Published in final edited form as:

J Rural Health. 2003 ; 19(2): 174–180.

The Experience of Native Peer Facilitators in the Campaign Against Type 2 Diabetes

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Abstract

Context—The use of peer facilitators in health-programs has great potential. One important application is prevention and control of type 2 diabetes among American Indians.

Purpose—To explore the experience of American Indian facilitators in a culturally appropriate intervention (Talking Circles) on 2 Northern Plains reservations. The Talking Circles offered a forum for educational dialogue on diabetes risk factors and the management of type 2 diabetes.

Methods—Phenomenology, a qualitative research approach, was used to answer the research question: “What did Native Talking Circle facilitators-experience?” Participants were 4 lay health workers from the intervention reservations who had been trained to present a diabetes curriculum while coordinating and guiding the group discussion. During open-ended, taped interviews, the facilitators shared their experiences conducting the Talking Circles. Analysis categorized the experiences into common themes to explain the phenomena and cultural construction of oral discussions (Talking Circles) of diabetes.

Findings—Themes included the concept of “a calling” to do the work, which included a self-growth process, a blending of 2 worldviews as a diabetes intervention strategy, the importance of translating educational materials in a liaison role, and commitment to tribal people and communities.

Conclusions—The experience of the facilitators was positive because they were knowledgeable about American Indian culture and worldview and were trained in both Talking Circle facilitation and type 2 diabetes.

Peer facilitators are often recommended in a wide variety of educational forums. Corkery et al¹ found that when community health workers acted as language interpreters and liaisons between health care information and inner-city Hispanics attending a program taught by a diabetes educator, more Hispanics completed the program, and their blood sugar levels improved. In situations where English is a second language and where culture or custom dictates the involvement of collaborators in the process, the use of peer facilitators can have a significant impact on the implementation and success of the event or project. Employing and training peer educators is not only recommended, but it can be less expensive and can facilitate a project with ease and greater acceptance. The method and application of community workers and how lay health workers are selected, trained,² and supervised² needs further examination. Their contribution to the efficacy of health care programs^{3,4} and in the prevention and control of diseases such as type 2 diabetes has enormous potential.

Type 2 diabetes is a chronic disease that affects the person with diabetes and his or her family. It has reached epidemic proportions among American Indians throughout North

America. In 1994–1996, the age-adjusted diabetes mellitus mortality rate for American Indians and Alaska Natives was 46.4 per 100 000.⁵ This was triple the US all-races rate of 13.3 per 100 000 in 1995. Several studies have documented diabetes rates ranging from 33% among the Midwestern Woodland Tribes⁶ to over 65% among Arizona tribes.⁷ Burrows et al⁸ examined the Indian Health Service outpatient database and discovered that the rates of diagnosed diabetes increased by 29% between 1990 and 1997. These findings prompted a search for new interventions and methods to prevent and control the escalating diabetes rates in American Indian communities.

In an attempt to combat diabetes, models of culturally based community interventions have been sought to prevent and control the disease. It is assumed that programs that improve diabetes knowledge, attitudes, and behaviors can be more readily received and adopted, given acceptance of the group leader. The factors that relate to and explain this relationship are best understood through analysis of the peer facilitators.

A University of Minnesota research project, Diabetes Wellness: American Indian Talking Circles, is 1 such model that has been tested at 2 rural Northern Plains reservations. This intervention used a Native approach, the Talking Circle, to provide adult Indians with information on diabetes risk factors and ways to improve diabetes self-management.⁹ The Talking Circle is a mechanism used in American Indian communities for conducting a group process. During the talking circle, the facilitator and participants sit in a circle, and oral tradition is used to carry out interactions among the participants. Even though the Talking Circle is an ancient Indian traditional method used in group processes, it remains a desirable method¹⁰ that continues to be used to convey information and education.¹¹ The Talking Circle has been shown to be an effective educational method among California Indian women to improve cervical cancer screening knowledge and behavior.¹² The purpose of this article is to explore the question, “What did the Native Talking Circle facilitators experience?”

