Soft skills Manual

For training of Trainers and Healthcare Staff

Developed in the Frame of the SUNI-SEA Project

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List of abbreviations

AAFP	American Academy of Family Physicians
AHPA	Australian Health Promotion Association
AI	Avian influenza
BCC	Behaviour Change Communication
BCI	Behaviour change intervention
BHS	Basic healthcare staff
BMI	Body mass index
BP	Blood pressure
CDC	Centers for Disease Control and Prevention
CHAP	Cardiovascular Health Awareness Program
CHD	Coronary heart disease
CM	Community Mobilisation
CPHC	Comprehensive primary healthcare
CVD	Cardiovascular diseases
DM	Diabetes mellitus
GNI	Gross National Income
HDL	High-density lipoprotein
HE	Health education
HP	Health Promotion
HT	Hypertension
IEC	Information, Education and Communication
LMIC	Low- and middle-income countries
M&E	Monitoring and Evaluation
MI	Motivational interviewing
NCDs	Noncommunicable Diseases
PHC	Primary healthcare
PLA	Participatory learning and action
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
SDH	Social determinants of health
SEA	Southeast Asia
SEAR	Southeast Asian region
SPHC	Selective primary healthcare
SST	Soft skills training
SUNI-SEA	Scaling-Up Noncommunicable Diseases Interventions in Southeast Asia
ToT	Training of trainers
T2DM	Type 2 diabetes mellitus
WHO	World Health Organization

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SOFT SKILLS TRAINING FOR HEALTH AND WELL-BEING

Manual for Training of Trainers and eventually Basic Healthcare Staff Developed in the Frame of the SUNI-SEA Project

FOREWORD

Rusnáková V.

The aim of project SUNI-SEA and basic healthcare staff capacity building

The project *Scaling-Up Noncommunicable Diseases (NCDs) Interventions in Southeast Asia (SUNI-SEA)* is funded from the EU Horizon 2020. The overall aim of the project is to implement scaling-up strategies of evidence-based prevention and management programmes for diabetes mellitus (DM) and hypertension (HT) in underprivileged communities. Activities are coordinated from the University of Groningen, Netherlands, and focused on Indonesia, Myanmar, and Vietnam from 2019 to 2022.

The health service capacity building component of the project is oriented towards:

- harmonizing NCDs prevention activities of medical/non-medical staff and community workers,
- cooperating with universities and community-based institutions like self-help groups/HelpAge for training needs assessments, to develop educational materials, for educational/training provisions, and eventual training certification, and
- reflecting on internationally accepted competency models for primary healthcare (PHC) service staff.

Soft skills training (SST) for health and well-being within the SUNI-SEA project

The fostering of relevant soft skills competencies in everyday practice, complementary to knowledge improvement, usually covered in the standard format of education and training, is often selected as the principal goal of training for staff in PHC facilities *for the prevention and care of patients with NCDs.* Nevertheless, achieved soft skills could be useful in the wider context of healthcare delivery activities for infectious diseases and behavioural health problem-solving.

Why SST?

Monitoring capacity building of professionals in the NCD field in Southeast Asian countries, but also internationally, indicates that attention is usually focused on theoretical concepts and expert Evidence-Based knowledge improvement. The progress in education is mostly achieved by adapting "hard knowledge" – knowledge that is accepted as indubitably uncontested. This type of competency enhancement is already documented in projects based on international recommendations and technical support, such as WHO PEN, 2020[1].

[1] WHO, 2020. WHO package of essential noncommunicable (PEN) disease interventions for primary health care

However, good practices in disease prevention and health promotion also depend on developing managerial and communication competencies known as "soft skills." Unfortunately, these competencies are frequently neglected within formal education.

Expertise and technical skills are among the prerequisites required to become a healthcare professional, but in practice, they are often insufficient to secure successful implementation and lasting results in the prevention and management of NCDs. Hence, paying attention to the mobilisation of initiatives in communities is required in advanced training. Activities should also recognise approaches to communicate behavioural changes effectively and cultivate health promotion. Several groups of experts systematically address issues such as Behavioural Science and the Public Health Network, wishing to develop an understanding of health and well-being from a behavioural, social, and psychological perspective. [2]

The decision to focus on SST was fortified by results from literature review and discussions with local experts. Available results from capacity and training needs assessment of first-line healthcare professionals were used as well. Initially, a form of training was proposed in cooperation with the Myanmar SUNI-SEA team (the University of Public Health and HelpAge representatives). Subsequently, the content of the training was specified. Young researchers and students of public health participated, to a large extent, in its development.

Contents of the training portfolio and target group selection

The contents of the training activities and supportive education materials in this manual are comprised of a series of elaborate learning sessions oriented to the following topics:

- Community mobilisation – 5 sessions,
- Behavioural change communication – 5 sessions and
- Health promotion – 2 sessions.

Two main target groups are proposed for training. The first target is basic healthcare staff (BHS) who work in the field as the ultimate recipients. The second is comprised of trainers and facilitators of training who are usually exposed first to educational materials.

Adjustments to the portfolio based on local conditions and requests of project partners/co-trainers are expected.

Overall learning outcomes

After the training, BHS participants will be able to:

- enhanced NCDs prevention and management activities emphasising soft skills

After the training, trainers or facilitators will be able to:

- train BHS and other relevant groups of participants to practise soft skills effectively,
- perform monitoring, supervision, and evaluation of training activities, and
- be familiar with online education and training.

https://www.who.int/publications/i/item/who-package-of-essential-noncommunicable-(pen)-disease-interventions-for-primary-health-care

[2] Behavioural Science and Public Health Network, 2020 https://www.bsphn.org.uk/

A detailed description of the learning objectives and outcomes can be found in the overview of training content and individual sessions below within the text.

Users' manual characteristics

This manual is primarily intended for the training of trainers (ToT). The purpose is to help a core group of trainers to design and organize their training programmes for soft skills development in already defined areas of Community Mobilisation (CM), Behaviour Change Communication (BCC), and Health Promotion (HP).

The interactive approach is advocated and applied in the teaching materials contained in the manual. It is expected that inventive forms of using the materials would also involve online education and webinars in a blended way.

The utilisation of developed SST materials and provided training should encourage skills and attitude of participants in upscaling prevention of NCDs in practice. The ambition is the harmonisation of healthcare staff activities and community initiatives to support integrated health care and patient-centred concepts in fieldwork.

Objectives of the proposed trainings and manual

Provide support to all users to:
(1) expand good practices in NCDs management and prevention (especially hypertension and diabetes) through the implementation of adequate soft skills,
(2) equip trainers to train BHS and eventually community workers to conduct SST at primary care level health centres.

The selected parts of the accessible materials in the manual can be used after adaptation and by participants of BHS training as reference.

After the ToT participants will be able to:
(1) conduct NCDs management and prevention activities emphasising soft skills,
(2) train BHS and other relevant groups of participants to practise soft skills effectively,
(3) perform monitoring, supervision, and evaluation of training activities,
(4) be familiar with online education and training principles.

What user will find in this training manual

Trainer's/facilitator's support

Training materials are introduced with basic *information* on the subject and clarification of main concepts for each training session. Exercises or case studies, topics for brainstorming, focus group discussions, role play plans, and group or individual assignments follow. In addition, the questions for theme reflection, glossaries of terms, lists of suggested additional readings, and PowerPoint presentations are at manual users' disposal.

Literature resources and the selection of the information available on the internet are an integral part of each session. The authors tried to respect the principles of originality to an acceptable extent when presenting downloaded information. The ideas and definitions of several authors and sources have been used. These sources have been paraphrased and placed in the context of the training content. However, in some cases, whole sections have been transcribed, especially when using the transcript of interviews (these are marked in italics and accompanied by a source). The principal intention is to provide novices with quick help and guidance on interesting and valuable resources.

For training delivery support, attendance criteria for participants were developed. See the document: Selection Criteria for ToT training participants for SST modules.
Inspirative examples of quality assessment tools are included in the manual as well.

Planned Webinar structure and lectures oriented to effective teaching, online education principles, and quality of training will be available as well.

Students access to training materials

A suitable selection of teaching materials could also be available on Moodle, a learning platform for students, depending on the teacher's choice.

All mentioned documents are available on Moodle, and eventually on Unishare (project common platform).

Content of training – syllabus

This training consists of three modules

1. Community mobilisation,
2. Behaviour change communication, and
3. Health promotion,

which have been divided into individual sessions with carefully defined learning outcomes and structures of each module – see below. Furthermore, the learning objectives are clearly defined in the documentation of individual sections of the manual and the presentations.

I. Community mobilisation

After the completion of the Community mobilisation module, the course participants will be able to:

- Define the main characteristics of a community and identify its health needs
- Describe the principles and goals of community mobilisation
- Understand the planning and implementation of a community mobilisation initiative
- Explain the importance of the role of community mobilisers

- Apply the basis of community mobilisation to non-communicable diseases prevention and management (hypertension, type 2 diabetes mellitus) – involvement in action

Structure of the module

1. **Community**
   - community criteria, defining needs, community (health) assessment
2. **Community mobilisation**
   - benefits, goals, principles. the theoretical basis for the community mobilisation approach (community action cycle), mobilisers
3. **Community mobilisation for NCD (hypertension, diabetes mellitus)**
   - examples of effective health promotion programmes (CHAP in Ontario, DMagic in Bangladesh etc.)
4. **Reducing the burden of NCDs**
   - acceptance of NCDs, risk factors
5. **Participation in NCDs screening**
   - NCD services, uptake

II. Behaviour change communication

After completion of the behaviour change communication module, course participants will/will be able to:

- improve knowledge about BCC,
- describe the communication process in health behaviour change and barriers in effective BCC,
- gain skills in how and when to use the BCC frameworks,
- identify main barriers and facilitators influencing behaviour change,
- describe the influence of the media in connection with BCC during outbreaks of communicable diseases applicable also for NCD,
- identify frame information on the implementation of BCC on a national level,
- gain skills in how to use BCC methods in the communication process with patients,
- identify phases in the development and management of behavioural change interventions, and
- describe elements of implementing behavioural change interventions.

Structure of the module

1. Introduction to behaviour change communication

What is BCC, the communication process and its barriers, improvement of communication skills, case studies

2. Theoretical concepts

What are BCC frameworks and why use them, Motivational interviewing, Stages of Change, 5 A's framework

3. BCC and communicable diseases/ Covid-19 and Avian Flu- as inspiration for NCD intervention

Case studies from Cambodia, Egypt, and United Kingdom

4. BCC and obesity

Case study on the promotion of healthy weight (Ask/tell/ask method, cultivating change talk)

5. Development and management of behaviour change interventions

Preparation phase, Implementation phase, Monitoring and Evaluation phase

III. Health promotion

After completion of the health promotion module, participants will be able to:

- understand the concept of health promotion at the PHC level,
- explain the roles of PHC staff in health promotion,
- propose health promotion activities at a PHC unit,
- identify determinants of health,
- identify the key determinants of hypertension and diabetes, and
- suggest how PHC staff and community workers can help to influence the determinants of hypertension and type 2 diabetes mellitus

Structure of the module

1. **Introduction**

   Ottawa Charter, Shanghai Conference, health promotion in the context of PHC

2. **Determinants of health**

   Detailed description and instructions to each session are as annexes.

Additional resources

An example of a quality assessment tool is provided to monitor feedback from participants as well as trainers. The assessment scheme focuses primarily on the teaching process (available online: https://moodle.truni.sk/pluginfile.php/100357/mod_folder/content/0/Evaluation%20and%20quality%20assurance/Evaluation%20of%20SS%20training%20v%2014_12_20.docx?forcedownload=1)

Presentations oriented towards effective teaching methods are on the list of annexes as well.

Individual sessions and presentations

Annex 1 Community mobilisation – Introduction
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/CM%20Module/CM1_Introduction_06_09_2020.pptx?forcedownload=1

Annex 2 Community mobilisation – Principles and Goals
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/CM%20Module/CM2%20_Principles%20and%20goals_23_10_2020.pptx?forcedownload=1

Annex 3 Community mobilisation – Effective Health Promotion Programs
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/CM%20Module/CM3_Effective%20health%20promotion%20programmes_05_11_2020.pptx?forcedownload=1

Annex 4 Community mobilisation – Reducing the Burden of Non-communicable Diseases
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/CM%20Module/CM4_Reducing%20the%20burden%20of%20NCDs_12_07_2021.pptx?forcedownload=1

Annex 5 Community mobilisation – Participation in Non-communicable Disease Screening
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/CM%20Module/CM5_Participation%20in%20NCD%20screening_12_07_2021.pptx?forcedownload=1

Annex 6 Behaviour Change Communication – Introduction
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/BCC%20module/1%20BCC%20Introduction.pptx?forcedownload=1

Annex 7 Behaviour Change Communication – Theoretical Concepts
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/BCC%20module/2%20BCC%20Theoretical%20concepts.pptx?forcedownload=1

Annex 8 Behaviour Change Communication – Case Study – Avian Flu, COVID-19
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/BCC%20module/3%20BCC%20Case%20study%20-%20Avian%20Flu%2C%20COVID-19.pptx?forcedownload=1

Annex 9 Behaviour Change Communication – Case Study – Obesity
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/BCC%20module/4%20BCC%20Case%20study-%20Obesity.pptx?forcedownload=1

Annex 10 Behaviour Change Communication – Development and Management of Behavioural Change Interventions
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/BCC%20module/5%20BCC%20Development%20and%20management.pptx?forcedownload=1

Annex 11 Health Promotion – Introduction
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/HP%20Module/HP1_introduction_04_04_2021.pptx?forcedownload=1

Annex 12 Health Promotion – Determinants of Health
Available online:
https://moodle.truni.sk/pluginfile.php/100353/mod_folder/content/0/HP%20Module/HP2_determinants_05_04_21.pptx?forcedownload=1

I. COMMUNITY MOBILISATION

Section 1: Introduction

Chebenová V., Hudáčková V., Melichová J.

This session of the module is focused on explaining the importance of understanding the community, describing the roles of community mobilisation in combating NCDs, and defining the benefits of community participation. Community mobilisation places particular emphasis on the vulnerable aspects of communities, which increases their independence and confidence in taking responsibility for themselves and question those who have the power and continue to strengthen their vulnerability. This process also entails mobilising the resources, disseminating information, generating support, and promoting interaction between the public and private sectors in the community.

Learning objectives:

- Explain the importance of understanding a community.
- Describe the roles of community mobilisation in combating NCDs – promote community mobilisation in combating NCDs.
- Define the benefits of community participation.

By the end of this session, participants will:

- understand the needs of a community,
- identify key information on cultures, customs, and values,
- understand how to mobilise a community,
- be able to answer questions about community mobilisation,
- be able to use knowledge to ramp up education and training, and
- be able to plan community mobilisation.

A community

Communities can be based on shared interests or characteristics, such as race, age, occupation, or religion, and they are typically defined by a geographic area. Also, a community refers to an area or a village with families that depend on one another in their day-to-day transactions, thereby creating mutual advantages (The Open University, 2011). People in a community come from various backgrounds and have their own cultures, customs, and values. This wide range of wisdom and ideas is very important to utilise and is critical to assessing the community needs and strategizing areas for improvement. Before assessing community needs, you should have a thorough understanding of the community's various cultural groups and the best way to collaborate with them to address their concerns (CDC, 2013).

In a healthy community, people have the opportunity to make healthy and correct decisions in safe, non-violent environments that focus on promoting health. Early childhood education, quality housing, jobs, and many other aspects of community development, such as financial inclusion, access to health clinics and healthy food, transportation, and renewable energy, all have an impact on health (Figure 1) (Build Healthy Places Network, 2015).

Figure 1 Elements of a healthy community (Build Healthy Places Network, 2015)

Community mobilisation

Community mobilisation is a process for reaching out to various segments of a community and building partnerships to target and ultimately address various issues (Huberman et al., 2014). It follows, that community mobilisation entails organising the community and all available community resources in order to move the community toward a specific health program goal. Having this idea in mind, community mobilisation is defined as a capacity-building process through which families (such as model families), groups and individuals, as well as organizations, plan, carry out and evaluate activities on a participatory and sustained basis to attain an agreed goal. This could be from their own initiative – or a goal stimulated by others (The Open University, 2011). This includes mobilising necessary resources, generating support, disseminating information, and fostering cooperation among the community's private and public sectors. Community partners carry out a community action plan by combining and leveraging resources such as funds, skills, and other assets (Huberman et al., 2014).

Community-based participatory approaches to community mobilisation will help attain a sustainable and reliable healthy lifestyle and behavioural changes. Through community involvement, lay and professional people study health problems, pool their experience and knowledge, and devise means and methods for resolving their health issues. HC workers role

is to assist the community with organizing itself so that learning will take place and action follows. The health activity is not capable of achieving the planned goals without involving the community. This can only be achieved by building on the community's knowledge and beliefs through an uninterrupted dialogue and not by dictating what they ought to do.

There are several benefits of community mobilisation that may help local ownership as well as the sustainability of the health programmes. Community mobilisation helps to motivate the people in your community and supports the participation and involvement of everyone while building community capacity to deal with and identify community needs. Community mobilisation promotes long-term commitment to a community change movement and its sustainability. Additionally, it motivates communities to advocate for policy changes that better pertain to their health needs (The Open University, 2011).

Principles of creating community mobilisation strategies:

- secure strong leadership,
- establish a formal structure,
- engage diverse organizations, community leaders, and residents,
- ensure authentic participation and shared decision making,
- ensure authentic and productive roles,
- develop a shared vision,
- conduct a community needs assessment,
- create a strategic plan,
- implement mutually reinforcing strategies,
- establish effective channels for internal communication,
- educate the community (The Open University, 2011).

Activity: Look at question number four in the *Discussion questions*

Community participation

Participation in community mobilisation is about meeting the interests of the entire community. When every member of a community has the possibility, directly or through representation, to participate in the design, implementation, and monitoring of community-level initiatives, there is a higher probability that the program accurately reflects their real needs and interests (Mercy Corps, 2009). Local people have a large amount of experience and insight into what works for them, what does not work, and why. Involving local people in planning may increase their commitment to the programme, and it can help them develop appropriate knowledge and skills to identify and solve their issues on their own. Involving local people helps extend the available resources for the programme, promotes self-reliance and self-help, and improves trust and partnership between health workers and the community. It is also a way to create 'social learning' for both local people and health workers. Therefore, if you involve

the local people in a programme that is developed for them, you may find that they are going to gain from these advantages (The Open University, 2011). The approach should consider the various experiences, capabilities, and needs of different groups in a diverse community – men and women, youth and the elderly, people with disabilities and the able-bodied, language/religious/ethnic majorities and minorities.

Community participation can take several forms. At one end of the spectrum is "passive participation," in which community members participate by being informed about something that will or has already occurred. At the opposite end of the spectrum is "self-mobilisation," where communities organize and take the initiative independent of any external actors (Figure 2) (Mercy Corps, 2009).

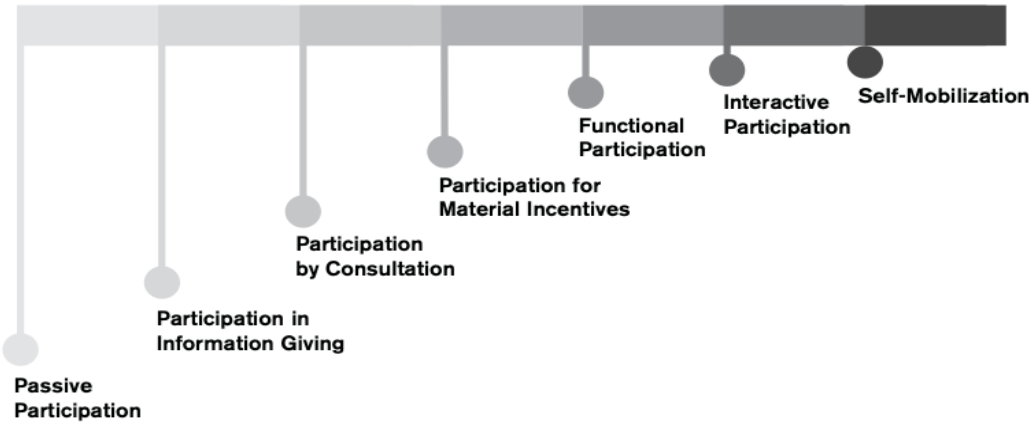

Figure 2 Levels of participation (Mercy Corps, 2009)

We can use typology to define, clarify, and illustrate the various conceptual approaches to community participation. There are four approaches in this typology: contributions, instrumental, empowerment, and developmental (Table 1). In this evolving categorisation, these different conceptual approaches to community participation often overlap and are difficult to tell apart in practice (Preston et al., 2010).

Table 1 Four conceptual approaches to community participation (Preston et al., 2010)

The contributions approach Participation in the contributions approach is defined primarily as voluntary contributions to a project, such as community-based knowledge, resources, or time. Professional developers, who are usually external to the community, lead participation and make the decisions about how the contributions will be used.
The instrumental approach The instrumental approach defines wellbeing and health as a result rather than a process, with community participation as an intervention supporting other public health or primary health care interventions, service development, or health planning. Participation is normally led by professionals; therefore, the important components of the interventions or programs are predetermined to be consistent with local and national priorities.

The community empowerment approach The community empowerment approach seeks to empower and support communities, individuals, and groups to acquire greater control over problems that affect their health and wellbeing. It includes the notions of private development, consciousness-raising, and social policy.
The developmental approach The developmental approach conceptualises social and health care development as an interactive, evolutionary process that takes place within a community of interest or location. Local people, in partnership with professionals, take part in deciding and achieving the outcomes they consider important. The developmental approach is supported by principles of social justice.

Community participation benefits

In primary healthcare (PHC), participation is inspired by the recognition that community members bring their perspective, expertise, and wisdom to issues in their community and that this wisdom can contribute a good deal more to the quality of choices than if decisions are made by health and social practitioners alone. Exclusion is disempowering for those that are most vulnerable. These skills, the networks people establish with others within the community, and their sense of having the ability to negotiate the system and achieve something, are valuable, and in some cases, they are more valuable than any outcome of the group's activity. Where community members have led the process and decisions, the outcomes are more likely to be sustained. The benefits of community participation are summarized in Table 2 (Lawson & Kearns, 2014).

Table 2 Benefits of community participation **(**Lawson & Kearns, 2014).

For the individual: self-esteem and new skills, • empowerment – it gives people a sense of power over the forces that determine their own lives, and • 'connectedness,' which is positively related to health in both morbidity and mortality data. **For the community:** • more educated public and a more cohesive community, • identification and mobilisation of untapped resources of community members; use of citizen' knowledge, • improved planning and decision-making by proponents, and • empowered community affects change or acts as policy advocates. **For the health promotion agenda or program:** • better community-wide (system-wide) programmes, • more relevant programme actions,

• improved and more relevant service delivery,
• greater public acceptance, and
• increased accountability.

For healthy public policy:
• gaining professional entry into social justice issues,
• responsive policy with a broader endorsement,
• intersectoral action on complex issues, and
• demonstration of government commitment.

Why community mobilisation in combating non-communicable diseases

Community mobilisation in combating NCDs is important to create demand for interventions, increase access to services, community ownership and sustainability; scale-up interventions, increase the effectiveness and efficiency of interventions, reach the most vulnerable and address the underlying causes of education.

Diabetes mellitus (DM) and hypertension (HT) are highly prevalent in low- and middle-income countries (LMIC), and they are leading risk factors that cause morbidity and mortality. Recent evidence on the effectiveness of PHC interventions has attracted renewed interest in their implementation. The aim of the Correia et al. study from 2019 was to synthesise evidence related to PHC interventions on DM and HT in LMIC. This framework provided a reproducible approach to classify interventions into four domains: community initiatives, health service organisation, policymaking, and those packing strategies from multiple domains. The majority of these strategies (76.3%) focused on healthcare service organisations, followed by community-level interventions (9.6%), and the creation of a positive policy environment (3.5%) (Correia et al., 2019).

Learning materials

Video 1: Community Health Assessment Overview (Public Health Centers for Excellence, 2015)

The following video provides basic information about the significance of community health assessments and the factors that influence available resources to address the factors that affect a community's health.

- The video is available at: https://www.youtube.com/watch?v=fGf-yFQnwvU

Video 2: Community Mobilization: Tasks Involved (D'Souza, 2018)

The following video provides basic information about the community mobilisation initiative as well as all the steps involved in community mobilisation.

- The video is available at: https://www.youtube.com/watch?v=JCqgNJCa7PE&t=144s

Discussion questions

Now that you have completed this study session, you can evaluate how well you have achieved your learning outcomes by answering the following questions:

1. **What comes to your mind when you think or hear the term "community"?**
   A community is a group of people, based on common values and norms, who live in a geographically defined area.
   A community refers to a village or an area with families that depend on one another in their day-to-day transactions, thereby creating mutual advantages.

2. **What are the things that bind the community together?**
   Language, Culture, Values, Beliefs, Territory, Religion, Occupation
   Utilizing this wide range is critical to assessing the community needs and strategizing areas for improvement.

3. **Are there any particular health problems in your community?**
   Answers will vary from person to person and their community. The point of this question is that the more people know about the community, the more likely they will be able to mobilise and empower the community in fighting against their issues, e.g., non-communicable diseases or any other health-related problems.

4. **Make a list of what you think are the benefits of community mobilisation.**
   Improve local ownership of the community, the sustainability of the health programmes, motivate people, encourage participation and involvement of everyone, the building of community capacity, policy changes, etc.

5. **What are the basic steps in community mobilisation?**
   Step 1: Identify the problem/issue.
   Step 2: Select a strategy to solve the problem.
   Step 3: Community mobilisation.
   Step 4: Implementation through people's participation.
   Step 5: Assess the result and improve.

6. **What areas of community development are the most important?**
   Poverty, health – maternal and child mortality, HIV/AIDS, malaria, education, women's empowerment, the prevention of HIV/AIDS, skill improvement, and water and sanitation.

Test questions

1. *Why is it important to understand a community?*
2. *What is the concept of community mobilisation?*
3. *What roles does community mobilisation play in tackling NCDs?*

Assignment – Who are you? (Focus group)

Make a group of four participants and discuss with the others your role and how you can help the people in your community. At the end of the discussion, every participant should share information about what they learned from their group. Think about what you have in common and how you can use it in community mobilisation.

Glossary of terms:

Community – a group of people sharing one or more characteristics like geographic location (e.g., a neighbourhood), culture, age, or a specific risk factor (The Open University, 2011).
Community mobilisation – a process for reaching out to different sectors of a community, as a capacity-building process, through which individuals, groups, and families (such as model families), as well as organisations, plan, execute and evaluate activities on a participatory and sustained basis to attain an agreed goal (The Open University, 2011).
Community development – community development enables individuals and groups to take action and address issues within their communities. Issues ranging from social to economic, cultural to environmental may help rebuild inequitable systems that leave certain demographic populations marginalized, isolated, and without access to important resources vital to living efficiently and successfully. This is a continuous effort to find community-beneficial solutions and enact collective action to empower individuals, groups, and agencies to improve and support the lives of disadvantaged communities (Net Impact, 2021).
Community participation – community members bring their perspective, expertise, and wisdom to issues in their community, and this wisdom may contribute a great deal more to the quality of decisions than if decisions are made by health and social practitioners alone (The Open University, 2011).
NCDs – non-communicable diseases, also referred to as chronic diseases, tend to be of long duration and the result of a mixture of genetic, physiological, environmental, and behavioural factors, i.e., cardiovascular diseases, cancers, diabetes, and chronic respiratory diseases (WHO, 2021a).
LMIC – low- and middle-income countries. Low-income economies are defined as those with a Gross National Income (GNI) per capita of $1,035 or less; middle-income economies are those with a GNI per capita between $1,036 and $4,045 (The World Bank Group, 2021).
A healthy community – a community where people have the opportunity to make healthy choices, free from violence, promote childhood education, quality housing and jobs, financial inclusion, access to health clinics, healthy food, and transportation (Build Healthy Places Network, 2015).
Community participations approach – participatory approaches are used in impact evaluation, which involves stakeholders, particularly the participants of a programme or those affected by a given policy, in particular aspects of the evaluation process (Guijt, 2014).

Hypertension – abnormally high blood pressure determined if, when measured on two different days, the systolic blood pressure readings on both days are ≥140 mmHg and/or the diastolic blood pressure readings on both days are ≥90 mmHg (WHO, 2021b).

Diabetes mellitus – a chronic metabolic disease characterized by elevated levels of blood glucose (or blood sugar), which leads over time to serious damage to the heart, blood vessels, eyes, kidneys, and nerves (PAHO, 2021).

