Helping people change

The busy healthcare practitioner’s guide to providing brief behaviour change counselling on non-communicable disease (NCD) lifestyle risk factors

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NCDs: Non-communicable diseases

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The **Chronic Diseases Initiative for Africa (CDIA)** is a network of researchers, which promotes collaboration across universities, government departments and research organisations in the development and evaluation of interventions aimed at preventing and controlling chronic diseases of lifestyle. These include: cardiovascular disease, cancer, diabetes and hypertension. Its members include leading scientists from the universities of: Cape Town, Stellenbosch, Western Cape and Harvard, and the Medical Research Council. The CDIA also works in close partnership with the Heart and Stroke Foundation; the Cancer Association of South Africa and the Department of Health.

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This manual and the training module were tested with groups of family medicine registrars, dieticians, biokineticists and nurses during the course of 2012 at the University of Stellenbosch. We gratefully acknowledge their valuable feedback in developing these practice support materials.
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ABBREVIATIONS AND ACRONYMS

AHA : American Heart Association
BBCC : Brief behavioural change counselling
MI : Motivational interviewing
NCDs : Non-communicable diseases / non-infectious disease
SNAP : Smoking, nutrition, alcohol and physical activity
USPSTF : US Preventive Services Task Force
WHO : World Health Organisation
YRBS : Youth Risk Behaviour Survey
section 1: overview
SECTION 1: OVERVIEW

Introduction

The burden of mortality and morbidity from chronic diseases of lifestyle or non-communicable diseases (NCDs) in South Africa is predicted to increase substantially over the next few decades. The leading causes of NCD related deaths in South Africa are, as in the rest of the world, cardiovascular disease; cancers; chronic respiratory disease and Type 2 diabetes (Bradshaw et al., 2011).

NCDs are associated with four particular behaviours – an unhealthy diet, physical inactivity, tobacco use and the harmful use of alcohol. These behaviours lead to overweight and obesity, high levels of blood glucose and cholesterol and raised blood pressure, which are the main risk factors for NCDs. Improving health behaviour is an important means of addressing health disparities in SA, because those who are economically and socially disadvantaged, disproportionately bear the burden of NCD risk (Mayosi et al., 2009).

NCDs are significant contributors to a growing public health burden in South Africa, which threatens social and economic development, as well as the sustainability of the health system. Yet, effective interventions which support healthier lifestyles can alleviate, and even prevent the problem (Renehan & Howell, 2005). Such interventions involve measures at a macro level which create enabling environments for healthy lifestyles through policy and legislation, and interventions at an individual level which promote behaviour change. It is here, that healthcare providers have a vital role to play in encouraging and supporting their patients or clients to make and maintain healthier lifestyle choices.

Major reviews of the research on lifestyle interventions show that brief behaviour change counselling by healthcare providers can be effective in changing NCD risk behaviours and improving self-management among patients with existing chronic conditions (Whitlock, 2002; Artinian, 2010).

The South African government’s recent national strategic plan to control the NCD epidemic (Department of National Health, 2012) places a strong emphasis on the need to improve the detection, early intervention and management of NCD lifestyle related risk factors, particularly at the level of primary healthcare. This includes a focus on strengthening the capacity of health service staff to provide brief counselling on the main lifestyle risk factors for NCDs.

This manual forms part of a printed resource package for healthcare providers, called ‘I CHANGE 4 HEALTH’, which includes educational/motivational materials for distribution directly to patients, on the topics of smoking, diet, physical activity and alcohol use.

The package has been designed to assist healthcare providers in South Africa to integrate brief behavioural change counselling into routine practice to prevent and control NCDs and to promote health and well-being. It aims to enhance the practitioner’s knowledge and skills to enable them to effectively motivate and assist patients make healthier lifestyle choices. The protocol and tools can be easily incorporated into usual clinical care and do not necessarily require any prohibitive or significant, additional investment of time and resources.

The package is applicable to both the private and public sector health service settings, although special attention has been given to tailor the educational materials to the needs of patients or clients of lower socio-economic status, as this sector of South African society, generally, has less access to appropriate information on NCDs.

