the daily life.

There was little variation in the answers regarding the number of meetings and the length of the meetings, but there was not really any explaining factor of which way to change them. This might be linked to the fact that participants wanted to know about nutrition or to lack of practice in the meetings, but those were not in the course schedule. This is something that we need to take into account in the future and ask it specifically in the feedback questionnaire.

There was some variation in what was expected from the content of this course and how the entity correlated with expectations. From the answers I did not find any other explanation for this than the fact that nutrition was not one topic in the course content and that there were too little practical and concrete hints to support the topics. Nutrition as a topic was excluded from the course content because it is included in the first knowledge courses in the Pori. Project group pondered that there could be some short chair gymnastic exercises or something in the meetings to keep up the activity and blood circulation. If the nutrition lecture is in the course structure, it could be interactive, and the course could contain making food or tasting some foods. This could mean that this meeting would have to be longer than 2,5 hours. For the first meeting it could be good idea to add a little introduction about the FDA and local branch. Also, the project group thought that expectations towards the course content could be better met with more specific description about the agenda of the course meetings. This could be done already in the advertising phase.

The relationship between the course participants, the peer support group leaders, the project leader, and the atmosphere during the course can influence the course. Peer support group leaders were part of the project group so the relationship between me as the project leader and group leaders had longer time to evolve into a trusting relationship. Relationship between me and course participants stayed in more clinical

relationship, because of dividing the responsibilities so that the peer support group leaders were the ones responsible about the meetings. The relationship between the peer support group leaders and the course participants according to the feedback, my own observation and conversations with the peer support group leaders was trusting and open. Relationship between the participants was not asked directly, but according to the feedback questionnaire and peer support group leaders, the relationship and the atmosphere were good and supported open discussion.

7.2 Support for the self-management of diabetes

The biggest epiphanies during the course related to reduced guilt which was felt because of diabetes, self-management needs practicing and confidence, and one can influence on one's health by lifestyle choices. All the participants either agreed totally or partly with the fact that the course had influenced on their attitudes, atmosphere felt safe and they had possibility for peer support and changing experiences. Knowledge and experiences from the course supported making different lifestyle choices and awareness about their impacts, and also reduced the stress of self-management. Many of the participants had added more physical exercise and changed their diet during this course.

We succeeded well in providing keys to people with diabetes through this course, although there was variation from totally agree to partly disagree in the question related to welfare increasement during the course. The question might have been too wide, because the welfare is quite a big concept which contains a lot more than the things related to type 2 diabetes or this course which is only few hours a day once a week. These might be reasons why there was variation in the answers. Some of the participants thanked all the stakeholders in the last question "Would you like to add something" and through the questionnaires answers the information, peer support, and atmosphere was seen productive.

7.3   Support for the local branch and guidelines for the future

During our work with the project group it became clear that the local branch is very interested in this kind of co-operation. They want to take part in planning and implementation, but coordination, structure, and reporting of the course must be in the responsibility of the central organization. The local branch is willing and interested in being present in the actual meetings and guide them if the plan is detailed and easy to follow. This is because they are volunteers and they do not have countless hours to spend in this. Moreover, the content is good to be attractive for the local branch and to the peer support group leaders, because it can motivate them to take part.

At this point it is quite simple to outline what kind of support the local branches need. In practice the local branches are different, and the needed support can vary. Based on Allergy, Skin and Asthma Federation's model (Pajunen, personal communication on 18.12.2018), our experiences, and data we wrote the guidelines to help organizing these courses in the future. Biggest difference between the base model of Allergy, Skin and Asthma Federation and our model is that our model is led by peer support group leaders.

The FDA and the local branch plan the course together; goals of the course, the structure and topics of the course, target group, criteria for selection of the participants, when, where, how, who are the peer support group leaders and the marketing. Then central organization takes the responsibility of booking the lecturers, creating and opening the application, and selecting participants. Implementation of the course in practice is most of the local branch's work but central organization is part of it giving its support if needed like participating on the first meeting, helping with the communication with the participants of the course, providing material, and creating feedback forms. Reporting and economics are the responsibility of the central organization. Regarding the future, it would be good idea to do a follow-up questionnaire to see what the participants feel about the course for example after three months and has it affected on their lives more permanently. These observations and what to consider in the future, when planning and implementing open-formed local diabetes courses led by peers, are presented in the guidelines as an Appendix 10.

8 DISCUSSION

Our collected data was tight but revealing and offered information for developing the course model. As a project leader, I think that we were able to follow the circle of the action research. In real life it was more like a spiral at least in the planning and conclusion phase of the course, because of the basic need for information from the viewpoint of the people with type 2 diabetes, finding out what would be the most needed information in the Pori area and timetable challenges. The timeline was tight; long enough to do the development work, but too short to do the follow-up of the participants and see if the things discussed during the course are still affecting one's life.

There were more people applying to this diabetes course than we were able to take along. Two of the applicants who were not selected were disappointed that they could not attend. Compared to findings of Choudhury et al. (2008, 40-43) our attendance rate 98% was better than their 53%. In the Choudhury (2008) study they also had four meetings but in six weeks' time. Both of these things; the disappointment of not been selected to participate and the attendance rate of the course in my mind tells about the need for these kinds of courses. We instructed the participants beforehand that it would be good to take part in every meeting and this can be one thing that influenced on the participation rate. It was discussed in the beginning of the course that it was possible to drop out if needed or be absent in case of sickness or another obstacle. The age difference of the participants could have had an influence on the results, but we did not find any proof of the impact on either way.

8.1 Influence of the open-formed local diabetes course

Comprehensive diabetes care is based on self-management and education to support self-management is the responsibility of the healthcare professionals (Ilanne-Parikka 2019a, 43-44). The idea of this course was to support the knowledge already learned and that's why the course was not for people who had just been diagnosed. Every participant reported that they had had information from the course to back-up their self-management. Based on our data it is not possible to evaluate how much knowledge the participants had before, but according to the feedback we can assume that the

information provided in this course gave them something new and updated knowledge, new perspectives, and experience-based knowledge to support their daily life with diabetes.

