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Review Article

Peer support interventions for self-efficacy and dietary and fluid adherence in adults receiving maintenance hemodialysis: A scoping review

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Abstract

Background: Adults receiving maintenance hemodialysis face persistent dietary and fluid-management demands. Peer support offers lived-experience assistance, but the scope and measurement of related interventions remain unclear.
Objective: To map peer-support delivery formats, components, and outcomes related to self-efficacy, dietary and fluid adherence, interdialytic weight gain (IDWG), symptom self-management, and quality of life in adults receiving maintenance hemodialysis.
Methods: This scoping review followed Joanna Briggs Institute methodological guidance and was reported with reference to the PRISMA extension for scoping reviews (PRISMA-ScR). Six sources (PubMed, Scopus, Web of Science, CINAHL, ProQuest, and ScienceDirect) were identified in the review records for publications dated January 2018–January 2026. Interventional primary studies involving adults receiving maintenance hemodialysis and an experiential peer-support component were eligible. Two reviewers screened records; findings were descriptively charted without meta-analysis.
Results: Of 658 identified records, 146 were duplicates, 512 were screened, 65 full-text reports were assessed, and 15 studies were included. Delivery formats included face-to-face groups, intradialytic sessions, telephone mentorship, virtual groups, and hybrid approaches. Outcomes encompassed self-efficacy, self-management, dietary and fluid adherence, IDWG, psychosocial well-being, and quality of life. Reported changes were sometimes favorable, but designs, measurement approaches, intensity, and follow-up were heterogeneous.
Conclusion: Peer support may complement dialysis nursing care, particularly through practical and psychosocial self-management support. Current evidence cannot establish comparative effectiveness, an optimal delivery format, or sustained benefit. Better-described, adequately powered comparative evaluations with validated measures and longer follow-up are needed.

Background

For people with kidney failure, maintenance hemodialysis adds recurring treatment sessions to complex everyday decisions about food, fluid intake, medications, symptom monitoring, and participation in family and community life. The burden is not restricted to biochemical outcomes: fatigue, pruritus, pain, psychological distress, and disruptions to ordinary routines can impair well-being and self-care (Himmelfarb et al., 2020; Flythe et al., 2019; Mehrotra et al., 2023). Comparative evidence also indicates that quality of life differs across dialysis modalities and is affected by broader treatment circumstances (Chuasuwan et al., 2020; Brito et al., 2019).

Dietary and fluid recommendations are especially challenging because thirst, food customs, family preferences, residual urine output, and individual treatment regimens interact. Interdialytic weight gain (IDWG) is frequently used as an observable fluid-management indicator, although it is not a pure measure of individual adherence. An Indonesian observational study linked fluid-management behavior with self-efficacy and clinical factors, illustrating why adherence should not be reduced to knowledge deficits (Perdana & Yen, 2021). A systematic review found mixed relationships between social support and treatment adherence, with potentially stronger associations for fluid restriction than for other behaviors (Sousa et al., 2019).

Peer support differs from clinician-only teaching by using the credibility of shared illness experience to offer affirmation, reciprocal encouragement, modeling, and context-specific problem solving (Dennis, 2003; Bennett et al., 2018). Earlier dialysis mentoring initiatives addressed supportive communication, experience sharing, and patient-centered engagement (Perry et al., 2005; St Clair Russell et al., 2017; Kha-Moua & Paulus, 2021). Qualitative and implementation work suggests that acceptability depends on

relationships, local resources, and trustworthy supervision rather than the mere existence of a group (Wood et al., 2022; Cervantes et al., 2023).

An expanding intervention literature has also evaluated educational, psychoeducational, and digital self-management support in kidney care, but these approaches are not automatically peer interventions: professional-led education (Zhianfar et al., 2020; Chen, H.-C., et al., 2023), mobile-app training (Pack & Lee, 2021; Torabikhah et al., 2023), and peritoneal-dialysis peer programs (Chen, X., et al., 2021) address overlapping outcomes while differing in the provider or population. Historical patient navigation programs similarly demonstrate models of lay support, but transplant-navigation evidence should not be conflated with a hemodialysis peer-intervention trial (Sullivan et al., 2012; Sullivan et al., 2018; Sieverdes et al., 2021).