These resources can also be accessed via the web at: www.ichange4health.co.za

This manual provides:
- Information on the burden of NCDs in South Africa, the main risk factors and the potential for prevention
- A clear rationale for why behaviour change counselling for NCD risk factors should be considered a vital element of primary care practice
- The evidence base for brief behaviour change counselling (BBCC) interventions and a description of current best practice methods and approaches
- Adapted best practice guidelines which offer a simple framework for counselling patients about smoking cessation, a healthy diet, physical activity and alcohol use
- Tools to assist the practitioner in broaching the subject of behavioural risks and jointly negotiating health goals
- Suggestions for how to integrate BBCC into routine primary care, acknowledging the typical constraints of time and resources
- A directory of other available resources, which may be useful for improving practice in this area
Who could benefit from using this manual

This manual is intended for use by a variety of healthcare providers, including medical doctors, nurses, dieticians, nutritionists, health promoters and biokineticists. The intervention proposed in this manual is relevant to any consultation where lifestyle change needs to be addressed in order to prevent NCDs or more effectively control an existing chronic condition. Whilst it is aimed chiefly at primary care providers, it is also appropriate for health professionals in the specialist fields of diabetes, hypertension, cardiovascular disease and cancer, as well as for various allied health professionals.

This manual may also be helpful to the cadres of health promoters and nurses employed by civil society organisations, such as the Cancer Association and the Heart and Stroke Foundation. It can also be used as a resource in the training of lay counsellors or community health workers, but in this situation, it will need significant adaptation and simplification.

How to use this manual

This manual is designed for flexibility. The intervention can be used opportunistically or in a planned way, by one practitioner or by a healthcare team.

How you use the manual depends on to what extent you wish to or can incorporate such prevention strategies into your clinical practice. You may simply browse through the manual for new ideas or to familiarise yourself with current, best practice approaches in order to enhance what you are currently doing. Alternatively, you may choose to closely follow the proposed framework for intervention and make full use of the support materials which accompany this manual (print ready copies of all the patient materials and tools are available at www.ichange4health.co.za).

This manual can be a helpful resource in the training of healthcare providers in counselling and communication skills, either in-service, as part of continuing professional development, or in an academic context. It can also be used to develop and plan the roles of various staff within a particular practice to establish a consistent approach for improved NCD risk factor assessment and management.

If you are interested in receiving expert training in this area and earning CPD points (8 points, level 1), the Division of Family Medicine and Primary Care at the University of Stellenbosch, at times, offers an accredited short course in Brief Behavioural Change Counselling (BBCC), which is based on this approach.

For enquiries in this regard, please contact Professor Bob Mash: rm@sun.ac.za or Dr Zelra Malan: zmalan@sun.ac.za

You can also earn 3 CPD points in level 2 through self-instruction, if you read this manual thoroughly, complete and submit the MCQ questionnaire and achieve a pass rate of 70%. The questionnaire can be downloaded and submitted online: Follow the link from: www.ichange4health.co.za
section 2: non-communicable diseases (NCDs) in South Africa
SECTION 2: NON-COMMUNICABLE DISEASES (NCDs) IN SOUTH AFRICA

Burden of disease

Information from Statistics SA shows that NCDs accounted for 40% of all deaths in SA in 2008, with the largest proportion caused by cardiovascular disease (Statistics SA, 2010).

With the exception of tobacco use, data shows that the pattern of NCD related risk behaviour has deteriorated substantially over the last 20 years among adults and is increasingly prevalent among children (Bradshaw et al., 2011).

The burden of disease is rising in rural communities, disproportionately affects poor people living in urban settings and is resulting in an increased demand for chronic care across the national health system (Mayosi et al., 2009).