Intervention – the deliberate involvement in a difficult situation in order to prevent it from worsening or to improve it (Cambridge Dictionary, 2021).

Primary healthcare – the provision of accessible and integrated healthcare services by clinicians that are accountable for addressing a large majority of personal healthcare needs, establishing a consistent partnership with patients, and practising in the context of community and family (Institute of Medicine, 1994).

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COMMUNITY MOBILISATION

Section 2: Principles and Goals

Chebenová V., Hudáčková V., Melichová J.

Introduction

The community mobilisation approach requires the involvement of an external agency that is highly inclusive, supportive and empowering of community structures and networks. There are several significant problems related to a community mobilisation approach. The interests of the entire community take priority over those of individuals. A way of ownership, on the part of the people themselves, helps to make sure that programmes reflect their culture and values as well as ensure sustainability.

Learning objectives:

- Describe the principles and goals of community mobilisation.
- Understand the planning and implementation of a community mobilisation initiative.
- Explain the importance of the role of community mobilisers.

By the end of this session, participants will:

- understand the goals and principles of community mobilisation,
- explain the importance of the role of community mobilisers,
- identify key steps in community mobilisation, and
- be able to define challenges in community mobilisation.

Goals of the community mobilisation

A community mobilisation approach is valuable as it recognises and fulfils people's rights to participate, be in control and determine their future. It enables groups to form local solutions to local problems. These local solutions are typically more sustainable than external solutions that do not fit well with the local culture, situation, and practices. When communities define problems, set common goals, and work together on their programmes to achieve the goals, the communities change in ways that will last even after the project ends.

One of the goals of community mobilisation is to extend individual, community, and group capacity to spot and satisfy needs and promote community interest. It is vital to encourage good leadership and democratic community-level decision-making. Everyone is given a chance to participate, ideas are exchanged freely, and discussion is promoted. While the democratic process focuses on group equality and the free flow of ideas and information, the group's leader is still present to provide guidance and control (Cherry, 2020).

Resources and needs are two sides of an identical coin. It is important to look at what you wish for and what you have got to induce a comprehensive view of your community. With these ideas in mind, you will have a positive impact on the issue you would like to deal with, and you will be able to plan the simplest use of assets. Individuals, organisations and institutions, landscapes, buildings, and equipment are all examples of assets or resources that can be used to improve the standard of life. Understanding the community's assets and needs will help your organisation clarify where it would prefer to go and the way it can get there. This highlights the importance of identifying all the available resources within the community and increasing additional resources to the community to create social networks to raise commitment, support, and changes in social norms and behaviours (Community Tool Box, 2014).

Community mobilisation is necessary for identifying specific groups to undertake specific problems. It also helps to enable the community to better govern themselves.

Principles of community mobilisation

Community mobilisation requires time and commitment. The key to success is to ensure the community is in the driving seat during the process. It allows a community to solve its problems through its efforts – a key to sustained outcomes. It fulfils people's right to participate and determine their future (Table 1) (Ezekiel, 2018).

Table 1 Community Mobilisation Principles Don'ts and Do's (Ezekiel, 2018)

DON'T	DO
Do it all for the community	Do [sic] it with the help of the community
See professionals as experts	Use community expertise
Deny ethnic and cultural differences of communities	Understand ethnic and cultural differences of communities and build on ethnic and cultural diversities
Plan mobilisation alone	Include others in (the) planning process
Focus solely on individual efforts	Develop community partnerships

Key steps in community mobilisation

There are several key steps to community mobilisation, which can be initiated by the community or by outsiders. For example, the community can request the local health workers to produce a health education session on malaria. This is an example of community mobilisation that has been initiated by community members. Alternatively, you may look at a community and consider that female genital mutilation is a serious local problem and choose to mobilise the community to fight it. This can be an example of community mobilisation initiated by others.

<u>Key steps in community mobilisation:</u>

- create awareness of the health problems,
- motivate the community through community preparation, capacity developments, organizational development, and bringing allies together,
- share communication and information,
- support them, provide incentives, and generate resources (The Open University, 2011).

There are many techniques and tools for collecting information that can help you to know more about your community, for instance: group interviews, direct observation, sketching maps, stories, role-plays, proverbs, and workshops (The Open University, 2011).

The community action cycle

The mobilisation process should start by organising a plan of work with the community. After that, explore all the most important health issues in order to understand what is currently happening in the community. Then, identify if and why any specific problems are occurring. Look for beneficial health practices, beliefs, attitudes, and knowledge within that community that are related to the health problem under consideration. Once the health issues are fully explored, set priorities, develop a more detailed plan of work, and carry out the plan. During the implementation of the programme, monitor and finally evaluate the activities. If the programme seems successful, think about how the method could be scaled up to a larger number of households. In this way, the action continues. These activities are known as the community action cycle (Figure 1) (The Open University, 2011).

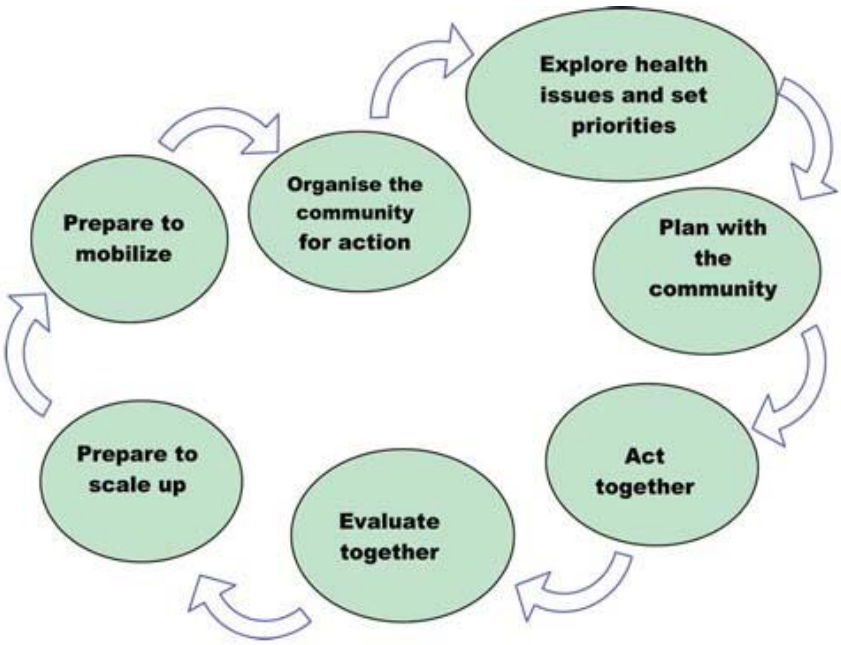

Figure 1 The community action cycle (The Open University, 2011)

Levels of community mobilisation

All community participation is not equal. The level of involvement in a programme can range from minimal to full ownership. Figure 2 depicts increasing degrees of participation from the low end of co-option to the upper end of collective action. This shows that as community participation increases, community ownership and capacity increase (The Open University, 2011).

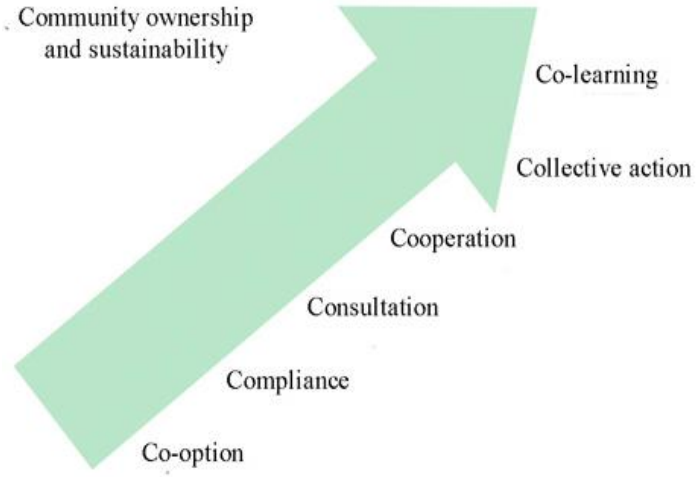

Figure 2 Degrees of community ownership and sustainability (The Open University, 2011)

Co-option: Local representatives are chosen but do not have any real power or input.
Compliance: Tasks and roles are assigned with incentives, but outsiders direct the method and decide the agenda.
Consultation: Local opinions are requested, and outsiders decide on and analyse a course of action.
Cooperation: Local people team up with outsiders to ascertain realities; outsiders are responsible for guiding the process.
Collective action: local people set their own agenda and organise themselves to achieve it without the involvement of external initiators and intermediaries.
Co-learning: Outsiders and local people share their knowledge to form a brand-new understanding and work together to make action plans, with outsiders facilitating (The Open University, 2011).

Community mobilisers

A community mobiliser is a person who enhances community participation by ensuring that the community's resources are mobilised toward a common goal. This common goal of the community could be to advocate enrolment and benefits of going to school, mainstream the underprivileged and vulnerable members in the community, educate parents on wholesome eating through their children, and exposure to traditional foods and foods that provide all the nutrients to the child, literacy campaigns for parents of school-going children, raising money to build school infrastructure, access to clean and safe drinking water, better and

improved health facilities, protecting children from all kinds of abuse, hygiene education, environmental protection and conservation, alleviate poverty in the community, capacity building, or raise awareness about the local community (D'Souza, 2018).

Whether the community development process began through the efforts of external entrepreneurs, local leaders, as a policy initiative, or was instigated by health or community practitioners themselves, health practitioners have an important role to play in supporting those involved in community development. There are two main reasons for this. First, the philosophy of comprehensive PHC and the action areas of the Ottawa Charter for Health Promotion guide health practitioners to take up community development strategies to promote the health of the people they are working with may mean that their work is contrary to mainstream political philosophy. Second, because they come into contact with members of marginalised groups, health practitioners are well positioned to work for community development. Special relationships of trust can develop in the context of 'crisis' situations where they often meet. Their close involvement with people in crises means that they can see, quite clearly, the health implications of poverty and disempowerment (Sterling, 2012).

Table 2 Skills of community mobiliser (D'Souza, 2018)

Attitudes: • respect for all the community members, • non-judgemental and accepting approach, and • belief in the community capacity to take effective action.
Personality skills: • good communication skills (listening, speaking, reading, and writing), • motivated and creative, • ability to handle any situation sensitively, and • good facilitation skills (to enable communities to conduct an analysis of their lives and situation).
Knowledge: • the community mobilisation process and its principles, • understanding of the possible ethical issues, and • knowledge of education-related issues and problems, causes, and effects.
Organisational skills: • ability to identify capacity-building needs among communities, • ability to help communities mobilise resources, • management skills, and • advocacy skills (promotion, support, etc.).

Challenges in community mobilisation

Often community mobilisation processes are designed only to solve issues rather than to explore community needs and priorities (resulting in the process losing its steam halfway

through). Communities will not be empowered to achieve long-term results if programmes do not embrace their values and principles. When communities do not develop the skills to utilize their own resources, problems arise when the external support comes to an end (citizens refuse to work on their own, and programmes cannot or will not meet the established expectations). It is also a challenge to develop/adapt materials for guidance on how to facilitate each phase of the action cycle.

Enhancing and sustaining community mobilisation processes is a challenge for the community. Aside from maintaining transparency and accountability, maintaining sincerity of purpose with the best interests of the community is a challenge. Building a strong leadership in the community; building team spirit and trust among the community are challenges that need to be addressed to bring about intra-group support structures. Community mobilisation necessitates time, investment, close mentoring, and intensive capacity building, none of which are inexpensive (CLAC, 2015).

Challenges of mobilisation and participation for community development: A study of the internally displaced person of Bakassi Peninsular, Nigeria

Mobilisation and participation have a particular impact on the socio-cultural lives of the people in Bakassi, owing to the type of forcible resettlement imposed on the citizenry. This study was conducted through a participatory rural appraisal technique (survey research) to determine and evaluate the fundamental needs of a typical rural setting in Nigeria, with a view of understanding the strategies for rural mobilisation and participation in a resettled environment. The main aim of the study was to explore the social-economic, cultural, and political factors influencing Bakassi's internally displaced people. Data for this study were obtained from two hundred respondents within the study area through a combined set of the research instrument and Focus Group Discussion. The respondents were randomly selected from the different areas under the study. The findings of the study have, among other things, shown that the people of Bakassi are not properly resettled despite the huge amount of government resources committed to the area. A majority of the people are underfed and poor, the settlers are without drinkable water, they have no access to good education, and there are poor health delivery services. Therefore, the study recommends that the Nigerian government should have the political will to create and implement policies targeted at ameliorating the plight of the resettled Bakassi people, especially regarding the provision of affordable social services and empowering the poor to design and implement policies that have the potential of meeting the essential needs of the people. The government should also begin with proper and effective resettlement that would get people closer to the water in order to continue with their normal marine occupation (Usang et al., 2014).

Learning materials

Video 1: Community Mobilizer: Role and Skills (D'Souza, 2018)

The following video explains the meaning of 'community mobilizer' and describes the roles and skills they should possess.

- The video is available at: https://www.youtube.com/watch?v=B87GpG5lBB4&t=54s

Study session 1: Identifying Community Assets and Resources (Community Tool Box, 2014)

The following resource explains how to identify community assets and resources, as well as how to involve them in the community change effort.

- The study session is available at: https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/main

Discussion questions

Now that you have completed this study session, you can evaluate how well you have achieved your learning outcomes by answering the following questions:

7. **What are the benefits of community mobilisation?**
   Help local ownership and the sustainability of the health programmes, motivate the people within the community, support participation and involvement of everyone, build community capacity to identify and address community needs, promotes sustainability and long-term commitment, motivate communities to advocate for policy changes to pertain better to their health needs.

8. **What are the tools and techniques you can use in your community for collecting information (that will help you know more about the community)?**
   - *direct observations,*
   - *group interviews,*
   - *sketching maps,*
   - *role-plays,*
   - *stories,*
   - *proverbs,*
   - *workshops.*

9. **What do you think you need to work on at the beginning of your community mobilisation activities?**
   Get the support of influential people within the community, including people who are called opinion leaders. Make certain that all the people in the community are informed about the health issues you want to address. Behave openly and honestly and try to act as a role model in the community.

10. **List the steps in the community mobilisation action cycle.**
    Step 1: Identify a significant health problem.

Step 2: Design and plan a strategy to solve the problem (conduct a workshop with influential people to sensitise the issue).
Step 3: Identify key actors and stakeholders (village chief, heads of families, etc.)
Step 4: Mobilise and activate these key actors and stakeholders for action (discussions and agreement on what to do and how).
Step 5: Implement solution-oriented activities (capitalise on the sensitization of the people in the workshop and intensify this through various follow-up activities).
Step 6: Assess the results of the activities carried out to solve the problem.
Step 7: Improve activities based on assessment findings.

Test question

1. *What are the key steps in community mobilisation?*
2. *Name all the steps in the community mobilisation action cycle.*
3. *What skills do community mobilisers need?*
4. *What challenges can we encounter in community mobilisation?*

Assignment – The writing essay

Make a historical profile of a village. This allows you to become familiar with the history of a village chosen for community mobilisation. A village's history will include the significance of its name, the people who founded it, and the major events that have marked it through time. After that, make a list of specific action cycle steps you can take in this village.

Glossary of terms:

Attitudes – a feeling/opinion about something/someone, as well as a way of behaving as a result of this (Cambridge Dictionary, 2021a).
Challenges – something that needs serious mental or physical effort to be done successfully and therefore tests somebody's ability (the situation of being faced with) (Cambridge Dictionary, 2021b).
Community mobiliser – a person who urges and prompts a community to take action against a shared issue or problem by using motivation, leadership, skills, political capital, and savvy (D'Souza, 2018).
Community partnerships – the state of being a partner with public agencies, non-profit organizations, government offices, schools, and certain private businesses to produce community service (Jepson, 2021).
Culture – the way of life, mainly the general customs and beliefs, of a specific group of people at a specific time (Cambridge Dictionary, 2021c).
Goals – an aim or purpose (Cambridge Dictionary, 2021d).

Knowledge of community mobilisers – knowledge that community mobilisers should know, including the community mobilisation process and its principles, understanding of the possible ethical problems, knowledge of education-related issues and problems, causes, and effects (Sterling, 2012).

Principles of community mobilisation – include shared humanity, diversity, inclusiveness, representation, responsiveness, and participation in the community (D'Souza, 2018).

Skills of community mobilisers – divided into personality skills like good communication skills, motivation, creativity, the power to handle any situation sensitively or good facilitation skills and organizational skills just like the ability to identify capacity-building needs, help communities mobilise resources, advocacy skills, and management skills (D'Souza, 2018).

The community action cycle – the theoretical basis for the community mobilisation approach and, in a general way, how members work together to identify and address local problems and evaluate the results (The Open University, 2011).

Tools and techniques in community mobilisation – used to collect information that may facilitate you to know more about your community, for instance, direct observation, group interviews, sketching maps, role-plays, stories, proverbs, and workshops (The Open University, 2011).

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COMMUNITY MOBILISATION

Section 3: Effective Health Promotion Programmes

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Introduction

In the early 1970s, community-based programmes for the prevention and control of cardiovascular diseases (CVD) began in Europe and the United States. The high CVD mortality rate in Finland led to the start of the North Karelia Project. Since then, a significant amount of scientific literature has accumulated to present findings and discuss different experiences. The findings indicate that heart health programmes are highly generalizable, cost-effective, and have the potential to influence health policy. Because of the common risk factors, the emphasis of programs shifted from CVD to NCDs in the 1980s. The focus has now shifted to promoting this approach in developing countries, where the prevalence of NCDs is increasing. According to theory and experience, community-based NCDs programmes should be planned, implemented, and evaluated using clear principles and rules, collaborate with all segments of the community, and keep in close contact with national authorities. Given the burden of disease they represent and of globalization, there is a great need for international collaboration. Practical networks with common guidelines that are adaptable to local cultures in a flexible manner have proven to be extremely beneficial (Nissinen et al., 2001).

Learning objectives:

- Describe the development of relevant strategies and tools to implement community-based interventions for the prevention of NCDs.
- Understand the design and implementation of large-scale community-based interventions for the prevention of NCDs through modification of risk factors.
- Define effective health promotion programmes, apply the basis of community mobilisation to NCDs (hypertension, type 2 diabetes mellitus) – involvement in action.

By the end of this session, participants will:

- be able to define challenges in combating NCDs,
- understand the process of community and individual empowerment,
- understand the principles of sustainability of community-based programmes, and
- be able to prepare a draft of a health promotion programme.

Challenges in combating non-communicable diseases

Primary healthcare facilities at the community level play a key role in the implementation of the strategies and programmes. They are tasked with providing essential health services to all residents, particularly children, pregnant women, the elderly, and patients with NCDs. Despite the wonderful progress made to manage and stop NCDs, great challenges remain. One challenge is a lack of knowledge and awareness about NCDs, particularly at the poor and rural community level. The first healthcare facilities at the community level are at the centre of NCDs prevention and management activities. Although there has been much effort and even a World Health Organization (WHO) action plan for the prevention and control of NCDs within the Southeast Asian region (SEAR), progress has been slow. This underscores the necessity for a regional response built on existing alliances and knowledge sharing for a concerted action plan towards NCDs.

Authors Ernita and Wibowo conducted a systematic review that found that policies and programs to combat NCDs in Asian countries required a health system approach that included all health sectors, related stakeholders, and non-government organisations. The review included eight studies (two from India and one each from Indonesia, Turkey, Bangladesh, Nepal, China, and Iran). The continuing programmes in tackling NCDs in Asian countries may follow a community-based approach, improve the skill of doctors, increase investment in public health intervention programmes, and involve all health sectors and related stakeholders. Policymakers should make programmes that focus on health promotion, strengthening infrastructure, including human resources, and early diagnosis of diseases (2019).

What makes an intervention successful?

Non-communicable diseases care must move towards an interprofessional, collaborative, transdisciplinary approach with seamless sharing of data and decisions to enhance effectiveness and efficiency in NCD care. The inclusion of patients, their families, and communities are vital to a successful continuum of NCD care (Bewer, 2017).

The implementation of NCD programmes is often supported through public-private partnerships; however, successful partnerships need an established regulatory framework and clearly outlined goals. Intervention programmes that engage the population through multiple activities or activities that are spaced over the whole duration of the programme are more successful than ones supported by one activity. Evidence-based digital technologies have the potential to enhance care coordination, prevent hospitalisations, and reduce health wastage. Technologies like computing have shown promise in assisting clinical decision support; however, these digital solutions need to be rigorously evaluated for safety and effectiveness in addition to ethical integration. Further research on patient beliefs and health-seeking behaviour in low-income settings and their effect on a healthy lifestyle can help tailor simpler NCD prevention programmes for the Association of Southeast Asian Nations (ASEAN) region.

Because it is the most frequent entry point for patients, medical care has the highest potential to screen and identify high-risk patients. Efficient use of limited healthcare facilities and human resources, sustainable health financing mechanisms, access to basic diagnostics,

essential medicines, organised medical information, and effective referral systems are imperative to ensure equitable primary healthcare in LMICs (Castillo-Carandang et al., 2020).

The proposed solutions for addressing clinical and public health practice gaps in NCD management require strengthening medical care services, employing a collaborative care approach, expanding the roles of medical aid healthcare professionals and pharmacists, and developing technology-based based healthcare solutions. Population-based and clinical approaches to stop NCDs must be prioritized in both urban and rural areas (Mahipala et al., 2019).

The success of population-based interventions

There are many examples of successful population-based interventions, notably the North Karelia Project in Finland, Pawtucket Heart Health programme, etc., for prevention and control of NCDs all over the globe. Valuable lessons are learnt from the implementation of projects in those countries and the evaluation of assorted community-based interventions. The extremely high cardiovascular mortality rate in an eastern province of Finland's North Karelia sparked widespread concern among the local population. Action to scale back the health issue was demanded in a petition to the Finnish government signed by local representatives of the population. In response, the North Karelia project was launched in 1972 with the goal of implementing a comprehensive community-based prevention programme. After the initial five years, prevention activities were also started nationally. The primary aim was to scale back the extremely high serum cholesterol and smoking levels and improve vital signs with lifestyle changes and improved drug treatment, especially for hypertension (HT). Major declines were seen in serum cholesterol and smoking levels, and improvements were seen in vital signs. Coronary mortality reduced in the population (aged 35–64) by 84% from 1972 to 2014. About 2/3 of the mortality decline was explained by risk factor changes and nearly 1/3 by the improvement of recent treatments developed since the 1980s. The most cost-effective and long-term method of controlling cardiovascular and other major non-communicable diseases is population-based prevention through changes in lifestyle and environment. In the current global situation, it is a compelling lesson (Vartiainen, 2018).

The Pawtucket Heart Health programme, a community prevention trial begun in 1980, tested the results of a community-wide education programme on levels of CVD risk factors and risk and rates of coronary heart disease (CHD) in an intervention city relative to a comparison one. The hypothesis was that the intervention site, Pawtucket, Rhode Island, would see a greater decrease in population risk factor "intensity" and projected CHD risk than a comparison city. The study strengths include the deployment of intensive community-based risk factor intervention efforts, several cross-sectional surveys, and long-term study follow-up. Pawtucket developed a community organisation strategy, which involves existing structures and institutions in health promotion. The study's limitations include only studying two communities and the lack of longitudinal (cohort) surveys to track changes. The results of this study, along with findings from other community-based intervention efforts, highlight the difficulties in implementing community-wide risk factor modification efforts and in outpacing population-

level changes in coronary risk factors that are occurring generally (University of Minnesota, 2006).

Behaviour change communication

Behaviour change communication is a communication strategy that encourages an individual or a community to change their behaviour. It is a strategy that triggers people, society, and communities to adopt healthy, beneficial, and positive behavioural practices. It is a powerful communication strategy that promotes changes in attitudes, norms, knowledge, behaviours, and beliefs. It is a powerful and fundamental human interaction (communication), which positively influences the dimensions of health and wellbeing. Behaviour change communication improves the knowledge and attitude of the people, helps to trigger and stimulate people for adopting positive behavioural approaches, promotes appropriate and essential attitude change, helps to increase learning and skills, and improves aptitudes and feeling of self-adequacy (Adhikari, 2019).

Community empowerment

Community empowerment refers to the process of enabling communities to increase control over their lives. 'Empowerment' refers to the process by which people gain control over the factors and decisions that shape their lives. It is the process by which they increase their assets and attributes and build capacities to gain access, partners, networks, or a voice, in order to gain control. The term 'enabling' implies that people cannot "be empowered" by others; they can only empower themselves by acquiring more of the various forms of power. It assumes that people are their most valuable asset and that the external agent's role is to help the community gain power by catalysing, facilitating, or "accompanying" them (WHO, 2008).

Empowerment is at the heart of all community development work and is a manifestation of social justice. Community participation is important during the processes of 'doing' community development work, and one of the outcomes of effective community development can be community empowerment. Practitioners of community development must pay special attention to the needs of those with little power. Community development provides an illustration and makes it easy to assume that a community development project is empowering for community members, but detailed analysis can illustrate the different perspectives on empowerment and show that a project may only be a form of tokenism; empowerment needs to be analysed from the perspective of each party in the process. Knowledge and health literacy are important preliminary skills in community empowerment. If people are unskilled in articulating their needs, or if they believe their needs are unlikely to be met, then they are less likely to express them. Finding out what they believe they need may be a slow process, but it is an important part of the community development practitioner's role. If the work begins before having a complete understanding of the people's situation and perspective, it is unlikely to succeed. People will not be committed to acting on issues they do not see as relevant to them.

People can gain confidence in their ability to effect change in the world around them through processes of meaningful participation. Participation allows people to gain a wide range

of skills, including working effectively with a group or within a workplace team, organisational and negotiation skills, submission writing, interview techniques, working with the media, and using social media for business expansion. The increased confidence and improved skills gained as a result of these processes increase people's ability to work effectively for change on future issues; in other words, the conditions are favourable for people to become empowered (Lawson & Kearns, 2014).

Power is a term that refers to unequal relationships between people and the ability of some people to influence the behaviour of others; power is not always evenly distributed among diverse individuals in a community. WHO concluded that empowerment could lead to better health outcomes. It can assist communities and individuals in developing opportunities, capacities, and tools that will benefit them, as well as ensuring that communities can mobilise targeted populations to obtain needed health resources by raising awareness of a given problem. It can also provide communities with tools for advocating for their members' access to prevention, screening, and treatment. Empowerment often refers to either individual or collective power (Thompson et al., 2016). Organisational empowerment deals with the potential ability of organisations to influence societal change for improvement. Community empowerment is concerned with power dynamics and intervention strategies that allow people to take control of the decisions that affect their lives and health (Tirunagari & Prathap, 2015).

Individual empowerment

Individual empowerment, also known as psychological empowerment, refers to individuals seizing control over their lives by building up self-confidence, boosting their self-esteem, critical awareness of their social context, and better decision-making capacity, resulting in participation in change for improvement (Tirunagari & Prathap, 2015).

Self-efficacy is often described as developing a way of private power, strength, or mastery that aids in increasing one’s capacity to act in situations where one feels a scarcity

of power. Individual self-efficacy is usually considered an individualistic construct built

on the concept that simply having a belief in one’s ability to realize a particular outcome is all someone needs for self-empowerment. This could imply that an internal belief in one's ability to change one's life is both sufficient and desirable (Cattaneo & Chapman, 2010).

Sustainability

Community-based programmes may contribute to sustainable community development by using local resources, improving transparency, and equitably distributing the benefits of development while, in long term, improving living standards and quality of life in the involved communities. A community-based programme must sustain itself to generate and achieve the expected impact upon the targeted community. Unfortunately, sustainability is seldom included in the programme planning while evaluation traditionally focuses on immediate outcomes, often neglecting long-term sustainability, even though, to some extent, without their accomplishment, it will prove unsustainable.

There are several reasons why programme sustainability is important:

- terminating an effective programme leads to negative effects for both the community involved and for the host organisation,
- programme initiation costs are high, and
- communities that experience unexpected programme termination lose trust when future programmes are introduced (Ceptureanu et al., 2018).

Since community-based programmes sustainability cannot be approached unilaterally, it is important to understand their features which differentiate them from traditional projects.

Community-based programmes:

- rely on a community-based approach,
- imply community acceptance and involvement,
- require socio-cultural acceptability, and
- require management capabilities (Ceptureanu et al., 2018).

