Module 2.1

Addressing **healthy lifestyle** in primary health care
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INTRODUCTION

Health care worker (HCWs) must have good communication skills. Many well-planned health intervention programmes fail due to ineffective communication between HCWs and their patients/clients, HCWs and supervisors or between supervisors and programme managers. The role of HCWs is very important in bridging this gap. A health programme can be sustained only if HCWs can deliver the key message successfully and change attitudes to and behaviours regarding health and disease. This module highlights the core communication skills and basics of the 5A’s and 5R’s that need to be implemented during patient/client interaction.

LEARNING OUTCOMES

At the end of the session, participants will be able to do the following:

- Understand the basics of counselling and motivational interviewing in promoting healthy lifestyles in primary health care (PHC).
- Employ the 5A and 5R techniques to target specific healthy lifestyle modifications.

TOPICS COVERED

- Micro skills in counselling.
- Basic principles and steps in motivational interviewing.
- 5A’s and 5R’s techniques in lifestyle counselling.

COMPETENCY

Ability to conduct motivational interviews and employ the 5A’s and 5R’s for healthy lifestyle counselling.
TEACHING AND LEARNING ACTIVITIES

Total session time: 90 minutes

Activity 1. Personal behaviour change: 10 minutes

Step 1. Ask participants to work in pairs.

Step 2. Discuss a positive behaviour change that you have successfully adopted in your personal life.

Use the following questions as a guide for this exercise:

- What made you decide that you needed to change this behaviour?
- How long did you spend thinking about it before you actually started trying to change?
- Did you manage to change to the extent you had planned or desired?
- What were some factors that helped you change?
- What kind of challenges did you face?
- How did you overcome those barriers to change?

Facilitator’s explanatory notes

Facilitator should emphasis the following key points:

- Change is not always due to lack of knowledge or information.
- Lack of change is due to a motivational issue.
- People are ambivalent about the change and get stuck. This leads to postponing the decision to change.
- The delay in the decision to change can be perceived by health care workers as resistance.

Activity 2. Explanation of the 5A’s and 5R’s model: 15 minutes

Step 1: Present the powerpoint slides with following contents:

- principles of behaviour change
- stages of behaviour change
- principles of motivational interviewing and techniques
- brief interventions using the 5A’s and 5R’s models.

Note: Include a reflection on personal behaviour change in the powerpoint discussion.
Step 2. Ask participants to reflect on the behaviour change described in the previous exercise and share their experience of moving through the stages of change model.

**Activity 3. Patient/client communication and motivational interviewing:** 35 minutes

Step 1. Ask the participants to think of the communication strategies that they use in their interaction with patients/clients. Discuss these skills using the following questions:

- Are there any specific techniques that work well?
- What about techniques that don't work well?
- Have you had any negative experiences with patients/clients?
- How did communication factor in these negative patient/client experiences?

Step 2. Ask participants the following questions.

- Do you employ motivational interviewing techniques in your clinical practice?
- What are some experiences in using motivational interviewing techniques in your clinical practice?

Step 3. Show a short video demonstrating the basics of motivational interviewing.

- Ask the participants to recall the lessons learnt from the video.

Step 4. Note the key lessons on a whiteboard or flipchart.

**Activity 4. Introducing the 5A’s and 5R’s frameworks:** 30 minutes

Step 1. Ask the participants to review the 5A’s and 5R’s frameworks provided in the workbook.

Step 2. Ask the participants to identify the part of the 5A’s counselling framework each of the following questions or statements would fall under.