The table below illustrates the comparative burden of disease in South Africa as of 2000. DALYs are a comprehensive measure of disease burden combining the years of life lost as a result of premature mortality and years lived with disability related to illness or injury.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk factor</th>
<th>% total DALYs</th>
<th>Rank</th>
<th>Disease, injury or condition</th>
<th>% total DALYs</th>
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<tbody>
<tr>
<td>1</td>
<td>Unsafe sex/STD</td>
<td>31,5</td>
<td>1</td>
<td>HIV/AIDS</td>
<td>30,9</td>
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<td>2</td>
<td>Interpersonal violence (risk factor)</td>
<td>8,4</td>
<td>2</td>
<td>Interpersonal violence injury</td>
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<td>3</td>
<td>Alcohol harm</td>
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<td>Tuberculosis</td>
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<td>4</td>
<td>Tobacco smoking</td>
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<td>4</td>
<td>Road traffic injury</td>
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<td>5</td>
<td>High BMI (excess body weight)</td>
<td>2,9</td>
<td>5</td>
<td>Diarrhoeal diseases</td>
<td>2,9</td>
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<tr>
<td>6</td>
<td>Childhood and maternal underweight</td>
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<td>6</td>
<td>Lower respiratory infections</td>
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<td>7</td>
<td>Unsafe water sanitation and hygiene</td>
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<td>7</td>
<td>Low birth weight</td>
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<tr>
<td>8</td>
<td>High blood pressure</td>
<td>2,4</td>
<td>8</td>
<td>Asthma</td>
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<tr>
<td>9</td>
<td>Diabetes (risk factor)</td>
<td>1,6</td>
<td>9</td>
<td>Stroke</td>
<td>2,2</td>
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<td>10</td>
<td>High cholesterol</td>
<td>1,4</td>
<td>10</td>
<td>Unipolar depressive disorder</td>
<td>2,0</td>
</tr>
<tr>
<td>11</td>
<td>Low fruit and vegetable intake</td>
<td>1,1</td>
<td>11</td>
<td>Ischaemic heart disease</td>
<td>1,8</td>
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<tr>
<td>12</td>
<td>Physical inactivity</td>
<td>1,1</td>
<td>12</td>
<td>Protein-nergy malnutrition</td>
<td>1,3</td>
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<tr>
<td>13</td>
<td>Iron deficiency anaemia</td>
<td>1,1</td>
<td>13</td>
<td>Birth asphyxia and birth trauma</td>
<td>1,2</td>
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<tr>
<td>14</td>
<td>Vitamin A deficiency</td>
<td>0,7</td>
<td>14</td>
<td>Diabetes mellitus</td>
<td>1,1</td>
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<td>15</td>
<td>Indoor air pollution</td>
<td>0,4</td>
<td>15</td>
<td>Alcohol dependence</td>
<td>1,0</td>
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<tr>
<td>16</td>
<td>Lead exposure</td>
<td>0,4</td>
<td>16</td>
<td>Hearing loss, adult onset</td>
<td>1,0</td>
</tr>
<tr>
<td>17</td>
<td>Urban air pollution</td>
<td>0,3</td>
<td>17</td>
<td>Cataracts</td>
<td>0,9</td>
</tr>
</tbody>
</table>
Prevalence of lifestyle risk factors

**Tobacco Use:**
In 2003 around 35% of South African adult men and 10% of women smoked cigarettes on a daily basis (Department of Health, 2004). The Youth Risk Behaviour Survey of 2008 found that 21% of grade 8-11 learners also smoke (Reddy et al 2010).

South Africa has made significant progress in the past decade in reducing tobacco use. Since the introduction of comprehensive tobacco control legislation in 1993, overall prevalence rates for adult daily cigarette smoking dropped from 31% to 24% in 2003. (Van Walbeek, 2002). Higher income and education are associated with a lower prevalence of smoking, while living in urban areas is associated with higher rates (Peer et al., 2009).

Tobacco use causes a number of different cancers, including cancer of the lung, throat, vocal cords, mouth, bladder, kidney and pancreas. It also causes emphysema, chronic bronchitis and cardiovascular disease (WHO, 2011). In South Africa, tobacco smoking accounts for an estimated 13% of all deaths in adults over the age of 35 (approximately 36 841 people a year) (Groenewald et al., 2007). Although the majority of smokers in South Africa say they would like to quit, most still grossly underestimate the health risks associated with tobacco use (Groenewald et al., 2007).

**Alcohol use:**
41.5% of South African men and 17.1% of women report current drinking. 17% of men and 2.9% of women are classified as risky or hazardous drinkers and there has been an increased prevalence of harmful levels of drinking since 2005 (Peltzer et al, 2011).

