

## Supplementary File

Country/State/City	Focus of the program	Population	Setting
Alabama	Diabetes management for African Americans with poorly controlled (A1c >7.5) type 2 diabetes; telephone intervention supplemented with monthly support groups over 12 months	Rural low-income African Americans with Type 2 diabetes	Community based/clinic. Participants were recruited from a local safety-net primary care clinic
California	Peer support for diabetes self-management of Latino adults with A1c levels >7	Latino adults > 18 years with Type 2 diabetes	Non-profit community clinic/ Federally Qualified Health Center (Clinicas de Salud del Pueblo, Inc)
Cambodia	Diabetes self-management	Rural and urban adults over 18 years with Type 2 diabetes	Community based organization
Cameroon	Diabetes management for adults with poorly controlled diabetes (HbA1c >7)	Urban adults with Type 2 diabetes	Participants recruited from hospital but peer support activities within the community
Illinois	Diabetes self-management and regular, appropriate care	Latino adults with type 2 diabetes	Federally Qualified Health Centers (FQHC)
Hong Kong	Frequent contacts via a telephone based peer support program to improve cardiogenic risk and health outcomes by enhancing psychological well-being and self-care in patients	Adult patients with Type 2 diabetes	3 publicly funded hospital-based diabetes centers
Thailand	Diabetes conversation map	Urban adults with type 2 diabetes	Hospital
Uganda	Peer support for adults with diabetes to test the feasibility and short-term impact on perceptions of social support, psychological well-being and glycemic control through engaging participants in diabetes self-care behaviors and fostering linkages to healthcare providers	Adults in rural Uganda with Type 2 diabetes	Rural district hospital
Vietnam	Diabetes self-management support intervention for adults 30 years or older with poorly controlled diabetes (HBA1c>7 in most recent 3 months)	Urban adults with Type 2 diabetes	University research center

Table 1: Description of the Peer Support Programs.

<p>A. Differences in Type of Support Provided By and To Female and Male Participants</p> <ol style="list-style-type: none"> <li>1. How would you describe the support provided by male and female peer supporters or differences in the support they provide in relation to:                             <ol style="list-style-type: none"> <li>a. Assistance with daily disease management?</li> <li>b. Emotional support?</li> <li>c. Linkage to clinic care and community resources?</li> <li>d. What about ongoing support?</li> </ol> </li> <li>2. In general, how did men and women differ in providing support?</li> <li>3. What, if anything, affected how men and women provided support?</li> <li>4. What if anything affected how men and women received or responded to support?</li> </ol>
<p>B. Differences in Participation of Female and Male Peer Supporters</p> <ol style="list-style-type: none"> <li>1. Over the course of the program, were there differences in how the male and female peer supporters participated? Please describe?</li> <li>2. Were there trends in participation over time? If so, did they vary by gender?</li> <li>3. What, if anything, worked in dealing with these gender differences? Please tell me more about this?</li> </ol>
<p>Is there anything else you'd like to add that we haven't talked about?</p>

Table 2: Interview questions.