(1) “This was a really productive visit. What are your thoughts about our conversation today? I am hoping to come back in a week’s time and just check how you are doing and whether I can offer some additional assistance and more information if you have any questions. It was a pleasure to meet you and I would like to congratulate you for planning to change your behaviour.” – ARRANGE
“Now that I have provided some information on the benefits of eating a healthy diet, are you ready to adopt a diet that will help you manage high blood pressure, high cholesterol and obesity?” – ASSESS

“I see that you are raising a family while also meeting the demands of your work. I understand that balancing these demands must be difficult. However, I would like to provide some information on how smoking and secondhand smoke increases your risk of developing cardiovascular disease (CVD) and harms your children.” – ADVISE

“Thank you for taking the time to speak to me. I would like to begin by asking you about your level of physical activity throughout a typical week.” – ASK

“It is really great that you are taking this step to change your lifestyle. I want to congratulate you for your willingness to start this process as soon as possible. Just so I that I can help you set goals better, what is a realistic start date for you to stop your tobacco use? Can we get someone in your family or a close friend to help you as you take this important step in lowering your CVD risk? What are some challenges that may stop you from going through with this plan? Can we take some measurable steps and help you remove tobacco products so that you are less likely to use them?” – ASSIST

Practical exercise – 5R’s

You may encounter patients who are not willing to change their behaviours. For these patients, the 5R’s counselling framework is a strategy that you can use to see if they might change their minds. In this exercise, match the following statements to the corresponding step in the framework.

1. “I am really interested in learning more about whether you have tried to change your consumption of alcohol in the past. Was there a time when you were successfully able to cut back on alcohol consumption? I recognize that this must be a challenging situation for you but if you are ready, I think we can explore some of the reasons why this may be a difficult change for you.” – ROADBLOCKS

2. “As you may know, there are several risk factors that can lead to CVD. I was just wondering if you were aware of the link between lack of physical activity and the higher risk of CVD. If not, I would love to share this information with you if you would like to learn more.” – RISKS

3. “Did you know that stopping the use of tobacco is the best change you can make for your health? Not only is there a direct benefit of decreasing your risk of CVD and other chronic diseases, but you may also notice a large financial difference over the period of a few months and years.” – REWARDS

4. “I understand that you may not be ready to change your behaviour at this time, but I just wanted to explore some reasons around this. Do you think your current level of physical activity is having any effect on your health and well-being?” – RELEVANCE

5. “I think this was a really productive visit. With the information I have provided today on the risks and benefits of changing your behaviour, are you ready to commit to a change?” – REPETITION
BACKGROUND INFORMATION

Communication skills

HCWs must have good communication skills. Many well-planned health intervention programmes fail due to ineffective communication between HCWs and their patients/clients, HCWs and supervisors or between supervisors and programme managers. The role of HCWs is very important in bridging this gap. A health programme can be sustained only if HCWs can deliver the key message successfully and change attitudes and behaviours regarding health and disease. This section highlights the core communication skills you should try to implement during patient/client interaction.

Appropriate physical environment

It is very important to establish an appropriate physical environment to enhance patient/client privacy, comfort and attentiveness. Small things such as arranging seating in a manner that is neither threatening nor distant, or having a curtain to create a sense of privacy will improve the outcome of patient/client interviews.

Greeting patients/clients

Greeting patients/clients in a manner that is acceptable within the cultural norms relating to age, sex, and so on will help maintain their dignity and encourage their participation. Using the patient’s/client’s name as appropriate where the patient/client is known to the health care workers or offering an appropriate signal of recognition are all acceptable ways to greet patients/clients.

Active listening

This involves using both verbal and nonverbal communication techniques. The health care worker should clearly signal that the patient/client has his/her full attention by look, and offer acceptance and continuation signals such as nods, phrases such as “right/I see”, etc. A willingness to listen actively is however best signalled by the use of open-ended questions to promote fuller answers.

Empathy, respect, interest, warmth and support

These issues are at the heart of interpersonal skills. health care workers should clearly signal their interest in how the patient’s/client’s problem is perceived, how it affects their life, whether it concerns them and what their hopes and expectations are. The health care workers should also show respect, interest, warmth and support, which involves being non-judgemental in attitude.

Language

Education (i.e. general literacy) and health literacy do not necessarily go hand in hand. Low health literacy adversely affects people’s health and is related to poorer health outcomes, especially among
people with chronic conditions. Therefore, it is very important to explain concepts in simple terms rather than use jargon with patients/clients. Some methods to help with this can include the following:

- use of plain language, both written and oral, when communicating health information;
- use of simple and straightforward images, graphs and processes when designing written materials;
- confirmation of the patient’s/client’s comprehension using the “teach-back” method;
- rigorous user testing of information with target audiences (e.g. patients/clients and caregivers, hospital managers, etc.).