Shame related to type 2 diabetes is causing guilt and eating away the self-esteem and the ability to take care of oneself (Järvinen 2017). In the feedback questionnaire, the participants brought up that the guilt and stress had reduced and motivation to self-management had improved. I think that this is one of our biggest achievements in this project. Self-management is hard work which can sometimes be exhausting and disressing (Ilanne-Parikka 2019a; 46; Websites of the Minä voin 2019). During the course participants had realized that they can influence on their self-management and it is a continuous learning process.

In comparison to earlier studies about diabetes education in which peer support was utilized the findings in this project were similar in many ways. In Baksi (2010, i40-45), Tang et al. (2015, 27, 33) and Deng et al. (2016, 270-274) locally based education was seen as a possibility for wider access and support for self-management. Our experience from cost-effectiveness, participation, the feedback, and the atmosphere of the course support this finding about self-management. Based on the budget cost-effectiveness in our model was achieved by utilizing the local actors both peer support group leaders and professionals and by using web meetings within the project group. Cost-effectiveness of courses led by peer support persons was pointed out also in the Johansson et al. (2015, 1-2, 8) study with the idea of additional support for the ones who are interested.

It was pointed out by Koski (2019, 25) and Nuutinen (2013) that it is more effective to influence on society and living conditions than individuals and that diverse support is more effective than support in just one area in life. Based on our findings our course model was influential and was able complete the knowledge and offer support to self-management. However, we do not know about the long-term impacts of this course. With diverse support, education, counselling from healthcare and equipment based on individual need, the self-management can evolve and the confidence grows which can lead to better self-management and less complications (Himanen 2015, 43-44; Ilanne-

Parikka 2019a, 43-44). Our findings support the idea that diverse and additional support influences positively on self-management of the ones who want it.

In Deng et al. (2016, 268) and Fisher et al. (2012, 13-131, 133) peer support was seen as ongoing support for the people with diabetes. It was possible for this course group to continue on their own as peer support group by the means of the local branch. In my understanding this did not happen, but the experiences of peer support during the course where supportive to the participants. The local branch told about the local possibilities with peer support in Pori.

The findings by Choudhury et al. (2008, 40-43) about the positive feelings towards the intervention, opportunity to discuss with others, learning of diabetes and self-management were similar to our findings. However, in the Choudhury et al. (2008, 40-43) study there was not clear behavior change but in our feedback questionnaire the participants reported making changes in their daily routines and attitude. Studies by Deng et al. (2016, 270-274), Fisher et al. (2012, 134-136) and Phillis-Tsimikas et al. (2011, 1928-1930) had findings about improved clinical outcomes during the interventions. We did not gather data to evaluate this and it was not possible because of the tight timeline.

8.2 Peer support and support for the local branch

Participants of the diabetes course felt that they got peer support and were able to change experiences with others. I think that our biggest innovation was that we decided to use peer support group leaders in this project; their enthusiasm towards the course and their own experiences about life with diabetes had an enormous impact in developing and implementing this course. The combination of peer support and professional knowledge was also been productive in Härkäpää et al. (2018, 155-156) study. Moreover, in the projects DEHKO and One life the peer support was seen as an important part of living with diabetes but one thing that affected on the continuing of the developed models were the lack of support from the professionals. In this new model we chose to pay attention to the support from the central organization.

The impact of the peer support group leaders was not asked directly from the participants. However, in the answers of the feedback questionnaire the atmosphere was seen positive and safe and the peer support group leaders were commented. In Fisher (2012, 134-136) peer supporters were seen as natural link to the community and in Streng (2014, 345) the learning was based on the interaction between the participants and the professionals, and peer support as an equal process between the participants. From my perspective the peer support group leaders were huge resource because they knew the local practices and professionals and that it eased my work as a project leader a lot. Moreover, Mäenpää (2014, 304) pointed out the importance of local connection in the planning as well. From the project groups viewpoint, it was important for us to be in contact and use the local health care professionals to ensure that things talked about in the course can be applied in the Pori area. The peer support group leaders had their own experience about diabetes which supported the conversation in the meetings. Peer support persons have the knowledge and experience as a people with diabetes which was detected to be positive thing in studies of Fisher et al. (2012, 134-136) and Philis-Tsimikas et al. (2011, 1927), as well.

8.3 Credibility of the research

As a project leader I was very lucky to have the project group working with me. Our strong point was multidisciplinary approach and collective creativity. Without the project group planning and implementing this development work would have been very difficult to do and one-sided. In this project it was possible that we, me and the project group, were bias because of the fact that we all wanted this model to succeed. Seeing the possibilities of this project was the force that kept us all going and trying our best. However, I think that we were critical towards the project. We all had different viewpoints to the development work, we had support from each other, and critical conversation flourished.

Based on our findings and communication between the project group our work did follow the path that was planned and respected the ethical issues regarding autonomy of the participants, avoiding harm, and data protection. As a project leader I tried to keep in mind all the time to talk with the project group from the things at hand and to

be open on every stage. I think the atmosphere of developing was open and interactive, though I did not ask any feedback from this. In my opinion our development work was done together with everyone participating and giving their best input.

The credibility of this research is in my opinion in a good level. We aimed for researching the things that we were supposed to research, and I think we managed to deliver this project very well. Writing a clear report about the proceeding of this project was a difficult task, but I think that by following this report the project could be repeated. The whole process has been planned and implemented with good quality and by following the research ethics. The development work and conclusions based on feedback have been done together with the project group, so there has been discussion about the process and the results which gives them more credibility. The deeper analysis of the whole process and writing this report are my doings based on the work that we have done together.

9 SUMMARY

As a result of good co-operation, we succeeded in giving keys to the participants for their self-management. However, we have to consider the fact that this course is one drop in the ocean. The care of diabetes and self-management are wider concept and the need for knowledge and support can be much larger than what we can provide through these open-formed courses. The time was limited in this course and its meetings. Nevertheless, this course can be one important part of one's life with diabetes and the idea is to offer knowledge and support in different form to support the counselling got from the healthcare.

In the future we need to develop and keep in mind that local planning is important and must be applied also in the future. Support for the peer support group leaders is important and they are great asset for the course atmosphere. One of the core topics in self-management of diabetes is nutrition and the importance of that was seen in this course. Including nutrition as one topic of the course must be considered in the future. Using the local professionals, we can have local knowledge and the course remains

cost-effective. The course content could be more interactive and involve some practical hints relating to the topics. Practical hints and exercises can help applying the knowledge in daily life and home tasks could be one idea to promote realization. We should add specific questions relating the length of the meetings to the feedback questionnaire. Peer support between the participants could be promoted by the introduction about the local branch in the beginning of the course and we could offer a possibility for a walk or something together with the group outside the course meetings.