Community group to prevent and control type 2 diabetes mellitus and intermediate hyperglycaemia in Bangladesh (DMagic)

Roughly 20–30% of adults in rural areas of Bangladesh have abnormal fasting glucose or impaired glucose tolerance (together termed intermediate hyperglycaemia), and about 10% have diabetes, with the prevalence of diabetes (mostly type 2 diabetes mellitus [T2DM]) expected to increase to 24–34% by 2030. Despite the high prevalence of diabetes and intermediate hyperglycaemia in Bangladesh, there is a lack of awareness and knowledge, and effective diabetes prevention and control strategies are urgently needed. Individually targeted strategies that use itinerant technology (mHealth) have been shown to scale back the incidence of T2DM in high-risk individuals. Community-based and peer support interventions can be an economical means of promoting lifestyle changes in LMICs.

DMagic was a cluster-randomized trial in Bangladesh that included participatory community mobilisation, mHealth transportable messaging, and usual care (control) in 96 villages (population: 125,000). Participatory learning and action (PLA) cycles focused on diabetes prevention and control were used in 18 monthly group meetings led by lay facilitators. It also involved mHealth with twice-weekly voice messages over 14 months promoting behaviour change to cut back diabetes risk. The primary outcomes were the combined prevalence of T2DM and intermediate hyperglycaemia within the overall population after the intervention implementation period and the 2-year cumulative incidence of T2DM in a cohort with intermediate hyperglycaemia at baseline. Primary outcomes were assessed through fasting glucose concentrations and 2-hour oral glucose tolerance tests among a cross-section of adults aged 30 years and older and a cohort of people identified with intermediate hyperglycaemia.

The post hoc analysis of the effect of PLA intervention on T2DM only (not combined with intermediate hyperglycaemia) showed a 48% reduction as compared to the control group with individuals identified as having T2DM by glucose testing. Self-awareness of diabetes

status was five times higher within the PLA group than within the control group, and the mHealth intervention increased knowledge and awareness of T2DM. This large and cost-effective impact suggests community mobilisation may also be beneficial in other low and middle-income countries with a high burden of T2DM.

This is a primary study to supply strong evidence that community mobilisation supported participatory learning and action is also a good tool for preventing and controlling T2DM (Fottrell et al., 2019).

Cardiovascular Health Awareness Program in Ontario

Cardiovascular Health Awareness Program (CHAP) is a community-based health promotion programme that targets cardiovascular risk factors, including the detection and management of HT. The programme combines individual- and population-level strategies for primary prevention. The purpose of the study was to determine the feasibility of a community-wide approach integrated with primary care to promote the monitoring of blood pressure (BP) and raise awareness of CVD risk. The participants were community-dwelling seniors.

The research team examined the distribution of risk factors among participants and predictors of multiple visits and elevated BP. Cardiovascular Health Awareness Program cardiovascular risk assessment and education sessions were held in community pharmacies. An environmental scan identified individuals and groups that might be instrumental in supporting and promoting the programme in each location. These included physicians, pharmacists, town council members, hospital administrators, community service groups, local public health units, and other health or community-oriented agencies. Community cardiovascular health profiles were developed using existing secondary data to provide a ‘snapshot’ of local demographics, language, education, and employment. The profiles also listed local family physicians, pharmacies, and resources for cardiovascular health promotion.

In partnership with local branches of the Kidney Foundation of Ontario, the programme hired a coordinator and a community health nurse for each site. The CHAP research team provided consultation and implementation tools, including standardized communication materials and centralized fax-to-database service. In-kind contributions from community agencies and local media helped reduce costs.

A communication plan was developed for each community. Individuals who were well-connected in their communities were recruited through networking. Meetings were held with physicians, pharmacists, seniors’ groups, and other stakeholders. A town hall meeting was organised in one community. On both sites, posters and flyers were widely distributed and, where channels existed and cost allowed, mass media advertising was used.

Cardiovascular Health Awareness Program sessions were offered in pharmacies and promoted to seniors using advertising and personalized letters from physicians. The CHAP cardiovascular risk assessment and education sessions were held in community pharmacies – trained volunteers measured blood pressure, completed risk profiles, and provided risk-specific education materials. The programme yielded learning about community mobilisation and identified a substantial number of seniors with undiagnosed/uncontrolled high BP (Karwalajtys et al., 2013).

Learning materials

Article 1: Community-based non-communicable disease interventions: lessons from developed countries for developing ones (WHO, 2001)

The following article discusses non-communicable disease interventions in communities: lessons from developed countries for developing countries.

- The article is available at: https://www.who.int/bulletin/archives/79(10)963.pdf

Case studies focused on non-communicable diseases:

Case study 1: Innovations in non-communicable diseases management in ASEAN: a case series (Lim et al., 2014)

- The case study is available at: https://www.tandfonline.com/doi/full/10.3402/gha.v7.25110?fbclid=IwAR2jxBC1eUwH7FK7N23AUYiiBR7m2qB8NmtVhOQGK2Zu5um7lFAvpKVXAwU

Case study 2: Improvements in health parameters of a diabetic and hypertensive patient with only 40 minutes of exercise a week: a case study (Seguro et al., 2019)

- The case study is available at: https://www.tandfonline.com/doi/abs/10.1080/09638288.2019.1583780?fbclid=IwAR2ZGfcjo8w4RQEOhqqk6PuaIF6NV-q_mDAm912hQNdluslfpLVHm3dxCgQ

Case study 3: Effectiveness of targeting the health promotion settings for non-communicable disease control in low/middle-income countries: systematic review protocol (Jeet et al., 2018)

- The case study is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6020988/?fbclid=IwAR3wz8KD8fitkimhzBCf-kIgxerG0BA2f0ntGERKgDmcd-q-sHzOuBucQKM

Case study 4: Comprehensive primary healthcare and non-communicable diseases management: a case study of El Salvador (Carrillo et al., 2020)

- The case study is available at: https://www.researchgate.net/publication/340462697_Comprehensive_primary_health_care_and_non-communicable_diseases_management_a_case_study_of_El_Salvador

Case studies focused on hypertension and diabetes mellitus:

Case study 5: OTC case studies: high blood pressure (Bridgeman & Mansukhani, 2019)

- The case study is available at: https://www.pharmacytimes.com/publications/issue/2019/February2019/otc-focus

Case study 6: Hypertension a case study (Gulzarand & Sadeeqa, 2019)

- The case study: https://medwinpublishers.com/VIJ/VIJ16000211.pdf

Case study 7: Diabetes treatment in the elderly: Kathryn (Shubrook, 2019)

- The case study is available at: https://diabetes.medicinematters.com/older-adults/type-2-diabetes/jay-shubrook-diabetes-elderly-multi-morbid-patient-case-study/17355182

Case study 8: Reaching hard-to-reach, high-risk populations: piloting a health promotion and diabetes disease prevention programme on an urban marae in New Zealand (Simmons & Voyle, 2003)

- The case study is available: https://academic.oup.com/heapro/article/18/1/41/895092

Case study 9: Putting theory into practice: a case study of diabetes-related behavioural change interventions on Chicago's South Side (Peek et al., 2014)

- The case study is available at: https://journals.sagepub.com/doi/full/10.1177/1524839914532292

Discussion questions

Now that you have completed this study session, you can evaluate how well you have achieved your learning outcomes by answering the following questions:

11. Could you describe in your own words what a community-based intervention is?

- *An intervention is an activity delivered over a given period of time with the intent*
- *to achieve given objectives.*
- *It targets communities.*
- *Involves collaboration between community groups and groups from outside*
- *of the community.*
- *Commonly acknowledges the importance of resources, power structures and commitment of groups involved.*
- *Involves evaluation plans to show what has been achieved.*

12. Do you know any examples of such interventions?

- *The Stanford Five-City Project*
- *The Minnesota Heart Health Programme*
- *The Pawtucket Heart Health Programme*
- *The German Cardiovascular Prevention Study*
- *The Norsjö Study in Sweden*
- *CINDI (by the WHO Regional Office for Europe (EURO))*
- *CARMEN (WHO Regional Office for the Americas (AMRO))*
- *Interhealth (WHO headquarters)*

Test questions

1. *How does one make an intervention successful?*
2. *How does one achieve sustainability for community-based interventions?*
3. *List successful strategies of community mobilisation.*

Assignment

Create workgroups of 3–5 people and then prepare a draft of a health promotion programme on any topic focused on NCDs community prevention according to the following requirements:

Content requirements:

- Provide an apt title of the study.

Introduction:

- Give a brief description of the current situation regarding the selected issue.

Objective of the programme:

- Clearly and concisely define the objective of the proposed programme.

Health promotion programme description:

- Define the design of the project.
- Define the setting of the programme.
- Define programme participants (community).
- Define the intervention.
- Define the method.
- Indicate how you would interpret the findings.

Conclusion:

- Describe how the results of the proposed programme would contribute to improving the health of the community.

Glossary of terms:

Behaviour – the way that a person, an animal, a substance, etc., behaves in a particular situation or under conditions (Cambridge Dictionary, 2021a).
Blood glucose – the main sugar that the body makes from the food in the diet; glucose is carried through the bloodstream to provide energy to all cells in the body, and cells cannot use glucose without the help of insulin (MedicineNet, 2021a).
Blood pressure – for most healthy individuals, normal blood sugar levels are between 4.0 to 5.4 mmol/l (72 to 99 mg/dL) when fasting (American Heart Association, 2016).

Cardiovascular diseases – the group of disorders of heart and blood vessels include hypertension (high blood pressure), coronary heart disease (heart attack), cerebrovascular disease (stroke), peripheral, vascular disease, heart failure, rheumatic heart disease, congenital heart disease, and cardiomyopathies (WHO, 2021).

Cardiovascular risk assessment – tools to estimate the patient's 10-year risk of developing cardiovascular disease (CVD), which should be used to identify high-risk people for primary prevention (Wong, 2020).

Cardiovascular risk factors – the most important indicators for cardiovascular diseases are personal health history, age, family history, weight, cigarette smoking, blood pressure, diet, exercise, physical activity, diabetes, and pre-existing heart disease (CDC, 2019).

Communication – the act of passing information from one location, person, or group to another; every communication involves (at least) one sender, a message, and a recipient (Cambridge Dictionary, 2021b).

Communication plan –a road map for getting your message delivered to your audience; it is an essential tool for ensuring an organisation sends a clear, specific message with measurable results (Karwalajtys et al., 2013).

Community empowerment – the process of enabling communities to increase control over the factors and decisions that shape their lives; it implies community ownership and action that explicitly aims at social and political change (WHO, 2008).

Cumulative incidence – an estimate of the risk that an individual will experience an event or develop a disease during a specified period of time, which is calculated as the number of new events or cases of a disease divided by the total number of individuals in the population at risk for a specific time interval (CDC, 2012).

Health promotion programmes –aimed to engage and empower individuals and communities to choose healthy behaviours and make changes that reduce the risk of developing chronic diseases and other morbidities (Karwalajtys et al., 2013).

Hyperglycaemia – the technical term for high blood glucose (blood sugar), high blood sugar happens when the body has too little insulin or when the body can't use insulin properly; defined as blood glucose levels greater than 7.0 mmol/l (126 mg/dl) when fasting (MedicineNet, 2021b).

Individual empowerment – when an individual seizes control over their lives by building up self-confidence, boosting their self-esteem, critical awareness of their social context, and better decision-making capacity (Tirunagari & Prathap, 2015).

Population-based interventions – may be directed at the entire population within a community, the systems that affect the health of those populations, or the individuals and families within those populations known to be at risk; seeks to alter our environment through policies, regulations, changes in practices, or by forging new social norms, with the creation of a culture of wellness and an environment that supports healthy choices (Minnesota Department of Health, 2019).

Prevalence – a statistical numerical term that indicates the occurrence of a certain phenomenon per 100 or 1000 people in a certain place and time (CDC, 2012).

Strategy – a detailed plan to achieve one or more long-term or overall goals under conditions of uncertainty (Cambridge Dictionary, 2021c).

Sustainability of programmes – using local resources and improving transparency and equitably distribution of the benefits of development while in the long-term improving living standards and quality of life in the communities involved (Ceptureanu et al., 2018).

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Section 4: Reducing the Burden of Non-communicable Diseases

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Introduction

After the Second World War, with medical achievements in terms of vaccination, antibiotics and improvement of life conditions, NCDs started posing major challenges in industrialized countries. Heart diseases, cancer, diabetes, and chronic pulmonary and mental diseases became a real burden for health systems in developed countries and were seen as diseases of the rich. In recent decades, however, there has been an increasing trend of morbidity and mortality due to NCDs in low and middle-income countries as well. Nowadays, many developing countries are suffering from a double or triple burden of disease as they endure the impact of the rising trend of NCDs while tackling emerging and re-emerging infectious diseases with inadequate healthcare systems. Treatment for diabetes, cancer, cardiovascular diseases, and chronic respiratory diseases is extremely expensive, and therefore the costs involved forces families into catastrophic spending and impoverishment. The costs to healthcare systems from NCDs are high, with increasing costs projected to have an enormous impact on the macroeconomic systems of a country (WHO, 2014a).

Learning objectives:

- Briefly describe the epidemiology of NCDs in the SEAR.
- Understand the most challenging problems in the management and control of NCDs.
- Describe the focus of primary care staff in their struggle against NCDs within a community.

By the end of this session, participants will:

- be able to define the epidemiological situation of NCDs in Southeast Asia (SEA),
- understand the main risk factors of diabetes and hypertension,
- be able to describe challenges in the management of NCDs, and
- understand how to prevent diabetes and hypertension.

Epidemiology of non-communicable diseases in Southeast Asia region

Non-communicable diseases – mainly cardiovascular diseases, chronic respiratory diseases, diabetes, and cancer – are the top killers within SEAR, claiming an estimated 8.5 million lives every year. One-third of these deaths are premature and occur before 70 years of age, thus affecting economically productive individuals. The four ‘major’ NCDs are caused, to a large extent, by four modifiable behavioural risk factors: tobacco use, unhealthy diet,

insufficient physical activity, and harmful use of alcohol. Non-communicable diseases disproportionately affect poor, impoverished families, and place a growing burden on healthcare systems (WHO, 2021). Each year, 64% of total deaths and 58% of total disability-adjusted life years are estimated to be due to NCDs. Globally, NCD deaths are projected to increase by 15% between 2010 and 2020 (to 44 million deaths), with an estimated 10.4 million deaths in SEA (WHO, 2020). Detection, management, and screening are key components of the response to NCDs.

Epidemiology of hypertension and type 2 diabetes mellitus in the Southeast Asia region

Hypertension is the most common chronic disease in both developed and developing countries and is a major public health concern affecting adults. It is the leading reason behind mortality and disability-adjusted life year globally, causes more cardiovascular deaths than any other modifiable cardiovascular risk factor, and is a leading cause of preventable mortality, second only to smoking. In the United States, from the National Health and Nutrition Examination Survey of more than 23,000 subjects, more than 50% of deaths from chronic heart disease and stroke occurred among patients with elevated BP. Approximately one billion people were hypertensive in 2000, and most of those identified to be hypertensive lived in LMICs. There have been several measures taken to control elevations in BP, and while in developed countries, the prevalence of HT appears to be stabilising, the rate in SEAR continues to rise.

Southeast Asia is a subregion in Asia consisting of Thailand, Malaysia, Indonesia, the Philippines, Singapore, Vietnam, Laos, Cambodia, Myanmar, and Timor-Leste. About a third of adults in the region have HT (34% prevalence), and more than 9 million deaths are attributed to HT. Hypertension represents an important public health issue, as this is partly due to absent or poor disease management, with rates of uncontrolled HT as high as 70% (Nawi et al., 2021).

The prevalence rates of DM and its complications in South Asia are much higher than in other developed and developing countries; therefore, DM has become a severe problem in this region. While the prevalence of DM in South Asia is remarkable, its characteristics and causes have not been well-elucidated. More than 85% of the diabetic population suffer from T2DM, and the causes can be divided into two categories: internal/traditional causes and causes induced by rapid development. Factors such as age, gender, diet, and lifestyle changes, including a lack of physical activity caused by modernisation and urbanisation, are major contributory factors. The majority of healthcare costs associated with diabetes are due to later complications and are not preventable. As a result, affordable treatment at an early stage of diabetes is critical. South Asians have the highest risk of developing diabetes, according to a recent study in Canada that used a Diabetes Population Risk Tool. A second study estimated that the prevalence rate of diabetes in South Asians was around four times higher than in other ethnic groups (Waisundara & Shiomi, 2017).

Behavioural risk factors of non-communicable diseases

The urban poor remains a neglected part of the urban population in terms of exploring their burden of behavioural risk factors and prevalence of NCDs among them. It has been found

that there are four important behavioural risk factors of NCDs – tobacco consumption, harmful use of alcohol, unhealthy diet, and physical inactivity (Oli et al., 2013).

"Double burden of non-communicable diseases"

A joint report from UNICEF, WHO, and ASEAN has shed new light on the nutrition situation of children across SEA. The report finds that several ASEAN members face simultaneous crises of over and undernutrition, with some children overweight while their peers suffer from stunting and wasting. This 'double burden' of malnutrition is occurring in LMICs like Indonesia, Malaysia, the Philippines, and Thailand. In Indonesia, the proportions are the same: 12% of children are overweight, and 12% are wasted. In Thailand, wasting and overweight children are both on the rise: between 2006 and 2012, wasting increased from 5 to 7%, and overweight children from 8 to 11%.

The causes of overweight and undernutrition are intertwined. A child whose growth was stunted in childhood is more likely to become overweight later in life. Increased access to junk food and drinks (those with high trans-fat or sugar content and low nutritional value), physical inactivity, and sedentary lifestyles all increase the risk of being overweight. This is a growing trend in many countries throughout the region, and it contributes significantly to the rising prevalence of chronic diseases such as diabetes and heart disease.

"Many countries in Southeast Asia have seen impressive economic gains in the last decade, lifting uncountable children out of poverty," said Christiane Rudert, Regional Nutrition Adviser for UNICEF East Asia and Pacific. "However, at the same time, we have seen the increase of conditions like obesity, previously associated with high-income countries. Asian children are now at risk of malnutrition from both ends of the spectrum."

Stunting and wasting continue to be a problem in most countries in the region, even those who have seen economic gains. In addition to poverty, other contributing factors include traditional diets that lack nutritious foods, poor infant feeding practices, inadequate clean water and sanitation, and farming a limited variety of crops. If children are stunted, their development is also impacted in other areas, including health and education, which affects their chances in life. The report finds that stunting prevalence is highest in Cambodia, Laos, and Myanmar, in addition to parts of Indonesia and the Philippines.

Child malnutrition also has a significant impact on a country's economy. It reduces the productivity of parents and creates a burden on health care systems. It can also lead to NCDs, disabilities, and even death, reducing the potential workforce. The annual economic cost of NCDs in Indonesia, much of which are diet-related, is estimated to be USD 248 billion (UNICEF, 2016).

Prevention of non-communicable diseases

A basic component of NCD prevention is the identification of the common risk factors, followed by preventive steps and control measures. Surveillance of the prevalence trend of the risk factors plays a fundamental role in controlling these diseases. Systematic surveillance of

risk factors offers comparable data trends to highlight the information in terms of levels and trends of major risk factors that predict NCDs (CDC, 2020).

How to prevent hypertension?

Eating a healthy diet – limit the amount of sodium (salt) in food and increase the amount of potassium in your diet; it is also important to eat foods that are lower in fat, plenty of fruits, vegetables, and whole grains.
Be physically active – adults should get at least 2 hours and 30 minutes of moderate-intensity exercise, such as brisk walking or bicycling, every week, that's about 30 minutes a day, five days a week; children and adolescents should get 1 hour of physical activity every day.
Keep a healthy weight – being overweight or having obesity increases the risk for high BP; maintaining a healthy weight can help control high BP and reduce your risk for other health problems.
Get enough sleep – getting enough sleep is important to overall health, and enough sleep is part of keeping the heart and blood vessels healthy; not regularly getting enough sleep is linked to an increased risk of high BP, heart disease, and stroke.
Don't smoke – smoking raises BP and puts you at higher risk for heart attack and stroke.
Limit alcohol – alcohol can raise blood pressure; men should have no more than two alcoholic beverages per day and women should have no more than one alcoholic beverage per day (CDC, 2020).

How to prevent type 2 diabetes mellitus?

Eating a healthy diet – reduce the number of calories in food and drink each day; diets should include smaller portions and less fat and sugar; they should contain a variety of foods from each food group, including plenty of whole grains, fruits, and vegetables, and red meat should be limited.
Losing weight and keeping it off – weight control is an important part of diabetes prevention; diabetes can be prevented or delayed by losing 5 to 10% of one's current weight.
Don't smoke – smoking can contribute to insulin resistance, which can lead T2DM.
Be physically active – exercise has many health benefits, including weight loss and lower blood sugar levels (NIDDK, 2017).

Challenges in the management of non-communicable diseases

Non-communicable diseases are an emerging concern globally. Gaps and challenges exist in political commitment, policy development, the health system, treatment-seeking behaviour, and the role of traditional medicine. National policies aimed at prevention – such as the promotion of healthy food, the creation of a healthy environment conducive to increased physical activity, restriction of marketing for unhealthy food, and the initiation of mass awareness-raising programmes – need to be strengthened. The existing NCD prevention initiatives are vertically channelled rather than horizontally integrated. Primary healthcare is

traditionally orientated towards the prevention of infectious diseases, and staff often lack training in the prevention and control of NCDs. Capacity-building activities have been modest to date and retaining trained health workers in diabetes-oriented activities is a challenge (Latt et al., 2016). Knowledge of diseases, especially NCDs, was reported to be low: more than half considered NCDs (namely diabetes, HT and chronic obstructive pulmonary disease) to be curable (like acute infectious diseases). This means that ensuring an appropriate understanding of the disease is important to improve follow-up, especially for less drastically symptomatic diseases such as HT (Saito et al., 2018; WHO, 2014b).

In the past, people used to seek treatment from local practitioners of traditional medicine. Today, poor people and those who could not afford medicine from reputable suppliers tend to buy medicine at local pharmacies, which are often run by unqualified sellers who sell a combination of medicines for symptomatic relief without proper pharmacology training. These kinds of local pharmacies are quite common in some communities, owing to the weak regulatory system for pharmacies and poor law enforcement. Because of the widespread practice of inclusion of steroids in these mixed medicines, people are prone to develop steroid-induced diabetes, resulting in the deterioration of diabetes control and the development of diabetes-related complications (Latt et al., 2016; WHO, 2014b).

An underlying theme behind most challenges to improve care and outcome is funding shortfalls. Resource constraints affect staff and patient education and motivation, quality of clinical care (available diagnostic tests, treatment, screening and referral options), and outreach activities (Saito et al., 2018).

Community-based approach

The socio-cultural epidemiological transition is the primary underlying risk factor for the rise in NCDs in the Asia Pacific region. The region's lifestyle and nutrition have changed dramatically as a result of economic development. As a result, the region's increase in NCDs, such as obesity and diabetes, has coincided with the region's increase in urbanisation and globalisation. Behavioural risk factors include tobacco use, alcohol consumption, an unhealthy diet, and physical inactivity.

Education on blood pressure, cholesterol, and weight should be emphasised at the school level, as it serves as an appropriate place for health promotion and education to reduce the risks of NCDs. Advocating for people to practice a healthy lifestyle through education (in and out of school) as well as through health promotion campaigns and support groups is deemed necessary.

The treatment of NCDs is not always accessible for all; therefore, primary care should focus on a country’s most deprived communities to help raise awareness of the risks of unhealthy lifestyle choices, making diagnosis and care more accessible and affordable. Primary healthcare providers play a key role in the management and control of these diseases (Low et al., 2015).

Five priorities to ensure healthy lives for all

Ensuring an appropriate understanding of HT and T2DM is important to improve scheduled appointments, follow-up, adherence to recommended lifestyle modifications, and medication adherence.

Promoting a healthy diet, physical activity, reduced alcohol use, and tobacco use cessation are simple and cost-effective measures to reduce premature death and disability from NCDs. Prevention strategies are effective not only for preventing the development of NCDs but also for reducing the burden of various NCDs and the risk of developing co-morbidities alongside existing illnesses (NCD Alliance, 2017).

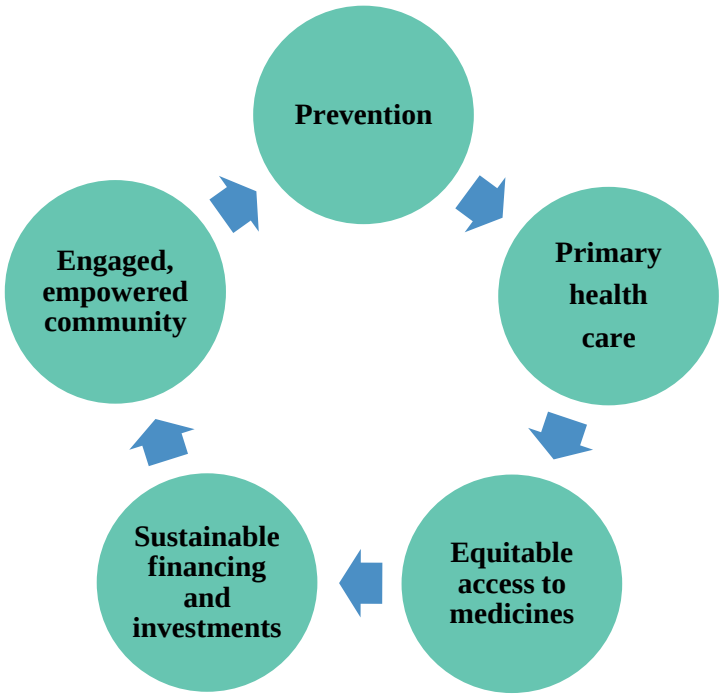

Figure 1 Five priorities to ensure healthy lives for all (NCD Alliance, 2017)

Learning materials

Video 1: What is Hypertension? (McMaster University, 2017)

This video outlines HT, principles of BP, HT prevention tips, and provides answers to basic questions about HT.

- The video is available at: https://www.youtube.com/watch?v=wJ7Ipa5Mgls

Video 2: What is type 2 diabetes (Diabetes UK, 2018)

This video describes T2DM, how it affects the body, and it outlines typical symptoms, treatments, and steps towards prevention.

- The video is available at: https://www.youtube.com/watch?v=4SZGM_E5cLI

Discussion questions

Now that you have completed this study session, you can evaluate how well you have achieved your learning outcomes by answering the following questions:

13. What are the most common misconceptions about NCDs in your country?

- *NCDs mainly affect the rich.*
- *NCDs are mainly diseases of the elderly.*
- *All NCDs are preventable.*
- *NCDs to are curable (like acute infectious diseases).*
- *No cost-effective solutions exist for NCDs.*
- *You cannot change human behaviour when it comes to NCDs.*

Test questions

- *What is the epidemiological situation of NCDs in Southeast Asia?*
- *What are the main challenges that primary care staff face regarding NCDs?*
- *How can primary care staff improve the management of patients' NCDs?*

Assignment – Role-play

A village is located in a very remote area where there is no access to any mode of transport. Most people who live in the village suffer from diabetes. There is no road or path between the village and the nearby district where the hospital is located. Four men died of diabetes or its complications this year.

If you were a community health worker in the field of health promotion for this community, what actions would you take to help these people? How would you mobilise the community to solve these problems? What prevention methods could you implement in this village? This is a significant problem and would require a substantial undertaking.

Glossary of terms:

Behavioural risk factor – risk factors that individuals have the greatest ability to modify, such as diet, tobacco smoking, and drinking alcohol (Low et al., 2015).

Junk food – unhealthy food that is high in calories from sugar or fat, with little dietary fibre, protein, vitamins, minerals, or other important forms of nutritional value (Cambridge Dictionary, 2021a).

Lifestyle – the particular way that a person or group lives, including interests, opinions, behaviours, and behavioural orientations of an individual, group, or culture (Cambridge Dictionary, 2021b).

Nutrition – eating a healthy and balanced diet; food and drink provide energy and nutrients, and, understanding these nutrition terms may make it easier to make better food choices (UNICEF, 2016).

Overweight – a body mass index (BMI) over 25; refer to body weight that is greater than what is considered normal or healthy for a certain height; overweight is generally due to extra body fat; however, overweight may also be due to extra muscle, bone, or water (WHO, 2021).

Premature death – a death that occurs before the average age of death in a certain population (National Cancer Institute, 2021a).

Risk factor – something that increases a person's chances of developing a disease (MedicineNet, 2021).

Tobacco – a plant whose leaves contain high levels of the addictive chemical nicotine; after harvesting, tobacco leaves are cured, aged, and processed in a variety of ways; the resulting products can be smoked (in cigarettes, cigars, and pipes), applied to the gums (as dipping and chewing tobacco), or inhaled (as snuff) (National Cancer Institute, 2021b).