**Nonverbal communication**

Skills in nonverbal communication such as eye contact, physical proximity and facial expression are also very important in making patients/clients feel comfortable.

**Collaborative relationship**

It is important for patients/clients to feel that HCWs clearly understand their needs, and are prepared to work with patients/clients to achieve them. This will also allow patients/clients to feel involved in the management plan and will make them more likely to follow counselling and treatment advice.

**What is healthy lifestyle counselling?**

Healthy lifestyle counselling is the second-last step in the treatment pathway (Fig. 1) and involves counselling for behavioural changes such as quitting tobacco use, increasing physical activity, eating a healthy diet and limiting the harmful use of alcohol. Healthy lifestyle counselling involves the use of specific, structured and evidence-based techniques to motivate patients/clients to undergo behaviour change.

It is important to recognize that behaviour change is difficult. However, it is also an underused strategy by HCWs and has been shown to improve outcomes if delivered as part of a comprehensive cardiovascular disease (CVD) risk prevention and management strategy. Behaviour change counselling involves the following:

- **Understanding the process of behaviour change**
  
  The *stages of change model* can assist in understanding the behaviour change process. It is used to map the patient’s/client’s readiness to change and helps to target the counselling approach to the patient’s/client’s needs.

- **How to provide counselling**
  
  This refers to the communication style that the health care workers uses to interact with the patient/client during the counselling session.

  - **Motivational interviewing** is an approach used to motivate patients/clients to undergo behaviour change by guiding self-exploration and drawing out the internal motivations unique to the person.
What a counselling session should include

This refers to the structure of the counselling process and the content that should be covered during the counselling session. Healthy lifestyle interventions can be delivered using brief interventions.

- A brief intervention is a short interaction of 3–20 minutes between health care worker and patient/client, which aims to identify a real or potential problem, provide information about it and then motivate and assist the patient/client to do something about it.

Two types of brief interventions can be used for healthy lifestyle counselling:

- The 5A’s (Ask, Assess, Advise, Assist, Arrange): an approach to help patients/clients who are ready to change their behaviour.
- The 5R’s (Relevance, Risks, Rewards, Roadblocks, Repetition): an approach to help increase motivation in patients/clients who are not yet ready to change their behaviour.

Counselling approaches to promote behaviour change

Lifestyle modifications for healthy living are a fundamental way to prevent CVD. Changing modifiable risk factors, such as bad habits into good ones that minimize risk, is the backbone of CVD prevention. Lifestyle modification can be implemented at every stage of the disease, and is therefore crucial to CVD prevention, even if the disease has already commenced. This section introduces the stages of change model and explain how motivational interviewing can be used to deliver brief interventions for a healthy lifestyle following the outlines of the 5A’s and 5R’s frameworks.

Understanding behaviour change and its stages

Reducing health risks may require changes to be made in some behaviours. Behaviour change is a complex issue and various models have been used to help understand it. The “stages of change” model shown below (also known as the “transtheoretical model of health behaviour change”) is one such example. In this model, behaviour change is not a one-off event but rather a set of different stages through which a person moves. Identifying a patient’s/client’s current stage can help to target a brief intervention toward their needs.

Behaviour change takes time and different people go through the stages at various speeds: some may remain indefinitely at one stage. Even though a person intends to start or maintain a new behaviour, for a range of reasons they may move back to an earlier stage. Relapse into an old behaviour does not necessarily mean a failure to change. Many people who eventually adopt a new behaviour make several attempts before it is maintained over the long term.
Addressing healthy lifestyle in primary health care

Figure 1: The stages of change model

5. Maintenance
   ♦ Maintains the behaviour change

4. Action
   ♦ Starts to make changes

3. Preparation
   ♦ Ready to change
   ♦ Collects information about the problem and options to address it
   ♦ May experiment with small changes
   ♦ May have concerns about possible failure