Prior synthesis is substantial rather than absent. Longley et al. (2023) examined peer interventions across kidney-failure populations and documented mixed findings. Elliott et al. (2025) described broad peer-support programs across chronic kidney disease; Friedrich et al. (2025) mapped randomized self-management trials in hemodialysis without limiting their scope to peer delivery; Gong et al. (2026) quantitatively synthesized peer-support outcomes in maintenance hemodialysis. Broader behavioral-intervention reviews also highlight heterogeneous active components (Ekholm et al., 2025). An additional mapping perspective remains useful because intervention delivery and outcome measurement—not a pooled intervention effect—are the focus here.

The specific contribution of this scoping review is to map peer-support formats and components alongside self-efficacy, dietary and fluid adherence, and IDWG outcomes in adults receiving maintenance hemodialysis, while distinguishing what is reported from what remains uncertain. We aimed to describe the available interventions, their measured outcome domains, the direction of reported findings, and gaps relevant to dialysis nursing and future comparative research.

Methods

Study Design

This scoping review used the framework of Arksey and O'Malley (2005) and methodological recommendations of the Joanna Briggs Institute (Peters et al., 2020; Peters et al., 2024). Its reporting was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco et al., 2018), an EQUATOR Network guideline. The PRISMA 2020 flow-diagram structure was used to display record selection (Page et al., 2021). Reporting is restricted to procedures ascertainable from the documented review process.

Protocol and Registration

The review was not registered and did not have a publicly accessible a priori protocol. In the absence of a registered protocol, prospective decisions and any changes to eligibility or synthesis methods cannot be independently traced.

Review Question and Eligibility Criteria

The review question was: What peer-support intervention formats, components, outcomes, reported findings, and evidence gaps have been described for adults receiving maintenance hemodialysis? The population–concept–context (PCC) framework specified: adults aged 18 years or older receiving maintenance hemodialysis (population); structured peer-led, peer-mentoring, or mutual-support interventions involving people with personal dialysis experience (concept); and facility-based, intradialytic, telephone, virtual, hybrid, or home-linked hemodialysis care (context).

Eligible studies were English- or Indonesian-language, peer-reviewed primary interventional evaluations dated January 2018 through January 2026. Randomized, cluster-randomized, quasi-experimental, and pre–post designs were eligible if they addressed self-efficacy, self-management, dietary or fluid adherence, IDWG, symptoms, psychosocial health, or quality of life. Children, peritoneal dialysis and transplant-only populations, clinician-only individualized education, secondary reviews, protocols, editorials, case reports, conference abstracts without full text, and records without a relevant intervention or outcome were excluded. The 2018 starting point provided a defined contemporary mapping window encompassing recent in-person and digitally enabled support formats; it was a scope decision, not evidence that earlier interventions lacked relevance or quality.

Information Sources and Search Strategy

The reported information sources were PubMed, Scopus, Web of Science, CINAHL, ProQuest, and ScienceDirect (a publisher full-text platform rather than a bibliographic indexing database). Search concepts combined peer support or mentoring, hemodialysis or kidney failure, and self-efficacy or dietary and fluid-management outcomes. A general Boolean expression is provided in Appendix A together with an explicitly illustrative PubMed field-tag translation. The historical platform-specific searches, their exact date of execution, applied filters, and complete electronic search logs were not preserved in the available audit trail. Therefore, the appendix should not be interpreted as a verbatim account of an executed search. Grey literature, registries, manual citation searching, author contacts, and handsearching were not documented.

Reported conceptual Boolean search: ("peer support" OR "support group" OR "peer mentoring" OR "peer-led intervention" OR "group therapy") AND ("hemodialysis" OR "chronic kidney failure" OR "renal dialysis" OR "ESRD") AND ("self-efficacy" OR "dietary adherence" OR "fluid restriction" OR "fluid compliance" OR "interdialytic weight gain" OR "IDWG").