Risky or harmful use of alcohol, such as binge drinking, drinking to intoxication and drinking whilst doing other activities like driving, is a major cause of injury, trauma and social problems. High levels of alcohol consumption increase the risk of liver cirrhosis, diseases of the central nervous system, hypertension and cancers of the head and neck, digestive tract, liver and breast (NIH, 2000). Drinking alcohol during pregnancy can cause fetal alcohol syndrome – a constellation of growth retardation, facial deformities and central nervous system dysfunction. Some parts of South Africa have among the highest rates of fetal alcohol syndrome (FAS) in the world (McKinstry, 2005).

**Unhealthy diet:**
Studies in dietary intake have shown significant changes in the South African diet, particularly among recently urbanised, black South Africans. This has involved a shift away from a traditional diet high in carbohydrates and fibre and low in fat, to a typical Western diet, which is characterised by the consumption of energy dense foods and snacks high in fats, sugars and salt and a low intake of unrefined carbohydrate and fibre (Steyn et al, 2006). The other ethnic groups in South Africa have followed this dietary pattern for many decades.

As the big, multi-national food and beverage companies have come to dominate the marketplace, South Africans are increasingly consuming unhealthy, commercially produced foods and drinks. For example, in 2010, South Africans drank an average of 254 Coca Cola products per person per year, compared to 139 in 1992 (Igumbor et al., 2012). Between 2005 and 2010, the sales of snack bars, noodles and ready-made meals increased by more than 40% (Igumbor et al., 2012). National surveys among school going children also show an increasing consumption of fast food, sweets and cool drinks (Reddy et al., 2010).

Biological risks arise from eating diets high in total calories, saturated and trans-fats, salt and sugar, as well as a low intake of fruit, vegetables and fibre (Stuckler & Siegel, 2011). A high intake of saturated and trans-fats results in raised cholesterol and lipids. A low intake of fruits and vegetables has been implicated in several kinds of cancers and heart disease. Salt is a leading cause of high blood pressure, which is a major risk factor for stroke and coronary heart disease (WHO, 2011).

**Physical Inactivity:**
South Africans have very high levels of physical inactivity. The 2003 National Demographic and Health Survey found that 48% of men and 63% of adult women were insufficiently active (Department of Health, 2004). In 2008, the Youth Risk Behaviour Survey (YRBS) showed that nearly 40% of school going children participated in less than the recommended amount of physical activity per week (Reddy et al, 2010).

There is strong evidence showing that physical inactivity is linked to heart disease, independent of diet. People who are insufficiently active have a 20-30 % increased risk of all-cause mortality, compared to those who engage in at least 30 minutes of moderate intensity physical activity on five or more days of the week (WHO, 2010). Regular physical activity can decrease the risk of stroke, coronary heart disease, some cancers, diabetes, osteoporosis, high blood pressure, high cholesterol and alleviate depression (WHO, 2011). The effect of physical activity and an improved diet is about equal to drug therapy for people with impaired glucose intolerance (WHO, 2011).
Overweight and obesity:  
These eating patterns and decreasing levels of physical activity are reflected in rising rates of overweight and obesity. The increased availability, affordability and marketing of processed food products, which are high in calories and low in nutrition, have created what some commentators have called an ‘obesogenic’ environment which favours the development of overweight and obesity. The fact that ‘the unhealthy choice has become the easier choice’ makes it considerably more difficult for the population to maintain a prudent and healthy diet (Igumbor et al., 2012).

In 2008, about 60% of South African women over the age of 15 were found to be either overweight or obese, and 31% of men (Ardington & Case, 2009). Obesity increases with age: around 70% of women over the age of 37 are either obese or overweight (Ardington & Case, 2009). Many obese adults in South Africa have been found to be micro-nutrient deficient, which further increases their risk of NCDs (Vorster et al., 2011).

Rates of obesity have risen in every age group for men and women, but the largest increase has been among those aged 15 to 24 (Ardington & Case, 2009).

Excess body weight leads to adverse metabolic effects on blood pressure, cholesterol, triglycerides and insulin resistance. Risks of coronary heart disease, ischaemic stroke and type 2 diabetes mellitus increase steadily with increasing body mass index (BMI) – a measure of weight relative to height (WHO, 2011). Raised BMI also increases the risk of cancer of the breast; colon; rectum; endometrium; kidney; oesophagus and pancreas (WHO, 2011).