Differences in Emotional Support	<p>“But what I would observe when the female would be on the phone is that I think they might have offered more social and emotional support.”</p> <p>“Female peer leaders provided the assistance with social and emotional support better than male peer leaders.”</p> <p>“The female peer supporters showed a greater sense of empathy probably due to the mother and caretaker role which they already occupied in normal day-to-day life.”</p> <p>“Perhaps female peer educators provide in general a softer voice to educate other members in their peer group.”</p> <p>“Female supporters might be more capable of providing emotional support, because they are more emotional themselves.”</p> <p>“In most households, women occupy the role of caregivers and are generally more likely to be the ones to modify their usual schedule to care for any sick relative.”</p> <p>“So...they would pick up on cues and be able to say, ‘you know, you don’t sound too good. Is everything ok?’”</p> <p>“You sound like really tired; your energy level sounds really low. What’s going on?”</p> <p>“They would be really good about trying to pick up on cues where they think there may be something going on with the patient socially and emotionally.”</p> <p>“We assigned the most effective peer supporters to men. These were usually women who were very caring, had a very soothing voice but who were also effective in holding people accountable.”</p> <p>“For social and emotional support, female are more likely to provide this support more than male. For example, when the one come in and look so tired female mostly say hi and ask that one do you have any problem today. Or the one look so happy they ask like what is your happy news something like this.”</p> <p>“Female participants were more likely to come to support groups and talk socially than male participants.”</p> <p>“Not to say that men don’t need social and emotional support, but I don’t know if they could express that need for social and emotional support as easily as – I think it’s harder for men than women to show that they have that need. But I feel like more social and emotional support was provided to women. Not that they need more of it, but they do a better job of expressing that they have that need for social and emotional support than men do.”</p> <p>“Female patients are often responsible for taking care of children/grandchildren, so they are more likely to be like a mom to their peers.”</p> <p>“Female peer supporters seemed to express more empathy and sympathy and used statements like ‘I understand’ and ‘I know this can be challenging’ more often than males.”</p> <p>“I would say that female peer supporters offered more social and emotional support by expressing more feelings of empathy and sympathy and also giving names of support organizations more often. They seemed more patient and would give patients/peers more time to talk about their problems (aka “desahogarse” in Spanish).”</p> <p>“Emotional impact of diabetes is more prominent among the women whereas men rarely discuss emotional side effects beyond diabetes impact on sexual function.”</p> <p>“More female peer leaders reflected that they felt happy and comfortable to talk and discuss with their partners. Besides, it found that female peer leaders’ moods were affected from health status and feeling of their partners.”</p> <p>“More participants in the intervention group evaluated their female peer leaders as kind, good, happy, friendly, optimistic, and sincerely persons who gave them many useful information, advice and great motivations to overcome barriers to diabetes self-care, as well as softened their suffering from illness and linkage them with health clinic any time.”</p>
Differences in Instrumental Support	<p>“Males didn’t spend as much time as females in establishing rapport. They would get into sharing information more quickly- they wanted to offer something concrete like information.”</p> <p>“From my experience, the male supporters (middle age) are more proactive and confidence in giving information to peers.”</p> <p>“If the topic is related to hard exercise like jogging male are givers more than female.”</p> <p>“In my project, it seems male supporters are more engaged and consistent in information sharing.”</p> <p>“Male participants received more directed goal setting and problem solving.”</p> <p>“For male they mostly share knowledge for others but not prepare or provide any material for the others.”</p> <p>“Male leaders liked to meet peer partners directly (face to face) and provide information.”</p> <p>“For male they mostly share knowledge for others but not prepare or provide any material for the others.”</p> <p>“Male participants [i.e., peer supporters] are much more straightforward with diabetes strategies (e.g., go to the doctor, take your medicines, eat right, and exercise).”</p> <p>“I don’t think there was gender differences specific to helping them with their daily disease management with regards to checking your glucose, understanding your glucose results, understanding side effects of insulin, what they needed to eat/not eat, portion sizes. I don’t think so.”</p>

Table 3: Continuing..