As said in the Heikkinen (2007, 36) and Lapan (2012, 291-292) in the action research the understanding of the topic and its interpretation increases little by little. This happened also in our project. First, we did have basic knowledge and idea about the topic and in the end, we had increased our knowledge about planning and implementation of the course. We were able to follow the plan, keep the budget and timeframe. Good co-working, enthusiasm, and commitment of the project group participants and course participants made this all happen. With this knowledge guidelines were written for the future. Through these findings the FDA can continue the development work of these courses in the future with the local branches. Every open-formed local diabetes course organized is going to be different because of the area and the target group, but now we have the base to lean on.

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Palautekysely Diabeteskurssi Porissa syksy 2019

Tämä on palautekysely liittyen Suomen Diabetesliitto ry:n ja Porin Seudun DIabeetikot ry:n järjestämään diabeteskurssiin 26.9.-17.10.2019. Kyselyn avulla saatavaa palautetta käytetään opinnäytetyönä tehtävän diabeteskurssi -mallin kehittämiseen sekä raportointiin suostumuslomakkeessa kerrotulla tavalla. Kyselyyn vastataan nimettömästi.

Kyselyyn vastaaminen kestää noin 10 minuuttia.

1. Mistä sait tiedon diabeteskurssista?

◯ Sähköpostilla

◯ Hoitopaikastani

◯ Muualta, mistä? _____

2. Mikä sai sinut hakeutumaan diabeteskurssille?

_____

_____

_____

_____

_____

3. Mille diabeteskurssin kerroille osallistuit (yhteensä 4 tapaamiskertaa)?

☐ 1. kerta: Jalkojen terveys ja hyvä hoito

☐ 2. kerta: Liikunta ja diabetes

☐ 3. kerta: Omahoidossa jaksamisen voimavarat

☐ 4. kerta: Tyypin 2 diabetes ja sen omahoito

4. Vastaa väittämiin siitä, miten diabeteskurssin sisältö ja toteutus vastasivat odotuksiasi?

	Täysin samaa mieltä	Osittain samaa mieltä	Osittain eri mieltä	Täysin eri mieltä
Kurssin sisältö vastasi odotuksiani	◯	◯	◯	◯
Tapaamisten määrä oli sopiva	◯	◯	◯	◯
Tapaamisten kesto oli sopiva	◯	◯	◯	◯

	Täysin samaa mieltä	Osittain samaa mieltä	Osittain eri mieltä	Täysin eri mieltä
Sain tietoa omahoitoni tueksi	○	○	○	○
Opin soveltamaan saamaani tietoa	○	○	○	○
Koen, että kurssi on vaikuttanut suhtautumiseeni diabeteksen hoitoon	○	○	○	○
Keskusteluilmapiiri oli turvallinen	○	○	○	○
Minulla oli mahdollisuus vaihtaa kokemuksia muiden osallistujien kanssa	○	○	○	○
Sain vertaistukea	○	○	○	○
Toiveikkuuteni tulevaisuuden suhteen lisääntyi	○	○	○	○
Kurssi on lisännyt hyvinvointiani	○	○	○	○
Kokonaisuus vastasi odotuksiani	○	○	○	○

5. Tärkein oivalluksesi diabeteskurssin aikana?

_____
_____
_____
_____
_____

6. Miten diabeteskurssi on vaikuttanut omahoitoosi?

_____
_____
_____
_____
_____

7. Miten kehittäisit diabeteskurssin sisältöä ja toteutusta?

_____
_____
_____
_____
_____

8. Haluaisitko vielä lisätä jotain?

_____

_____

_____

_____

_____

9. Hyväksyn tietojeni käsittelyn tietosuojaselosteen mukaisesti, tietosuojaseloste löytyy täältä *

○ Hyväksyn

Diabeteskurssi Porissa
Tietoa kehittämisprojektin sisällöstä ja suostumus osallistumiseen.

Kehittämisprojektin yhteystiedot

Projektin vastuuhenkilö:
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Projektiryhmä:
Virpi Kohtamäki ja Taina Katiskalahti, Porin Seudun Diabeetikot ry
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Kehittämisprojektin tarkoitus ja tavoite

Kehittämisprojekti "Diabeteskurssi" tehdään opinnäytetyönä Diabetesliiton toimeksiannosta. Opinnäytetyön tekee järjestösuunnittelija Marianne Kukkasniemi osana kuntoutuksen YAMK-tutkintoa, joka suoritetaan Satakunnan ammattikorkeakoulussa. Projektin raportti tehdään englanninkielellä, koska koulutusohjelma on englanninkielinen (Master's Degree in Rehabilitation).

Kehittämisprojektin tarkoituksena on kehittää Diabetesliiton paikallisia palveluita. Yhtenä paikallisena palveluna voidaan tulevaisuudessa tarjota diabeteskurssia, jonka tavoitteena on tukea diabeetikon omahoitoa vertaistuen ja tiedon avulla. Projektissa kehitettävän diabeteskurssimallin avulla toimintaa voidaan laajentaa eri puolille Suomea.

Diabeteskurssi toteutetaan 26.9.-17.10.2019 Porissa yhteistyössä Porin Seudun Diabeetikot ry:n kanssa. Kurssiin sisältyy neljä tapaamista, joista jokainen kestää 2-3 tuntia. Tapaamisia paikan päällä ohjaa vertaistukiryhmänohjaajat ja jokaisella kerralla on eri ammattilaisen luento.

Kehittämisprojektin rahoittaa Suomen Diabetesliitto ry.

Osallistuminen

Osallistuminen diabeteskurssille (kehittämisprojektiin) on täysin vapaaehtoista. Diabeteskurssille hakeudutaan vapaaehtoisesti ilmoittautumalla ja osallistujat valitaan satunnaisesti ilmoittautuneiden joukosta, kunhan kriteerit (diabetestyyppi, ikä, alue) täyttyvät. Valituille ilmoitetaan valinnasta ja missä tahansa vaiheessa osallistuja voi keskeyttää osallistumisensa.