Methods

Four rural Plains reservations were randomly assigned into control and intervention groups. The 2 intervention sites, the Oglala Sioux’s Pine Ridge Reservation and the Winnebago Reservation, had curricula-driven Talking Circle sessions held during the 2-year intervention phase (1999 to 2001). Participants at the control sites received usual diabetes care at the tribal clinics. Peer facilitators were hired and trained to coordinate and conduct the Talking Circles at the 2 intervention sites. One hundred people with diabetes and people “at risk” for diabetes were recruited at each of the 4 sites. Three hundred twenty-four adult Indians participated in the project.

Focus groups were initially conducted on the 2 reservations to discover needed and desired information relating to type 2 diabetes. These data were used to develop and implement a 12-week educational curriculum that provided adult participants with information on many aspects of diabetes. Curriculum topics included the basic etiology of diabetes, nutrition facts, and healthy lifestyles related to the physical, mental, spiritual, family, and community⁹ (see Table 1 for an outline of the Talking Circle curriculum guide).

Two of the 4 reservations were randomly assigned as intervention sites and thus became the 2 sites analyzed in this paper. These 2 reservations, the Winnebago of Nebraska and the Pine Ridge of South Dakota, are approximately 350 miles apart. The Nebraska Winnebago tribe reports 3736 Winnebago tribal enrollees, many of whom speak the Winnebago language. The reservation size is 30 647 acres, overlapping a small portion of Iowa.¹³ The Pine Ridge Reservation reports 17 775 Lakota Sioux tribal enrollees, and many speak the Lakota

language. The reservation has a landmass of 2 000 000 acres and is located in southwestern South Dakota on the Nebraska state line.¹⁴

According to the US Department of Health and Human Services,⁵ American Indians residing in this geographic area are poorer and less educated than the general population. Average unemployment rates were 26.5% for Indian males and 19.4% for Indian females age 16 and over, compared with 6.4% and 6.2%, respectively, for all races in the United States. Median reservation household income was reported to be \$12 310, compared with \$30 056 for all races in the United States. High levels of poverty are reported for reservation residents (49.6% compared with 13.1% for the general population). Education levels, reported as the number of people who graduated from high school and higher, were lower (64.4% Indian graduates versus 75.2% for all races in the United States).

The National Institutes of Health (NIH)-supported project was implemented and tested as a culturally appropriate intervention to prevent and control type 2 diabetes among American Indians. The qualitative research study described in this manuscript was funded as a Minority Supplement to the larger NIH R01 grant. In this Minority Supplement segment, phenomenology was used to answer the research question, “What did the Native Talking Circle facilitators experience?” During open-ended, taped interviews, 4 American Indian Talking Circle facilitators shared their experience in leading the Talking Circles. They were asked questions about facilitating the Talking Circle, leadership, strengths and challenges of the Talking Circle, the meaning and cause of diabetes, and the effect of diabetes on their culture. They were also asked to provide demographic data. Prompts were used as appropriate to elucidate fuller explanations and understandings of the experience.

Phenomenology is a qualitative method that examines the lived experience, or the meaning or essence of a phenomenon.¹⁵ Phenomenology asks, “What is this or that kind of experience like?”¹⁶ (p9) This methodology is used when very little (or nothing) is known about the nature or meaning of a lived experience.¹⁷ In this case, the phenomenon analyzed is the experience of the peer facilitators conducting the diabetes Talking Circle.

The data analyzed for this study were obtained during open-ended individual interviews that lasted 1 to 2 hours with the 4 peer facilitators who led the Talking Circles. The 4 facilitators were contacted by the project coordinator and informed that a researcher would be approaching them to explain the phenomenology study and to ask for their participation. The researcher contacted the facilitators by telephone to provide an overview of the study and to explain that they would be asked to describe their experience of facilitating the Talking Circle(s). The Talking Circle facilitators were informed that participation in the study was not mandatory and that they could withdraw from the study at any time without adverse effects from the University of Minnesota, the tribes, or their employer. The research study acquired approval from the University of Minnesota and the Indian Health Service Institutional Review Boards. Before the interviews, informed consent was obtained from the 4 peer facilitators. Permission to tape the interviews was obtained. The interview process ended when the facilitator felt there was nothing left to say or describe. The interviews were conducted in a location chosen by the peer facilitator. Without exception, these sites were their employment offices or the Indian Health Service clinic. The data became redundant after 3 interviews. The researcher not only conducted the interviews but also observed 2 Talking Circles with permission of the Talking Circle facilitator and participants. This observation helped the researcher fully understand the mechanisms of the Talking Circle.