<p>Who is a Peer Supporter?</p>	<p>“Hispanic women tend to seek out health services much more readily than men do; that is something that I’ve observed and I’ve heard others also communicate that in their observations.”</p> <p>“More women than men see themselves as the primary caregivers in the Latino community and therefore they are more likely to offer support to others.”</p> <p>“Latino males I think traditional gender roles where men are -- I think maybe seeking out health services may be seen as a weakness and men are not supposed to appear weak.”</p> <p>“More women than men on staff at our clinics, 27 of 28 peer supporters were women.”</p> <p>“People in the Hispanic community (male and female included) are more used to receiving education or support services from a woman.”</p> <p>“If support is offered in the home, a woman feels much more comfortable receiving it from another woman.”</p> <p>“If a man is a peer supporter or educator, he would have to be accompanied by a woman if visiting a female patient in order for the female patient to feel comfortable and for her spouse/partner to not get suspicious of his intentions.”</p> <p>“We only had one peer supporter that was a male out of the group of eight or nine. I think that the end we might have lost one or two people. So it was really one and the rest were women peer supporters.”</p> <p>“We have not had any success recruiting a male peer supporter/CHW. I know other programs have had some limited success.”</p> <p>“Our male peer supporter ended up not being as dedicated (mostly because of work obligations) as other peer supporters and so some of the patients assigned to him had to be reassigned to someone else.”</p> <p>“The majority of PE who are volunteering with organization are male (71%).”</p> <p>“In my peer support project, 15 out of the 23 peer supporters are male, and two out of eight female peer supporters dropped out in the middle. Only one male supporter dropped out. When they made the commitment, male supporters were more responsible.”</p> <p>“If the supporter is much younger than the peer, the peer might doubt their capability and experiences, unless the younger peer has much longer diabetes duration and claim this on the first phone call.”</p> <p>“MoPoTsyo peer support program consider selection of new Peer Educators by providing opportunity to female in its coverage areas. But some barriers such as family burden, low education background and social discouragement maybe affect negatively their involvement as Peer Educator.”</p> <p>“In general, is more difficult to find literate women than men in the age group (50+) from which we employ the Peer Educators, new generation of educated women is not yet diabetic. MoPoTsyo has encouraged female to involve in program planning in selecting PE by provide high priority to choose female first. In practice, more females are sharing less time to join any activity in program.”</p> <p>“Some barriers such as family burden, low education background and social discouragement maybe as affect to their involvement as PE.”</p> <p>“Working as PE requires sometimes travel and work independently out from their home such as meeting, peer home visit, and stay over nights for training far from home. So the other household members and the female are not allowed to join those activities because traditional society unfortunately still considers females as home based workers.”</p> <p>“Men in our study were more likely to be engaged in work that involved travel. Men had higher education levels than women. One problem that arose was that men who had to travel were not available to participate as a peer supporter as consistently as others and several dropped out of the study for this reason.”</p>
<p>Matching Peer Supporters and Support Recipients by Gender</p>	<p>“We paired participants in dyads and triads and avoided male/female dyads.”</p> <p>“So we really made a conscious effort to give that one male peer supporter male patients. However, the female peer supporters - that didn’t really come into play so much. Like we weren’t trying to intentionally give them all women and no men.”</p> <p>“There were times where the patients would come into the clinic and see their peer supporter one-on-one since they would already be in the clinic and do whatever follow-up they needed to with that peer supporter and whatnot. And so traditionally because of like very traditional gender roles and things like that - we didn’t want to go down that road where people would question why a female patient had a male peer supporter and what’s going on with that male peer supporter and why are you guys meeting in a private office, because that happens.”</p> <p>“Our patients – a lot of them have immigrated into this country so bring with them, still, this very way of thinking. And so – and I’ve seen it in other work places - we didn’t want to provide any opportunity for those kind of tensions to possibly happen within a family.”</p> <p>“And a lot of times, a lot of their contact with patients was over the phone so we didn’t want the male partner of a female patient thinking why is this person – this male person at Alivio – calling you constantly. So we didn’t want to offer any opportunity for that to possibly happen.”</p> <p>“We assigned only male patients to male peer supporters. For women peer supporters, patients were assigned to them regardless of gender. We just tried to match them to those that lived closest to them.”</p>

Table 3: Continuing..