2. Contemplation (This stage can last for years)
   ♦ Seriously considering change
   ♦ Recognizes the behaviour as a problem
   ♦ Starts to consider the pros (benefit/rewards) and cons (risks/consequences)
   ♦ May have mixed feelings about making changes; may see costs as outweighing benefits

1. Pre-contemplation
   ♦ Not intending to start changing in the near future
   ♦ May not be aware that the behaviour is a problem
   ♦ May be in denial
   ♦ May not feel confident about ability to change

Relapse/recycling
This is not a stage and can occur at any point.
   ♦ Returns to previous behaviour
   ♦ May feel disappointed, frustrated or tired

Using motivational interviewing to trigger behaviour change

Motivational interviewing is a style of talking with a person that can help in motivating them to change. In motivational interviewing, the counsellor does not try to convince the person to change but instead guides them to reach conclusions themselves and draws out the internal motivations that are unique to the person.

A central idea in motivational interviewing is that most people experience some ambivalence or “mixed feelings” about change. They have some reasons to change and also some reasons for staying the same, and may remain “caught in the middle”, unable to change. Motivational interviewing encourages people to explore these mixed feelings so that they can move toward positive change.
Motivational interviewing meets people where they are. This means gaining an understanding of the person and their circumstances so that the counsellor can adapt the communication approach to the person’s current behaviour change stage.

A comprehensive explanation of motivation interviewing is beyond the scope of this module. The next section summarizes some key principles and communication techniques for motivational interviewing. Further reading is suggested at the end of the module.

**Key principles for motivational interviewing**

The following principles can be used to guide the overall approach of motivational interviewing.

1. **Don’t tell the person what to do**
   Telling people what to do can result in resistance. The patient/client should be the one to decide that they need to change and how they will do it. In motivational interviewing, rather than taking the role of an advising expert, the counsellor becomes a partner. The counsellor and patient/client work as a team toward the goal of behaviour change.

2. **Listen and show empathy**
   In motivational interviewing, the patient/client does most of the talking. The counsellor listens and shows that they understand the patient’s situation, without judging or criticizing. Empathy can be described as “getting into the person’s skin” to understand how they think and feel and see the world. Empathetic listening creates an environment of acceptance and respect that can help the patient to be open to exploring the reasons for their behaviour and options for change.

3. **Help the patient/client see the gap between where they are and where they want to be**
   This is also called “developing discrepancy”. By asking questions about the patient’s/patient’s goals and values, and then about the behaviour and its consequences, the counsellor helps the patient/client to see the difference between their life as it is now (with the behaviour and its consequences) and the way they want their life to be.

4. **Let the patient/client tell you that they need to change**
   Rather than telling the patient/client that they need to change, the counsellor draws out the patient’s thoughts and feelings, helping them to find their own reasons for change and ways to start the change process.

5. **Help the patient/client to feel confident about changing**
   If a person is convinced of the need for change, but does not feel confident about succeeding, they may not even make an attempt to change. The patient/client needs to believe that change is possible. This is called self-belief or self-efficacy. The counsellor can support self-efficacy by highlighting previous successes or strengths that the patient/client may already have.

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(6) Roll with resistance

During a counselling session, a patient/client might show resistance to change in different ways, for example, by interrupting, becoming defensive or appearing to lose interest. This is an indication that the counsellor needs to adapt the communication approach. Direct confrontation or argument should be avoided. Rolling with resistance means acknowledging the resistance and adjusting to it, for example, by expressing understanding of the patient’s/client’s point of view, acknowledging personal choice and control, and redirecting the conversation.

Key communication techniques to use in motivational interviewing

Using four basic communication techniques can help the counsellor to build a relationship with the patient/client and understand them and the issues they face. These techniques can be remembered using the acronym “OARS”.

○ Open-ended questions

Open-ended questions cannot easily be answered with a single word such as “yes” or “no”. For example, rather than asking, “Do you think that smoking is bad for your health?” ask, “What are some of the effects that smoking could be having on your health?” Open-ended questions can help to start a conversation and can provide in-depth information to help the counsellor in understanding the patient/client.

○ Affirm

Help the patient/client to recognize their strengths and have a more positive view of themselves. Ask questions that help them to verbalize positive things about themselves and give positive feedback on any past success.