Illustrative PubMed field-tag translation of these concepts (not the archived, executed query):

(("peer support"[Title/Abstract] OR "support group"[Title/Abstract] OR "peer mentoring"[Title/Abstract] OR "peer-led intervention"[Title/Abstract] OR "group therapy"[Title/Abstract]) AND ("hemodialysis"[Title/Abstract] OR "renal dialysis"[Title/Abstract] OR "chronic kidney failure"[Title/Abstract] OR "ESRD"[Title/Abstract]) AND ("self-efficacy"[Title/Abstract] OR "dietary adherence"[Title/Abstract] OR "fluid restriction"[Title/Abstract] OR "fluid compliance"[Title/Abstract] OR "interdialytic weight gain"[Title/Abstract] OR "IDWG"[Title/Abstract])) AND ("2018/01/01"[Date - Publication] : "2026/01/31"[Date - Publication])

Study Selection

Two reviewers independently screened titles and abstracts and evaluated potentially eligible full texts. Disagreements were resolved through discussion and, when necessary, by a senior reviewer. The recorded screening pathway is shown in Figure 1. The software used for deduplication and screening was not reported.

Data Charting and Synthesis

The documented charting fields comprised citation, country, study design, sample size, peer-support format, comparator, measured outcomes, and principal results. It cannot be determined from the preserved review documentation whether charting was performed by one reviewer or independently by two reviewers, whether the form was piloted, or how possible extraction discrepancies were reconciled. Consequently, no unsupported claim of duplicate data extraction is made. Available evidence was grouped descriptively by delivery format and outcome domain; no numerical synthesis, pooled effect estimate, cross-format ranking, or mediation analysis was undertaken.

Critical Appraisal

A reproducible study-level critical-appraisal procedure and appraisal ratings were not documented. Because critical appraisal is not mandatory for the descriptive purpose of a scoping review (Peters et al., 2020), the findings are presented as evidence mapping rather than a certainty-rated appraisal of intervention effectiveness.

Results

Figure 1 presents the documented flow of records. A total of 658 records were identified through PubMed (n = 112), Scopus (n = 148), ScienceDirect (n = 167), Web of Science (n = 84), CINAHL (n = 51), and ProQuest (n = 96). Following removal of 146 duplicates, 512 records were screened and 441 excluded. Of 71 reports sought for retrieval, six were unavailable; 65 reports were assessed in full text. Fifty reports were excluded because the outcome was ineligible (n = 18), the intervention did not involve peer support (n = 14), the population did not receive hemodialysis (n = 8), or the report was a review, protocol, or editorial (n = 10). Fifteen studies remained included. These are study-selection counts, not independent estimates of effect.

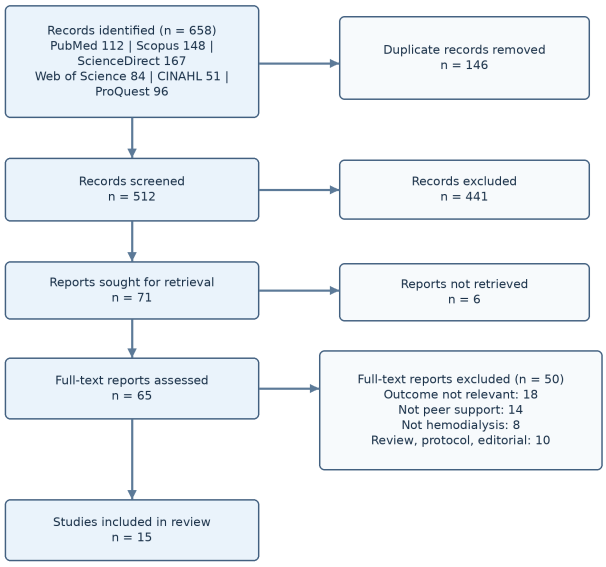


Figure 1. PRISMA 2020 study-selection flow diagram.

The mapped evaluations encompassed randomized, cluster-randomized, quasi-experimental, experimental, and single-group pre–post designs. Delivery was reported as face-to-face peer groups, support during hemodialysis sessions, telephone mentoring, message-enabled or virtual groups, and hybrid combinations. Peer-delivered activities included experiential discussion, mutual encouragement, practical problem solving, goal setting, and follow-up support. Some programs included clinical staff or family participation. Peer selection and training, supervision, contact frequency, duration, intervention fidelity, and sustained engagement were reported inconsistently. These are descriptive categories; the preserved study chart does not permit reliable study-by-study frequencies.

Self-efficacy and self-management were generally assessed using patient-reported measures; dietary and fluid adherence used questionnaires, reported behaviors, or physiologic indicators including IDWG. Other endpoints included symptoms, psychological well-being, health-related quality of life, and selected laboratory indicators. Several evaluations described favorable change, but reported outcomes differed in definition, timing, instrument, comparison group, and precision. The available charting information does not permit enumeration of statistically significant results by outcome or inference about the proportion of studies demonstrating benefit. Table 1 organizes the supported descriptive evidence.