Constant comparative analysis methods and phenomenological data analysis techniques taken from Colaizzi,¹⁸ van Manen¹⁶ and Rose¹⁹ were employed during data collection, data analysis, and validation of study results. After the audiotapes were transcribed verbatim, the

data analysis steps were as follows: (1) each audiotape was listened to guided by transcripts to verify accuracy; (2) a second review of the audiotape was conducted in an attempt to grasp the participant's meaning regarding her experience; (3) each transcript was intuited and reflected upon separately; (4) themes and supporting statements were extracted from the first transcript; (5) the process was repeated for the other 3 transcripts to compare and contrast research participants' descriptions so redundancies could be eliminated; (6) all research participants received a summary of the findings and were contacted in person to clarify and validate the essential themes; (7) after comments were integrated into the final product, the final product was distributed to 2 Talking Circle facilitators for further critique; and (8) the final interview report incorporated suggestions derived from the steps just described. Oiler¹⁵ states that validity is reached when research findings are recognized to be true by those living the experience. Validity occurred when Talking Circle facilitators who participated in the study verified the research results as their experience.

Talking Circle facilitators were interviewed between December 2000 and February 2001 on their reservations. All 4 identified themselves as: (1) enrolled members of an American Indian tribe, (2) residents of the community where the Talking Circles were held, and (3) personally affected by diabetes. One facilitator was a 17-year diabetes patient; the other 3 reported family members with diabetes. Peer facilitators were women; ages ranged from 31 years to 48 years. Employment status included that of an administrative assistant, diabetes prevention outreach worker, project coordinator, and court advocate.

A total of 16 Talking Circles were conducted, 9 on the Pine Ridge Reservation and 7 on the Winnebago Reservation. Each peer facilitator conducted 2 to 6 circles (12 weekly Talking Circle sessions were held for each "circle"). In all, 147 adult American Indian community members (over the age of 18 years) participated in the Talking Circles at the 2 sites.

Findings

Findings point to the significance of the work as well as the successful utilization of Native peer facilitators in educational programs. Common themes were identified illustrating the experience reported by the facilitators. These themes surround the concept of "a calling" to do the work, which included a self-growth process, a blending of 2 worldviews as a diabetes intervention strategy, the importance of translating educational materials in a liaison role, and commitment to tribal people and communities.

A Calling to Do the Work

The peer facilitators described their role as being more than just a job. Talking Circle facilitators described their work as the right thing to do for them, as a responsibility, and as an important undertaking in the war against diabetes—one in which together they could "take a proactive stance." In other words, there were good reasons to be employed as a Talking Circle facilitator.

One facilitator described her facilitation as, basically, keeping the circle moving. It is listening to what someone else has to say and keeping the discussion going. "So, the only hard thing about being a facilitator is actually getting people to show up (for the circles) and to break the ice and start talking." "[On our reservation,] we've got so much going on here with diabetes and have other programs that target diabetes. I am really proud of what we have all done." The facilitator described attending a program event: "I actually cried when I walked into that room, to see the people they got to go to this [event on diabetes]."

Two of the facilitators became facilitators because of family influences. "I lost my mother to diabetes complications ... so, I started the first memorial walk for diabetes. I did it in

memory of my mom, because she loved her home. She loved her land. ... So it was a spiritual connection. ... I know my mother's last words to me before she died were 'My girl, take care of yourself. Don't end up like I did.' "

Another stated, "It has been quite an experience. I was never in the field of any kind of health-related issues. I guess it's my family that got me motivated to try to get this job of being a facilitator. ... That's what motivates me. ... I don't want any more of my family to have to go through this [suffer from diabetes]."