Hypertension, diabetes and high blood cholesterol:  
According to the National Income Dynamics study, from 1998 to 2008, the prevalence of hypertension rose from 26% to 36% for women and from 24% to 31% for men (Ardington & Case, 2009). The study also confirmed the association between a high BMI and the risk of hypertension: analysis of the data showed that for each one unit of increase in BMI, the risk of suffering from hypertension rose by a percentage point (Ardington & Case, 2009).

There is a paucity of national data on the prevalence of diabetes and high cholesterol. A recent cross sectional survey in Cape Town however, showed a dramatic increase of diabetes in the urban, coloured population from 20 years ago. The crude prevalence of Type 2 diabetes was 28.2%. Undiagnosed Type 2 diabetes was present in 18% of the sample (Erasmus et al., 2012). Historically, the average total cholesterol has been low in most of the black population in SA, but two Cape Town studies have shown an increase over time among urban black South Africans (Levitt et al, 1993; Oolofse et al, 1996). Atherogenic complications from long term antiretroviral therapy are also becoming an increasing problem as greater numbers of people have gained access to treatment (Mayiso, 2009). People with diabetes require at least 2 to 3 times the healthcare resources compared to people who do not have diabetes (Zhang et al., 2010). According to the Department of Health, around 17 million visits at health centres in SA per annum are related to hypertension and diabetes (Department of Health, 2012). Mash et al (2012) found that high blood pressure was by far the leading reason for attendance at primary healthcare facilities amongst public sector patients in 2010.

On average, South Africans visit primary healthcare services 2.5 times a year, with smokers attending more frequently (SA Info, 2013). Primary healthcare providers therefore have repeated opportunities to assess and discuss behavioural risk factors with their patients.

Research shows that primary healthcare providers CAN make a difference

Smoking: Healthcare providers effectively help smokers quit by providing brief advice on how to quit, medical treatment for withdrawal symptoms (NRT) and referral to support services such as Quitlines. Patients report that what doctors say and do about smoking in the consultation makes a huge difference to their motivation to quit and increases the likelihood of long term success (Zwar et al, 2004; Aveyard & West, 2007; Fiore et al., 2008; USPSTF, 2009).

Risky alcohol use: brief counselling interventions in primary care settings and patient-centred counselling, such as Motivational Interviewing, are effective in reducing the overall level of alcohol consumption, changing harmful drinking patterns, preventing future drinking problems and improving health with people who are not heavily dependent on alcohol (Bien et al, 1993; USPSTF, 2004; Vasilaki et al, 2006, WHO, 2001).

Physical Activity: patients increase their levels of physical activity in response to brief advice and print materials given by primary care clinicians. Longer counselling sessions and follow up visits are also effective (Smith, 2004).

Nutrition: Low-intensity interventions by primary care providers of 5 minutes or less, supplemented by patient self-help materials, can increase the intake of fruits, vegetables and high fibre and reduce dietary fat intake. Medium-to-high intensity counselling in either group or individual sessions by a nutritionist, dietician or a specially trained primary care clinician has a larger effect. On-going support is necessary for successful, sustained weight loss (USFSTF, 2003).
South African’s response to NCDs

Since 1994 the Directorate of Chronic Disease, Disability and Geriatrics in the National Department of Health has led government’s response to the emerging NCD epidemic. Many clinical practice guidelines and standards addressing NCDs have been issued (see Strategic Plan for NCDs, 2012), but it is clear that the early detection, management and outcomes of care for those with NCDs remain sub-optimal (Bradshaw et al. 2011). Various studies have highlighted the need to improve the quality of preventive and treatment services for NCD patients, particularly at the primary care level (Department of Health, 2012; Mayiso et al., 2009). Reasons for this include critical structural and human resource issues, but the Strategic Plan also acknowledges that there is an urgent need to build staff capacity through appropriate training and the provision of resources and tools. For example, a study by Parker et al (2010; 2012) showed that despite identifying lifestyle modification education as one of their major roles, nurses, medical students and practicing doctors in Cape Town, had low levels of relevant knowledge and skills. Recent situational analyses have found that there is little emphasis in the training of nurses, doctors and other allied professionals on their potential role in lifestyle modification and NCD risk management (Parker, 2010; Malan, personal communication, 2012). Furthermore, an audit of existing education materials dealing with NCDs and/or their risk factors showed that there were very limited materials available for health workers to use with public sector patients and that most health professionals relied on the mass media for their information (Parker et al, 2010, 2012).