Urbanisation – the process by which large numbers of people become permanently concentrated in relatively small areas, forming cities (Cambridge Dictionary, 2021c).

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COMMUNITY MOBILISATION

Section 5: Participation in Non-communicable Disease Screening

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Introduction

Non-communicable diseases result from a combination of genetic, environmental, physiological, and behavioural factors, and contribute to up to 70% of mortality globally. Current evidence has demonstrated that screening programmes are an efficient tool for disease detection and enable precautionary measures to be taken. A study from WHO involving 133,065 participants showed a 31% reduction in breast cancer mortality for those attending screening programmes compared to the control group. Screening and early detection programmes play notable roles in disease prevention, and hence the benefits rely on their application. The prevalence of health screening attendance in many countries remains alarmingly low. Participation in health screening programmes varies across populations and even within segments of a population in Asian countries, owing to socio-demography, personal attitudes, and beliefs. In addition, factors affecting the decision to attend a screening programme could include type and cost of screening, location of recruitment, and an invitation to screening programmes. It has also been predicted that annual income, level of education, and marital status significantly affect the decision to undergo health screening programmes (Suhaimi et al., 2020).

Learning objectives:

- Recognise NCDs as a major challenge for Sustainable Development Goals (SDGs).
- Describe the current status of NCDs.
- Describe factors affecting the uptake of NCDs screening in a community.
- Mobilise people in NCD screening.

By the end of this session, participants will:

- be able to define challenges for non-communicable diseases in SDGs,
- understand the factors affecting the uptake of NCDs in the community, and
- understand the process of screening.

Non-communicable diseases in Sustainable development goals

Non-communicable diseases are recognized as a major challenge for sustainable development in the 2030 Agenda for Sustainable Development, which was adopted at the United Nations Summit on Sustainable Development in September 2015. The diseases were

not addressed in the Millennium Development Goals. Heads of State and Government committed to develop national responses to the Agenda's overall implementation, including:

i. reduce by one-third premature mortality from NCDs through prevention and treatment and promote mental health and well-being,
ii. strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol,
iii. halve the number of global deaths and injuries from road traffic accidents,
iv. strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate,
v. support the research and development of vaccines and medicines for NCDs that primarily affect developing countries, and
vi. provide access to affordable essential medicines and vaccines (WHO, 2021a).

Hypertension and diabetes at primary healthcare

Management of NCDs requires regular availability of medication, laboratory facilities, data collection tools, trained healthcare workers, and educated and empowered patients, in addition to health services tailored to the social and life characteristics of individuals. There is compelling evidence that primary care is one of the most cost-effective strategies in curbing morbidity, disability, and premature mortality from HT.

The need for effective primary care interventions was stated in the Alma Ata Declaration in 1978, which emphasized effective healthcare systems as a reflection of social determinants instead of hospitals and doctors alone. The Declaration proposed attention to PHC which challenged the view of biomedicine dominated healthcare systems. PHC conceptualized healthcare as scientific, socially acceptable, universally accessible, and based on the principles of equity and community participation. Primary healthcare has again been in the spotlight with the 40th anniversary of the Alma-Ata Declaration and the global community reasserting its principles in the Astana Declaration, which emphasized the importance of PHC in achieving universal health coverage and the SDGs, and on the prevention and management of NCDs (Correia et al., 2019).

Shifting focus from expensive tertiary care of NCDs to primary and secondary prevention provided by primary healthcare and the community would be cost-effective and save lives. Prevention requires reaching the individual before the disease takes hold, which necessitates intervening at an earlier stage of life.

Most preventive healthcare and screening for early disease detection and management occur within PHC setting. Primary healthcare facilities are on the frontline of healthcare and are ideally positioned to supply regular contact with patients and to apply the preventive measures and continuum of care that people need to prevent or delay disabilities caused by chronic health conditions. Primary healthcare facilities can deliver a defined package of services to prevent and control HT, consisting of information, education and communication related to a healthy lifestyle and proper nutrition, smoking cessation services, and regular medical check-ups for adults over 40 years old. Primary healthcare facilities screen for HT,

map diagnosed cases, set up a community-based follow-up system, treat HT and undertake relevant emergency management. Other important activities for PHC facilities include strengthening collaborative work with various stakeholders and community groups involved in this area and developing initiatives based on best practices by supporting information exchange among care providers.

Actions for the health system include: integrating NCDs in the work of PHC facilities, ensuring access to essential medicines and protocols for treatment of HT, setting up referral facilities for complicated cases or resistance to medication, developing and testing service delivery reforms that combine health promotion, prevention, screening, and treatment, as well as providing a continuum of care.

It is important to strengthen health promotion and prevention services at PHC level to ensure access to "healthy options" such as management of lifestyle-related risk factors including obesity, tobacco consumption, physical inactivity, and unhealthy diet as part of PHC interventions.

It is necessary to strengthen the volunteerism approach, involve community health workers and non-governmental organizations, and establish home-visit programmes for awareness-raising, counselling, monitoring, follow-up and linking people with PHC facilities.

To develop a better understanding of NCDs and HT, data collection and surveillance related to NCDs, and HT must be efficiently captured, analysed, and utilised.

Finally, to bring about lasting changes to the role of PHC providers, continuous in-service training must be provided for the prevention of HT and to enhance staff communication skills (WHO, 2012).

Actions for health care providers:

- Ask
  - Ask all patients over the age of 40 years about their smoking habits, nutrition, alcohol consumption, and physical activity and record this information in a household file.
- Advise
  - Provide brief, non-judgmental advice using education materials and motivational interviewing.
- Raise awareness
  - Inform the catchment population about causes of HT and diabetes, preventive measures, and the major signs and symptoms of HT and diabetes.
- Assess
  - Map high-risk and diagnosed cases within the catchment area of PHC facility.
- Assess behavioural risk factors, socio-economic status, and medical history
  - Ask about smoking habits for every patient over ten years of age, ideally at each consultation.
  - Discuss nutrition by asking and recording the number of portions of fruit and vegetables eaten per day and types of fat eaten.

- For overweight and obesity, measure body mass index (BMI) and adult waist circumference especially, for those patients who appear overweight.
- Determine physical activity by asking about the current level and frequency of physical activity per week.
- Inquire about alcohol consumption by asking each person 15 years and over about whether they drink or not, and if yes, the quantity and frequency of alcohol intake (WHO, 2012).

Screening process of non-communicable diseases

Hypertension is the most common condition seen in primary care that can lead to health consequences and death if not detected early and treated appropriately (Naing et al., 2014). All adults should be screened for high BP. Measuring BP is the only way to diagnose HT, as most people with raised BP have no symptoms. Blood pressure measurements should be conducted on adults during routine visits to PHC facilities, including all adults at first presentation to the facility and, if found to be normal, periodically thereafter (e.g., every 1–2 years). Every patient with elevated readings requires immediate follow-up, according to protocol. This measurement is particularly important in adults who have had a prior heart attack or stroke, are obese, use tobacco, or have a family history of heart attack or stroke (WHO, 2018).

Blood pressure is monitored and measured with an inflatable cuff that fits over the upper arm. Blood pressure is checked in a clinical setting as an initial screening for high blood pressure (office measurement). Additional checks are sometimes performed to confirm the diagnosis, such as home BP monitoring or ambulatory BP monitoring (repeated home measurements over a period of 12 to 24 hours). The goal of high BP screening is to reduce the risk of adverse health outcomes such as heart attack, stroke, and death. High BP screening is an accurate way to diagnose high BP sooner rather than later, resulting in earlier treatment. As a result, while there is limited direct evidence from studies linking high BP screening to health outcomes, there is compelling evidence of a significant benefit for screening due to accurate tests and effective treatment (JAMA, 2021).

Diabetes leads to severe damage to the heart, blood vessels, eyes, kidneys, and nerves over time. The starting point for living healthily with diabetes is early diagnosis, as the longer a person lives with undiagnosed and untreated diabetes, the greater the possibility for worse health outcomes. Blood sugar tests are taken to measure high blood sugar levels, which is a risk factor for diabetes. Increased blood glucose or hyperglycaemia is the most common sign of this disease. Blood cholesterol tests are taken to measure the total cholesterol and high-density lipoprotein (HDL) cholesterol levels. High levels of cholesterol in the blood are also a risk factor for CVDs. Management of T2DM should be initiated as soon as a diagnosis is established even if the patient is asymptomatic. Initial assessment and management of the patient have to be carried out at the community health centre level or the secondary care level. Individuals suspected of having T2DM need to be subjected to risk assessment, which includes history and physical examination, assessment of blood glucose levels, presence of CVD risk factors (lipid profile), and end-organ damage (urine for protein/ECG/fundus examination of the eye) (WHO, 2018).

Central obesity, as measured by waist and hip circumferences, is a significant diabetes risk factor. In Asian studies, waist circumference has been identified as a potentially sensitive tool for detecting prediabetes and metabolic obesity. The typical morphology of a small body with a fat belly and large waistline is known to be an indicator of metabolic obesity among Asians, which is a predictor of metabolic diseases. Identifying at-risk people and recommending lifestyle modifications can help to prevent diabetes and avert health expenditure for the lifelong treatment of diabetes and its complications.

Simple lifestyle interventions, such as promoting a healthy diet and physical activity are effective in the prevention of diabetes; however, the way to integrate these within a country's social and cultural context is often challenging (Latt et al., 2019).

Lifestyle management (diet and physical activity) accompanied by drug therapy or insulin is the cornerstone of diabetes management. The basic principles in the management of T2DM are modifying lifestyle, diet, and physical activity, reducing insulin resistance through a reduction in weight, specifically reduction of fat mass, and pharmacological treatment (WHO, 2018).

Factors affecting the uptake of non-communicable disease screening in a community

Subjective norm

Trust at the community level can be identified as an important facilitator for effective participation. A subjective norm is a form of perceived social pressure to do or not to do it, which could affect the intention to participate in conducting NCD screening. The uptake of NCD screening in the integrated guidance post cannot be separated from the norm or social norm. The social norm is a standard rule in a socio-cultural group that is determined by social or religious authority (Firdaus et al., 2019).

Health information exposure

Participation in the behaviour of using NCD screening is affected by external factors such as information factors, namely experience, knowledge, and mass media coverage. High participation is caused by good knowledge about the disease, but low participation is caused by ignorance or lack of understanding. Knowledge and trust are the most important issues in the uptake of disease prevention services, which influences perception and attitude towards screening. Health information support would increase knowledge, understanding, and trust (Firdaus et al., 2019).

Family support

Family support is a potential motivator that encourages family members and decision-makers to participate in the uptake of NCD screening. High family support has a positive effect on health promotion behaviour (Firdaus et al., 2019).

Support of health cadre

Health cadre is an integral part of the community that can reach groups with complex social needs. They can help overcome language barriers in increasing participation in the uptake of NCD screening. A strong health cadre can affect the conviction and trust when deciding to do NCD screening (Firdaus et al., 2019).

Healthy behaviour

There is a correlation between healthy behaviour and participation in the uptake of NCD screening. Positive healthy behaviour likely affects the conviction to do NCD screening (Firdaus et al., 2019).

Health status

High knowledge of disease can affect attitude and conviction to have healthy behaviour. Someone who suffered from or had a history of chronic disease was positively and significantly associated with participating in the uptake of NCD screening. People with chronic diseases really hope to recover. Support is a strong source of motivation for healthy behaviour (Firdaus et al., 2019).

Attitude

An attitude that referred to behaviour was how far a person had a favourable or unfavourable evaluation or assessment, or how far the behaviour performance was valued positively or negatively. High knowledge affects perception and attitude to do NCD screening (Firdaus et al., 2019).

Intention

Individual behaviour in general is based on the intention to behave. Intention is affected by the knowledge and perception of the individual who encourages a different person to participate in the screening activities (Turnbull et al., 2018).

Type of integrated health post

Some characteristics affecting the use of health services are demographic factors including age and sex, social structure factors including the individual status in the community, factors of conviction, attitude about medical care, doctors, and disease. Distance, availability of facilities, access to resources, time, cost, and family support are factors affecting an individual's decision to use health services (Firdaus et al., 2019).

Discussion questions

Now that you have completed this study session, you can evaluate how well you have achieved your learning outcomes by answering the following questions:

1. **Describe your role and responsibilities in NCD screening at your duty station.**
2. **How do you do a screening of hypertension and diabetes in your community?**

Assignment – Group work

Make a group of participants and discuss with others what factors influence the uptake of NCD screening in your community. Think about how you can mobilise your community in order to increase uptake of NCD screening. The group discussion will be followed by a short presentation of your results.

Glossary of terms:

Attitude – a feeling or opinion about something or someone, or a way of behaving that is caused by this (Cambridge Dictionary, 2021a).
Awareness – the state of being conscious of something, more specifically, the ability to directly know and perceive, to feel, or to be cognizant of events (Cambridge Dictionary, 2021b).
Counselling – an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem-solving, and interpersonal relationships (Counselling Directory, 2021).
Essential medicines – medicines that satisfy the priority health care needs of the population; they are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness (WHO, 2021b).
In-service training – professional training or staff development, where professionals are trained and discuss their work with others in their peer group; education and training delivered in the practice setting as facilitation of an individual's ability to function within a given agency (WHO, 2012).
Obesity – defined as an abnormal or excessive fat accumulation that poses a health risk; person's body mass index (BMI) of over 30 is considered obese (WHO, 2021c).
Prediabetes – a blood sugar level higher than normal but not enough to be classified as T2DM; it's not high enough to be cl T2DM, but without lifestyle changes, adults and children with prediabetes are more likely to develop T2DM (CDC, 2020).
Screening process in healthcare – a medical test that doctors use to check for diseases and health conditions before there are any signs or symptoms; screenings help find problems early on, when they may be easier to treat and, getting recommended screening tests is one of the most important things you can do for your health (MyHealthfinder, 2021).
Secondary prevention – trying to detect a disease early and prevent it from getting worse (HealthLinkBC, 2016).

Sustainable development goals – the Global Goals were adopted by all United Nations Member States in 2015 as a universal call to action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity by 2030 (WHO, 2021a).
Tertiary care in health care – highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities (Merriam-Webster, 2021).

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II. BEHAVIOUR CHANGE COMMUNICATION

Section 1: Introduction

Mračková T., Gába P., Sivčo P.

Changing human behaviour to achieve positive health outcomes is a very complex and long-term process. If a certain behaviour is promoted and disseminated to people or even accepted and understood by them, permanent change in the behaviour is rarely seen and requires regular follow-ups, evaluation, and motivation. The strategic use of communication, i.e., behaviour change communication (BCC), is based on the theories and models of behavioural change that have been proven effective in shaping and reinforcing the desired behaviour. To alter the patient's/client's behaviour successfully, it is essential to understand the communication process between the sender and recipient, its barriers, pitfalls, and to discover the ***patient's reason to change***. Using BCC and its techniques systematically within the framework requires a good theoretical background, but it also requires practice and the desire for improvement from health care practitioners. This chapter will investigate BCC history, explain the steps in the BCC strategy and communication process, and give tips on improving communication skills with practical examples.

Learning objectives

- Improve knowledge about behavioural change communication
- Describe the communication process in health behaviour change and the barriers in effective behavioural change communication
- Gain skills in how and when to use the BCC framework

By the end of this session, participants will:

- be able to describe behaviour change communication as a component of Health promotion,
- be able to identify frameworks to implement BCC in practice,
- understand barriers in effective behavioural change communication,
- understand how behaviour change communication helps to improve health.

A brief history of behaviour change communication

Health communication embodies several strategies to share information for achieving better health outcomes. Activities in this form of communication vary widely based on the

objectives of communication, target audience, and communication channels. For example, health communication can be used to promote actions against communicable and non-communicable diseases within the individual, community, or population level or to advocate essential changes in health regulations to policymakers (Manoff Group, 2012).

In the early 1970s, when the use of mass media proved to be a useful tool for disseminating health information, the **Information, Education and Communication (IEC)** strategy was developed. IEC specifically focuses on the communication aspect, utilizing a wide range of media channels and materials from didactic and one-way communication to interactive and entertaining methods. In its principle, the IEC approach assumes that the adherence of people to health advice will increase if the proper information is provided to them (Manoff Group, 2012).

Although commonly used in the context of marketing of pro-health behaviours, social marketing has also become closely associated with the other processes, including the distribution, promotion, and sale of health products at subsidized prices. Health care workers have realized the need to specifically focus on changes in patients' behaviour, centring on the correct use of products as well as the promotion of actions not involving products at all. Therefore, an evidence- and research-based process of using communication to promote behaviours was proposed - **Behaviour Change Communication (BCC):** *"BCC intends to foster necessary actions in the home, community, health facility or society that improve health outcomes by promoting healthy lifestyles or preventing and limiting the impact of health problems using an appropriate mix of interpersonal, group, and mass-media channels"* (Manoff Group, 2012).

BCC efforts to achieve changed behaviour emphasize the patient's opinions, feelings, and current emotional situation, mainly on the individual level. However, the understanding that behaviours are rooted in and influenced by various social and health determinants has become more widespread among practitioners and other health care workers. The inclusion of the socio-ecological context has led to an expansion of the BCC approach into the new concept - **Social and Behaviour Change Communication (SBCC)**. *"SBCC is driven by epidemiological evidence and client perspectives and needs. SBCC . . . incorporates both individual level change and change at broader environmental and structural levels"* (Manoff Group, 2012).

What is behaviour change communication?

BCC can be viewed as an interactive process of developing and communicating specifically tailored messages (with individuals or communities) via various communication channels. Messages are oriented on the development, promotion, and sustainment of behaviour changes on individual, community, and societal levels and often are part of a broader action plan or program. BCC also embodies a systematic process consisting of formative research and behaviour analysis, communication planning, implementation, monitoring, and evaluation. The target audiences are analysed and carefully segmented, and the messages or any other material

for the communication are pre-tested and used via both interpersonal channels and mass media. (USAID, 2002). In addition, some specific and individual factors that can prompt people to change their behaviour should be kept in mind:

- *physical stimuli* that emerge from a person's fear of future pain or discomfort, a memory of past pain, or based on a person's current physical state
- *rational stimuli* that are based on knowledge, i.e., if a person has the facts, the reasoning to do the right thing is clearer
- *emotional stimuli* based on a person's feelings such as fear, pride, love, or hope
- *skills* that are translated into a person's capacity to adapt and continue a new behaviour (Ngigi & Busolo, 2018).

The key role of BCC can be summarized as follows:

- help to start a new and good behaviour,
- help to modify existing behaviour,
- prevent the adoption of harmful behaviour,
- and to stop doing something damaging (Ngigi & Busolo, 2018).

Behaviour change communication strategy

To ensure that our behaviour change communication will achieve the desired outcome, it should be used following the behaviour change communication strategy. Following parts were taken from the SNV's Behaviour Change Communication Guidelines (SNV, 2016). The development of this strategy should follow multiple steps (Figure 1).

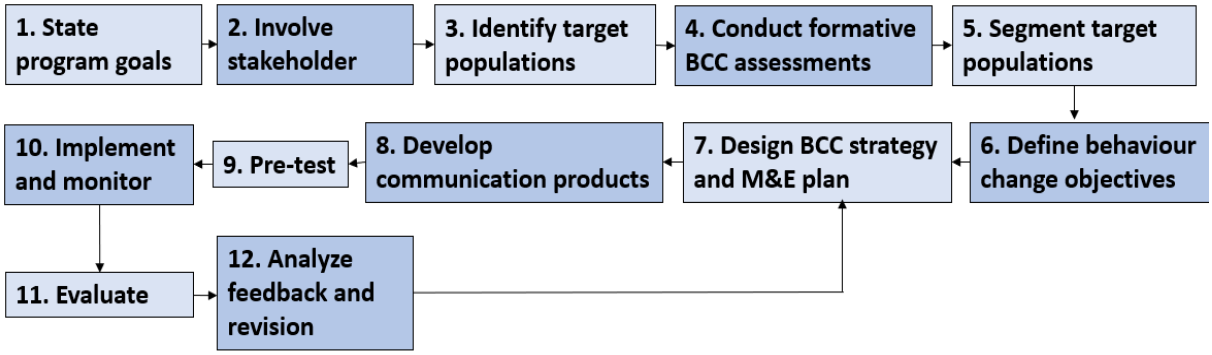

Figure 1 Steps in developing a behaviour change communication strategy

State program goals and involve stakeholders

Clear identification of overall program goals is the first step in developing a BCC strategy. The goals should be SMART (S = specific, M = measurable, A = achievable, R = realistic, T = time-bounded) and based on existing data, epidemiological information, and in-depth program situation assessments.

Stakeholders' active participation during the stages of BCC strategy development is crucial. Meetings should be conducted in the early stages of strategy development, ensuring the proper planning process as well as the development of a strategy's coordination mechanism.

Identify target populations

Based on the intention of the BCC program (intervention), target audiences should be analysed and carefully segmented. The impact of such intervention can be recognized as primary, on populations whose behaviour is intended to be influenced, or as secondary, on populations that are influenced by the ability of the primary population to adopt the desired behaviours.

Conduct formative BCC assessments

In the beginning, it is essential to seek out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioural surveillance surveys, and other related studies. Formative BCC assessments make use of qualitative methods, such as focus group discussions, key informant interviews, direct observation, etc. In this stage, it is advised to cooperate with institutions and organizations engaged in the population with assistance from appropriate research institutions.

Segment target population and define behaviour change objectives

The population can be grouped more specifically according to work location (street, home, health-care facilities), income level, ethnicity, language, and other various psychosocial and demographic characteristics. Population segmentation is followed by defining what changes in behaviour the program intends to achieve. While behaviour changes may not have been specified in the project documents, they can be inferred from project goals. Common examples of behaviour change interventions are:

- the decline in stigma associated with diseases,
- increased incidence of healthcare-seeking behaviour,
- adherence to treatment guidelines by medical practitioners.

Design BCC strategy and Monitoring and Evaluation (M&E) Plan

The next step is to adjust the strategy's design to get the right mix of approaches to involve the target population, to get their attention, and to promote and enable action. A well-designed BCC strategy should include:

- clearly defined BCC objectives,
- an overall concept or theme and key messages,
- identification of channels of dissemination,
- identification of partners for implementation (including capacity-building plan),
- a monitoring and evaluation plan.

Develop communication products and conduct pre-testing

The development of specific communication support materials should be based on decisions made about channels and activities. They can include printed materials for educators and workers, television and radio spots for the general population, advocacy promotion materials, or scripts for theatre. Pre-test all materials with the audience for whom the communication is intended to evaluate the audience's comprehension, attraction, persuasion, acceptability, and degree of identification.

Implement, monitor, evaluate and get feedback

All partners, programmers, and channels of the BCC strategy must be closely coordinated during the implementation phase (e.g., via regularly scheduled meetings). Timing and coordination are key to managing a program effectively. Review the preceding steps in the BCC process to ascertain whether the program has been addressing the target audience's previously identified problems and needs and monitor the implementation process by specific personnel. The needs of target populations must be periodically reassessed to understand where they stand along the behaviour change continuum. Assessment of a project's implementation against its stated objectives and in reference to a baseline may be qualitative or quantitative (or both). Monitoring and evaluation may reveal the need for modifications of the overall program, the BCC strategies, messages, or even the approaches (SNV, 2016).

Communication planning/process in health behaviour change

Because the direct linking of a person's current health concern with their health behaviour can lead to resistance to advice, patients/clients are likely to be **more receptive** when they have **initiated** the discussions about health behaviour change. When the topic is raised, it is recommended to use collaborative health behaviour change talk, further inviting and accommodating the **patient's perspective** during subsequent advice-giving. To deliver the message as intended, the sender of the information needs to be aware of the communication process and any interfering elements that are present. Some of them are logically inevitable, emerging from the communication process itself, but others can be reduced.

The process of communicating an intended message broadly follows:

1) the sender has an intention,
2) this is encoded into a form that can be shared with the receiver,
3) the message is transmitted to the receiver via a chosen medium,
4) the receiver receives the message, and finally,
5) the receiver decodes the message so that it is understood and has meaning (Albury et al., 2019; SNV 2016).

Barriers to effective communication

- physical barriers
- perceptual and emotional barriers
- cultural and language barriers

- interpersonal barriers (withdrawal, rituals, pastimes, working, games, closeness)
- gender barriers (Impact factory, 2020)

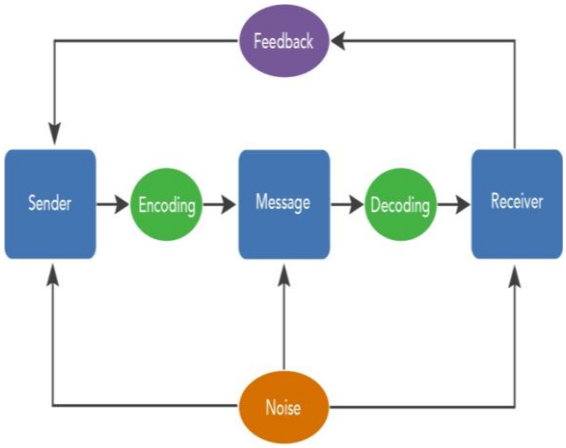

Figure 2 The process of communication

How to improve communication skills?

A key element is an empathetic therapeutic approach, which emphasises active listening to understand the patient's perspective and experiences, that embodies the health care practitioner's respect for the dignity of others, developed self-discipline, and a non-judgmental attitude to their patients/clients.

We offer a few practical tips to become an **active listener:**

- use eye contact (non-verbal communication)
- use open-ended questions
- check your understanding by summarizing
- use a tone of voice that shows interest

In contrast, the following examples **interfere with the active listening process:**

- Interrupting the client unnecessarily
- Letting your mind wander and spending time listening to formulate your responses
- Finishing the client's sentences (AUSMED, 2019).

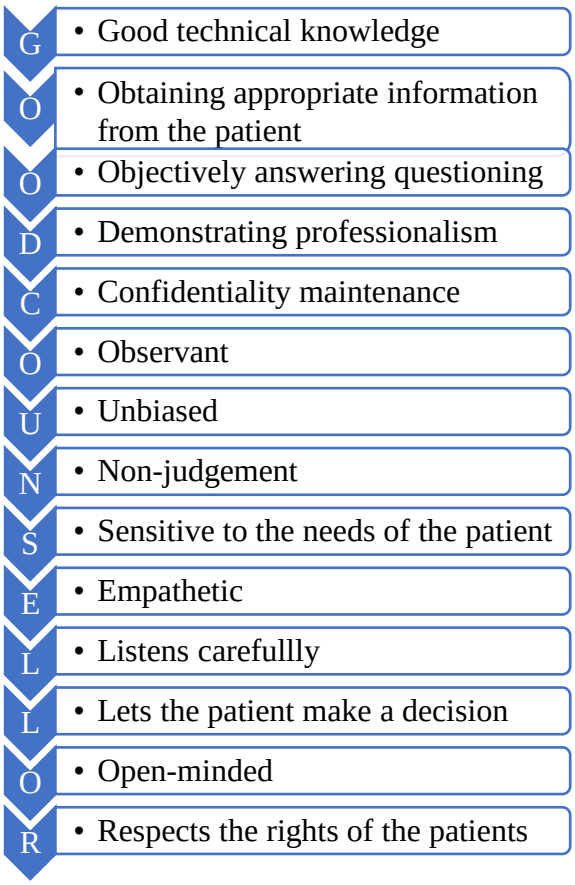

Figure 3 Good counsellor qualities and attitudes

Communication tips (Robinson et al., 2006; Shaw, 2018)

Give patients more time

- Let the patients take time to process the information, especially the elderly. Although they have an increased need for information, older people tend to be more nervous and lack focus more often than younger patients. Additional time may prove very useful.

Reduce external interruptions

- Try to avoid external factors that can potentially lead to perplexities or distractions. Researchers recommend that if you give your patients your undivided attention in the first 60 seconds, you can *"create the impression that a meaningful amount of time was spent with them"* (Baker, 2004).

Make sure your back is not away from the patient

- During the session, sit face-to-face with your patient. Patients want to feel their importance and this simple act sends an essential message about your focus and commitment.

Maintain keen eye contact

- Eye contact is one of the most direct and powerful forms of nonverbal communication. It creates a more positive and comfortable atmosphere that helps build trust between you and the patient.

Use effective listening skills

- Be an active listener. The most common complaint patients have about their doctors is that they don't listen. Do not allow yourself to let your focus fade from what the patient is telling you. Be there for him or her and listen closely.