For another facilitator, to "facilitate the talking circle is really something like a dream that came true for me ... to find some way to work in diabetes prevention, diabetes awareness, diabetes knowledge. ... So it's kind of like a personal thing for me. And I feel like it is a personal victory for me. I get to use [the circle] to get the message out to the people ... not wanting anybody to be illiterate with diabetes information. Because I know what that is like from my history of living with diabetes." Also, facilitating the Talking Circle gave another facilitator the opportunity to perform some "meaningful education in the communities, because the valiant efforts with pamphlets [given to clients in the Indian Health Service clinic] don't get Indian people to change behavior."

A Journey of Self-growth

For each facilitator, her role in the Talking Circle resulted in self-growth. One stated, "It has been a real enriching and educational experience for me as a facilitator. ... I've really learned a lot about diabetes, as far as living with diabetes from the participants ... their fears and beliefs about diabetes ... what that experience has been or whether a loved one has diabetes and what the experience was."

A facilitator said that when she took the role as a facilitator it became a spiritual thing. She described it as energizing. Another viewed it as part of a healing process to assist with the trauma that family members had endured from diabetes. "I have a lot of family members that are diabetics now, have died because of complications of diabetes. With these circles, it helps the people, but it also helps me get over my grieving for the people that I have lost to diabetes."

Blending American Indian Culture and Western Medicine as a Strategy to Affect Diabetes

In leading the Talking Circles, the facilitators utilized the strength and wisdom of their culture and their knowledge of Western medicine. An observation of the Talking Circles clearly showed this phenomenon. At the beginning of each circle, the meeting area was cleansed and purified with sage (a traditional herb). A prayer was said by one of the Talking Circle participants "over the food, over what we are doing ... and the positive things that come out of it." Tobacco, along with a plate of food served at the Talking Circle meal, was offered to the spirits/creator. The curriculum itself included Western explanations and presented diabetes as a disease entity. During the course of the Talking Circles sessions, however, values of American Indian culture began to percolate through the Western material in the form of dialogue, exchanges, and responses to the curriculum. Humor was much in evidence, as well as respect for the opinions of all and the ability to "talk about a lot of things ... to talk about the culture" and "wanting to be well for the future of our children." These strategies ensured that a bond and connection, very important in Indian culture, were formed between the facilitator and the participants. "The circles bonded them [participants] closer.... The Talking Circle participants are doing more stuff together than before. ... And even after they [the circles] are over ... it's like they're still linked together somehow. ... Mainly the bonding strength of knowing they're not the only ones dealing with this [diabetes]."

The vision of using a cultural approach (the Talking Circle) to combat type 2 diabetes came as a spiritual revelation during a Sun Dance. In this came the realization that the answer to diabetes lay within the American Indian traditions themselves. According to 1 facilitator, the Sun Dance is one of the 7 sacred ceremonies of the Lakota people that utilizes 2-legged, 4-legged, plant, and animal life, with the wind, sun, and Mother Earth. This is an extremely important point because, as the facilitator explained, no one heretofore has asked “what they [American Indian people with diabetes] think, or what could be a better solution. We [as Indian people] need another way to look at it [diabetes]. ... So, I prayed about it.” Diabetes education, in other words, can only take place in a form that resonates with Indian culture.

An American Indian campaign against diabetes requires the involvement of all. Every tribal member will have a role to play in combating this epidemic and in discovering ways to find balance (or wellness) again. “They have an important place. Whether it as a community member, researcher, practitioner, spiritual leader, or whether you are part of the culture, we all have an important place. If we can find the balance, we would be disease free. Even from diabetes. Even beyond diabetes. It’s just finding the balance.” Another said, “You need your spirituality or connection. You need to get to your center, so you know there’s a place to go, up and down,” and “if we let people know what we mean [about diabetes] ... what we’re saying from the heart, they will listen.”