Table 1. Descriptive map of reported peer-support delivery and outcome domains

Mapped domain	Reported characteristics	Limits of interpretation
Face-to-face/intradialytic support	Peer discussion, experiential education, problem solving, and scheduled contact	No supported comparative ranking or uniform intervention dose
Telephone/virtual support	Remote mentoring, messaging, or group-based communication	Access and acceptability are not equivalent to proven clinical effectiveness
Hybrid or family-linked support	Contact integrating peer communication with other supports	Contributions of peer versus family or clinical staff cannot be isolated
Psychosocial/self-management	Self-efficacy, self-management, stress, hope, and quality-of-life outcomes	Tools, timing, and comparators varied
Adherence/clinical proxies	Dietary or fluid adherence, IDWG, and selected biochemical indicators	IDWG has clinical determinants beyond self-reported adherence

No delivery format was directly established as optimal. Face-to-face interaction may allow real-time group exchange, remote formats may offer greater accessibility, and hybrid approaches may combine these advantages. However, differences in delivery, outcome selection, and follow-up mean that such plausible practical advantages are not evidence of superiority. The reviewed records did not establish a tested mediating pathway from peer support through self-efficacy to adherence or IDWG.

Discussion

Peer-support evaluations in maintenance hemodialysis addressed an interrelated set of confidence, self-management, adherence, and well-being outcomes, but their format and reporting differed substantially. The contribution of this map is not a new estimate of benefit; it is

the identification of intervention-design and measurement questions that matter for nursing decisions. Results should be read alongside broader systematic evidence reporting both favorable and null findings (Longley et al., 2023; Gong et al., 2026).

Conceptually, credible peers may offer social comparison, encouragement, practical demonstrations, and reassurance that complement professional education (Dennis, 2003; Reblin & Uchino, 2008; Vila, 2021). The proposed link to self-efficacy is plausible but remains a hypothesis: most mapped evaluations did not document the temporally ordered measurement and formal mediation tests needed to establish self-efficacy as a mediator. Evidence from trials of non-peer psychoeducation or behavioral self-regulation should not be treated as interchangeable. For example, studies of clinician-directed programs describe potential behavioral or psychosocial changes while also illustrating the difficulty of demonstrating between-group improvements in fluid indicators (Howren et al., 2016; Chen, H.-C., et al., 2023).

Fluid management is particularly sensitive to this distinction. Patients attempt to accommodate thirst, food choices, work, and family demands while clinicians interpret IDWG in the context of treatment prescription and residual kidney function (Perdana & Yen, 2021). A physiological proxy can triangulate patient-reported adherence but is not a mechanistic demonstration of support-driven behavior change. Future evaluations should distinguish dietary adherence, sodium intake, fluid-management practices, and IDWG; define assessment windows; and report effect estimates with confidence intervals rather than relying solely on within-group comparisons (Ekholm et al., 2025).

Accessibility and implementation deserve equal attention. Dialysis schedules and post-treatment fatigue can limit attendance, making telephone, message-supported, or blended formats attractive. Experience from nurse- and peer-oriented kidney programs indicates that staff oversight, culturally responsive approaches, confidentiality, and patient choice matter for uptake (Bennett et al., 2018; Wood et al., 2022; Kha-Moua & Paulus, 2021). Peer mentor preparation is itself a distinct intervention component requiring feasible training and supervision, as highlighted by dialysis mentor feasibility studies and protocols (Golestaneh et al., 2022; Golestaneh et al., 2023). Evidence reported in a subsequent peer-mentorship trial also illustrates why implementation context and outcome selection warrant attention (Golestaneh et al., 2025).

Appropriate boundaries are critical to practice. A peer mentor can share coping routines and encourage patients to raise concerns, but should not independently modify dialysis prescriptions or provide individualized medical advice. Nurse coordinators could define eligibility, orient mentors to escalation of distress or medical warning symptoms, schedule encounters around dialysis fatigue, and assess patient preferences. Peer activity should be integrated with symptom assessment and multidisciplinary follow-up (Taylor et al., 2016; Mehrotra et al., 2023). The potential value of hope and psychological support seen in related hemodialysis evaluations does not establish an effect on dietary or fluid outcomes (Irajpour et al., 2018; Pasyar et al., 2020).