Communicate clear and loud

- Don't rush through your instructions to the patients, especially the elderly. Speak clearly and loudly, but do not shout. From time to time, ask if they have perceived the information and understood it.

Use simple phrases

- Simplify the information and the terminology you are using. Medical jargon and technical terms can confuse patients. Speaking in a manner that can be easily understood is one of the best ways to ensure that your patients will follow your instructions.

Avoiding overwhelming topics on a patient

- Stick to one topic at a time and explain any important information in a series of steps. Do not overwhelm patients with too much information. For example, first talk about the lungs; second, talk about blood pressure; and third, talk about smoking.

Provide pictures to clarify information

- Visual aids will help patients better understand their condition and treatment.

Frequently summarize the most important points

- Ask your patients to repeat your instructions. Do not wait until the end of the session; ask them to repeat instructions in the middle of or during the discussion. If you think that the patient did not understand your instructions, simply repeating them may work.

Allow the patient to ask questions

- Do not let the session evolve into a one-way instruction-sharing lecture. Emphasize the importance of questions and let it be clear that they are most welcome. This will allow them to express any apprehensions they might have and help to ensure that the information you provided will be used effectively.

Learning material

Malaria control

In the efforts to improve malaria control, the crucial problems of behavioural barriers have been well-known - inconsistent or non-use of bed nets, delays in seeking effective treatment, and distribution of intermittent preventive therapy with partial or no explanation of its usage to pregnant women. The role of BCC in malaria interventions is to help people to overcome these barriers. Evidence of effective usage of BCC in malaria control is growing, mostly when used in conjunction with other approaches (mass media, interpersonal communication, and structural approaches). BCC can be used in many areas, such as promotion of testing and treatment in hotspot areas, prophylaxis use for travellers, to improve treatment adherence, and to increase demand for and recognition of quality drugs. Its integration into malaria control strategies should be done from the start of the intervention and can contribute greatly to malaria elimination (Koenker et al., 2014).

Improving Maternal, Neonatal Health, and Child Survival

In 2010, **BRAC**, an international humanitarian organization, employed the BCC strategy to improve maternal, neonatal, and child survival in rural Bangladesh. The study revealed the importance of interpersonal communication and barriers in understanding, cultural acceptance of some materials used, and the limited reach of activities for audiences such as men and the elderly. The authors suggested the material improvement and implementation of then unused social media and text messaging to increase the coverage of BCC in the community. Together with building community support for new behaviours, BCC activities should lead to improved health outcomes for mothers, newborns, and children (Rahman et al., 2016).

Reducing the incidence of NCDs

The scientific information provided to the population must be transformed into an understandable and applicable manner. The messages that will most likely resonate with consumers are simple and realistic. Key messages to the public should take into

consideration an individual's lifestyle, their beliefs and tailor the information positively.

The government and the stakeholders should make specific efforts to teach the targeted audience how to evaluate health information. Although it is not easy, the most effective time to begin is early in life. The EPODE program in France is a good and successful example that illustrates how connecting with children early in life can benefit the whole family. This program used the personalization approach (for food, nutrition, and health information). However, even the authors of this program stated that it might not work for every individual. To achieve the best results, health communicators should bear in mind at least some of the key tenets conducted by Dr Fernstrom (Fernstrom et al., 2012):

1. Use easy-to-understand messages.
2. Set realistic goals.
3. Connect with children early in life on how they can succeed.
4. Focus on "how to do it" instead of "what to do."
5. A key message should be "do something."
6. Be open to more variety in your daily diet.
7. All physical activity counts.
8. Remember, energy balance sustains a healthy weight – "calories in equal calories out."
9. Address what consumers are willing and able to do.
10. Develop a culture of wellness.

Video 1: What is Social and Behavior Change Communication? (The Health Communication Capacity Collaborative, 2015)

This animated video defines Social and Behaviour Change Communication (SBCC) and outlines how to begin to devise an SBCC program.

- The video is available at: https://www.youtube.com/watch?v=RN0F7jAFkgw

Video 2: WHO: Bringing health to life (WHO, 2013)

This animated video illustrates the actions conducted by the World Health Organization. Do you see some BCC in there?

- The video is available at: https://www.youtube.com/watch?v=hSYaGCfPrxo

Video 3: High Blood Pressure (Pfizer, 2019)

This animated video shows doctor-patient conversations using multiple approaches and methods, some of them mentioned earlier.

- The video is available at: https://www.youtube.com/watch?v=T3FQuAEnAM0&feature=emb_logo

Discussion questions

1. How can you change deep-rooted habits or community norms which are harmful to health?

- *By application of the evidence-based approach in BCC – know how and when to use specific methods within the frameworks to generate change talk, remove existing barriers and achieve the desired outcome.*

2. Have you ever felt the fear of causing a patient offense during your communication?

- *Fear of causing offense is a common problem in many BCC therapies. By becoming an active listener and letting the patient tell his/her story (the core concept of many BCC techniques), you can facilitate the desire to change and ideas on how to achieve the change from the patient without offending him/her.*

Test questions

- *What is the difference between IEC and BCC?*
- *How can effective communication in behaviour change communication help patients with NCD? Give a practical example.*
- *How can behaviour change communication help patients with CD? Give a practical example.*
- *What qualities do you need to establish a good rapport with a client or patient?*

Assignments for participants

Position yourself as a doctor during a behaviour change communication session. Prepare a short transcript (15-20 sentences) of the doctor-patient behaviour change communication session. Knowingly make five mistakes in the communication process using the knowledge gained from this chapter.

- Give the transcript to your colleague (and receive one from him/her) and identify these mistakes. Prepare an alternative transcript with suggested revisions.

Glossary of terms

Behaviour Change Communication – is a communication strategy which encourages individual/community to change their behaviour or to adopt healthy, beneficial, and positive behavioural practices (Adhikari, 2019).

Communicable diseases – are illnesses that result from the infection, presence, and growth of pathogenic biological agents in an individual human or another animal host (Wisconsin Department of Health Services, 2021).

Health communication – is a broad term that describes several strategies to share information that can lead to better health outcomes (Manoff Group, 2012).

Information, Education and Communication – is a public health approach aiming at changing or reinforcing health-related behaviours in a target audience, concerning a specific problem and

within a pre-defined period of time, through communication methods and principles (WHO, 2014).

Non – communicable diseases – non-infectious health condition that cannot be spread from person to person (also known as a chronic disease) (Cirino, 2018).

Social and Behaviour Change Communication – is the strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs, and behaviours (Johns Hopkins University, 2020).

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BEHAVIOUR CHANGE COMMUNICATION

Section 2: Theoretical concepts – Behavioural Change Models

Mračková T., Gába P., Sivčo P.

Introduction

Change implies making either an essential difference often amounting to a loss of original identity or a substitution of one thing for another. Change in human behaviour is based on the use of various techniques that have proven to be effective in shaping and reinforcing the desired behaviour. To achieve change in the client's behaviour, it is important to know their current health status, its determinants and to choose the correct technique of conversation with the patient, using supportive and motivating words. This chapter will provide answers to the question: ***How to make behaviour change easier?*** It will also more closely examine the effectiveness of motivational interviews. Finally, it will show when to use specific frameworks.

Learning objectives

- Identify main elements influencing behaviour change
- Describe three behaviour change techniques
- Create an example of doctor-patient/client conversation using motivational interviewing

By the end of this session, participants will:

- understand how to make behaviour change easier using frameworks,
- be able to describe keystones of the motivational interviewing approach,
- be able to explain 5 A's framework,
- be able to identify the patient's/client's stage of change,
- know when to use a specific framework,
- understand pitfalls for these approaches - what should I be aware of or avoid?

Behaviour change technique

The term **'behaviour change technique'** refers to the component of an intervention that has been designed to change behaviour, such as social support. The technique must have clear criteria that can be generally used. Behaviour change techniques should be irreducible because they are the smallest component in the behaviour change process. These techniques can be used individually as well as in combination.

A brief intervention includes an interview (in person or online), support, and encouragement with or without a proposal for measures and changes. It may include guidance on more specialized technical assistance, suggestions for further interventions, and other

recommendations. A brief intervention can be provided by anyone who undergoes the necessary training. A brief intervention takes a short time (usually only a few minutes) (NICE, 2014).

How to make behaviour change easier

The basics are to use proven and effective behavioural change techniques. **Goals and planning** are part of the techniques that help meet goals effectively. Action plans prepare us to deal with crises, stressful situations and talk about the distribution of progress in change (when and what will happen). Goals can be adjusted during the process according to the person's progress.

Work with the client to:

- set goals and expected results together,
- draw up a detailed plan with priorities,
- prepare for crisis management and prevent relapse, and
- consider other goals of the plan once the results have been achieved.

When **monitoring feedback**, it is necessary to record specific behaviours and the outcome of those behaviours. Based on these records, the patient is provided with feedback, which is important as motivation to create change or set goals. Supporting the patient and acknowledging that change helps is beneficial and can improve their results.

Social support mainly includes family and friends or someone else in whom a person has confidence and wants to help change behaviour (for example, lose weight). It can take the form of:

- Practical help (seek help from someone, with the availability of a service such as taking someone to the pharmacy or a meeting).
- Emotional support (support of a partner or friend by spending time together, joint physical activity. or cooking healthier food together, if they want to lose weight).
- Appreciation of effort and results, regardless of scope (congratulations even for small steps) (NICE, 2014).

Frameworks

Theoretical frameworks

The theoretical frameworks for designing and evaluating interventions help to improve results and can provide us with information on why the intervention was effective or why it was not effective. So far, several theoretical frameworks have been developed, with further evidence still emerging (NICE, 2014).

Behavioural determinants

There are several different approaches used to understand behavioural determinants. A behavioural model, or framework, helps us understand behaviour and its underlying factors. The value of using a model is in providing a way to organise our thinking and analyse our

findings. To change behaviour, we need a better understanding of the factors that influence that behaviour. These factors are based on evolving theories of behaviour change. Behavioural frameworks commonly group the factors that may influence whether an individual has the opportunity, ability, and motivation to engage in the behaviour.

Figure 1 Role of behavioural determinants in relation to changing behaviour (SNV, 2016)

Motivational interviewing

"***Motivational interviewing (MI)*** *is a collaborative, goal-oriented style of communication with attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's reasons for change within an atmosphere of acceptance and compassion"* (Miller & Rollnick, 2013). Four basic MI processes describe the course of the conversation, and we can move back and forth between processes, if necessary.

1. Engaging: This is the basis of MI. It is important to form a relationship in which the person trusts us and knows that they will be heard. By listening thoroughly, we understand the exact situation in which a person finds themself and express support for change.

2. Focusing: In this process, we draw on a person's knowledge and try to share our expertise with them. We agree on a common purpose of change and the subsequent process.

3. Evoking: Here, we help the person realize their reason for change, and we instil in them the motivation to change. It is essential that a patient talks about change on their own and that they are motivated and determined to change. Ambiguous opinions are common from the outset and can be resolved.

4. Planning: When a person is ready, it is essential to develop a plan based on the person's knowledge and motivation to change. The general practitioner tries to guide the person to gradual and timed solutions to the problem. This process is not mandatory, but in its implementation, the readiness of persons is important.

For chronically ill people, e.g., those with diabetes, it is difficult to follow complicated daily regimens. Typical patient responses to supportive questions from their physicians are

ambivalence or resistance. Another frequent response is to consent to the doctor during the interview but poorly adhere to the plan subsequently.

D: *"Why don't you try to add some vegetables or try some physical activity?"* or *"Your severe lows are worrying me; the hospital has a new hypoglycaemia group starting in the evenings that you should think about attending."*

P: ambivalence, *"Hmm, I don't know,"* or resistance, *"Yes, but...,"* (Welch et al., 2006).

Stages of Change Model (The Transtheoretical Model)

The Stages of Change Model was developed in the late 70s by Prochaska and DiClemente by observing smoking cessation. They researched why some smokers stop smoking on their own, and some need help to quit smoking. It turned out that people stopped smoking only when they were ready themselves.

This model focuses on individual and intentional changes with specific goals. It assumes that change does not happen quickly and easily. Behavioural change from normal behaviour is a gradual process that needs to be worked on constantly and consistently.

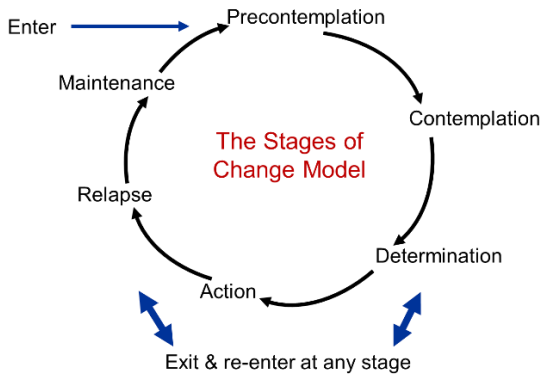

Figure 2 The Transtheoretical Model (La Morte, 2019)

The Stages of Change Model is not a theory, but it is a model that uses theories in the phases in which they are most effective.

The Stages of Change Model that people move through has **six stages of change**: *pre-contemplation, contemplation, preparation, action, maintenance, and termination*. At each stage of change, the intervention strategies that best suit the patient's situation are used.

Precontemplation People do not need to start the change in the next six months. People usually do not consider their behaviour to be problematic or that it can have negative health consequences. At this stage, more attention is often paid to the negatives that change brings than to the positive impact that occurs after the change.

Contemplation Ambition to start changing behaviour within six months. People realize that they should change their behaviour and consider their behaviour problematic. People consider the pros and cons of their behaviour and may still feel ambivalent.

Preparation The change will begin within the next 30 days. With small steps, they begin preparations to change to a healthier lifestyle.

Action People maintain a change in behaviour for less than six months but still want to continue to improve the change. At this stage, people adjust their behaviour or learn completely new habits.

Maintenance People have maintained the change for at least six months, are still working to maintain the change, and are trying to prevent relapse or postpone it as far as possible.

Termination In the last phase, people are sure that they do not want to return to their previous unhealthy behaviour and lifestyle. They are certain that they will not relapse. Because reaching this stage is very rare, most people are still in the maintenance phase (La Morte, 2019).

Five A's framework

Ask: Ask about the factors that influenced the drive for change and the choice of priorities when setting goals.

Advise: Provide clear and comprehensible advice, together with all the necessary information on the benefits of change and the possible risks of remaining in the current behaviour.

Agree: Together with the patient, select the most appropriate plan with goals set according to the patient's needs.

Assist: With the help of behaviour change techniques, we help a person achieve set goals or skills that help to attain end goals. We increase a person's self-confidence and thus their motivation to remain in the pursuit of change. We can also supplement specialized medical examinations.

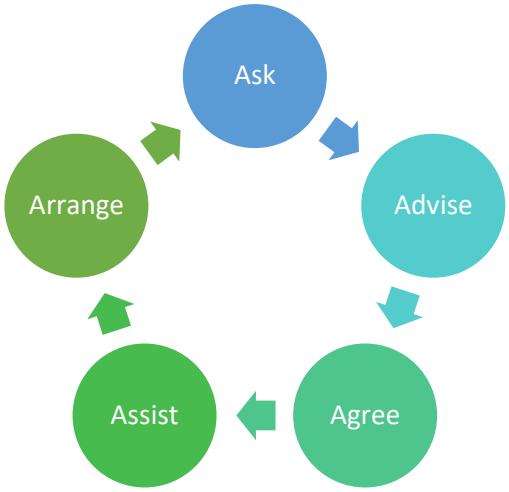

Figure 3 The 5 A's framework (Glasgow et al., 2002)

Arrange: Schedule a follow-up plan and visit (in-person or online) and continue to provide support; intervene if necessary (Glasgow et al., 2002).

Ten Strategies for Evoking Change Talk

1. Ask Evocative Questions	Ask an open question that will lead to a conversation about change.
2. Explore Decisional Balance	Ask what suits the person to the current situation and about the aspects which are not as positive.
3. Ask for Elaboration	Ask for more details. *"In what ways? When do you feel like that? Can you tell me more about it? What is it like?"*
4. Ask for Examples	Ask for specific examples. *"When was the last time that happened? Give me an example."*
5. Look Back	Ask what it was like before the worries. What made it different?
6. Look Forward	Ask what happens if things do not change and, conversely, what it would be like if the change succeeds. What exactly would the difference be?
7. Query Extremes	*"What are the worst things that might happen if you do not make this change? What are the best things that might happen if you do make this change?"*
8. Use Change Rulers	Ask, *"On a scale from zero to five, how important is it to you to change?"* Follow up: *"And why is it that number not lower or higher than x? What might happen that could affect your choice?"* It is important to specifically name the size of the problem. The question, "How prepared are you?" can be confusing.
9. Explore Goals and Values	Explore the position of values in their lives. You can consider using value cards. If there is any problematic behaviour, ask how they feel about this behaviour in relation to their values. *"Do values help to achieve set goals or is it irrelevant?"*
10. Turn	Stand on the other side. *"Maybe it's so important to you that you can't live without it?"* (Motivational Interviewing, 2020).

Learning material

Example of Motivational interviewing for hypertension (Jones-Smith, 2016)

What to do	Example
Set an agenda **Get the permission**	*"Thank you for coming in. As you know, you just underwent a few tests to evaluate your heart health. I have some of the results here, and I would like to discuss them with you. Would that be OK?"*
Give the information **End with an open-ended question**	*"Your blood pressure readings show that your blood pressure is high, and in the range for you to be considered 'hypertensive.' What do you make of that?"*
Develop discrepancies **Roll with resistance or ambivalence, reflect**	*"High blood pressure often goes unnoticed by many people because there are very few symptoms. Most people report feeling just fine. Of the things you mentioned, smoking, your weight, perhaps your level of physical activity, I wonder if you could tell me about which of these, if any, concerns you most?"*
Assess readiness and motivation for change	*"How ready and motivated do you think you are to make a change now, let's say, on a scale from 0 to 10 (where 0 is not at all motivated and 10 is extremely motivated)?"* *"Now tell me, why are you at a 7 or 8 and not a 2 or 3?"* *"So, on the same scale from 0 to 10 (where 0 is not at all confident and 10 is extremely confident), if you decided to quit smoking now, how confident do you feel in your ability to quit?"*
Support self-efficacy or confidence in the ability **Close a deal**	*"What do you think it would take to get you to a higher number (i.e., what would it take to boost your confidence)?"* *"So, knowing yourself, the patch sounds like a good place to start. And having your wife's support would certainly help! I can give you a prescription and once you start, we can follow your progress to see how it's working."*

Stages of change - an eating disorder (NEDC, 2016)

Stage	Example
Precontemplation	The patient may object: *"I don't have an eating disorder; I don't understand why everyone thinks that!"* Talk about things they cannot experience due to an eating disorder and, with understanding, try to show them that living without an eating disorder would be better.
Contemplation	*The patient does not deny the presence of an eating disorder but is not motivated to do anything about it.*

	Encourage the person to trust you. Listen carefully and show understanding, especially encouraging ideas in favour of change. Make the person feel that you are supporting them in the process and that they can contact you at any time.
Preparation	*The patient is getting ready to change, complies with the beginning of the process against an eating disorder.* Set goals with the person and create a detailed change plan.
Action	Emphasize the complexity of the whole process, letting the person know that you believe in them. Pay attention to all the positives that change brings and that the demanding process is followed by the coveted reward. Explain that relapse is normal and reassure the person that you will help them recover.
Maintenance	Define any triggers that can affect recovery and create a plan to prevent relapse. It will show that you care about the person, be patient and considerate.

Five A's framework definition - smoking cessation (Lawson et al., 2009)

5 A's task	U.S. Public Health Service definition	5A-DOC operationalized definition
Ask	Find out the frequency of smoking at each visit.	*Does the person need to smoke in addition to visit?*
Advise	Unequivocally recommend every smoker to quit.	*What are the reasons for trying to quit smoking?*
Assess	Ask if the person is currently willing to quit smoking (e.g., in a few days or weeks).	*Is the patient ready to quit smoking?*
Assist	For a patient who is motivated to quit smoking, take all possible support steps like advice, medications, and other materials to help them quit.	*Does the patient know what the specific steps to quit smoking are? Can the patient continue treatment alone or do they need the help of family and friends?*
Arrange	Schedule a follow-up meeting, preferably within the first week after the quit date.	*Is there a smoking cessation monitoring plan?*

Five A's framework practice – smoking cessation (CPHA, 2013)

5 A's task	Examples
Ask	*"Do you smoke?"* or *"Has your smoking status changed since your last visit?"* If a current smoker, *"Would you be willing to talk for a few minutes about your smoking?"* If yes, *"How do you feel about quitting smoking?"*
Advise	*"Reducing or quitting smoking is an important step in improving your health."*
Assess	**Stage of Change Assessment based on the patient's answers:** *"Do you ever plan to quit smoking?"* *"Have you successfully quit smoking?"* *"If ever, how long have you gone without smoking?"* *"Are you 100% sure that you have no temptation to smoke?"* *"How do you handle risky situations without smoking?"*
Assist	**Based on the patient's stage of change:** Precontemplation Ask if there are any demands to quit smoking at home/work. Attempt to find out where the smoking cessation requirement comes from (home, work, etc.). Offer assistance and schedule a follow-up appointment. Contemplation Help patients with problem-solving in order to decrease the barriers to quitting, such as weight gain, withdrawal, social/behavioural habits, or a history of failure at quitting. Preparation Ask if the quit date has been set, determine whether patch or gum is appropriate, help identify rewards for each smoke-free day. Action Congratulate on success; offer continued support, identify triggers and strategies/alternatives to prevent slips or relapse. Maintenance Identify potential or unexpected triggers and create strategies to deal with them. Termination Patient experiences no temptations and is 100% confident that they will not smoke in all previous situations where they were at high risk for smoking.
Arrange	Schedule another meeting and continue exploring *"Do you have a strong will even in stressful situations?" or "Have you ever considered lighting a cigarette?"*

Motivational Interviewing for Weight Loss

Current weight maintenance challenges have led to further research. Behavioural strategies based on MI were examined. The PRIDE study looked at overweight and urinary incontinence in women after completing a 6-month group intervention for weight loss. Subsequently, these women were divided into two groups. The first group was provided with a comprehensive 12-month skills training program, which is a typical standard approach to weight control. The second randomized group received a new 12-month motivation program.

It included various approaches that helped maintain motivation to lose weight, such as physical activity and self-control. The results suggest that motivational intervention is a feasible support approach in addition to traditional and effective programs (DiLillo & West, 2011).

Video 1: Introduction to Motivational Interviewing (Bill Matulich, 2013)

This slide presentation video talks about the basic concepts of Motivational Interviewing, a brief definition, topics include: the Spirit of MI, the four basic OARS skills, and the "processes" of MI.

- The video is available at: https://www.youtube.com/watch?v=s3MCJZ7OGRk

Video 2: 5As: Advise, Agree, Assist (Meant 2 Prevent, 2019)

This animated video defines three parts of 5As: Advise, Agree, Assist. It focuses on obesity risks.

- The video is available at: https://www.youtube.com/watch?v=KCuzAzPAq7A

Video 3: 5As: Assessment (Meant 2 Prevent, 2019)

This animated video is a continuation of the previous one. It describes a comprehensive assessment of obesity-related risks.

- The video is available at: https://www.youtube.com/watch?v=sWuo2kt8fFo

Video 4: Putting It All Together (Meant 2 Prevent, 2019)

This animated video shows a summary of all 5As by a sample clinical encounter that incorporates the 5As of paediatric obesity management.

- The video is available at: https://www.youtube.com/watch?v=jJ2zSkX8TwE

Discussion questions

1. How can a framework help reduce NCDs?

- *The overarching objective of the framework is to accelerate in-country, sustainable population-level behaviour changes at the individual, family, community, and institutional level to scale up demand for and use of key health interventions and practices. By eliminating shared risk factors, such as tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol, almost 80% of heart disease, stroke, type 2 diabetes, and over a third of all cancers could be prevented. In addition, improved disease management can reduce morbidity, disability, and death and contribute to better health outcomes. Overall, proven cost-effective strategies do exist to prevent and control this growing burden.*

2. Explain the differences between behaviour change technique and framework.

- *'Behaviour change technique' is used in this module to refer to the component of an intervention that has been designed to change behaviour, such as social support. The*

technique must meet specified criteria so that it can be identified, delivered, and reliably replicated. 'Behaviour change framework' describes the knowledge and skills required to deliver interventions to people to help them change their behaviour.

3. Name four behavioural determinants.

- *Diet, physical activity, alcohol, cigarette, and other drug use.*

Test questions

- *Think about behavioural determinants and name what can influence behaviour change?*
- *Write down a possible example of motivational interviewing for a patient with type 2 diabetes.*
- *Write down a possible example of the Stage of Change Model for a patient with cancer.*
- *Write down a possible example of the 5 A's framework for physical activity increase.*

Assignments for participants

- In pairs, choose one of the following diabetes topics and discuss it using motivational interviewing.

Glossary of terms

The behaviour change technique – is defined as an observable and replicable component designed to change behaviour (Michie et al., 2015).

Feedback – transmission of evaluative or corrective information about an action, event, or process to the original or controlling source (Tuma & Nassar, 2021).
Motivational interviewing – collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (Miller & Rollnick, 2013).
Social support – the provision of assistance or comfort to others, typically to help them cope with biological, psychological, and social stressors. Support may arise from any interpersonal relationship in an individual's social network, involving family members, friends, neighbors, religious institutions, colleagues, caregivers, or support groups (APA, 2020).
The Transtheoretical Model – model that operates on the assumption that people do not change behaviors quickly and decisively. Rather, change in behavior, especially habitual behavior, occurs continuously through a cyclical process (LaMorte, 2019).

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BEHAVIOUR CHANGE COMMUNICATION

Section 3: Case study – Avian Flu, COVID-19

Mračková T., Gába P., Sivčo P.

Introduction

Responses to public health emergencies require changes in regular behavioural patterns. Encouraging these changes requires coordination and an understanding of the culture and communities affected. Effective and compelling communication is crucial for bringing about positive behaviour change. During a pandemic, using the correct form of communication can mean the difference between life and death. During outbreaks of epidemics or pandemics of communicable diseases, we should be able to answer the following question: ***How might we rapidly inform and empower vulnerable communities to stay safe and healthy?*** This chapter will provide you with frame information when using behaviour change communication (BCC) during outbreaks of communicable diseases.

Learning objectives

- Improve knowledge about BCC in the context of communicable diseases.
- Describe the influence of the media in connection with BCC during outbreaks of communicable diseases.
- Identify frame information on the implementation of the behaviour change intervention (BCI) on a national level.

By the end of this session, participants will:

- be able to explain the BCC approach during a disease outbreak,
- know how BCC can be implemented into focus groups,
- be able to describe media utilization in the context of BCC, and
- understand the essential aspects of BCI implementation on a national level.

Avian influenza and BCC

Social and behaviour change communication (SBCC) efforts have proven effective in prevention, control, and treatment. "*Because they are unpredictable and can evolve to become transmissible among humans, avian flu viruses can trigger a public health emergency at any moment. With an increase in international trade and travel, a serious outbreak can have devastating consequences on local and global economies. Critical to any prevention strategy is a national emergency preparedness plan which includes guidance for an SBCC component"* (Martin, 2015).

Priority Behaviours

- *Report unusual sickness/death among poultry, wild birds, and other animals immediately to the authorities.*
- *Seek treatment immediately if you have a fever after contact with sick birds.*
- *Wash your hands frequently with soap and water.*
- *Clean clothes, footwear, vehicles, and cages with soap or disinfectant.*
- *Separate poultry: by species; from wild birds; from new birds; from living areas.*
- *Handle, prepare, and consume poultry safely.*
- *Burn and/or bury dead birds safely* (WHO/FAO/UNICEF, 2006).

Figure 1 Key behavioural interventions for reducing animal-to-animal and animal-to-human transmission (H5N1) (WHO/FAO/UNICEF, 2006).

COVID 19 and BCC

Ten steps to developing a communications strategy to help combat COVID-19

Step 1 **– Create a task force for communication.** It is necessary to create an agile, activity-oriented working group to implement a BCC strategy. This group should be coordinated by the national contact point and should include representatives of all stakeholders (Ministry of Health, trade unions, public and private sector liaison bodies, scientists, experts, communication specialists, media, etc.).

Step 2 **– Mobilise resources.** During the pandemic/emergency, it is necessary to mobilize all possible resources from the government. These resources should be supplemented by resources from the private sector, including financial donations and non-financial resources (human capital, technologies, etc.).

Step 3 **– Define target groups and key steps for behaviour change.** Campaigns must be specific and target-oriented, with a clear intention to change behaviour. It is necessary to outline specific actions and patterns of behaviour that we want to achieve in the selected

population. For example, to eliminate the spread of COVID-19, we should pay attention to hand hygiene and social distancing.