Providing Information to Talking Circle Participants

Talking Circle participants receive much essential information on diabetes. “There are some incredible misconceptions out there. Myths with diabetes.” According to the research project coordinator, each of the Talking Circle facilitators is in effect a translator or interpreter. This complex body of technical, scientific knowledge is translated into a dialogue the Indian participant can easily understand. The facilitator uses the oral tradition of storytelling and dialogue to reinforce the educational points. One facilitator questioned how to make the information provided meaningful: “How can I touch them with this information—other than it just being routine? How can I help people see diabetes in a different way and open their minds ... help them feel it?” How can they better understand the disease and work toward prevention and control?

During the course of the Talking Circle, participants thrived as they shared and learned from each other. The information provided in the circles was said to be clearer and more understandable. It was like “an awakening. It seemed like we were all in a deep dark sleep ... and people were asleep to diabetes all this time.” The information is needed “here and everywhere else ... any reservation in the USA.” One facilitator, after being diagnosed with diabetes, had felt neglected. Now, she feels her role in providing information to Indian people is about empowering people, about opening their hearts and minds. If you want to affect someone’s life, you “don’t hold back and think, ‘I’ll wait for somebody else to do it.’ Go for it.”

One of the facilitators’ major challenges lay in creating a stress-free and relaxed environment. The surroundings in the Talking Circles had to be comfortable, and confidentiality had to be ensured. As happens in rural areas, Talking Circle participants may have had previous incidents or disagreements with each other in the community; there were old scars and wounds. Long and Weinert²⁰ discussed this occurrence, finding that a lack of anonymity implied a limited ability for rural people to have private areas in their lives. The facilitators overcame this difficulty by offering several different Talking Circles and grouping participants according to their comfort level and needs of their timetables. If an individual was uneasy with the participant mix in 1 group, the facilitator assisted the individual in joining a more congenial group.

Passion and Commitment to American Indian People and Tribes

The facilitators felt their part in the campaign against diabetes to be part of a long process. One said she was in it for the “long haul ... even if there is just one thing that I can change. That is what I want to do. Until we can get to the point where we don’t have to worry about it [diabetes] any more. I’m proud of it [my job]. I do it just to help my people. You know, help my people here on the Res [reservation].” For another facilitator, “hearing people say, they don’t want any more dialysis units, they don’t want any more amputees. That’s quite a vision. You know, it gives me hope.” However, this will be a long process, and it will take a long time to affect diabetes in these communities.

The facilitator who has diabetes said, “It may be too late for me but not for others. I look at my children. They are my biggest inspiration to keep fighting diabetes. My biggest dream is a diabetes-free tomorrow. As long as we hang onto that dream ... I would like to think that I had a small part in helping make that difference. It means a lot to me.”

Lastly, “As devastating as diabetes is ... and I have helped family members get buried because of it ... I believe what the elders said about diabetes ... that diabetes is like a last warning from the Creator. That we have got to get back in balance. With who we are as a nation. As a nation with a language, with the ceremonies, with the traditional ways that we’re supposed to practice. So, diabetes, it is a bad thing that happened to us, but we can turn it into a good thing by our response to it.” Type 2 diabetes is one more of the many diseases that have threatened to conquer and defeat American Indian people, even to annihilate them. From this point of view, it may well be considered the last warning.

Discussion

Not only does this article describe the powerful experience of peer facilitators of a diabetes Talking Circle intervention, but also the findings illuminate ways in which lay health workers are well equipped and able to act as an intermediary between 2 cultures. The ability to interpret and communicate complex Western medical knowledge on type 2 diabetes to their American Indian community members who lived in rural, remote, underserved American Indian reservations is significant. The study’s Talking Circle participants, who possess different cultural beliefs and values and may speak their Native language, are often described as a hard to reach group with complex health care barriers. The peer facilitators were able to act as cultural liaisons, offer support, and establish social networks because they intimately knew the community.

Lessons learned from the Talking Circle peer facilitators are many. These lessons surround the concept of “working with the community” and using community resources. The congruence of the peer facilitators and of the culture of the community acted to reinforce the acceptance and adoption of the intervention.