○ Reflective listening

Show that you have heard and understood the patient/client by reflecting on what they have said. For example: Patient: “I don’t want to quit smoking right now.” Counsellor: “So you think that quitting won’t work for you in your present circumstances.”

Reflective listening can also help the patient/client to hear themselves and think about what they have said. It can also help to draw their attention to inconsistencies.

○ Summarize

At intervals, summarize what has been covered up to that point during the counselling session. This confirms mutual understanding and can help draw the patient’s/client’s attention to the most important parts of the discussion.

Targeting the brief intervention to the patient’s/client’s needs

Using the stages of change model, you can determine which stage a patient/client is at and whether they are ready to change. Ideally, we want patients/clients to be at the preparation staircase in Fig. 1 as this is a stage where counselling interventions such as the 5A’s may work best.
However, as the next section explains, you can still deliver an intervention called the 5R’s to patients/clients who are not ready to change. This is also very important because these interventions could help patients/clients move from the pre-contemplation and contemplation stages to the preparation stage.

In both instances (5A’s and 5R’s approach), the communication style should reflect the motivational interviewing concept to help patients/clients explore their feelings about behaviour change.

**Tools to encourage behaviour change and self-care**

**The 5A’s and 5R’s brief interventions**

Primary health-care workers play an important role in helping patients/clients change their unhealthy behaviours and maintain healthy behaviours. Short interactions of between 3 and 20 minutes, called brief interventions, aim to identify a real or potential problem, provide information about it, and motivate and assist the patient/client to do something about it.

Brief interventions can be made using two key tools:

- **The 5A’s (Ask, Advise, Assess, Assist, Arrange)** brief intervention, which helps people who are ready change their behaviour.
- **The 5R’s (Relevance, Risks, Rewards, Roadblocks, Repetition)** brief intervention, which helps to increase motivation among those not yet ready to change.

**The 5A’s brief intervention: how to do it**

The 5A’s summarize what a health care worker can do to help someone who is ready to change.

- **Ask:** provides sample questions on the most important aspects of the behavioural risk factor.
- **Advise:** provides the minimum key messages that the health care worker should provide to all patients/clients.
- **Assess:** helps the health care worker to find out whether the patient/client is ready for additional information and assistance.
- **Assist:** provides guidance on more in-depth counselling and assistance.
- **Arrange:** provides guidance on referral and follow-up actions.
### Table 1: The 5A’s: General theoretical framework for how to do it

<table>
<thead>
<tr>
<th>5A’s</th>
<th>What to say/do and how to say/do it</th>
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</table>
| **Ask** | Ask the patient about the relevant risk factor(s) at every visit.  
Ask in a friendly way, without being judgmental.  
Keep the questions simple.  
Record the information in the patient’s medical record/notes. |
| **Advise** | Health care workers have special authority because of their training. Patients usually respect this expertise. Provide information, key messages and advice in a clear, simple, and personalized manner. Link the advice to something that is relevant for the person. For example:  
- a person with hypertension may be interested in the benefits of reducing salt intake  
- people with young children may be concerned about the effects of secondhand smoke. |
| **Assess** | Assess the patient’s readiness to start making a change by asking two questions:  
1. Are you ready to have a diet that includes more healthy options? Be more physically active? Be a non-smoker? Be a lower-risk drinker?  
2. Do you think you will be able to make the change?  
| Question 1 | Yes | Not sure | No |
| Question 2 | Yes | Not sure | No |
| **Assist** | Help the person to develop a plan that can increase the chance of success. Provide practical counselling that focuses on:  
- provision of basic information about the risk factor  
- identification of situations that could trigger relapse  
- ways of coping with trigger situations. Provide social support including:  
- providing encouragement  
- communicating interest and concern  
- encouraging the person to talk about the change process with family and friends.  
| Provide and ensure availability of health education materials and details about additional resources, such as support groups, quit lines, etc. |
The 5R’s brief intervention: how to do it

The 5R’s (Relevance, Risks, Rewards, Roadblocks, Repetition) are areas that should be addressed in a brief intervention to help people who are not ready to change at this time (see Table 2). These people are in the pre-contemplation or contemplation stage of behaviour change. If the person does not want to change or does not think that the change is important, focus on the risks and rewards. If they are considering the change but do not feel confident about being able to achieve it or have mixed feelings about it, focus more time on roadblocks. The sample questions below address diet, but they can be adapted to address other behavioural risk factors.