Step 4 **– Monitor and compare the situation at national and international levels.** National programs should be based on transnational recommendations. Therefore, it is extremely important to compare developments in the international spectrum. International focal points and authoritative sources of information should be organizations such as the WHO, CDC, Compass, the World Bank, the Hygiene Hub, etc. In this step, the working group needs to be able to distinguish relevant data from hoaxes and establish an effective strategy to eliminate the spread of alarm.

Step 5 **– Include the latest information.** An effective national plan must reflect the current situation, attract people's attention, and motivate them. In this step, in-depth research on the current behaviour of people is important, with an emphasis on monitoring the behaviour of vulnerable and marginalized groups. The working group should look for ways to persuade people in these communities to adopt the required behavioural changes as the current standard.

Step 6 – Produce a creative brief and theory of change. A creative brief is a guiding document that sets out the problem, purpose, objectives, target behaviours, audience characterization, channels of communication, persuasive argument, tone, personality, measures of impact, and the materials required from the creative team.

Step 7 **– Create a unifying "campaign brand" and slogan.** The brand/logo is a clear indicator of the credibility of the campaign information. It helps people select valid information from hoaxes. The brand should contain common elements but also innovative changes to attract people. The slogan should reflect the intent of the campaign, be concise and easy to remember.

Step 8 **– Choose the proper communication channel.** A variety of mass media should promote the campaign to reach as many people as possible. In addition to the usual communication channels (newspapers, TV, radio, leaflets, billboards, brochures, discussions, etc.), it is recommended to use modern methods of communication and online content (social networks, podcasts, short commercials, memes, etc.).

Step 9 **– Rapidly pre-test and continually revise materials.** Preliminary testing can be performed before the release of materials and during the campaign (e.g., by telephone inquiry). Feedback from the selected population sample allows for the correction of materials, with emphasis on the current requirements of the population. It is recommended to define the time intervals in which the materials will be revised, with the aim of updating the available data.

Step 10 **– Monitor and evaluate the strategy/campaign/program.** Continuous monitoring of results allows for the adaptation of the strategy more effectively to strengthen its impact. The overall evaluation of the strategy after its completion should provide clear evidence of its effectiveness, possibilities of use, and the need for revision, with regard to future application in similar situations (Sara et al., 2020).

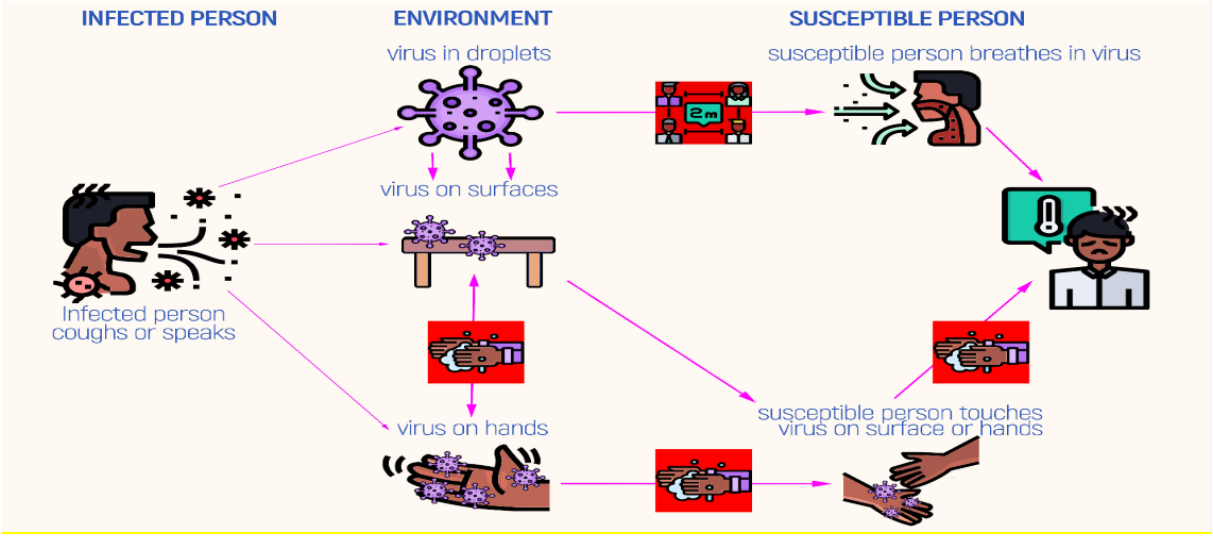

Figure 2 Breaking the chain of COVID-19 transmission in the community (Sara et al., 2020).

Learning material

Applying anthropological concepts to the control of avian influenza in Cambodia (WHO, 2012)

In the period after 2004, a series of intensive nationwide campaigns were carried out to raise awareness of avian influenza and publicly promote information on the prevention of the disease. These campaigns emphasized: the importance of reporting cases of sick and dead poultry to the competent authorities; thorough hand hygiene after handling poultry; having children avoid contact with sick or dead poultry; safe processing, handling, and preparation of poultry.

In 2007, several social surveys were conducted. They found that despite the population's high awareness of bird flu, no significant changes in human behaviour were observed. In other words, people theoretically were well informed about the virus, but they did not implement their knowledge in practice by changing their behaviour. The surveys confirmed that a checklist for situational market analysis is a useful tool for local analysis. It provides specific information about decisions, which cohorts of the population to focus on, with whom to speak to, and where to go. From the results of surveys, it was possible to distinguish four distinct samples.

1. **The first sample** was very similar to the samples in the quantitative surveys. This sample contains the following localities and people: places with a high population and poultry density, areas with significant cross-border poultry movement, and smallholdings with household poultry. It was expected that the chosen cohort of people would be properly acquainted with the key reports of avian influenza. The sample did not include areas where outbreaks of H5N1 disease occurred.
2. **The second group** of participants was selected from districts and villages where outbreaks of avian influenza directly occurred. Discussions were carried out in the four

localities where cases of the occurrence of the disease in poultry were described, and in two other areas, where cases of bird to human transmission of the disease were confirmed. This action was implemented to improve communication materials in the event of a deteriorating epidemiological situation in Cambodia.

3. **The third group** of participants included a selection of people from areas with a high proportion of duck breeding households. It was assumed that this group of people would be significantly different from other farmers who use poultry for their own use and not as a source of income. The analysis focused on duck breeding because avian influenza can circulate in flocks without showing any specific symptoms.
4. **The fourth set** of participants included people who had not been involved in sociological surveys in the past. It contains local authorities from Rattanakiri province, migrant labourers, and farmers. This group included communities of ethnolinguistic minority populations, which differed from local farmers in their social customs. There was a presumption that these groups were less exposed to reports of avian influenza.

The discrepancy between administrators and local evaluators and their priorities has proven to be one of the most important and widespread shortcomings in the association between bird flu awareness and behavioural change. Respondents assessed that the bird flu reports were presented as a comprehensive set of commands without any explanation as to how behaviour change could be useful to farmers. Thus, several theoretically proposed interventions did not contain sufficiently explained benefits of their implementation in practice. Participatory research yielded the results that people were aware of key messages, memorized them, and understood them; however, they could not understand why they should do things differently. "*This suggested that social mobilization strategies should better link behavioural messages with local values and priorities"* (WHO, 2012).

Communication Strategy and Workplan for Avian Influenza in Egypt, 2007–2008 (UNICEF, 2008)

In 2007 and 2008, interventions were carried out in Egypt, under the auspices of UNICEF, to eliminate the spread of avian influenza. The main objectives of these interventions were to support the government in controlling the spread of the virus, reduce the risk of contact with sick poultry, early surveillance, and review possible preventive measures to prevent a pandemic.

The specific communication goals included:

1. Raising awareness of good hygiene practices, such as the risk of children contacting or handling poultry and the means to dispose of poultry waste.
2. Increasing the amount of literacy on avian influenza and to awareness of possible risks in individuals and populations.
3. Eliminating children's contact with poultry, reducing the number of children in intervention areas that are exposed to, handle, or play with poultry.
4. Reducing the purchase of chicken and poultry from unverified sources (lay merchants)

Community Awareness Campaign

An intervention campaign was carried out in medium and high-risk districts to achieve higher health awareness. Important information was processed graphically and advertised on billboards in highly populated parts of the area, at train and bus stations, and in markets. In addition, posters and brochures were posted at post offices, schools, kindergartens, medical facilities, doctors' clinics, etc. The campaign was implemented with the aim of publishing uniform high-priority information through various mass media channels in order to reach as many people as possible and change their behaviour.

A key part of the campaign was **community workers** and volunteers, who were properly trained to intervene with house-to-house behavioural change activities. The campaign involved more than 4,000 community workers in various parts of Egypt. The priority was not only to achieve meaningful change but also to create an environment for sustainable changes. Community workers and volunteers also completed refresher training and continuously updated their knowledge throughout the campaign.

Educational material

The possibility of feedback from the audience (community, schools) was used to evaluate the educational materials. A system based on survey evaluation was chosen to improve the proposed educational materials. The working group also decided (based on the survey) on its preference of the quality of publication materials (choice of quality of papers, the brevity of information, choice of presentations, poster designs, etc.). From this, a distribution plan was developed. It was based on the principle that not all promotional materials were used throughout the campaign. Mass media should be used depending on the impact on the population, popularity, and effectiveness. The choice of communication channels was flexible throughout the campaign. The initial list of promotional materials included:

a) *Community flip chart,*
b) *Community educational video,*
c) *School posters and stickers,*
d) *School educational video, and*
e) *Social marketing materials (signs in markets, billboards in busy areas, walls, bus and train stations signs, etc.).*

Media as a Change Agent

The results of the research prove that mass media are the most important source of information in the field of avian influenza, as well as other public health problems. That is why any intervention should benefit from the publication of measures through the mass media. However, it is very important to correctly choose the most effective communication channel. A communication strategy that considers costs and benefits should be developed before any intervention starts to make the right decisions (UNICEF, 2008).

Video 1: EGYPT Influenza: Avian Flu TV Spot (Johns Hopkins CCP, 2011)

This animated video illustrates the summary of the hygiene measures for avian influenza.

- Video is available at: https://www.youtube.com/watch?v=HqV5XXfukps&list=PLflIHdtzuE_EQDM-dw1JmXZUvRye4Ee4_&index=6

*Public Health and Risk Communication During COVID-19—Enhancing Psychological Needs to Promote Sustainable Behaviour Change (***Porat et al.***, 2020)*

The arrival of the COVID-19 pandemic required immediate behaviour change. The key to eliminating the spread of the virus was to maintain behavioural change. With the growing amount of information, a phenomenon called infodemic has manifested itself in the world. **Infodemic** can be characterized as excessive amounts of data and information about a problem. The problem that occurred in parallel with this phenomenon was the enormous incidence of hoaxes as well as false and misleading information. This has caused uncertainty in people's decisions, chaos, fear, and even mental disorders, such as depression and anxiety. A tool that can be used to combat this global problem is to rethink the way that information is communicated and to use proper health communication that will support the basic psychological needs of an individual and the general population. In this context, it is possible to use guidelines that provide a "springboard" for choosing and applying the right communication strategy in the field of public health. The following guidelines provide five practical suggestions for proper communication to suppress hoaxes, support behavioural change, and maintain mental well-being.

Guideline 1: ***Create an autonomy-supportive health care climate***

Some countries motivate their citizens to change their behaviour through controlled motivation. This form of motivation is applied through authority, coercion, and external regulation. On the other hand, some countries use a system of autonomous motivation through identified regulation that leads to understanding and promoting the importance of behaviour. A clear and immediate response, adherence to the set measures, and effective management were crucial for eliminating the spread of the virus and reducing the trend of pandemic development in the initial stages.

Countries with high levels of cultural tightness (strict norms and little tolerance for deviance) and government efficiency were found to have lower mortality rates compared with countries that have only one of these factors or neither. Residents of countries with a governing regime may be more willing to comply with prescribed measures and standards (e.g., social distancing, hand hygiene, etc.). In democratic countries, less citizen participation can be observed. Citizens generally expect an explanation and a precise justification from competent authorities as to why their social and individual rights and freedoms have been restricted. There is scientific evidence that an autocratic and directive approach to pandemic management has been much more effective than a democratic one.

Governments of countries with higher freedom index rates should focus on the autonomy-supportive health care climate to maintain public health. They should achieve this by strongly motivating individuals to engage and apply healthy behaviours on their own initiative. This effort should take into account the appreciation of success, emotional factors,

and the removal of obstacles in the process of behaviour change. It should be built on mutual respect, tolerance, and trust.

Guideline 2: ***Provide choice within limitations***

It is highly effective to support people's initiative and guide them to make constructive decisions. It is useful to deepen their proactive approach in resolving the crisis that is fundamentally affecting them. This approach can activate a sense of stability and control and eliminate feelings of hopelessness and helplessness. Last but not least, it can reduce the feeling of fear by building a sense of control over the situation.

Guideline 3: ***Apply bottom-up (vs. top-down) communication using principles of co-production***

In the ***top-down*** *model of science communication,* scientific evidence is primarily simplified/explained and interpreted to the public in such a way that it is understandable to as large a population as possible. This model focuses on shifting the available data from scientists/experts to the general public while maintaining the highest possible quality.

An alternative framing would start ***bottom-up*** *from the informational needs of a given audience.* The moment we define the information needs of an audience, we can select the necessary scientific evidence and arguments. The purpose of this model is to create targeted communication based on population health awareness and the ability of people to take necessary steps. It allows flexible adaptation of communication based on the changing situation and specific requirements of population groups. It also helps to select scientific evidence and concretize it as a way to increase health literacy and ensure the desired change in behaviour. This model brings the available scientific evidence closer to ordinary citizens.

Guideline 4: ***Create solidarity (We are all in this together)***

Building solidarity is one of the main keys to the success of behaviour change. How someone else behaves can influence others and their behaviour. The improvement of societal standards create a safer environment for at-risk populations. Leaders/influencers (celebrities, priests, mayors, etc.) can help build solidarity and motivate their followers. Social networks can also be an effective platform for sharing motivation. For example, notifications that inform about activities in the community had a positive effect on behavioural changes during the COVID-19 pandemic. However, there is a very fine line with the application of solidarity in communication. If communication loses autonomy and is misused to promote hoaxes, the strategy can be counterproductive. A danger to collective support is the "us vs. them" behavioural mentality, in which groups of people with different opinions begin to deliberately gather and protest the regime.

Guideline 5: ***Be transparent and acknowledge uncertainty***

The absence of transparency causes chaos, mistrust, and confusion. Doubts often lead to the search for alternative sources of information that can be unreliable and misleading. Social networks and many other mass media channels currently provide a large amount of

misinformation. In the fight against misinformation and hoaxes, it is crucial to argue with strong scientific evidence (Porat et al., 2020).

Questions for topic reflection and discussion

Describe

- What is avian flu?
  - *Avian influenza (AI) is a slightly misleading term, as influenza is among the natural infections found in birds. The term avian influenza used in this context refers to zoonotic human infection with an influenza strain that primarily affects birds. Influenza virus is an orthomyxovirus—an enveloped, segmented, negative-sense RNA virus. Influenza virus has three strains—A, B, and C*

- Why is AI considered a serious threat to human health?
  - *According to the World Health Organization, H5N1 was first discovered in humans in 1997 and has killed nearly 60% of those infected. Currently, the virus isn't known to spread via human-to-human contact. Still, some experts worry that H5N1 may pose a risk of becoming a pandemic threat to humans.*

- How can AI be prevented in terms of BCC?
  - *There should be policies, legislation, and regulations in place to create an environment conducive to AI prevention and control. Concerted efforts are required to:*
    - *Plan AI prevention and control programmes that have clear objectives and implementation strategies.*
    - *Build capacities at the national level for intersectoral planning, implementation and evaluation of all AI prevention and control activities.*

Answer the following questions:

- What is a focus group?
  - *A focus group is a research technique used to collect data through group interaction.*

- Name at least three practices that can be influenced by BCC for COVID 19 transmission prevention
  - *Wear a mask to cover your nose and mouth,*
  - *Stay 2 meters (6 feet) apart from others who don't live with you,*
  - *Wash your hands often with soap and water or use hand sanitizer if soap and water are not available, and*
  - *Get a COVID vaccine when it is available for you.*

Test questions

- *How can be BCC used to prevent the transmission of communicable diseases? Write five examples*
- *How can you utilize media channels in BCC for disease prevention in your country?*
- *What are the steps to develop a communication strategy to help combat COVID-19? (Name at least five steps)*

Assignments for participants

Design a campaign to address the local epidemic of hand, foot, and mouth disease in your country.

- Describe what tools you would use to raise people's awareness.
- What population groups would you target?
- Define the specific steps you would recommend to these population groups in terms of BCC.

Glossary of terms

Focus group – qualitative research method in which a trained moderator conducts a collective interview of typically six to eight participants from similar backgrounds, similar demographic characteristics, or both (Lavrakas, 2008).
Hazard – inherent property of an agent or situation having the potential to cause adverse effects when an organism, system or (sub) population is exposed to that agent (WHO, 2004).
Change agent/agent of change – anyone who has the skill and power to stimulate, facilitate, and coordinate the change effort (Lunenburg, 2010).
Risk – the probability of an adverse effect in an organism, system or (sub) population caused under specified circumstances by exposure to an agent (WHO, 2004).

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BEHAVIOUR CHANGE COMMUNICATION

Section 4: Case study – Obesity

Mračková T., Gába P., Sivčo P.

Introduction

Overweight and obesity are defined as abnormal or excessive fat accumulation that may impair health. Obesity is currently one of the most serious public health problems. In 2016, 39% (1.9 billion) of adults aged 18 years and over were overweight. Of these, over 650 million adults were obese. Overall, about 13% of the world's adult population (11% of men and 15% of women) were obese in 2016 (WHO, 2020). ***How to talk with patients about weight loss?*** This chapter contains specific examples on how to solve this problem at the individual level, using behavioural change interventions.

Learning objectives

- Improve knowledge about behavioural change interventions and their scope.
- Describe the concept of behaviour change communication methods and their application for overweight patients.
- Gain skills in how to use behaviour change communication methods in the communication process with patients

By the end of this session, participants will:

- be able to describe the role of behaviour change communication in behavioural change interventions,
- understand the six key elements to support patient's changes toward healthy eating and active living necessary to achieving and maintaining a healthy weight,
- know how to use the Ask-Tell-Ask method and lead communication with patients,
- understand the concept of change talk and how to use it, and
- be able to explain motivational interviewing techniques using the case study.

What are behavioural change interventions?

Behavioural Change Interventions (BCI) is a file of multiple well-defined strategies that are designed to address the behaviour of the human population in complex settings. Behavioural change intervention strategies are extremely important in strengthening policies and structures that support healthy lifestyles, especially in the field of health promotion. It is important to note that BCI is different than behaviour change communication (BCC) or health education (WHO, 2008a).

Behavioural change intervention incorporates health education and BCC concepts within the health promotion framework. Behavioural change intervention does not only cover

communication and education of individuals and communities. It also covers a wide range of actions and interventions that can be implemented to achieve and sustain behaviour change. The foundations of the BCI strategy take into account that human behaviour is complex and influenced by several factors, including cultural, economic, social, political, and legislative determinants. It also respects the availability and unavailability of services and a person's ability to learn and make decisions to improve their quality of life (WHO, 2008a).

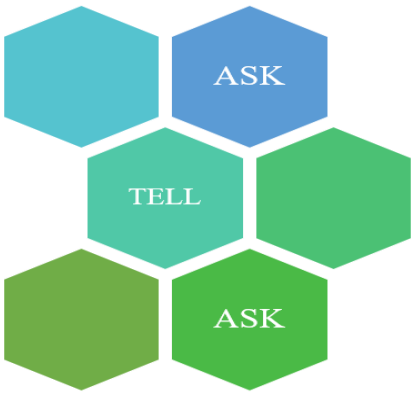
Health education (HE) is a complex educational experience aimed at simplifying voluntary actions that lead to health. It is one of the main tools of public health, applied primarily in schools, communities, and during public health interventions (Hahn, Truman, 2015). As an integral part of most national health programmes over the past several decades, it has evolved into health promotion. Health promotion is based on the premise that only ignorance or lack of information prevents people from adopting healthy behaviour (Kok, 2001; WHO, 2008a). The term '**Health Promotion**' **(HP)** covers a set of strategies, tools, techniques, and skills based on humanitarian and social sciences, arts, communication, marketing, and education, among others. In particular, HP's primary function is to disseminate information in order to raise public health awareness (WHO, 2008b). As HE and HP are essential for achieving behaviour change in the population, their principles and methods are beyond the scope of this chapter.

Focusing on BCC in the context of BCI, there are **six key skills** adapted from motivational interviewing and the evidence on which it is based (Reims & Ernst, 2016). To improve conversations with patients about obesity and healthy weight, you may wish to incorporate some or all these ideas:

- share the agenda,
- raise the issue,
- be respectful and express empathy,
- build on what you hear (Ask-Tell-Ask),
- cultivate change talk, and
- guide toward a specific plan.

The Ask-Tell-Ask method and the concept of change talk are discussed in more detail below. These skills were not mentioned in previous chapters; thus, we believe they deserve more attention here. The other four skills are mentioned later in the case study example.

Ask-Tell-Ask method



Ask-Tell-Ask is a basic tool of medical coaching. This approach is focused on the interaction of a health trainer with their client and the elimination of one-way communication. It is a simple three-step conversational structure that develops a patient's abilities, helps to identify the individual's strengths, and uncovers shortcomings and areas for improvement. Last but not least, it allows preceptors to deliver constructive and positive feedback (PAEA, 2017). The process begins with the ASK phase (what they already know and would like to know), followed by the TELL phase (what they want to know), and ends again with the ASK phase (what they understood and what they would like to know). Each of these phases has some rules:

Ask:

- Always make sure you can start a conversation.
- Ask the client to tell you about the doctor's visit. Ask them if everything is clear and if they know and understand their health condition. This step is necessary to adapt the conversation to the client's mental state and understanding.
- Active inquiry will help you identify the client's goals (what they want to achieve) and design a suitable communication strategy.

Tell:

- Provide the client with simple and clear information that interests them. Do not use short sentences.
- Share information that the physician has authorized the coach to provide.
- Use simple colloquial language. Avoid professional medical terminology or jargon.

Ask again:

- Make sure the client understands what you told them. Ask them to repeat your recommendations in their own words.
- Do not forget to ask if the client wants to know something else or has any other questions (AMA, 2016).

This communication structure can be used repeatedly throughout the entire session. It is most often applied to a motivational interview, with key phrases or sentences typical for each step. These phrases are used by an expert (doctor, public health officer, community worker) who leads the session:

STEP	Typical phrase
ASK Ask permission to share information OR ask what they know or want to know.	"Would it be OK if we talked about…?" "What do you know about… ?" "What would you most like to know about?"
TELL State information clearly and in small amounts.	Make it pertinent and only focus on one or two key messages. Use plain language and pictures and figures as appropriate. Emphasize options and avoid using 'can't', 'must', or 'have to'.
ASK Ask for feedback or to check understanding.	For feedback, ask: "What do you think of that?" "How are you feeling about what I just talked about?" For understanding, ask: "I'd like to make sure I did a good job explaining. Would you mind describing what you will do so I know I was clear?"

Using the Ask-Tell-Ask tool has advantages on two levels. On the one hand, a professional approach and the provision of valid information can be attractive to the patient in terms of gaining new knowledge. On the other hand, this approach helps clients to examine the problem in detail, thus achieving the client's active thinking about shortcomings (Reims & Ernst, 2016). To provide more specific insight, see *Case studies* provided later in this chapter.

Change talk

'Change talk' is what people say in favour of changing behaviour. Research has shown that change talk impacts actual behaviour change. Therefore, it is necessary to emphasize the analysis, elaboration, and refinement of behavioural conversations, using structures and techniques such as reflexive listening, asking open-ended questions, and the cyclical provision of ongoing strategic assessments and summaries. Additionally, it is essential to use simple language, phrases, and terms used by the patient. The key is to frame specific lifestyle changes in the context of broader life goals and values that the client themselves upholds (DiLillo & West, 2011).

'Sustain talk' is speech that favours the status quo. It is a common phenomenon that people use sustain talk and change talk in the same sentence. For example, the phrase "*I know it's necessary for me to lower my blood pressure as soon as possible*" speaks to the client's need (and perhaps the desire) to change. The rest of the sentence "*but I've tried it several times without any results*", suggests that the change is difficult for the patient or even that the client does not know how to change (Reims & Ernst, 2016).

Generating change talk within motivational interviewing is based on a non-confrontational approach to the resistance of behaviour change that sometimes arises. Resistance is understood here as a sign that the professional is pushing for change in the client's

behaviour, rather than the patient desiring to change. Assertive persuasion, finger-pointing, or arguing are not in line with the principles of a motivational interview. They are not even considered effective in behaviour change communication (DiLillo & West, 2011)

Using Motivational Interviewing to Promote Healthy Weight[3]

Case study: Mrs. Jones is a 55-year-old female who is well-known to the doctor and followed for high blood pressure, glucose intolerance, and obesity with a body mass index (BMI) of 32 and a waist-to-hip ratio of 0.95. She is scheduled for a 15-minute appointment, primarily to check her blood pressure. Her vital signs are unremarkable, with a blood pressure of 128/82. She has gained three pounds over the last three months and seven pounds over the last year. An A1C drawn last week is 6.3 percent.

Transcript example from a doctor-patient conversation using the principles and frameworks of BCC:

Role	Conversation	Note
Doctor	Hi, Mrs. Jones! It is good to see you!	*Greet the patient.*
Mrs. Jones	Good to see you too, doctor.	
Doctor	How would you like to spend our time together today?" *OR* "We have about 15 minutes today. How would it be best to spend our time together?	*Ask an open-ended question with or without time specification.*
Mrs. Jones	Well, I wanted to ask you about my knee. It is hurting whenever I do anything!	*The patient expresses her concern.*
Doctor	OK, we can definitely talk more about your knee. What else?	*Do not begin the assessment of the first problem until the patient's concerns have been fully surfaced and catalogued.*
Mrs. Jones	Well, I also want to know what you think of my blood pressure. I think it is good!	
Doctor	OK, so your knee and blood pressure. Anything else?	*Summarize what you heard so far and ask again.*
Mrs. Jones	Oh, and I did get some blood drawn. We should talk about that too.	
Doctor	OK, your knee, blood pressure, and the lab results from last week. Anything else?	
Mrs. Jones	No, I think that's everything!	

If there are too many topics to cover within the allotted time, tell the patient and negotiate what will be addressed today and what should wait.

[3] Note: This part is taken from the authors Reims, K. G. & Ernst D. (2016)

Doctors may avoid the topic about weight because it is a sensitive issue for patients, they lack the skills to comfortably have the conversation, they think having conversations about weight loss with certain patients are futile, or they believe they lack the time. Focusing on skills that make these conversations more constructive can help physicians gain the confidence to raise this important issue.

Doctor	OK. I have a concern to add to our conversation as well. Would that be OK? I want to talk about a trend I noticed with your weight. So, where should we start?	*Asking permission is respectful and further engages the patient despite the sensitive topic. Finally, the patient is given the option to prioritize the agenda.*
Mrs. Jones	Well, my knee is giving me a fit when I walk! So, let's start there. You mentioned my weight, and I think it is a problem because everything I do makes my knee hurt, so I can't do anything but eat!	*Often when you raise the issue of weight, patients will begin to think about it even though they may not want to tackle it first.*

The physician explains that the symptoms and exam are consistent with osteoarthritis and deconditioning. After discussing the options, Mrs. Jones agrees to a standing x-ray to confirm the diagnosis. Acetaminophen is recommended for pain. A more comprehensive treatment program will be discussed once the diagnosis is confirmed.

Doctor	I think the topics of increasing weight, high blood pressure, and the trouble with the glucose in your blood are related. Would it be OK if we talked about those together?	*Having addressed the patient's priority, the physician moves to the next items on the agenda. Because they are related, they can be integrated. If they were not related, the patient could be asked which item to discuss next.*

Maintaining a healthy weight can positively benefit many clinical issues, so you should regularly make it a priority to discuss what benefits even modest weight loss can produce, but it is important to do so with respect and empathy. It is helpful if we respect the patient's perspective and express empathy, not impatience or frustration. How you raise the issue can either set the stage or sabotage the best of intentions. A good approach is simply to ask and use the answers to help understand what is on the patient's mind.