	<p>“If support is offered in the home, a woman feels much more comfortable receiving it from another woman. If a man is a peer supporter or educator, he would have to be accompanied by a woman if visiting a female patient in order for the female patient to feel comfortable and for her spouse/partner to not get suspicious of his intentions.”</p> <p>“Some physical problems and symptoms that patients experience maybe directly related to their sex, male or female. That can make it difficult if the patient wants to talk with their peer educator to ask advice if the peer educator is from the opposite sex. That is why we always want to create groups of patients, because within the groups women can discuss with women and men with men.”</p> <p>“Participants in control and intervention groups were sex-matched.”</p> <p>“Some women, especially those from the Northern part of the country, feel rather uncomfortable to express themselves or even sit in the presence of men so it was anticipated that they would be put in a group in which they felt most comfortable.”</p> <p>“Peer leaders had the right to choose their partners who had the similar characteristics such as age, sex, and location.”</p> <p>“When we did our final evaluation, the participants suggested that we should have cared less about married men and women being partners and instead have chosen peer partners by geographic proximity.”</p> <p>“We tried to match peer supporters with peers according to comparable age, gender and location.”</p> <p>“It could be interesting to explore the possibility of single-sex peer support groups. This would eliminate any problems that could arise due to sex roles as defined by society.”</p>
<p>Gender Differences in Participant Availability or Need</p>	<p>“Many of our female participants are caregivers for parents, grandparents, and others, which brings challenge of time management in balancing all their duties and diabetes management.”</p> <p>“In Cameroon’s urban settings, diabetes is more prevalent in women than in men. Women tend to use health care services more often than men so are more likely to become aware of their condition sooner than the men.”</p> <p>“Patients with similar social, professional or cultural affinity were put in the same group. This is relevant because women tend to be more sensitive to differences in these areas and would generally modify their behavior depending on whether they view the setting as threatening or friendly.”</p> <p>“One cultural value is that married men and women did not interact too closely with the opposite sex beyond their spouse and so we paired participants in dyads and triads and avoided male/female dyads.”</p> <p>“Many husbands do not want their wife to become a peer educator. Members in the household can be unhappy when the mother is not paying as much attention to them and is busy going around the area in order to care for other people. They demand the matriarch to be available 100%.”</p> <p>“Male patients are easier to motivate, while female patients always complain they have too many household duties to do, e.g. raising grandchildren, cooking for the family, etc.”</p> <p>“I think gender definitely comes into play with regards to self-care in general. Women I think tend to – Hispanic women, rather – tend to seek out health services much more readily than men do. And so I mean that is something that I’ve observed and I’ve heard others also kind of communicate that in their observations as well.”</p> <p>“I think the other issue with gender as well is that when someone does have a chronic illness – also I think my observation has been, and I hate to generalize but you know – my observation is that once diagnosed with a chronic illness and this example is obviously is diabetes – it’s easier to engage women in their care than it is men.”</p> <p>“I think traditional gender roles where men are – I don’t know – I think maybe seeking out health services may be seen as a weakness and men are not supposed to appear weak. I’m not sure. But definitely I can see that.”</p> <p>“More women than men (59% vs 41%) are diagnosed with diabetes in our clinics. Men were more likely to be classified as non-adherent. More women than men (63% vs 37%) participated in diabetes self-management support program.”</p> <p>“There are, in total, over 21,000 people with diabetes and people with hypertension have registered with Peer Educator program of MoPoTsyo. Patient Information Center at the end of 2014. There are about 69% of them are female. However, the majority of PE who are volunteering with organization are male (71%). This figure shows the different gender proportion between registered members versus volunteers among them.”</p> <p>“There is also an imbalance in the gender of patients...but this is the opposite! The proportion of 1/3 male versus 2/3 female patients has not changed since 2005.”</p> <p>“About 70-80% female, 20-30% male. Today we have conducted a conversation with group total of the participants at 10 people, femaleseven and male three.”</p> <p>“Male patients seem to be easier to motivate, while female patients always complain they have too much household duties to do, e.g., raising grandchildren, cooking for family, etc.”</p> <p>“The thing is that even with our classes and our support groups, we definitely saw more women patients than men and I don’t know that we – I think we could have dived into that a little deeper to try to figure out how to engage men more into coming to the classes. But I think the obvious thing is that they tend to be the breadwinners. So a lot of our patients don’t have these traditional 9-5 jobs. So that makes it even harder for them to engage in their care, let alone attend an evening class after working 12-13 hour days. Do you know what I mean? So again, most of those that did come to our group classes and support groups were women.”</p>

Table 3: Themes and Illustrating Quotes.

Finding	Implications for Peer Support Programs
Differences in emotional support Differences in instrumental support	Training should emphasize importance of both emotional and instrumental/informational support as well as sensitivity to women's, men's, and individuals' preferences for type of support and how it is delivered. Supervision and monitoring should be constructed to avoid missing important emotional needs of clients, especially when male coaches provide peer support. Likewise, instrumental tasks and objectives should be monitored more closely when female peer supporters are involved.
Who is a peer supporter?	Understanding the likely gender distribution of the peer supporters should significantly influence training content, paying attention to the aspects of support that may receive the least attention by the dominant gender peer supporters. For instance, if more men are peer supporters while more women are support recipients, training should emphasize those aspects of peer support that will make the participants feel well supported.
Matching peer supporters and support recipients by gender	Gender matching of peer supporters and participants should be included in program design where practicable. Gender-matched peer supporters and participants may be more comfortable providing/receiving support and discussing certain personal issues, such as sexual concerns. When it is not possible to gender-match peer supporters and participants, programs should have built-in systems for how participants can get the emotional and informational support that they need.

Table 4: Major Findings and Implications of Study of Gender Considerations in Peer Support Programs.