Vakuutukset

Diabeteskurssi on Diabetesliiton toimintaa. Diabetesliiton järjestämissä tapahtumissa, koulutuksissa ja kursseilla on voimassa osallistujien tapaturmavakuutus.

Projektissa kerättävän aineiston käyttötarkoitus, käsittely ja säilyttäminen

Projektissa kerättävää aineistoa käytetään diabeteskurssi-mallin kehittämiseen, projektin raportointiin ja jatkokehittämiseen nimettömästi ilman tunnistetietoja.

Projektissa kerätään tietoa kurssille osallistuvien henkilöiden kokemuksista. Kurssille ilmoittautuminen on vapaaehtoista. Ilmoittautumisen yhteydessä tallennetaan aineistorekisteriin henkilön nimi, syntymävuosi, sukupuoli, diabetestyyppi ja asuinpaikka. Ilmoittautumisen yhteydessä kerättyjä tietoja käytetään yleisellä tasolla projektista raportoitaessa kuten kurssille osallistujien määrä, sukupuolijakauma, osallistujien ikähaarukka, diabeteskurssin paikkakunta sekä osallistujien diabetestyyppi, yksilöityjä henkilötietoja ei käytetä raportoinnissa.

Projektissa kurssille osallistujilta kerättävää aineistoa ovat osallistujien kokemukset kurssista ja kehittämisehdotukset, jotka kerätään palautekyselyn avulla kurssin viimeisellä kerralla. Kokemukset ja kehittämisehdotukset projektin raportissa esitellään siten, että niistä ei voi yksittäisen henkilön vastauksia tunnistaa.

Kerättyä aineistoa säilytetään Diabetesliiton salasanalla suojatulla Sharepoint-verkkoasemalla. Sharepoint-verkkoasemalle on projektin aikana pääsy projektin vastuuhenkilöllä ja projektiryhmään kuuluvilla Diabetesliiton työntekijöillä. Webropol-ohjelmalla kerätään sekä ilmoittautumiset että nimettömänä täytettävä palautekysely. Palautekysely on mahdollista täyttää myös paperisena versiona. Webropol-ohjelman käyttöoikeus on rajattu salasanalla ja kyseisiä lomakkeita käsittelee projektin vastuuhenkilö.

Diabetesliitolla on käytössään tietosuojaselosteet ilmoittautumisiin ja palautteeseen liittyen. Tietosuojaselosteet ovat kaikkien saatavilla Diabetesliiton internet-sivuilla www.diabetes.fi/yhteiso/yhteystiedot/tietosuojaselosteet

Projektin päättymisen jälkeen aineisto ilman tunnistetietoja arkistoidaan Diabetesliiton Päättyneet projektit Sharepoint-verkkoasemalle, johon Diabetesliiton työntekijöillä on mahdollisuus päästä.

Suostumus

Olen tutustunut tämän kehittämisprojektin tavoitteeseen ja sisältöön sekä kerättävän aineiston käyttöön, osallistujien oikeuksiin ja vakuutusturvaan. Suostun osallistumaan projektiin annettujen ohjeiden mukaisesti. Voin halutessani peruuttaa tai keskeyttää osallistumiseni tai kieltäytyä osallistumisesta projektiin missä vaiheessa tahansa. Kerättyä aineistoa saa käyttää ja hyödyntää sellaisessa muodossa, jossa yksittäistä osallistujaa ei voi tunnistaa.

Suostumus allekirjoitetaan kahtena kappaleena, joista toinen jää osallistujalla ja toisen arkistoi projektin vastuuhenkilö.

___ / ___ /2019 _____
　　　　　　　　Paikka　　　　　Osallistujan allekirjoitus ja nimenselvennys

___ / ___ /2019 _____
　　　　　　　　Paikka　　　　　Projektin vastuuhenkilön allekirjoitus ja nimenselvennys

Kurssi tyypin 2 diabeetikoille syksyllä 2019

Kurssi toteutetaan yhteistyössä

Porin Seudun Diabeetikot ry:n ja Diabetesliiton kanssa.

1. Osallistujan tiedot

Etunimi	
Sukunimi	
Matkapuhelin	
Sähköposti	
Osoite	
Postinumero	
Postitoimipaik-ka	
Puhelin	

2. Sukupuoli

◯ Mies

◯ Nainen

◯ Muu

3. Syntymävuotesi

_____

4. Onko sinulla?

◯ Tyypin 2 diabetes, sairastuin vuonna
_____

◯ Muu, mikä _____

5. Oletko osallistunut Porin perusturvan tyypin 2 diabeetikoille suunnattuun ensitietoryhmään?

◯ Kyllä

◯ En

◯ En tiedä

6. Miksi haluat osallistua diabeteskurssille? Perustele lyhyesti.

7. Erikoisruokavalio/ruoka-aineallergia tai muuta huomioitavaa

8. Vahvistan hyväksyväni Diabetesliiton tietosuojakäytännöt *

◯ Hyväksyn tietosuojakäytännöt

DIABETESLIITON DIABETES.FI-SIVUSTOLLA TÄYTETTÄVÄT WEBROPOL-VERKKOLOMAKKEET

1. Rekisterinpitäjä ja yhteyshenkilö

Rekisterinpitäjä: Suomen Diabetesliitto ry
Osoite: Näsilinnankatu 26, 33200 Tampere
Puhelin: 03 2860 111
Tietosuojavastaava: Sari Koski, p. xxxxxx, sähköposti xxxxxx

2. Rekisteröidyt

Diabetesliiton diabetes.fi-verkkosivustolla Webropol-järjestelmässä ylläpidetyn verkkolomakkeen täyttäneet. Lomakkeella voidaan esimerkiksi ilmoittaa muutoksista jäsentiedoissa, ilmoittautua vertaistukiryhmään tai pyytää lisätietoja.

3. Henkilötietojen käsittelyn peruste ja käyttötarkoitus

Rekisterin käyttötarkoitus on lomakkeen täyttäneiden pyyntöihin vastaaminen.