Table 2: Sample questions for a 5R’s brief intervention to motivate for a healthy diet

<table>
<thead>
<tr>
<th>5R’s</th>
<th>What to say/do</th>
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<tbody>
<tr>
<td>Relevance</td>
<td>What kind of effects do you think your current eating habits are having on your life and health?</td>
</tr>
</tbody>
</table>
| Risks     | What do you understand about the risks to your health of unhealthy eating habits?  
           | Go over the list of risks of an unhealthy diet and ask the person if they are concerned about any of these. |
| Rewards   | Can you think of any benefits that could happen if you made some changes to your eating habits?  
<pre><code>       | Go over the benefits of a healthy diet, specifically highlighting the ways in which healthier choices could address the concerns previously mentioned. |
</code></pre>
<table>
<thead>
<tr>
<th>SR’s</th>
<th>What to say/do</th>
</tr>
</thead>
</table>
| **Roadblocks** | *Have you ever tried to change your eating habits in the past?*
|        | *Are there things that make it difficult to change your eating habits?*
|        | *Can you think of ways to reduce these difficulties?*
|        | Acknowledge the challenges and encourage the person to think of various options to address them. |
| **Repetition** | *Now that we have had a chat, let’s see if you feel differently.*
|        | 1. *Would you like to make changes to your eating habits, to help you achieve a healthier diet?*
|        | 2. *Do you think you have a chance of successfully making changes to your eating habits?*
|        | If the person remains unwilling to start making changes to their diet at this time, end the discussion in a positive way, assure them of your support and invite them to return for further discussion if they change their mind. |
|        | Provide health education materials. |
|        | At the next CVD follow-up visit, ask again if they feel ready to make changes to their eating habits. |
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Activity 2: Step 1

Basics of counselling

- Appropriate physical environment
- Greeting patients
- Active listening
- Language
- Empathy, respect, interest, warmth and support
- Non verbal communication.
Principles of behaviour change

Behaviour change counselling involves the following:

• Understanding the process of behaviour change
• HOW to provide counselling
• WHAT a counselling session should include.

Stages of behaviour change

1. Pre-contemplation
   - Not intending to start changing in the near future
   - May not be aware that the behaviour is a problem
   - May be in denial
   - May not feel confident about ability to change

2. Contemplation
   - (This stage can last for years)
   - Seriously considering change
   - Recognizes the behaviour as a problem
   - Starts to consider the pros (benefits) and cons (disadvantages)
   - May have mixed feelings about making changes; may see costs as outweighing benefits

3. Preparation
   - Ready to change
   - Collects information about the problem and options to address it
   - May experiment with small changes
   - May have concerns about possible failure

4. Action
   - Starts to make changes

5. Maintenance
   - Maintains the behaviour change

Principles of motivational interviewing and techniques

• Don’t tell the person what to do
• Listen and show empathy
• Help the patient see the gap between where they are and where they want to be
• Let the patient tell you that they need to change
• Help the patient to feel confident about changing
• Roll with resistance.
A brief intervention is a short interaction of 3–20 minutes between health worker and patient, which aims to identify a real or potential problem, provide information about it and then motivate and assist the patient to do something about it.
What is 5R’s?

The 5R’s (Relevance, Risks, Rewards, Roadblocks, Repetition) brief intervention, which helps to increase motivation among those not yet ready to change.

Using the five R’s

Brief interventions using the 5A’s and 5R’s models

- **The 5A’s (Ask, Advise, Assess, Assist, Arrange)** brief intervention, which helps people who are ready change their behaviour
- **The 5R’s (Relevance, Risks, Rewards, Roadblocks, Repetition)** brief intervention, which helps to increase motivation among those not yet ready to change.