Doctor	What do you understand about how your weight affects your health?	*Ask an open-ended question that elicits the patient's perspective.*

Mrs. Jones	I know how important it is for me to lose weight, but nothing I have tried has worked for long!	*Physicians are trained to listen for problems and may hear "nothing worked". Instead, focus on the importance of weight loss.*
Doctor	Ok, continue.	
Mrs. Jones	I know my weight makes my sugar go up, too. It is so frustrating that I cannot get this under control.	*This response again indicates that the patient understands the importance of weight loss, and the idea of gaining control is raised by the patient.*
Doctor	I can see how challenging this is for you. You understand a lot about how weight is related to your health, and you really want to be in more control. Would it be OK if we talk about some ways that we could work together on this?	*Empathize with the patient's struggle. Do not jump in with suggestions or advice, but rather seek partnership with the patient to move forward.*
Mrs. Jones	I would really appreciate that!	

Remember to let patients tell their stories. Rather than making assumptions about what type of support the patient will find most helpful, acknowledge what they have told you and ask permission to explore the topic further.

Doctor	You have been successful at losing weight in the past, right? What has worked for you before?	*Asking the patient to discuss a past success is one way to discover patient strengths.*
Mrs. Jones	Well, I lost weight a few times just by eating fewer carbs. I was able to do a lot more walking, working in the garden, and playing with Gracie, my granddaughter. But then I started having problems with my knee, and I couldn't move around as well and started to eat more.	*Besides describing what worked in the past, the patient may also tell you what caused weight loss to stop.*
Doctor	OK, let me recap what I think I heard. When your knee started to hurt, you slowed down your activities, and the weight came back – in fact, you gained even more. Until then, you were able to lose weight several times by cutting back on bread and pasta. You found you had more energy and were able to do more walking and gardening. Your	*Summarize what you have heard. Emphasize what worked, acknowledging that the patient was frustrated when the weight loss stopped, and that healthier weight appears to be important to them. This shows that you have been listening, summarizes the*

	granddaughter even noticed that you played more with her! Did I get that right?	*reasons for change, and highlights past success. Notice that this summary ended on the weight loss benefits that Mrs. Jones described. Patients most often will respond to what they hear last.*
Mrs. Jones	Oh yes! Gracie and I had the best time! We even flew a kite together. She loved it!	
Doctor	Playing with Gracie is fun and really important to you!	*Acknowledge the enthusiasm and mirror the patient's emotion. This links the conversation with a value the patient holds dear.*

This is also a great opportunity to explore expectations for weight loss and reframe them if needed. Even the idea of simply not gaining more weight can be woven into the 'tell' part of 'Ask-Tell-Ask' and could be important for the patient to hear.

Doctor	"We should talk about the next steps. Would it be OK if we talked about your lab and blood pressure briefly first?"	*'Ask'.*
Mrs. Jones	"Sure!"	
Doctor	"You are right that your blood pressure is good today. I am concerned that your A1C is a bit higher than last year at 6.3 percent. That is even closer to the diabetes range. We know that weight loss will benefit your glucose level as well as help that blood pressure stays in control."	*'Tell'. Information is given in a context important to the patient and linked to weight.*
Mrs. Jones	"How do you feel about what I just said?"	*'Ask'.*
Doctor	"Oh, I was afraid of that, honestly. I knew gaining weight was bad. I am even more frustrated now! I have to get this under control."	*The patient voices frustration but also reasons to change.*

People most often make changes when they decide to, not because they were told. Our goal is to strengthen the change talk and diminish the sustain talk.

Doctor	Yes, I am sure that was not the news you wanted to hear. On the other hand, we agree that weight loss is a good idea. You know that it will help your health and allow you great times with	*Practice reflective listening with empathy and emphasize your partnership.*

	Gracie. We can figure out together what might work best for you.	
Mrs. Jones	Yes, I have to do something. I have lost weight before. It is just this darned knee.	*Change talk, sustain talk.*
Doctor	Yes, you did a great job changing your diet and increasing your activity. Would it help if we talk about how some of my other patients with knee problems stay active?"	*Acknowledge the patient's sustain talk but move the conversation forward by beginning 'Ask-Tell-Ask'.*
Mrs. Jones	I have heard about tai chi but have never tried it. I used to like to swim but hate the way I look in a bathing suit. I can walk, though, as long as I know I won't be causing further damage. I want to figure this out!	*Exploration, sustain talk, change talk.*
Doctor	OK, it sounds as though you have some options to think about. That's great! If it is OK with you, we can talk more about the specifics once we get your x-ray back.	*Close the visit on a hopeful note with a bridge to the next encounter. It is premature to plan.*

When the patient seems ready to make a change, you can suggest helping them create an action plan. That can be done during the same visit, over the phone, or at a follow-up visit. You can preface the discussion by confirming the patient wants to take some next steps, explaining the benefits others have received from having a specific action plan, and asking if the patient wants to make one. If so, the plan should follow the SMART model – specific, measurable, achievable, relevant, and time-bound.

Doctor	Now that we know more about your knee, could we talk more about those options for exercise we discussed at your last visit?	
Mrs. Jones	Well, I like to walk when the weather is nice like it is now.	
Doctor	It sounds as though you are ready to take some next steps. Many people find it helpful to make a specific plan about what they will do. Is that something you would be willing to do?	
Mrs. Jones	OK. I guess I could do that.	
Doctor	If you were to decide to walk regularly, what would that look like for you?	*Resist the temptation to guide her. Let the patient tell you what she is thinking.*
Mrs. Jones	Well, I was thinking about walking around my neighbourhood. There are some beautiful gardens!	

Doctor	You look pretty happy about that. How far do you think you might go?	*Guide toward as much specificity as seems natural.*

Mrs. Jones decides that she will walk three days a week, starting at about 20 minutes and trying to work up to 30 minutes each time. She plans to start tomorrow.

Doctor	That sounds like a great plan. Just to make sure I am clear about what you plan to do, could you say your plan back to me?	*Having the patient repeat the plan provides another chance for the patient to say what they will do – and commit to it out loud.*
Mrs. Jones	[Restates her plan.]	
Doctor	Sometimes when people plan to make a change, it may be a bit daunting. On a scale of 0 to 10, where 0 is not at all confident and 10 is absolute certainty that you can do this, how would you rate your confidence to follow through on your plan?	*When patients state their plan, you may see their enthusiasm or that they are having second thoughts.*
Mrs. Jones	I think I am about a 5.	
Doctor	That is a lot of confidence! What makes you a 5 instead of a 2 or 3?	*Try not to look disappointed if the patient expresses a lack of confidence. Ask about the confidence level in a way that encourages the patient to talk about their strengths, not their barriers.*
Mrs. Jones	Well, I really want to do what is best for my health. But honestly, I am worried about wearing myself out. I haven't done much walking lately.	
Doctor	I can see how important it is to you to be as healthy as you can be. We know that people are more likely to be successful following through with their plan when their confidence is 7 or above. What do you think you could do to raise your confidence a bit more?	*Reflect on the change talk and sidestep the barriers. Explain why the confidence level is important and invite the patient to think about how to enhance their confidence.*
Mrs. Jones	Well, I think I would feel better about starting out for just 10 minutes. Would that be OK?	*Patients may try to create plans that are not realistic because they want to please us. Resist the urge to give your permission.*
Doctor	You really know yourself. That's great. With that change in your plan, what do you think your confidence level would be?	*This is the patient's plan, so affirm her thinking and her*

Mrs. Jones	I think I could do 10 minutes. I'm sure I can. And I am determined to work my way up to longer walks.	*autonomy. Then check back with her confidence.*
Doctor	You are really committed! Walking will really benefit your health, and I look forward to talking with you about how things are going at your next visit.	

The doctor ends the visit by talking with Mrs. Jones about arranging a check-in, which helps provide some additional accountability and contributes to success. She agrees to check in with her husband in two weeks to talk about how it is going, putting the date in her calendar (Reims & Ernst, 2016).

Learning material

Text material: Ten strategies for evoking change talk (Lifespan, NA)

- Available at: https://www.lifespan.org/sites/default/files/lifespan-files/documents/centers/injury-prevention-center/tips-developing-change-talk-web.pdf

Text material: Talking with Patients About Weight Loss: Tips for Primary Care Professionals (U.S. Department of Health and Human Services, 2005)

- Available at: https://ehhapp.org/uploads/Talking-With-Patients-About-Weight-Loss-1.pdf

Text material: Motivational Interviewing for Diet, Exercise and Weight (Yale Rudd Center for Food Policy and Obesity, NA)

- Available at: https://media.ruddcenter.uconn.edu/PDFs/MotivationalInterviewing.pdf

Text material: Doctor-Patient Communication: A Review (Ha F. J., Longnecker N., 2010)

- Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3096184/

Video 1: Using Ask-tell-ask method (National Institute of Diabetes and Digestive and Kidney Diseases, 2019)

This short video demonstrates Ask-Tell-Ask, an essential communication skill for discussions with patients who have chronic kidney disease.

- Video is available at: https://www.youtube.com/watch?v=jiXAUV3qZBU

Video 2: What Does Change Talk Sound Like in Motivational Interviewing? (Chicago Compass Counseling LLC, 2018)

This video reviews the four categories of preparatory Change Talk you'll want to listen for using your "rabbit ears."

- Video is available at: https://www.youtube.com/watch?v=0_rc4QknGjE&t=2s

Discussion questions

- **Why do you think asking patients for permission to share information is so valuable?**
- *Successful behaviour change communication is based on trust and mutual respect between patient and doctor. Asking for the patient's permission is the first step. To achieve the desired outcome (sustainable behaviour change), it must be done within a non-judgmental and open-minded environment so, when the relapse comes (and it does), the patient is not afraid to visit again.*

- **In what types of situations do you think 'Ask-Tell-Ask' can improve health and health care?**
- *The method can improve the outcome in any situation when communication is used to change behaviour – especially against communicable and non-communicable diseases.*

Test questions

- *Name five aspects important for effective behavioural change conversations with patients about obesity and healthy weight.*
- *Describe key principles of generating change talk.*
- *Define the steps of the Ask-Tell-Ask method and write two examples for each of them.*

Assignment for participants

Imagine you are a primary care provider seeing a new patient. You have just identified several metabolic risk factors (e.g., high blood pressure and high fasting blood sugar) in your patient, and you think she could benefit from increasing her physical activity and quitting smoking. What would you ask before delivering this advice? What would you ask afterwards to understand how she felt about your recommendations?

- Find a partner and role play using the 'Ask-Tell-Ask' method.

Glossary of terms

Ask-Tell-Ask – is a collaborative communication method that includes asking patients open-ended questions and assessing their existing knowledge before sharing information (UCSF Center for Excellence in Primary Care, 2012).
Behavioural Change Interventions – is a package of well-defined multiple strategies designed to address human behaviour in complex settings (WHO, 2008a).
Change talk – is client talk that leans in the direction of change (DHS, 2011a).

Health education – any combination of learning experiences designed to facilitate voluntary actions conducive to health (Green & Kreuter, 1991).
Health promotion – the process of enabling people to increase control over and to improve their health. It represents a comprehensive social and political process, which includes actions for improving the skills and ability of individuals to increase control over the determinants of health, and actions towards changing social, environmental and economic conditions to address their impact on public and individual health (EuroHealthNet, 2019).
Motivational interviewing – person-centered method of guiding to elicit and strengthen personal motivation for change (Miller & Rollnick, 2009).
Sustain talk – when the client is talking about the change, but mainly talking about why they can't do it. Sometimes we confuse sustain talk for change talk (DHS, 2011b).

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Section 5: Development and management of behavioural change interventions

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Introduction

Setting up appropriate behavioural change interventions is a complex process requiring in-depth knowledge of the at-risk population, its behaviour, habits, and culture. For the effectiveness of intervention, it is necessary to define the mechanism by which the intervention will be applied and the technique (how it will be implemented in practice). The key to a successful intervention is to evaluate the process of creating and managing goals, such as ***will the interventions be effective, what impact they will have, and how well they will work?*** This chapter will show you phases in the development and management of behavioural change interventions and their implementation.

Learning objectives

- Identify phases in the development and management of behavioural change interventions.
- Describe elements of implementing behavioural change interventions.

By the end of this session, participants will:

- be able to explain the process of behavioural change interventions development,
- know how to describe the phases of behavioural change intervention development,
- understand the need for a detailed planning process including situational analysis,
- be capable of recognizing the core elements of behavioural change implementation, and
- be able to describe the monitoring and evaluation process and its forms.

Development and management of behavioural change interventions

Behavioural Change Interventions (BCI) are a set of strategies that are well-defined and designed for human behaviour in environments. In the field of health, these strategies are particularly important in promoting a healthy lifestyle and the policies that strengthen these structures. In BCI, a distinction must be made between health education and communication to change behaviour.

"*The development and management of BCI is in three distinct but interrelated phases:* ***preparation, implementation and monitoring and evaluation***. *Programme planners and managers can decide whether to implement BCI as a pilot, demonstration or institutionalized project"* (WHO, 2008).

Following parts were taken from WHO's Guidelines for Developing Behavioural Change Interventions in the Context of Avian Influenza (WHO, 2008):

Performing BCI situation analysis

An analysis should include available epidemiological and behavioural data, information on national policies and their organizational structures. This information is the basis for planning, programming, and policymaking.

A situation analysis for developing BCIs helps to:

- provide an overview of the current situation in support of behaviour change in a country (which regulations and legislations are in force, and which are missing),
- identify community approaches to BCI, including political infrastructure and leadership, finance, and human resources, and
- identify the level of awareness of citizens, define gaps in knowledge, and anticipate which gaps can be filled in order to improve awareness towards disease prevention.

A situation analysis should be conducted by a multidisciplinary team with expertise in both qualitative and quantitative research methodologies.

Establishing BCI goals and objectives

A 'goal' is a broad intent of the desired outcome. 'Objectives' are clear and specifically stated desired outcomes.

A statement of objectives must be '**SMART**', namely:

- **Specific** — for the target audience in the context of their knowledge, skills, attitudes, behaviour, beliefs, and perceptions, among others.
- **Measurable** — for assessing behavioural impact.
- **Achievable** — or attainable under the set conditions.
- **Relevant** — to or contribute to the activity.
- **Time-bound** — with results expected within a given time

Identifying settings and the target audience

Extensions require the treatment of individuals within the larger social units (communities) in which they live, work, and exist. Schools are an ideal place for BCIs, with constant access and opportunity to conduct BCIs for students, teachers, and parents.

Establishing BCI stimulus

Communication is a key element of BCI; however, it must be integrated into the whole strategy and not used as a stand-alone intervention. The most important factor in communicating behaviour change is building trust. It is therefore important to build a trustworthy relationship in order to accept and achieve the desired change. Another factor is the realization that BCIs must deviate from traditional top-down, one-way processes. Goals and solutions should therefore be proposed by, or have knowledge of, the target community.

For BCIs to be more effective, community members must be part of the decision-making process. They are often the first adopters who are considered to be credible sources of information, leading them to be called agents of change. Communication of behavioural changes should be primarily utilized by health professionals, with non-health professionals

functioning only as helpers for the entry of individuals, families, and communities into the process (by adapting time, language, and other activities), called a 'basically' approach.

Conducting Audience Analysis

Once BCI targets have been identified, it is necessary to focus on the target population and evaluate the epidemiological data as:

- who is the target group – age, gender, economic status, location, education, occupation, language, preferred channels of communication, etc.,
- what is the target population's knowledge of the topic,
- what are the related socio-cultural and behavioural characteristics of the target population,
- whose behaviour needs to change to bring about the desired health or social outcome,
- what are the predisposing, enabling, and reinforcing factors likely to promote or hinder the achievement of desired behavioural change outcomes, and
- what reinforcing factors (policy, structure, political commitment, legislations, etc.) are needed by the affected and service providers to bring about desired results?

Conducting communication diagnosis

Behavioural change intervention is based on communication to achieve the desired change in behaviour. It should be noted that all communities are not the same, so it is necessary to assess each group or community before identifying the most appropriate approaches before starting the process. Information or communication messages are most often disseminated among people or through mass media. Interpersonal communication, which also includes group media, aims to reach a specific group with a specific message. Discussions, videos, movies, drama, songs, or games can also be used as a medium. Group media supports interpersonal face-to-face communication with small groups. In contrast, the mass media channel aims to quickly reach large sections of the population in various locations. This medium uses, among other things, television, radio, posters, and billboards. As a prerequisite for success, the programme planner or facilitator should identify the strengths and limitations of each communication medium in order to take an approach that is likely to produce the desired results in changing behaviour (WHO, 2008).

Phase 2: Implementation of BCI

Implementation of BCI includes the following seven elements:

Element 1. Communication for behaviour change

Behaviour change communication is one of the basic and critical elements for successful interventions. Communication is described in previous chapters.

Element 2. Governance: Policy coherence and political commitment

Behavioural change intervention requires the support of all stakeholders at the transnational and national levels involved in disease control and prevention. Defective ministries are important stakeholders. In particular, the following actors should be involved: health, animal husbandry, agriculture, information, and trade. Political commitments should be the way to introduce new state policies in the form of laws, regulations, and ordinances. Financial and technical support to communities should also be included to ensure that communities are protected from diseases. It is essential to assess the extent to which the communication of information could be limited in terms of the media settings and policies of the countries concerned.

Element 3. Planning and implementation

The key to a successful BCI is planning. This should consider age, gender, socio-economic and political factors of the community. We must not forget to consider culture as an important planning factor. It is culture that is responsible for behaviour, mindset, and belief that can have a significant impact on health. On the other hand, culture can be a significant barrier to the implementation of interventions; however, no single approach or strategy can break the transmission chain.

Element 4. Capacity building

Behavioural communication implementation requires concerted efforts in building national capability to plan, implement, and manage activities associated with disease prevention and control. Training in BCI strategies and techniques should be available to both medical and non-medical experts. It should also be available to community leaders and civil society groups involved in disease prevention and control at the national, provincial and, district levels.

Element 5. Community and social mobilization

Community and social mobilization are an essential element of BCI. It is responsible for bringing stakeholders together and connecting them directly to the community in order to identify and decide on measures that need to be taken to ensure success. In this context, it is aimed to demand services and assist in its delivery for sustainability and self-reliance and raise people's awareness about diseases.

Element 6. Partnerships, alliances, and networks

The participation of various partners, civic associations, communities themselves, the media, the private sector, and transnational organizations (such as the UN, CDC, WHO, etc.) is key to the implementation of BCI. The role of partnership is to bring in additional technical and financial resources and to increase social responsibility among partners and acceptance by communities.

Element 7. Resource mobilization

Human resources, infrastructure, and financial resources are needed to provide BCI. Resource mobilization requires a process of detailed planning, monitoring, and evaluation. In

addition, the government is expected to set aside a financial package to fight disease, ensure quality healthcare, and ensure the use of modern technology and techniques. It is recommended to use information and communication technology elements in this area. Ultimately, financial regulation should oversee the monitoring and evaluation plan (WHO, 2008).

Phase 3: Monitoring, evaluation, and research

Monitoring

'Monitoring' is the systematic monitoring of the implemented progress of activities to ensure the fulfilment of the set objectives of BCI. All BCI activities should include monitoring to ensure the continuity and implementation of the program. Monitoring is also useful in identifying bottlenecks so that corrective action can be taken. In the planning phase of BCI, it is necessary to design appropriate monitoring indicators and create a feedback system. Monitoring activities are mostly conducted by examining records, reports, surveillance visits, and interviews. Staff can provide significant feedback on the progress of intervention through regular face-to-face meetings with beneficiaries.

Evaluation

An evaluation assesses whether the set objectives of the program, the output, and the impact have been met. Evaluation is important for influencing the program and policy direction of disease prevention and control. It is also helpful for all stakeholders (including the target community) to assess the outcome of the programme in the implementation of BCI. In this step, it is important to select suitable indicators for measuring BCI elements in terms of impact and result. The least acceptable indicator of behaviour change is the reported increase in knowledge. Community members should be involved in this process, even though evaluation should include internal and external experts. With community members involved, they can gain skills and a sense of ownership.

Research

Research has an irreplaceable position in influencing policies, proposing interventions, and setting communication strategies. In the context of BCI, it is recommended to use elements of quantitative and qualitative research methods, with a strong emphasis on behavioural research and priorities set through a participatory process, mobilising all those involved in effecting behavioural change. Research goals must be clear, concise, clearly defined, and realistically formulated. High demands should be placed on their fulfilment. Socio-cultural and behavioural theories should be considered. These theories attempt to explain the relationship between human behaviour and risk-taking while searching for new context and information. Last but not least, it is most important to ensure that the results of the research are further disseminated to all stakeholders and implemented throughout the strategy so that appropriate and effective measures can be set up and used (WHO, 2008).

Questions for topic reflection and discussion

1. In what spatially defined place can interventions be applied? (Name 5 examples)

- *Markets, schools, workplaces, households and communities, restaurants, sports centres…*

2. What factors of the target group need to be considered when creating intervention activities?

- *Age, gender, religion, economic status, education, occupation, culture, and other socio-cultural and behavioural characteristics*

3. Write at least ten measurable indicators with which we can evaluate the success of the intervention.

- *Reduced/increased incidence and prevalence, reduced morbidity and mortality, elimination of DALYs and YLDs, increase of QUALYs, risk reduction, reducing the number of people exposed to the risk factor.*

Test questions

- *What is behavioural change intervention?*
- *What is the purpose of the preparation phase of BCI development?*
- *What forms of evaluation do you know?*

Assignments for participants

Try to design a BCI strategy. You can focus your strategy on preventing, diagnosing, treating a disease, or tackling another public health problem. Define the target group, set appropriate goals, describe the basic steps, use of resources, and methods.

List of suggested additional readings

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Glossary of terms

Behavioural change interventions – involve sets of techniques used together, which aim to change the health behaviours of individuals, communities, or whole populations (NICE, 2014).
Behavioural change programmes – are a coordinated set of more than one intervention that share common aims and objectives (NICE, 2014).
Community-level interventions – target larger portions of the population to address a recurring problem among these groups, who are categorized into the same demographic (and share the same problems) by regional trends, age, parental status, education level, socioeconomic status, or several other factors (Kalantjankos, 2019).
Incidence – a measure of the frequency with which new cases of illness, injury, or other health condition occurs among a population during a specified period (CDC, 2014).
Morbidity – disease; any departure, subjective or objective, from a state of physiological or psychological health and well-being (CDC, 2014).
Mortality rate – a measure of the frequency of occurrence of death among a defined population during a specified time interval (CDC, 2014).
Prevalence – the number or proportion of cases or events or attributes among a given population (CDC, 2014).
Quality-adjusted life year (QALYs) – A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One quality-adjusted life year (QALY) is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the person's ability to carry out the activities of daily life, and freedom from pain and mental disturbance (NICE, 2021).
Disability-adjusted life year (DALYs) – A measure of the impact of a disease or injury in terms of healthy years lost (NICE, 2021).
YLDs – Years lived in less than ideal health. This includes health loss that may last for only a few days or a lifetime (GBD, 2015).

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III. HEALTH PROMOTION MODULE

Section 1: Introduction

Plančíková D., Paulík S.

Introduction

Health promotion is one of the most important fields of public health. The fundamental idea of health promotion is to improve the health of individuals and communities by involving them in the process of controlling health aspects in their lives. Therefore, the principle of health promotion is to build a responsible approach of individuals in relation to health, education in public health policies, educational and counselling activities in the field of maintaining health, and elimination of risk factors. Health promotion plays a significant supporting role in the epidemiology of non-communicable diseases (NCDs).

Learning objectives

- Understand the concept of health promotion.
- Understand the concept of health promotion at the primary healthcare (PHC) level.
- Explain the roles of PHC staff in health promotion.
- Identify health promotion activities provided by a PHC unit.
- Propose health promotion activities at a PHC unit.

By the end of this session, participants will:

- understand the goals and principles of health promotion,
- be able to explain the importance of the role of health promotion at the PHC, and
- understand the PHC unit's role in health promotion activities.

Discussion questions

Trainers can start the session with a brief discussion on the term "health promotion." The discussion can include the following questions:

What does the term "health promotion" tell you? Where did you hear about it? In what context?

Facilitator's notes

After the brief discussion, the session will continue with an introduction to health promotion principles and goals. This part of the session is mainly based on documents published by the World Health Organization (WHO) – the Ottawa Charter in 1986 and the Shanghai Declaration on Health Promotion in 2016.

Health promotion principles and goals

In order to provide trainees with skills related to health promotion, it is essential to clarify how health is defined. The most known definition of health was adopted in 1946 by 61 WHO member states as follows: "health is a state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity" (WHO, 1948).

Health promotion is defined by WHO as "the process of enabling people to increase control over, and to improve their health" (WHO, 1986). The definition of health promotion and its principles and objectives were presented at the first international conference on health promotion held in Ottawa in November 1986. According to the Ottawa charter, health is seen as "a resource for everyday life, not the objective of living" (WHO, 1986).

The Ottawa conference was organised as a response to growing expectations for a new public health movement. Previous documents on primary healthcare, Health for All, and the discussion at the World Health Assembly on intersectoral action for health invigorated the development of the Ottawa Charter (WHO, 1986).

Health promotion covers a wide range of social and environmental interventions. These are designed to address and prevent the main causes of diseases, not just focusing on treatment and cure (WHO, 2016a).

Peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity are considered basic prerequisites for health. Health promotion focuses on achieving equity in health by reducing differences in current health status and ensuring equal opportunities and resources to all. People need to take control of things that determine their health, such as a secure foundation in a supportive environment, access to information, life skills, and opportunities for making healthy choices. The Ottawa conference resulted in five integrated action areas for health promotion and three strategies, which are also shown in the emblem of the Ottawa charter (Figure 1).

The five action areas are:

1. building healthy public policy,
2. creating supportive environments,
3. strengthening community action,
4. developing personal skills, and
5. reorienting health services (WHO, 1986).

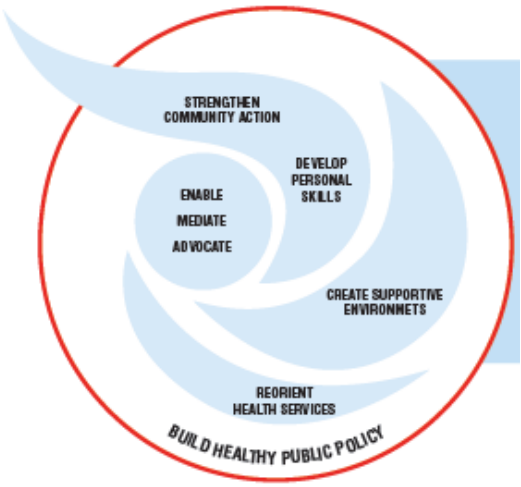

Figure 1 Integrated action areas for health promotion (WHO, 1986)

Reorient health services

The most relevant in relation to PHC is the fifth action area – Reorient health services. This action area shows that the role of the health sector must move in a health promotion direction. Health promotion is not only a responsibility of health professionals, health service institutions, and governments; it is also shared among individuals and communities. All of these groups should work together to create a healthcare system that helps achieve the health of individuals and communities. In order to reorient health services, changes in professional education and training must be implemented. Additionally, health research should receive more attention (WHO, 1986).

Shanghai conference – 9th Global conference on health promotion

In November 2016, the 9th Global conference on health promotion was held in Shanghai. The outcome of the conference was the Shanghai Declaration on Health Promotion, which followed up on the Ottawa charter and complemented the idea of health promotion (WHO, 2016b).

In the declaration, three key pillars of health promotion were stated as follows: good governance for health, healthy cities and communities, and health literacy (Figure 2).

1. The first pillar of health promotion – **good governance for health** – puts emphasis on the fundamental responsibility of governments at all levels to address the damaging effects of unsustainable production and consumption.
2. The Shanghai declaration emphasises **the concept of healthy cities and communities** (the second pillar). The settings of everyday life should be created in a way that enables people to live, love, work and play in harmony and good health. The concept of healthy cities contributes to making cities inclusive, safe, and resilient for the whole population.
3. **Health literacy** is the third pillar of health promotion and should be recognised as a critical determinant of health. It helps people to make the healthiest choices and decisions for their families and themselves (WHO, 2016b).

Figure 2 Key pillars of health promotion (WHO, 2017)

The Shanghai Declaration commitments are provided in Table 1 in more detail.