4. Käsiteltävät henkilötiedot

Rekisterissä käsitellään lomakkeen täyttäneiden henkilötietoja, joita voivat olla:

- etu- ja sukunimi
- syntymäaika
- tieto diabeteksesta (tarvitaan esimerkiksi leirejä ja vertaistukiryhmiä varten)
- sähköpostiosoite
- puhelinnumero

5. Säännönmukaiset tietolähteet

Henkilötietoja kerätään rekisteröidyiltä itseltään verkkolomakkeella.

6. Henkilötietojen suojaaminen ja tietoturva

Henkilötiedot on tallennettu Webropol Oy:n ylläpitämille palvelimille, joiden suojaamisesta ja tietoturvasta huolehtii Webropol yhdessä alihankkijoidensa kanssa.

Henkilötietoja ylläpidetään Webropol-järjestelmässä, jonka käyttöoikeus on Diabetesliiton henkilökuntaan, sekä Webropolin henkilökuntaan kuuluvilla erikseen nimetyillä henkilöillä, joiden työtehtäviin järjestelmän ylläpito kuuluu. Myös videovälitteisen vertaistukiryhmän vetäjillä on käyttöoikeus tietoihin. Käyttöoikeudet on suojattu käyttäjätunnuksella ja salasanalla.

7. Henkilötietojen säännönmukaiset luovutukset ja siirrot

Henkilötietoja ei luovuteta tai siirretä.

8. Henkilötietojen siirrot Euroopan unionin tai Euroopan talousalueen ulkopuolelle

Henkilötietoja ei siirretä Euroopan unionin tai Euroopan talousalueen ulkopuolelle.

9. Henkilötietojen säilytysaika

Henkilötietoja säilytetään enintään 6 kk lomakkeen lähettämisestä, vertaistukiryhmän päättymisen jälkeen tiedot poistetaan.

10. Rekisteröidyn oikeudet

Diabetesliitto ei luovuta rekisteröidyn henkilötietoja kolmansille tahoille, eikä käytä henkilötietoja suoramarkkinointitarkoituksiin.

Rekisteröidyllä on lähtökohtaisesti oikeus soveltuvan tietosuojalainsäädännön mukaisesti:

- saada tieto henkilötietojensa käsittelystä
- saada pääsy omiin tietoihinsa ja tarkastaa itseään koskevat Diabetesliiton käsittelemät henkilötiedot
- vaatia epätarkan ja virheellisen henkilötiedon oikaisua ja tietojen täydentämistä
- vaatia henkilötietojensa poistamista
- peruuttaa suostumuksensa ja vastustaa henkilötietojensa käsittelyä siltä osin kuin henkilötietojen käsittely perustuu rekisteröidyn suostumukseen
- vastustaa henkilötietojensa käsittelyä henkilökohtaiseen erityiseen tilanteeseensa liittyvällä perusteella siltä osin kuin henkilötietojen käsittelyperusteena on Diabetesliiton oikeutettu etu
- saada henkilötietonsa koneluettavassa muodossa ja siirtää kyseiset tiedot toiselle rekisterinpitäjälle edellyttäen, että rekisteröity on itse toimittanut kyseiset henkilötiedot Diabetesliitolle, Diabetesliitto käsittelee kyseisiä henkilötietoja rekisteröidyn suostumuksen perusteella ja käsittely suoritetaan automaattisesti
- vaatia henkilötietojensa käsittelyn rajoittamista.

Rekisteröidyn tulee esittää edellä mainitun oikeuden toteuttamista koskeva pyyntö tämän tietosuojaselosteen Yhteydenotot-kohdan mukaisesti. Diabetesliitto voi pyytää rekisteröityä tarkentamaan pyyntöään kirjallisesti ja varmentamaan rekisteröidyn henkilöllisyyden ennen pyynnön käsittelemistä. Diabetesliitto voi kieltäytyä pyynnön toteuttamisesta sovellettavassa laissa säädetyllä perusteella.

11. Oikeus valittaa valvontaviranomaiselle

Jokaisella rekisteröidyllä on oikeus tehdä valitus asianomaiselle valvontaviranomaiselle taikka sen Euroopan unionin jäsenvaltion valvontaviranomaiselle, jossa rekisteröidyn asuinpaikka tai työpaikka sijaitsee, mikäli rekisteröity katsoo, että hänen henkilötietojaan ei ole käsitelty soveltuvan tietosuojalainsäädännön mukaisesti.

12. Yhteydenotot

Rekisteröidyn oikeuksien käyttämistä koskevat pyynnöt, kysymykset tästä tietosuojaselosteesta ja muut yhteydenotot tulee tehdä sähköpostitse: tietosuoja(at)diabetes.fi.

Rekisteröity voi myös ottaa yhteyttä henkilökohtaisesti tai kirjallisesti alla olevaan osoitteeseen:

Suomen Diabetesliitto
Tietosuoja
Näsilinnankatu 26
33200 Tampere

13. Muutokset tähän tietosuojaselosteeseen

Tätä tietosuojaselostetta voidaan päivittää aika ajoin esimerkiksi lainsäädännön muuttuessa. Tämä tietosuojaseloste on viimeksi päivitetty 24.9.2018.

Kurssin aiheet ja aikataulu

Suunniteltu aikataulu kesäkuu 2019

Torstai 26.9.   Omahoidossa jaksamisen voimavarat
Torstai 3.10.   Liikunta ja diabetes
Torstai 10.10   Jalkojen terveys ja hyvä hoito
Torstai 17.10.   Tyypin 2 diabetes ja sen omahoito

Toteutunut aikataulu syys-lokakuu 2019

To 26.9. klo 17.00 – 19.45
Tyypin 2 diabetes ja sen omahoito

To 3.10. klo 17.00- 19.30
Liikunta ja diabetes

To 10.10. klo 17.00 – 19.30
Omahoidossa jaksamisen voimavarat - mitä voit tehdä itse?

To 17.10. klo 17.00 – 19.45
Jalkojen terveys ja hyvä hoito

Ohjeistus jokaiselle tapaamiskerralla:

To 26.9. klo 17.00-19.45 Tyypin 2 diabetes ja sen omahoito

Klo 17.00 aloitetaan, Marianne kertoo opinnäytetyöhön liittyvät asiat, mikä on Tainan ja Virpin rooli vertaistukiohjaajina, eivät ammattilaisen roolissa vaan hoitoon liittyvät kysymykset ohjataan esittämään omalle lääkärille, hoitajalle. Säännöt, poissaolot ilmoitetaan Mariannelle, salassapito.