There have been several significant NCD related interventions at a national level – the most successful being the implementation of comprehensive tobacco control measures, which have had an evident impact. In contrast, the development of an alcohol policy has been piecemeal, slow and bedevilled by conflicting interests and values. The National Liquor Bill, which aimed at regulating the huge numbers of unlicensed liquor outlets was enacted in 2004, but this virtually ignored the need to address public health concerns (Parry, 2010). In 2007, after a protracted campaign by civil society groups, legislation was successfully passed banning the sale of cheap, bulk wine (papsakke) in an effort to curtail alcohol abuse by farmworkers. Since 2003, there has been a policy of progressive, above inflation, taxes on alcohol products. In 2009, regulations mandating health warnings on alcohol products were promulgated, but calls from public health advocates to further regulate alcohol advertising have been met with vigorous and organised opposition from industry, effectively stalling the policy process (Parry, 2010). Recent positive developments include a national South African summit on NCDs, which was attended by various government departments, civil society groups, professional organisations and academics. The summit formally adopted a Political Declaration on NCDs and set 10 targets to be reached by 2020. In the aftermath of this meeting, a Strategic Plan for the Prevention and Control of NCDs was drafted by the National Department of Health, signalling recognition of the pressing need to take concerted action, strengthen government commitment and give clear direction as to how the targets may be met. The plan is to be formally presented in 2013 (Strategic Plan, Pretoria, April 2013).
In line with WHO recommendations (WHO GSR 2011), the Strategic Plan prioritises so called ‘best buy’ and ‘good buy’ interventions, as these produce accelerated results in terms of lives saved, disease prevented and heavy costs avoided. A best buy is an intervention which is proven to be both highly cost effective and highly feasible in low, middle and high income countries. Good buys are other interventions which may cost more or generate less health gain, but are still considered feasible and good value for money (see table below). It is worth noting that in every category brief behavioural change counselling in primary care is included as a proven ‘good buy’.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Effective interventions:</th>
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<td>Tobacco use</td>
<td><strong>Best buys:</strong></td>
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<td>Increased taxes on tobacco</td>
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<td></td>
<td>Smoke free policies in public places and workplaces</td>
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<td>Mass media campaigns on health risks and warnings on packaging</td>
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<td></td>
<td>Bans on tobacco advertising, promotion and sponsorship</td>
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<td><strong>Good buys:</strong></td>
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<td></td>
<td><em>Tobacco cessation counselling and treatment for tobacco dependence as part of primary healthcare</em></td>
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<td></td>
<td>Toll free quit lines and Quit media campaigns</td>
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<tr>
<td>Harmful use of alcohol</td>
<td><strong>Best buys:</strong></td>
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<td>Restricted access to retailed alcohol</td>
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<td>Bans on alcohol advertising, promotion and sponsorship</td>
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<td>Drink-driving laws</td>
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<td><em>Brief counselling interventions for harmful drinking and treatment of alcohol disorders</em></td>
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<tr>
<td>Unhealthy diet</td>
<td><strong>Best buys:</strong></td>
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<tr>
<td></td>
<td>Reduction in salt intake through reformulation of manufactured food</td>
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<tr>
<td></td>
<td>Mandatory replacement of trans-fats with polyunsaturated fats</td>
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<td></td>
<td>Promotion of public awareness about a healthy diet through mass media campaigns and food labelling</td>
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<td></td>
<td><strong>Good buys:</strong></td>
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<tr>
<td></td>
<td>Restrictions on marketing of unhealthy foods and beverages, especially to children</td>
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<tr>
<td></td>
<td>Replacement of saturated fat with unsaturated fat</td>
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<td></td>
<td>Taxes on unhealthy foods and subsidies for healthy foods</td>
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<td><em>Counselling in primary care</em></td>
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<td>Worksite wellness programmes</td>
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<td>Multi-component programmes in schools</td>
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<tr>
<td>Physical activity (PA)</td>
<td><strong>Best buy:</strong></td>
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<td>Promotion of PA through the mass media</td>
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<td></td>
<td><strong>Good buys:</strong></td>
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<tr>
<td></td>
<td>Provision of safe and accessible opportunities for PA in communities through urban design, active commuting strategies, sports and leisure facilities and group programmes</td>
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<tr>
<td></td>
<td><em>Counselling in primary care</em></td>
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<tr>
<td></td>
<td>Multi-component programmes promoting PA in the workplace</td>
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<td></td>
<td>School based PA activities</td>
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</tbody>
</table>
South Africa’s Strategic Plan for the Prevention and Control of NCDs