The distinction between contextual evidence and eligible intervention evidence is essential. Earlier dialysis peer mentoring (Perry et al., 2005; St Clair Russell et al., 2017), a peritoneal-dialysis peer trial (Chen, X., et al., 2021), telephone peer-support reviews across conditions (Dale et al., 2008), transplant navigation (Sullivan et al., 2012; Sullivan et al., 2018), and transplant-waitlist digital education (Sieverdes et al., 2021) illustrate conceptual possibilities; they do not expand the 15-study hemodialysis intervention sample. Similarly, app-based self-management (Pack & Lee, 2021; Torabikhah et al., 2023) can inform delivery design without constituting peer intervention evidence.

For research comparability, peer-support protocols should prespecify the active ingredients, who delivers them, intensity, tailoring, fidelity, and supervision. The Template for Intervention Description and Replication (TIDieR) and behavior change technique taxonomy offer established reporting structures (Hoffmann et al., 2014; Michie et al., 2013). Evaluations should report both patient outcomes and distinct implementation outcomes such as reach, feasibility, acceptability, fidelity, and sustainability (Proctor et al., 2011). These distinctions may explain why promising small-scale programs are difficult to interpret or sustain across sites.

Strengths and Limitations

A focused PCC framing, several identified information sources, independently completed screening, and an internally consistent selection flow strengthen the descriptive organization of this review. In particular, mapping psychosocial constructs alongside dietary and fluid-management outcomes highlights domains relevant to dialysis nursing rather than treating peer support as a uniform exposure.

There are important limits to reproducibility and inference. The review was limited to English- and Indonesian-language peer-reviewed interventions published in a defined contemporary window. Unreported grey-literature and trial-registry searching may increase publication bias. The exact original search strings and execution dates, full study-identification and extraction audit trail, data-charting reviewer arrangement, and reproducible quality-appraisal results were not available for verification. Accordingly, complete study-level characterization and independent confirmation of all 15 included records are not possible from the documented materials. This uncertainty cannot be corrected through retrospective reconstruction of hypothetical methods. Heterogeneous interventions and outcomes, variable comparators and follow-up, and lack of effect-level synthesis further preclude comparative or causal conclusions.

Implications for Nursing Practice and Research

For dialysis nurses, peer support is best conceptualized as an optional adjunct embedded within individualized education, nutritional counseling, symptom assessment, and multidisciplinary care. Before implementation, a unit should clarify patient suitability and preferences; select and prepare mentors; set boundaries regarding clinical advice; provide confidential contact channels; appoint nurse supervision; and define escalation when participants describe distress, symptoms, or adherence difficulties. Programs should not replace clinical monitoring or be represented as a proven method for reducing IDWG.

For future research, priority questions include whether particular peer components enhance confidence or adherence above a credible comparator; what dose, duration, and mode are acceptable and feasible; whether benefits persist; and how to operationalize culturally and digitally equitable delivery. Prospectively registered, adequately powered comparative studies should prespecify validated measures, objective indicators including IDWG when appropriate, clinically relevant follow-up, and analyses that distinguish intervention effect, mediation, and implementation outcomes (Hoffmann et al., 2014; Proctor et al., 2011).

Conclusion and Recommendation

The available studies describe multiple peer-support delivery modes for adults receiving maintenance hemodialysis and examine self-efficacy, self-management, dietary and fluid adherence, IDWG, psychological well-being, and quality of life. Some reports describe favorable outcomes, but inconsistent intervention descriptions and measurement prevent firm conclusions about effectiveness, optimal format or duration, and longer-term benefit. Peer programs warrant carefully supervised evaluation as complements to existing dialysis nursing care rather than unqualified routine implementation.

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The authors declare no competing interests.

Declaration on the Use of AI
The authors declare that artificial intelligence (AI) tools were used solely to improve the readability, grammar, language, and overall clarity of the manuscript. All scientific content, including research design, data collection, data analysis, interpretation of results, and conclusions, was developed and verified by the authors. The authors take full responsibility for the accuracy, originality, and integrity of the manuscript.

Data Availability Statement
Data sharing is not applicable to this article.

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