17.15 Ryhmäytyminen: Etunimi-/lempinimiesittely. Ryhmiin jakautuminen korttien avulla (Marianne tuo) kolme 4 hlön ryhmää. Ryhmäläiset selvittävät kaikille 4 yhteistä asiaa, mitkä liittyvät 1) arjen tekemiseen 2) harrastuksiin 3) kiinnostuksen kohteisiin. Ei sairauksiin liittyviä asioita. Nämä kerrotaan muille ryhmille.

17.30 luento

18.30 kahvit, keskustelua,

19.20 ryhmän päätös
Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia)

19.35 Lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.45 Kiitos ja hyvää kotimatkaa 🙂

To 3.10. klo 17.00-19.30 Liikunta ja diabetes

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jakaudutaan: jako kolmeen
1) Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin.

17.15 Luento

18.15, kahvit, keskustelua,

19.00 ryhmän päätös
Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia)

19.20 lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.30 Kiitos ja hyvää kotimatkaa 🙂

To 10.10. klo 17.00-19.30 Omahoidossa jaksamisen voimavarat - mitä voit tehdä itse?

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jako korttien avulla (samat, mitä ekalla kerralla käytettiin)
1) Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin?

17.15 Luento

18.15 kahvit, keskustelua

19.00 ryhmän päätös
Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia)

19.20 Lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.30 Kiitos ja hyvää kotimatkaa 🙂

To 17.10. Jalkojen terveys ja hyvä hoito

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jako: jako kolmeen
1) Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin?

17.15 Luento

18.15 kahvit, keskustelua

19.00 Palautekyselyn täyttäminen

19.20 Ryhmän päätös
Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia),

19.35 Lopuksi palataan omalle paikalle ja kerrotaan muutamalla sanalla, mitä kurssista jäi päällimmäiseksi mieleen

19.45 Kiitos ja hyvää kotimatkaa 🙂

Tyypin 2 diabetes ja sen omahoito.

Liikunta ja diabetes.

Jalkojen terveys ja hyvä hoito.

Omahoidossa jaksamisen voimavarat – mitä voit tehdä itse.

Haluaisitko oppia lisää ja saada käytännön vinkkejä diabeteksesi hoitoon?

Tule mukaan Porin seudun tyypin 2 diabeetikoiden kurssille syys-lokakuun 2019 vaihteessa!

Kurssin tavoitteena on tarjota tietoa ja vertaistukea tyypin 2 diabeteksen omahoidon tueksi. Tapaamisia on neljä, ja jokaisella tapaamiskerralla on varattu aikaa sekä asiantuntijan luentoon että yhteiseen keskusteluun ryhmän kesken.

Tapaamiset pidetään Porin Seudun Diabeetikot ry:n tiloissa viikoilla 39–42 torstaisin klo 17–20, aikataulu tarkentuu vielä syksyllä.

Kurssi toteutetaan yhteistyössä Porin Seudun Diabeetikoiden ja Diabetesliiton kanssa. Kurssi on osa opinnäytetyötä, jossa kehitetään uutta paikallista toimintamallia diabeetikoiden hyvinvoinnin tueksi. Osallistuessasi kurssille osallistut myös toiminnan kehittämiseen.

Kurssi on maksuton, ja kurssille otetaan 12 henkilöä. **Ilmoittaudithan 31.8.2019 mennessä** https://link.webropolsurveys.com/EP/16D4BF314ECCF00E

Lisätietoja kurssista saat Diabetesliiton järjestösuunnittelijalta Marianne Kukkasniemeltä, marianne.kukkasniemi@diabetes.fi tai p. 050 465 3703 ja Porin Seudun Diabeetikot ry:n sivuilta

www.porinseudundiabeetikot.fi/

Porin Seudun Diabeetikot

diabetesliitto

Diabeteskurssi Porissa

Tietoa kehittämisprojektin sisällöstä ja suostumus osallistumiseen.

Kehittämisprojektin yhteystiedot

Projektin vastuuhenkilö:
Marianne Kukkasniemi
Järjestösuunnittelija, Suomen Diabetesliitto ry
Näsilinnankatu 26, 33200 Tampere
puh. 050 465 3703
sähköpostiosoite marianne.kukkasniemi(at)diabetes.fi

Projektiryhmä:
Virpi Kohtamäki ja Taina Katiskalahti, Porin Seudun Diabeetikot ry
Anneli Jylhä ja Kirsi Heinonen, Suomen Diabetesliitto ry

Kehittämisprojektin tarkoitus ja tavoite

Kehittämisprojekti Diabeteskurssi tehdään opinnäytetyönä Diabetesliiton toimeksiannosta. Opinnäytetyön tekee järjestösuunnittelija Marianne Kukkasniemi osana kuntoutuksen YAMK-tutkintoa, joka suoritetaan Satakunnan ammattikorkeakoulussa. Projektin raportti tehdään englanninkielellä, koska koulutusohjelma on englanninkielinen (Master's Degree in Rehabilitation).

Kehittämisprojektin tarkoituksena on kehittää Diabetesliiton paikallisia palveluita. Yhtenä paikallisena palveluna voidaan tulevaisuudessa tarjota diabeteskurssia, jonka tavoitteena on tukea diabeetikon omahoitoa vertaistuen ja tiedon avulla. Projektissa kehitettävän mallin avulla toimintaa voidaan laajentaa eri puolille Suomea.

Diabeteskurssi toteutetaan syksyllä 2019 Porissa yhteistyössä Porin Seudun Diabeetikot ry:n kanssa. Kurssiin sisältyy neljä tapaamista, joista jokainen kestää 2-3 tuntia. Tapaamisia paikan päällä ohjaa vertaistukiryhmänohjaaja ja jokaisella kerralla on eri ammattilaisen luento.

Kehittämisprojektin rahoittaa Suomen Diabetesliitto ry.

Osallistuminen

Osallistuminen kehittämisprojekti diabeteskurssille on täysin vapaaehtoista. Diabeteskurssille hakeudutaan vapaaehtoisesti ilmoittautumalla ja osallistujat valitaan satunnaisesti ilmoittautuneiden joukosta, kunhan kriteerit (diabetestyyppi, ikä, alue) täyttyvät. Kurssille valituille ilmoitetaan valinnasta ja missä tahansa vaiheessa kurssia osallistuja voi keskeyttää osallistumisensa.