The draft Strategic Plan is closely aligned to the UN/WHO recommendations and places a strong emphasis on intervention in three distinct areas, which evidence shows can produce rapid gains in reversing the epidemic:

1. The prevention of NCDs and the promotion of health at a population, community and individual level. The plan motivates for stronger inter-sectoral collaboration in addressing the broader societal determinants of health and acknowledges the role that prevailing inequalities in income, education and healthcare have in influencing people’s vulnerability to NCDs and their consequences. Proposed interventions include establishing a national NCD stakeholder forum; introducing multi-sectoral policies, laws and regulations to create sustainable, health promoting environments and reduce modifiable risk factors for NCDs; expanding the school nursing and health promotion services and implementing mass media campaigns to enhance health literacy.

2. Improved control of NCDs through the strengthening of the health system. The plan commits to strengthening the primary healthcare services to cater for the growing numbers of patients with NCDs. Important strategies for secondary prevention and increasing life expectancy include: proactively identifying individuals at risk, providing early medical treatment and assisting them in lifestyle modification; establishing a patient-centred chronic care service for people already diagnosed with a NCD, which supports them in adherence to treatment and sustaining lifestyle change; and improving access to essential medicines and new technologies. Other stated priorities for strengthening the capacity of the public healthcare services are improved liaison between the different levels of healthcare, as well as between the different members of the multidisciplinary primary healthcare team; the up-skilling of mid-level healthcare workers; improved clinical support through the introduction of family physicians responsible for comprehensive district care and the integration of community-based health workers into the district health system (Department of Health, 2012). Current policy proposals suggest that primary healthcare outreach teams will be established in every community ward in SA and will have a strong role in promoting healthy lifestyles and in treatment adherence.

3. Comprehensive monitoring of NCDs and their risk factors. Thirdly, the plan emphasises the importance of establishing more effective and reliable national surveillance mechanisms, health information systems and dissemination processes to assist with policy, planning and management, and to enable the evaluation of NCD prevention and control interventions.

Healthcare provider training

The need for healthcare provider training in evidence-based lifestyle interventions – both at an undergraduate level and in-service – is acknowledged by the Department of Health in the Strategic Plan. Whilst training providers at all levels in effective communication skills is seen as necessary, primary healthcare personnel (nurses, doctors, health promoters and community health workers) are identified as having a particularly important role to play, given the potential for prevention and control of NCDs at this level of the system. The need to shift to a patient-centred approach to care, which emphasises the importance of actively engaging the patient in decision making about their health, is stated as a critical objective in ‘re-orientating’ the primary healthcare system to effectively address NCDs.
section 3: evidence-based healthcare interventions for promoting lifestyle change
There is a considerable body of research that strongly supports the benefits of lifestyle change as a means of decreasing NCD risk. Even modest changes in behaviour can substantially reduce morbidity and mortality (Artinian, 2010). A recent, seminal scientific review, commissioned by the American Heart Association (AHA), provides a comprehensive overview of the current evidence base for healthcare interventions for improving lifestyle (Artinian et al, 2010). These individually focused interventions complement macro-level policy and environmental measures.

The most effective interventions use multi-component delivery strategies and combine cognitive, behavioural and informational strategies. Such interventions can be successfully delivered by a variety of healthcare professionals including physicians, nurses and health educators/promoters. Lay counsellors and community health workers, drawn from the local community, can also play a constructive role, especially in tailoring messages to the unique needs and cultural values of the target population (Artinian, 2010).