Peer Facilitators as Natural Helpers

The Talking Circle facilitator is a trained adult American Indian community member who organizes the Talking Circles, recruits and engages Talking Circle participants, presents the curriculum, and guides the discussion, which is offered through oral storytelling format. Adults who fill such roles (excluding adolescent peer educators) have been labeled as lay health workers, lay health advisors, lay health educators, peer educators, or community health workers. Lay health workers are used in the community to provide education to people similar to themselves,³ and they perform several tasks. These responsibilities include serving as cultural mediators and links between minority people and health agencies, helping to establish social networks, offering social support,²¹ mobilizing community health care

resources,²² providing health knowledge,²³ and improving quality of health care through continuous utilization of services.⁴

The peer facilitators viewed their job as important, the right thing to do, as a responsibility and a commitment to their people and tribes. The facilitators or lay health workers could be described as natural helpers²² who undergo self-growth in the job. Within the facilitator role, they were positioned to make a difference, even if it was small, in the war against diabetes. The facilitators knew that eliminating diabetes would involve a long process, but they desired to be continuously involved. The facilitators were instrumental in coordinating a safe environment for the Talking Circle participants, because they “had to open people’s hearts and minds to diabetes knowledge and preventive behaviors.” The holistic nature of American Indian culture understands that imparting information only to the mind will not totally enhance learning knowledge and behavior change. To be successful, the learning process must include a trusting environment and must be provided in a culturally sensitive manner.

Use of Community Resources

Designing and implementing a culturally appropriate approach to education entails more than the use of the Talking Circles. The peer facilitators were important members of the research team, acting as interpreters and liaisons to the community. Community members and tribal staff were excellent resources to be used as sounding boards and to provide direction in relations with the community. In this study, the peer facilitators were trained on the disease aspects of diabetes and were then able to interpret this information in a format understandable to the study participants. This was done in a cultural context that did not negate the illness beliefs of the Native participants, but provided a contextual format for better understanding and thus a higher probability of acceptance and adoption of recommended behaviors.

Incorporating Cultural Approaches to Healing

The American Indian culture is losing elders early to diabetes. This is serious, because traditional knowledge is passed to future generations through oral teachings and role modeling by elders. Without elders, cultural wisdom may not continue to be transferred. An approach to preventing and controlling diabetes lies with the incorporating of American Indian cultural approaches to healing and Western medicine. The Talking Circle facilitators were successful because they were knowledgeable about American Indian culture and worldview and were trained in both Talking Circle facilitation and type 2 diabetes. This is an important factor that needs to be taken into consideration when developing and implementing similar programs.

This study is significant because it has captured a little-known phenomena—the experience of Native peer facilitators conducting educational interventions. The facilitators’ successes lie in the congruence of culture, language, illness beliefs, and illness experiences. American Indian culture encourages the collaboration of all members in activities affecting the tribe. This may not be possible in another culture where autonomy is emphasized, medical confidentiality is valued, and peer involvement in the medical arena is not encouraged. American Indian culture, however, values extended family involvement and, indeed, extended tribal involvement in everyday life experiences. This involvement can be characterized as “collective” group process and is accepted on a wider scale than is seen in other cultures.

Acknowledgments

This study was funded as a Minority Supplement to Diabetes Wellness: American Indian Talking Circles 3 R01 NR04722-04S1 (F.S.H.) from the National Institutes of Health, National Institute of Nursing Research (2000–2002).