Vakuutukset

Diabeteskurssi on Diabetesliiton toimintaa. Diabetesliiton järjestämissä tapahtumissa, koulutuksissa ja kursseilla on voimassa osallistujien tapaturmavakuutus.

Suostumus

Osallistujan suostumus kehittämisprojekti Diabeteskurssille allekirjoitetaan kurssin ensimmäisellä tapaamisella kahtena kappaleena, joista toinen jää osallistujalla ja toisen arkistoi projektin vastuuhenkilö.

Projektissa kerättävän aineiston käyttötarkoitus, käsittely ja säilyttäminen

Projektissa kerätään tietoa kurssille osallistuvien henkilöiden kokemuksista. Kurssille ilmoittautuminen on vapaaehtoista. Ilmoittautumisen yhteydessä tallennetaan aineistorekisteriin henkilön nimi, syntymävuosi, sukupuoli, diabetestyyppi ja asuinpaikka. Ilmoittautumisen yhteydessä kerättyjä henkilötietoja käytetään yleisellä tasolla projektista raportoitaessa. Raportoitaessa projektista esille tulee osallistujien määrä, sukupuoli, osallistujien ikähaarukka, diabeteskoulun paikkakunta sekä diabetestyyppi.

Projektissa kerättävää aineistoa ovat osallistujien tavoite ja tavoitteen toteutuminen sekä palautekyselyn vastaukset.

Kerättyä aineistoa säilytetään Diabetesliiton salasanalla suojatulla Sharepoint-verkkoasemalla. Sharepoint-verkkoasemalle on projektin aikana pääsy projektin vastuuhenkilöllä ja projektiryhmään kuuluvilla Diabetesliiton työntekijöillä. Webropol-ohjelmalla kerätään sekä ilmoittautumiset että palautekysely. Webropol-ohjelman käyttöoikeus on rajattu salasanalla ja kyseisiä lomakkeita käsittelee projektin vastuuhenkilö. Projektissa kerättävää aineistoa käytetään projektiryhmässä mallin kehittämiseen, projektin raportointiin ja jatkokehittämiseen nimettömästi ilman tunnistetietoja.

Diabetesliitolla on käytössään tietosuojaselosteet ilmoittautumisiin ja palautteeseen liittyen. Tietosuojaselosteet ovat kaikkien saatavilla Diabetesliiton internet-sivuilla www.diabetes.fi/yhteiso/yhteystiedot/tietosuojaselosteet

Projektin päättymisen jälkeen aineisto sekä suostumuslomakkeet arkistoidaan Diabetesliiton Päättyneet projektit Sharepoint-verkkoasemalle, johon Diabetesliiton työntekijöillä on mahdollisuus päästä.

Haluaisitko oppia lisää ja saada käytännön vinkkejä diabeteksesi hoitoon?

Tule mukaan tyypin 2 diabeetikoille suunnatulle kurssille syys-lokakuun 2019 vaihteessa!

Kurssin tavoitteena on tarjota tietoa ja vertaistukea tyypin 2 diabeteksen omahoidon tueksi. Tapaamisia on neljä ja jokaisella tapaamiskerralla on varattu aikaa sekä asiantuntijan luentoon että yhteiseen keskusteluun ryhmän kesken. Kurssin aiheita ovat:
- Jalkojen terveys ja hyvä hoito
- Liikunta ja diabetes,
- Omahoidossa jaksamisen voimavarat - mitä voit tehdä itse?
- Tyypin 2 diabetes ja sen omahoito

Tapaamiset pidetään Porin Seudun Diabeetikot ry:n tiloissa viikoilla 39-42 torstaisin klo 17-20, aikataulu tarkentuu vielä syksyllä.

Kurssi toteutetaan yhteistyössä Porin Seudun Diabeetikoiden ja Diabetesliiton kanssa. Kurssi on osa opinnäytetyötä, jossa kehitetään uutta paikallista toimintamallia diabeetikoiden hyvinvoinnin tueksi. Osallistuessaan kurssille, osallistuu myös toiminnan kehittämiseen. Osallistuminen kurssille on vapaaehtoista.

Kurssi on maksuton ja kurssille otetaan 12 henkilöä. Ilmoittautuminen 31.8.2019 mennessä **tähän linkki ilmoittautumislomakkeelle**

Lisätietoja kurssista ja osallistumisesta toiminnan kehittämiseen saa liitteestä Tiedote sekä Diabetesliiton järjestösuunnittelija Marianne Kukkasniemeltä, marianne.kukkasniemi@diabetes.fi tai p. 050 465 3703 ja Porin Seudun Diabeetikot ry:n sivuilta
Tiedote liitteenä tähän loppuun.

Paikallinen avomuotoinen diabeteskurssi yhteistyössä yhdistyksen kanssa; vaiheet ja vastuut.

Perustuu Allergia-, Iho- ja Astmaliitto ry:n avomuotoisen sopeutumisvalmennuskurssin malliin.

Suunnittelu

- Millä tahansa diabetesyhdistyksellä on mahdollisuus järjestää diabeteskurssi alueellaan yhteistyössä Diabetesliiton kanssa. Diabetesliitto informoi aktiivisesti mahdollisuudesta ja kumpi tahansa; yhdistys tai keskusjärjestö voi tehdä aloitteen kurssin järjestämiseksi.
- Sovitaan yhteinen suunnittelutapaaminen, jossa päätetään
  - teema ja aikataulu (huomioidaan paikallinen tarve)
  - kohderyhmä (lapset/ perheet/ aikuiset)
  - kurssin tavoitteet
  - ketkä toimivat kurssin vertaistukiohjaajina
  - kurssin runko ja ohjelma
    - luennoitsijat, verkkoluennot, tilat, tarjoilut, hakulomakkeet määritellään vastuut (mitä keskusjärjestö hoitaa ja mitä yhdistys)
    - keskusjärjestö varaa luennoitsijat
    - yhdistys varaa tilat ja tarjoilut
  - sovitaan markkinoinnista (sähköposti, some, julisteet, lehti-ilmoitus jne., paikallinen terveydenhuolto)
  - sovitaan raportoinnista
- Kurssille osallistujia 6-12 riippuen kurssin teemasta ja sisällöstä, diagnoosista jne.
  - kurssista ilmoitettaessa kerrotaan kurssille valintakriteerit sekä miten ja millä perusteella valinnat tehdään
  - keskusjärjestö ottaa vastaan ilmoittautumiset, huolehtii kurssivalinnoista ja kurssilaisten informoinnista
- Kustannuksista huolehtii keskusjärjestö ja laskut voidaan lähettää suoraan keskusjärjestölle, jos mahdollista. Hyväksyttäviä kustannuksia ovat muun muassa:
  - kurssin tilavuokra ja tarjoilut (kohtuullinen kustannus)
  - luennoitsijapalkkiot