Table 1 Shanghai Declaration commitments (WHO, 2016b)

Governance	Healthy cities	Health literacy
• apply fully the mechanisms available to government to protect health and promote wellbeing through public policies; • strengthen legislation, regulation, and taxation of unhealthy commodities; • implement fiscal policies as a powerful tool to enable new investments in health and wellbeing - including strong public health systems; • introduce universal health coverage as an efficient way to achieve both health and financial protection; • ensure transparency and social accountability and enable the broad engagement of civil society; • strengthen global governance to better address cross border health issues; • consider the growing importance and value of traditional medicine, which could contribute to improved health outcomes, including those in the SDGs.	• prioritise policies that create co-benefits between health and wellbeing and other city policies, making full use of social innovation and interactive technologies; • support cities to promote equity and social inclusion, harnessing the knowledge, skills and priorities of their diverse populations through strong community engagement; • re-orient health and social services to optimise fair access and put people and communities at the centre.	• recognise health literacy as a critical determinant of health and invest in its development; • develop, implement and monitor intersectoral national and local strategies for strengthening health literacy in all populations and in all educational settings; • increase citizens' control of their own health and its determinants, through harnessing the potential of digital technology; • ensure that consumer environments support healthy choices through pricing policies, transparent information and clear labelling.

Core competencies for health promotion

According to the Australian Health Promotion Association (AHPA), core competencies for health promotion include the minimum set of competencies and skills that provide a baseline for health promotion roles: “They are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field” (AHPA, 2009).

In Figure 3, the core competencies for health promotion are presented. Ethical values and the health promotion knowledge base are displayed as integral parts of the diagram which support all the other domains. The remaining domains include enabling change, advocating for health, mediating through partnership, communication, leadership, assessment, planning, implementation, and evaluation and research. Each of these domains covers a specific area of health promotion practice (IUHPE, 2016).

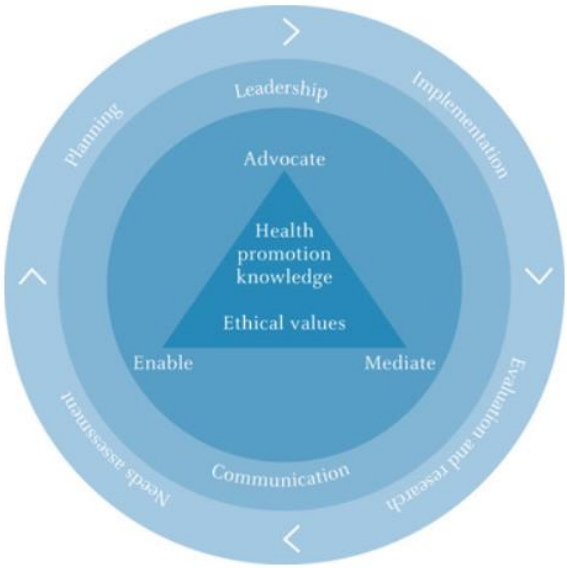

Figure 3 Core competencies for health promotion (IUHPE, 2016)

Discussion

After the introduction to health promotion, the interaction between trainers and trainees and among trainees will continue with a discussion on providing health promotion interventions at PHC units.

Do you provide any health promotion interventions at your PHC unit?

The following part focuses on the implementation of health promotion in PHC. Several examples from the field are provided by using two case studies from the South-East Asian region.

Health promotion in primary healthcare

PHC is an essential component of human development. It is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families, and communities. Its focus is on the comprehensive and interrelated aspects of physical, mental, and social health and well-being. PHC provides lifelong whole-person care for health needs. One of the PHC tasks is to ensure that people receive quality comprehensive care that ranges from promotion and prevention to treatment, rehabilitation, and palliative care.

WHO has developed a definition based on three components:

- Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course;
- Addressing the broader determinants of health through evidence-informed public policies and actions across all sectors; and
- Empowering people to optimize their health as advocates for health promotion and health protection policies as co-developers of health and social services and as self-carers and caregivers to others (WHO, 2019).

Roles of nurses and midwives

Nurses and midwives can make important contributions to address NCDs and reduce risk factors (especially tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol). Nurses and midwives, along with other members of the healthcare team, must be directly engaged in reducing risk factors.

Nursing's holistic approach to health will not only prevent diseases but also promote health. Nurses, as members of the healthcare team, receive public trust and respect. They have access to all levels of the population, including the underserved, throughout the lifespan and in a variety of settings.

Nurses and midwives are well-positioned to provide interventions at the individual and community level, including providing crucial follow-up to behavioural interventions that aim to modify the key risk factors for NCDs and promote health. They are well situated to reduce risk factors associated with NCDs by implementing policies on smoke-free environments and smoking cessation interventions, promoting physical activity, providing dietary education and guidance, and preventing and treating the harmful use of alcohol.

Addressing NCDs through existing healthcare programmes can also amplify reach. Examples of such an approach include:

- smoking cessation interventions as part of programmes for tuberculosis patients,
- integrating treatment for NCDs with HIV/AIDS care, and
- diet and physical activity education in mother-and-child health and immunisation clinics (WHO, 2012).

Case study 1: Ways of promoting health to patients with diabetes and chronic kidney disease from a nursing perspective in Vietnam: A phenomenographic study

This study aimed to describe nurses' perceptions about health-promoting activities for patients with type 2 diabetes mellitus (T2DM) or end-stage renal disease. Interviews were conducted with twenty-five nurses working at two major hospitals in Hanoi, Vietnam. The responses were grouped into four categories.

Health was promoted by creating a positive relationship: The nurses spent more time together with the patients than the practitioners, so they were able to promote health through this close relationship. A positive approach and use of humour were described as ways how to connect with the patients. Various difficulties in creating a positive relationship with the patients were described, including the patients' physical or mental health conditions (such as severely ill patients, patients with depression, or Alzheimer disease); difficulties in connecting to patients from ethnic minorities (language barrier and cultural differences); and patients' lack of motivation to listen to the nurses' advice.

Health was promoted by supporting patients to take part in their social context: The nurses could promote health by involving patients in community activities, patient clubs, or through media. Support from other patients and relatives was considered important. On the other hand, both groups could also be a barrier in the nurses' health-promoting work. The patients' economic conditions might also cause some obstructions when promoting health.

Health was promoted by educating patients and relatives: The nurses emphasised the importance of patient education, which could lead to a better quality of life and better health. They used different ways to educate patients, such as answering questions, instructing, and giving advice about health and disease. Patient compliance to the treatment was important, and the nurses helped patients follow the doctors' advice.

Health was promoted by supporting patients to be physically active: The nurses described how physical activity was important for patients by improving their physical and mental health and helped prevent complications of diseases. The nurses emphasised that health promotion, which included techniques such as massages and light movements with the patient's legs and arms, was also essential for bedridden patients to avoid complications such as decubitus (Pham and Ziegert, 2016).

Case study 2: Development of a community participation programme for diabetes mellitus prevention in a primary care unit, Thailand

The purpose of this study was to create and test a prevention model for T2DM in a PHC unit in Thailand and to develop a programme for the prevention of T2DM, including education, care, and assessment specifically designed for that community. A PHC unit can provide proactive services for T2DM prevention and diabetic screening, which was used to identify the patients with an increased risk for T2DM.

The programme was validated by three experts (a family doctor, a nurse educator, and a nurse practitioner). The health promotion programme for 160 persons at risk of T2DM consisted of nutritional education and exercise activity. The programme's effectiveness was measured by using a pre-test post-test design. The programme was run by health volunteers by

providing nutritional education using food pyramid guides and plastic food models. The health volunteers selected appropriate types of exercise for a three-month fitness phase in each village.

The community participation programme was effective in enhancing health promotion behaviour. The BMI, waist circumference, and systolic BP of the persons who were at risk of T2DM decreased during the three-month programme (Oba et al., 2011).

Discussion

Now that you have completed this study session, you can assess how well you have achieved your learning outcomes by answering the following questions:

- Would you like to implement any health promotion interventions which have been mentioned?
- Would you propose any further health promotion interventions?
- How would you proceed in order to implement any health promotion intervention at your PHC unit?

Learning materials

The following additional learning materials can be used as supporting materials during the course or as tools for trainees to revise and strengthen their knowledge on health promotion.

Video 1: An introduction to health promotion and the Ottawa Charter
This video introduces health promotion, the process of enabling people to increase control over and improve their health. It also focuses on the Ottawa Charter – a landmark document that has been influential in providing guidance to the goals and concepts of health promotion.

- The video is available at: https://www.youtube.com/watch?v=G2quVLcJVBk

Video 2: Let's be active for health for all
The Let's be active campaign promotes the advice of the WHO Global action plan on physical activity.

- The video is available at: https://www.youtube.com/watch?v=uZX14W4rVCU

Case study 3: Health promotion innovation in primary healthcare
This study provides arguments for training PHC professionals in health promotion and encouraging them to embrace innovation within their practice to improve the effectiveness of treatment (McManus, 2013).

- The case study is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3575061/

Test questions

1. *What is health promotion?*
2. *What are the two documents on which the concept of health promotion is based?*
3. *Name five action areas for health promotion that were formed by the Ottawa Charter.*
4. *Explain the role of a PHC unit in promoting health.*

Glossary of terms

Health – a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity (WHO, 1948).
Health promotion – the process of enabling people to increase control over, and to improve their health (WHO, 2021).
Ottawa Charter for Health Promotion – an international consensus statement from the First WHO International Conference on Health Promotion, held in Ottawa, Canada, in November 1986 (WHO, 2021).
Primary health care – an overall approach to the organization of health systems which encompasses the three aspects of: multisectoral policy and action to address the broader determinants of health; empowering individuals, families and communities; and meeting people's essential health needs throughout their lives (WHO, 2021).
Well-being – a positive state experienced by individuals and societies. Similar to health, it is a resource for daily life and is determined by social, economic and environmental conditions (WHO, 2021).

More terms related to health promotion can be found in the WHO *Health Promotion Glossary of Terms 2021* at https://www.who.int/publications/i/item/9789240038349.

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HEALTH PROMOTION MODULE

Section 2: Determinants of Health

Plančíková D., Paulík S.

Introduction

There are many factors that affect the health of people. The health of individuals and communities is determined by their circumstances and environment. Factors such as residence, the state of the environment, economic and social status, income, relationships, genetics, education level and health services have a considerable impact on health.

Learning objectives

- Identify determinants of health.
- Understand the relationships between determinants of health and health outcomes.
- Identify the key determinants of hypertension and diabetes.
- Suggest how PHC staff and community workers can help influence the determinants of hypertension and diabetes.

By the end of this session, participants will:

- be able to define determinants of health,
- understand how determinants of health affect the health of people, and
- explain the key determinants of non-communicable diseases (especially hypertension and diabetes mellitus).

Training methods

- Individual/group discussion questions
- PowerPoint presentation

Facilitator's notes

Determinants of health

The health of individuals and communities is determined by many factors that include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours. Factors such as where people live, the state of environment,

genetics, income and education level, relationships with family and friends, and access and use of health services affect health (WHO, 2017).

In order to illustrate the determinants of health, you can use the Dahlgren-Whitehead "rainbow model" developed by Göran Dahlgren and Margaret Whitehead in 1991 (Figure 1). This model puts in the centre the individuals with their demographic characteristics and constitutional factors. The individuals are surrounded by various layers – individual lifestyle factors, social and community networks, living and working conditions, and the general socio-economic, cultural, and environmental conditions.

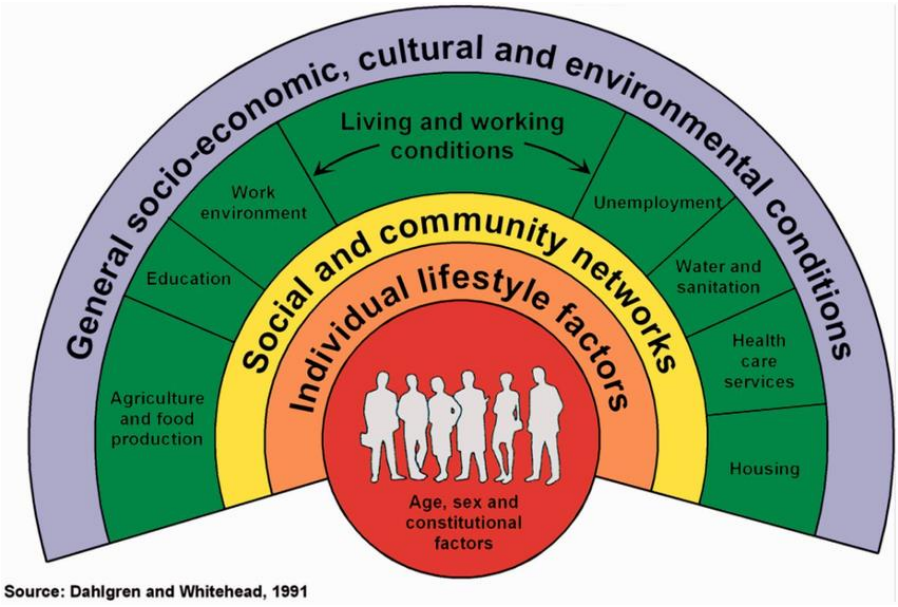

Figure 1 Determinants of health scheme (Dahlgren and Whitehead, 1991)

Determinants of health include:

- **Income and social status** – higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.
- **Education** – low education levels are linked with poor nutrition (risk factor), more stress, and lower self-confidence (a precondition for making less healthy decisions).
- **Physical environment** – safe water and clean air, healthy workplaces, safe houses, communities, and roads all contribute to good health.
- **Employment and working conditions** – people with employment are healthier, particularly those who have more control over their working conditions.
- **Social support networks** – greater support from families, friends, and communities is linked to better health.
- **Culture** – customs, traditions, and the beliefs of the family and community affect health.
- **Genetics** – inheritance plays a part in determining lifespan, healthiness, and the likelihood of developing certain illnesses.
- **Personal behaviour and coping skills** – a balanced diet, keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.

- **Health services** – access and use of services that prevent and treat disease influence health.
- **Gender** – men and women suffer from different types of diseases at different ages.
- **Early development** – maternal education, healthy nutrition of pregnant women, and supporting breastfeeding leads to better health.
- **Health services** – equitable access to and use of services that prevent and treat disease, and out-of-pocket expenses contribute to health.
- **Priority public health conditions related to behaviour within the social context** – policies reducing tobacco, alcohol, and drug use and improving under- or over-nutrition lead to better health (WHO, 2015; Talbot & Verinder, 2017).

After the explanation of determinants of health, you can continue with the Country Health Rankings model, which provides a distribution of determinants of health in relation to their contribution to health.

As presented in Figure 2, social and economic determinants (such as education, employment, income, etc.) and behavioural factors (alcohol and drug use, smoking, etc.) have the highest impact on health.

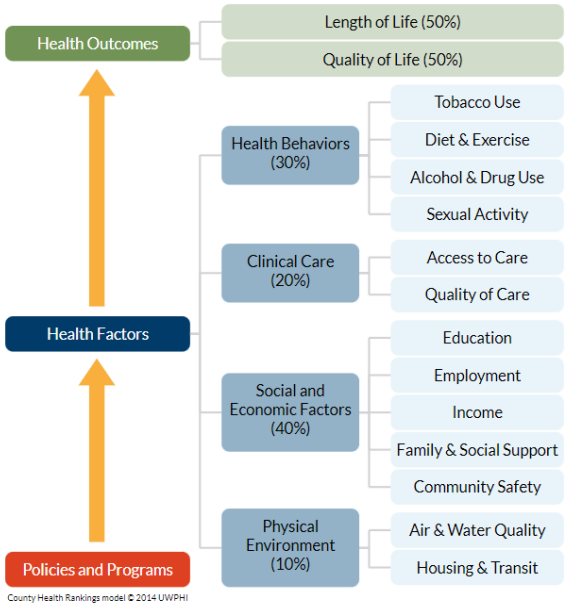

Figure 2 Country Health Rankings model (University of Wisconsin Public Health Institute, 2014)

The explanation of determinants of health can be enriched by Video 1 listed under section Learning materials.

Activity

In the following activity, trainees will explore the determinants of hypertension and type 2 diabetes by using the Health Iceberg model.

- *Trainees will be divided into small groups and will try to identify the factors that contribute to hypertension and diabetes by using the Health Iceberg model.*
- *Subsequently, they will report their findings and discuss them with all the trainees and their trainer.*

Using the Health Iceberg model to examine the determinants of hypertension and diabetes

Use the Health Iceberg model and answer the following questions:

- What are the factors that contribute to hypertension and diabetes?
- What are the structural issues?
- What are the lifestyle behaviours that contribute to heart disease?
- What are the lifestyle behaviours that contribute to diabetes?
- What are the psycho–socio–cultural factors that contribute to heart disease or diabetes via the factors above them in the iceberg?

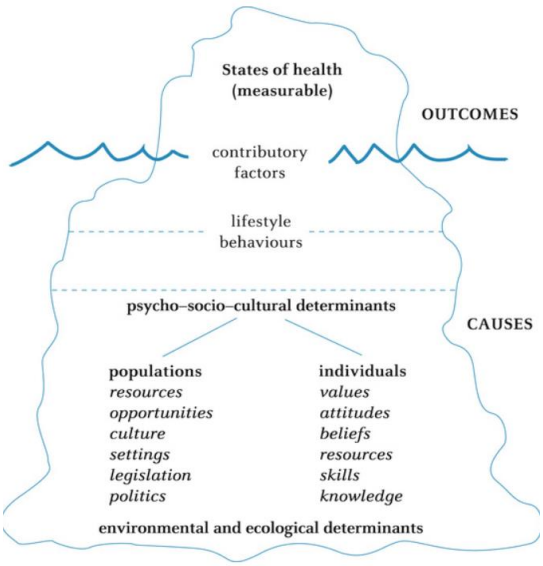

Figure 3 The health iceberg – a method for examining the determinants of health (Talbot & Verinder, 2017)

Discussion

After the determinants are identified, trainees will discuss in small groups which of them they are able to address at their PHC units.

Comparison of selective and comprehensive primary healthcare

Selective primary healthcare (SPHC) is based on a medical model of healthcare and concentrates on treating diseases. It is organised in a way that assumes that only the health system and health professionals create and maintain control over health.

Comprehensive primary healthcare (CPHC) is based on health, and the provision of medical care is only one aspect of providing healthcare. CPHC aims to address determinants of health. CPHC focuses on the process of empowerment and increasing people's control over all determinants impacting their health. It enables societies to take action on the prerequisites for health and address the socio-ecological determinants of health (Talbot & Verinder, 2017).

The CPHC concept is in line with the WHO definition of PHC, which is stated in the Alma-Ata declaration as follows: “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (WHO, 1978).

Examples of SPHC and CPHC:

- Médecins Sans Frontières distributes essential drugs and assists local communities with water and sanitation programs – SPHC.
- Training of local personnel to work with disadvantaged groups in remote areas – CPHC.

Primarily, CPHC focuses on preventing illness and treating disease by providing essential medical care while also assisting with essential infrastructure support in a socially acceptable and empowering way to improve living conditions and healthcare (Talbot & Verinder, 2017).

Social determinants of health

WHO defines social determinants of health (SDH) as “the non-medical factors affecting health outcomes” and “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” To these forces and systems, we can include economic policies and systems, development agendas, social norms, social policies, and political systems.

Research has shown that SDH can influence health to a greater extent than healthcare and lifestyle choices. These SDH can be responsible for between 30-55% of health outcomes. It is necessary to address SDH to improve health and reduce health inequities.

These are examples of the SDH which can influence health equity:

- income and social protection,
- education,
- unemployment and job insecurity,
- working life conditions,
- food insecurity,
- housing, basic amenities, and the environment,

- early childhood development,
- social inclusion and non-discrimination,
- structural conflict, and
- access to affordable health services of decent quality (WHO, 2021b).

Addressing the social determinants of health

Framework for addressing SDH in primary care of the American Academy of Family Physicians (AAFP) is based on a three-phased process that encourages family physicians and their healthcare teams to:

1. **Ask** patients about their SDH,
2. **Identify** resources in patients' communities that can help address SDH, and
3. **Act** to help connect patients with resources to help address patients' SDH.

Other efforts, such as speaking out, advocating, providing testimony, and collaborating with organizations to address SDH, are ways to advance health equity. The AAFP suggests starting small and fitting these efforts into a practice as time and resources allow (AAFP, 2018).

Figure 4 provides a flowchart of sample patient visits with Steps, Actions and Considerations recommended in addressing SDH.

Sample Patient Visit Flowchart	
Step	**Actions and Considerations**
Patient checks in ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient sits in waiting room ↓	Social determinants of health (SDOH) screening tool is distributed to patients at check-in to be completed in the waiting room.
Height and weight checked in hallway ↓	Nurse or medical assistant confirm social needs with patient and provides information to office clerk to cross reference social needs with available community resources.
Remaining vital signs checked in exam room ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient meets with clinician ↓	Clinician discusses social needs with patient and available resources and works to develop a plan to address the patient's SDOH.
Patient meets with counselor ↓	Nurse or medical assistant finalizes plan to address patient's SDOH and referrals to community resources.
Patient stops at billing/scheduling station ↓	Office staff schedules follow-up appointment.
Patient leaves ↓	

Figure 4 Sample Patient Visit Flowchart (AAFP, 2018)

Paediatric practice – the patient-centred medical home is promoting health through addressing the SDH. Children are considered to be an at-risk population because of their vulnerability to the deleterious effect of the social and physical environment, especially poverty (Garg, Jack and Zuckerman, 2013).

Regular health supervision visits are important in the context of the family and community. The most important SDH in paediatric practice are child maltreatment, early childhood adversity, and stress (Garg, Jack and Zuckerman, 2013). Psychosocial issues such as substance abuse, maternal depression, and intimate partner violence are also important. Screening for basic unmet material needs (food, employment, benefits, education) performed

by PHC units can increase physician referrals and family contact with community resources (Garg et al., 2007).

The goal of home visiting programmes is to promote child development and parenting skills and assist parents with specific needs (school enrolment, employment, etc.). Home visits are provided by nurses and paraprofessionals.

Nurse home visitation programs are also used in **geriatric practice.** The primary goal is to maintain or improve the functional status of the elderly. Home visitation may become an important cost-saving investment. It is an opportunity to care for those patients who access medical services in PHC settings as well as to expand the scope of care to patients who do not make office visits (Garg, Jack and Zuckerman, 2013).

Activity

Identify potential solutions addressing SDH which you can recommend or offer to your patients and clients.

Role-playing – 2 roles:

- Health workers - ask questions related to SDH.
- Patients - respond to the questions.

Use questions included in the following document:

Social Determinants of Health: guide to social needs screening

How to work with patients

After a patient's social needs have been identified, it is important to prepare a plan of action and connect the patients with community-based resources. PHC workers should talk with their patients about getting help. If the patient is unsure about getting help, their reasons for refusing help must be determined. PHC staff is encouraged to ensure patients about help by providing statements like, "I have referred many of my patients to this service, and they have found it helpful." If the patient is not interested, a printout of the resources can be offered. In case the patient is interested, a referral should follow, and the PHC worker should contact the community-based resource to inform them about the patient (AAFP, 2018).

More information about what can be done at the patient, practice, and community levels can be found at: https://doi.org/10.1503/cmaj.160177.

Case studies of addressing SDH:

- Launching an income security health promotion service in Toronto, Canada: Two full-time income security health promoters were integrated into the clinical team and received referrals directly from other health providers. Individual assessments and group education sessions are used to increase income (e.g., government benefits), reduce expenses (e.g., identify free services and goods), and improve financial literacy (Raza et al., 2015).

- Establishing a medical-legal partnership in United States: A medical-legal partnership (Health Justice Initiative) was established with a coalition of legal aid clinics. A lawyer has since provided legal services to patients full-time. The Health Justice Initiative has three core aims:
  1) to provide legal advice and assistance to patients to avoid legal crises and health consequences;
  2) to train health staff and develop tools or interventions in order to improve the ability of the health system to detect and respond to legal concerns; and
  3) to promote change outside the system, and advocate for amendments of laws and regulations to increase the benefits for vulnerable populations (Sandel et al., 2010).
- Addressing SDH in a clinic setting: The WellRx pilot in Albuquerque, New Mexico: An 11-question instrument (WellRx) was used to screen patients for SDH. WellRx showed that almost half of patients screened positive for at least one area of social need, and 63% of those had multiple needs. Subsequently, medical assistants and community health workers connected patients with appropriate services and resources to address the identified needs. Demonstrated feasibility of WellRx led to its institutionalization at a university hospital. WellRx has been established as a useful tool in revealing information about patient's social needs (Page-Reeves et al., 2016).
- Addressing social determinants of health by integrating assessment of caregiver-child attachment into community-based primary healthcare in urban Kenya: A secure attachment between a caregiver and child is a key determinant of early childhood development. The integration of caregiver-child attachment by community health workers was assessed. Out of 2,560 children under 5 years of age, almost 10% were assessed as being at risk for having an insecure attachment. Community health workers organised parent workshops as a primary intervention. Subsequent reassessment of attachment showed positive results (Bryant et al., 2012).
- Other case studies are provided by Pinto and Bloch (2017) in their paper on a framework for building primary care capacity to address the social determinants of health.

Activity

In this activity, trainees will try to identify the barriers to address SDH at the PHC level.

- What are the barriers to address SDH at your PHC unit?
- How can they be overcome?

Figure 5 provides information on overcoming barriers to adopting a social determinants of health approach in clinical practice.

Barrier	Facilitator
Medical model bias and the treatment imperative in health care	Health care provider reminder and recall systems to adopt a more holistic and biopsychosocial approach
Patients who experienced prior stereotyping and discrimination in clinical care	Treating patients with dignity and respect and creating "safe spaces" for disclosure
Physicians feeling overwhelmed, overworked and lacking time	Taking a few extra minutes per consultation to address complex health and social needs
Physicians not knowing what resources exist in the local community	Providing a mapping of benefits and local referral resources for specific social challenges
Physicians unsure of what concrete actions to take to address social determinants	Resources, training and ongoing support of physicians and allied health care workers

Figure 5 Overcoming barriers to adopting a social determinants of health approach in clinical practice (Andermann, 2016)

Although physicians generally recognise that social determinants influence the health of their patients, many are unsure how they can intervene. Many avoid asking about social issues, preferring to focus on medical treatment and lifestyle counselling. Health equity needs to become a priority in the health sector. Training health workers to address SDH is considered one of the key principles for promoting more equitable health outcomes for patients, families, and communities (Andermann, 2016).

Learning materials

The following learning materials can be used as supporting materials during the course or as tools for trainees to revise or strengthen their knowledge on determinants of health.

Video 1: Determinants of health

This short video explains determinants of health and gives a practical example for better understanding.

- The video is available at: https://www.youtube.com/watch?v=eX1tlU-MZYw&ab_channel=TWakelin

Video 2: Determinants of Health – A practical approach!

The video summarises the determinants of health as factors that can influence a person's health. Special attention is paid to the social determinants of health.

- The video is available at: https://www.youtube.com/watch?v=zSguDQRjZv0&feature=emb_rel_pause&ab_channel=Let%27sLearnPublicHealth

Study 1: Addressing social determinants of noncommunicable diseases in primary care: a systematic review

This systematic review explores how primary care organisations assess and subsequently act upon the social determinants of non-communicable diseases in their local populations (Allen et al., 2020).

- The systematic review is available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7607469/

Test questions

1. *What are determinants of health?*
2. *Which group of determinants of health is most affectable?*
3. *Name at least five social determinants of health.*
4. *Why is addressing social determinants of health in primary healthcare important?*

Glossary of terms

Determinants of health – the range of personal, social, economic and environmental factors that determine the healthy life expectancy of individuals and populations (WHO, 2021a).
Environmental determinants of health – the physical conditions in which people live and work that have an impact on health (WHO, 2021a).
Social determinants of health – the social, cultural, political, economic and environmental conditions in which people are born, grow up, live, work and age, and their access to power, decision-making, money and resources that give rise to these conditions of daily life (WHO, 2021a).

More terms related to health promotion can be found in the WHO *Health Promotion Glossary of Terms 2021* at https://www.who.int/publications/i/item/9789240038349.

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From reviewers' reports

"The manual fills in the gap in the literature and the topicality of the chosen subject should be appreciated, especially in the context of the increasing burden of chronic diseases and the related need for care reorganization, better health, and social care, as well as new roles and job demands for the health workforce".

"The publication presented is extremely up to date, due to the act that non communicable disease management based on communication and behavioural aspects in intervention process is now a key priority in the non-communicable diseases control and prevention."

"Overall, the publication deals with a topic that is highly actual, not only in its content but especially in terms of focusing on underprivileged communities. The quality and relevance of the publication is underlined by the amount of good quality references used in the training manual. It declares that the working team of editors and authors is highly specialized in the topic, and they have created a manual that is original, with high quality and applicable in any field."

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