References

1. Corkery E, Schechter CB, Palmer C, Frisher L, Foley ME, Roman SH. Effect of a bicultural community health worker in completion of diabetes education in a Hispanic population. *Diabetes Care*. 1997; 20:254–257. [PubMed: 9051367]
2. Hill MN, Bone LE, Butz AM. Enhancing the role of community-health workers in research. *Image J Nurs Sch*. 1996; 28:221–226. [PubMed: 8854543]
3. Poss JE. Providing culturally competent care: is there a role for health promoters? *Nurs Outlook*. 1999; 47:30–36. [PubMed: 10070651]
4. Witmer A, Seifer S, Finocchio L, Leslie J, O'Neil E. Community health workers: integral members of the health care work force. *Am J Public Health*. 1995; 85:1055–1058. [PubMed: 7625495]
5. US Department of Health and Human Services. *Regional Differences in Indian Health*. Rockville, Md: US Department of Health and Human Services; 1998–1999.
6. Centers for Disease Control and Prevention. *Inter-tribal Heart Project: Results from the Cardiovascular Health Survey*. Atlanta, Ga: Centers for Disease Control and Prevention; 1996.
7. Lee ET, Oopik AJ, Howard BV, et al. Diabetes and impaired glucose tolerance in three American Indian populations aged 45–74 years. *Diabetes Care*. 1995; 18:599–610. [PubMed: 8585996]
8. Burrows NR, Engelgau MM, Geiss LS, Acton KJ. Prevalence of diabetes among Native Americans and Alaska Natives, 1990–1997. *Diabetes Care*. 2000; 23:1786–1790. [PubMed: 11128353]
9. Center for American Indian Research and Education. *Diabetes Wellness: American Indian Talking Circles Curriculum*. Berkeley, Calif: Center for American Indian Research and Education; 1998.
10. Strickland CJ, Chrisman NJ, Yallup M, Squeoch MD. Walking the journey of womanhood: Yakima Indian women and Papanicolaou (Pap) test screening. *Public Health Nurs*. 1996; 13:141–150. [PubMed: 8936248]
11. Hodge FS, Pasqua A, Marquez CA, Geishirt-Cantrell B. Utilizing traditional storytelling to promote wellness in American Indian communities. *J Transcultural Nurs*. 2002; 13:6–11.
12. Hodge FS, Fredericks L, Rodriguez B. American Indian women's talking circle: a cervical cancer screening and prevention project. *Cancer*. 1996; 78(suppl 7):1592–1597. [PubMed: 8839577]
13. Winnebago Tribe of Nebraska Community Environmental Profile. Available at: <http://www.mnisoseorg/profiles/winnebaghtml>
14. Oglala Sioux Tribe Community Environmental Profile. Available at: <http://www.mnisoseorg/profiles/oglahtml>
15. Oiler C. A phenomenological approach in nursing research. *Nurs Res*. 1982; 31:178–181. [PubMed: 6918925]
16. van Manen, M. *Researching Lived Experience*. Albany: State University of New York Press; 1990.
17. Munhall, P. Qualitative designs. In: Brink, PJ.; Wood, MJ., editors. *Advanced Design in Nursing Research*. Newbury Park, Calif: Sage Publications; 1989. p. 161–179.
18. Colaizzi, PF. Psychological research as the phenomenologist views it. In: Valle, R.; King, M., editors. *Existential Phenomenological Alternatives for Psychology*. New York, NY: Oxford University Press; 1978. p. 48–71.
19. Rose, JF. *The Voice of Inner Strength in Women: A Phenomenological Study* [dissertation]. Austin, Tex: University of Texas; 1988.
20. Long KA, Weinert C. Rural nursing: developing a theory base. *Sch Inq Nurs Pract*. 1989; 3:113–127. [PubMed: 2772454]
21. Brownstein JN, Cheal N, Ackerman SP, Bassford TL, Campos-Outcalt D. Breast and cervical cancer screening in minority populations: a model for using lay health educators. *J Cancer Educ*. 1992; 7:321–326. [PubMed: 1305418]

22. Eng E, Smith J. Natural helping functions of lay health advisors in breast cancer education. *Breast Cancer Res Treat.* 1995; 35:23–29. [PubMed: 7612900]
23. Dignan MB, Michielutte R, Wells HB, et al. Health education to increase screening for cervical cancer among Lumbee Indian women in North Carolina. *Health Educ Res.* 1998; 13:545–556. [PubMed: 10345905]

Table 1**Diabetes Wellness Curriculum**

Session	Topic
1	Introduction
2	Diabetes: Perceptions
3	Diabetes: Facts and prevention
4	Diabetes: Secondary prevention
5	Nutrition: Basics
6	Nutrition: Preparation
7	Nutrition: Traditional foods
8	Healthy lifestyles: Physical
9	Healthy lifestyles: Emotional/spiritual
10	Healthy lifestyles: Family
11	Healthy lifestyles: Community
12	Closure