Toteutus

- Tehdään jokaiselle kurssin tapaamiselle käytännön suunnitelma toteutuksesta esimerkiksi Liite 1. sekä jokaisen kerran pienryhmäkeskustelun kysymykset jaettavaksi ryhmäläisille ks. Liite 2.
- Keskusjärjestön työntekijä ohjaa ensimmäisen tapaamisen, muut kurssin tapaamiskerrat ohjaavat vertaistukiohjaajat
  - Yhteydenpito vertaistukiohjaajien ja keskusjärjestön välillä oltava helppoa → tuki ja yhdessä suunnittelu, sovitaan yhdessä, miten pidetään yhteyttä
- Materiaalia keskusjärjestöstä (esitteet, verkkoluennot, videot yms.)
- Viimeisellä kerralla palautekysely (keskusjärjestö).

Kurssin jälkeen

- Purkukeskustelu keskusjärjestön, yhdistyksen ja kurssin vertaistukiohjaajien kanssa; mikä onnistui, mitä pitää huomioida ensi kerralla jne.
- Seurantakysely 3 kk kurssista, keskusjärjestö huolehtii tästä. Tavoitteena selvittää onko kurssilla ollut vaikutusta osallistujan arkeen pidemmällä ajanjaksolla.

LIITE 1.

Ohjeistus jokaiselle tapaamiskerralla, esimerkki aikataulusta:

Päivämäärä, kellonaika, aihe

Klo 17.00 TERVETULOA! Kerrotaan lyhyesti kurssista, paikallisesta yhdistyksestä ja Diabetesliitosta sekä vertaistukiohjaajien roolista; eivät ammattilaisen roolissa vaan hoitoon liittyvät kysymykset ohjataan esittämään omalle lääkärille, hoitajalle. Yhteiset säännöt ja salassapito sekä kenelle ilmoitetaan poissaoloista.

17.15 Ryhmäytyminen: Etunimi-/lempinimiesittely. Ryhmiin jakautuminen korttien avulla kolme 4 hlön ryhmää. Ryhmäläiset selvittävät kaikille 4 yhteistä asiaa, mitkä liittyvät 1) arjen tekemiseen 2) harrastuksiin 3) kiinnostuksen kohteisiin. Ei sairauksiin liittyviä asioita. Nämä kerrotaan muille ryhmille.

17.30 luento

18.30 kahvit, keskustelua,

19.20 ryhmän päätös
→ Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia) Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

19.35 Lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.45 Kiitos ja hyvää kotimatkaa 🙂

Päivämäärä, kellonaika, aihe

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jakaudutaan kolme 4 hlön ryhmää: jako kolmeen

Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin. Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

17.15 Luento

18.15, kahvit, keskustelua

19.00 ryhmän päätös
→ Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia). Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

19.20 lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.30 Kiitos ja hyvää kotimatkaa 🙂

Päivämäärä, kellonaika, aihe

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jako (kolme 4 hlön ryhmää) merkattujen nimilappujen avulla.

Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin? Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

17.15 Luento

18.15 kahvit, keskustelua

19.00 ryhmän päätös
→ Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia) Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

19.20 Lopuksi palataan omalle paikalle ja kerrotaan yhdellä sanalla, mitä kerrasta jäi päällimmäiseksi mieleen

19.30 Kiitos ja hyvää kotimatkaa 😊

Päivämäärä, kellonaika, aihe

klo 17.00 Tervetuloa! Pienryhmissä keskustelua, miten muutostavoitteet toteutuivat. Ryhmiin jako kolme 4 hlön ryhmää: saa itse päättää mihin ryhmään tällä kertaa haluaa

Miksi toteutui? 2) Miksi ei? 3) Mitä tekisin toisin? Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

17.15 Luento

18.15 kahvit, keskustelua

19.00 Palautekyselyn täyttäminen

19.20 Ryhmän päätös
→ Alun pienryhmä kokoontuu yhteen ja pohtii, mitä kokoontumisen aikana opittua/pohdittua kukin aikoo siirtää arkeensa (konkreettisia, pieniä muutoksia). Kysymykset jaetaan jokaiselle ryhmälle muistin tueksi ja lopussa kerätään pois.

19.35 Lopuksi palataan omalle paikalle ja kerrotaan muutamalla sanalla, mitä kurssista jäi päällimmäiseksi mieleen

Palautelomakkeen täyttäminen.

19.45 Kiitos ja hyvää kotimatkaa 😊

Esimerkki – Kysymykset pienryhmiin:

Tutustuminen ensimmäisellä kerralla:

Etunimi-/lempinimiesittely. Ryhmäläiset selvittävät kaikille 4 yhteistä asiaa, mitkä liittyvät (ei sairauksiin liittyviä asioita):

1) *arjen tekemiseen*
2) *harrastuksiin*
3) *kiinnostuksen kohteisiin.*

Seuraavien tapaamisten alussa pienryhmän kysymykset jokaiselle ryhmälle yksi lappu tulostettuna:

1) *Miten viime kerralla asettamasi muutostavoitteet toteutuvat?*
2) *Miksi toteutui?*
3) *Miksi ei?*
4) *Mitä tekisin toisin?*

Kurssitapaamisten lopuksi pienryhmille esitettävät kysymykset; jokaiselle ryhmälle yksi lappu tulostettuna:

1) *Mitä tänään opitusta/kuullusta/yhdessä pohditusta siirrät omaan arkeesi?*

   Konkreettisia asioita.