**Effective strategies include:**

1. individual sessions, in which the healthcare provider assesses risk and readiness to change and works collaboratively with the client to set realistic goals and develop specific plans on how to change a targeted behaviour
2. self-monitoring strategies with verbal, written or electronic feedback to help the person recognise progress towards an agreed goal
3. group sessions which offer social support from peers and opportunities for role modelling, shared problem solving and skills development
4. motivational interviewing, particularly with people who are ambivalent about or resistant to change
5. follow up contact, either face-to-face, by telephone, e mail or internet, to reinforce progress and prevent relapse
6. prompting patients to seek on-going support from family, peers or community based organisations. (Artinian et al, 2010).

Another systematic review by the Counselling and Behavioural Interventions Work Group of the US Preventive Services Task Force (USPSTF,2002 & 2009) concluded that there is strong evidence to show that brief counselling assistance can be effective in changing NCD risk behaviours and in improving self-management practices, which are needed to maintain healthy behaviour. Such interventions can also produce clinically meaningful improvements in important biological outcomes. The strongest evidence for these types of interventions comes from tobacco cessation research and problem drinking, but there is accumulating evidence to show that similar, brief interventions integrated into routine primary care can effectively address risk behaviours such as poor diet, physical inactivity, substance use and risky sexual behaviour (Elford et al., 2001; Whitlock et al., 2002; Walker et al., 2010). Whilst effective interventions typically involve behaviour change counselling and the use of supplementary resources, clinician interventions as brief as just a few minutes can still make a difference and prime patients to attend to and act on subsequent educational information (Whitlock et al., 2002; Kreuter et al, 2000).

Based on the available evidence, the USPSTF recommends: proactive, routine assessment of lifestyle risk behaviours and brief, individual, behavioural change counselling as an essential component of primary care. Furthermore, they advise that there is no need to use a different intervention approach for different health behaviours: they recommend using the ‘5 A’s’ Clinical Practice Guideline as a unifying, conceptual framework for brief behavioural counselling across multiple risk behaviour targets. This guideline was judged to have the highest degree of empirical support for each of its elements.
The 5 A’s Clinical Practice Guideline

This guideline was originally developed by the National Cancer Institute in the US to guide clinician intervention in smoking cessation and formed the basis for recommendations by the USPSTF in 2003 and 2009. Its compilation was based on a rigorous review of the scientific literature, including over 35 meta-analyses, by an independent panel of scientists and clinicians. It remains widely used in smoking cessation, but is currently also recommended to healthcare providers as a general approach to engaging patients to consider behavioural change (Goldstein et al., 2004; Van Schayck, 2008, Whitlock, 2002). Whilst more intensive counselling might have greater impact, the delivery of the 5 A’s in five to ten minutes makes it a feasible option for integration into primary healthcare services (USPSTF, 2009).

The content and intensity of each step in the 5 A’s necessarily varies according to the specific behaviour, practice setting and the individual’s readiness to change, but interventions targeting any behavioural risk can be organised with reference to the following five components.

Important, Step 3 in the guideline incorporates the concept of ‘Stages of Change’ from the Transtheoretical Model (Prochaska and DiClemente, 1986). Using this theory, the proponents of the 5 A’s argue that one cannot assume that all patients or clients are at the same ‘stage of behavioural change’. Assessing readiness to change is an essential step in determining what kind of counselling assistance to offer in Steps 4 and 5.

Several other important professional bodies in different countries have endorsed the 5 A’s Guideline for lifestyle risk management, adapted it for application in their setting and actively promoted its integration into primary care practice. These organisations, include:

- The Department of Health and Aging in the Australian government and the Kinect consortium (Lifescipts Practice Manual, Supporting Lifestyle Risk Factor Management in General Practice, Canberra; Commonwealth of Australia, 2010);
- The Royal Australian College of General Practitioners (SNAP: A population health guide to behavioural risk factors in general practice, 2004);
- The Canadian Task Force on Preventive Health Care (Elford et al., 2001);
- The International Primary Care Respiratory Group (IPCRG) (Van Schayck, 2008);
- The National Health Service in the UK (Aveyard & West, 2007) and the American College of Obstetricians and Gynecologists (ACOG).
Ideally, we would enter the contemplation stage and move smoothly through the preparation and action stages to maintain the change in behaviour. However, it is common for people in the action or maintenance stages to relapse and to revert back to their old behaviour. Fortunately, when this occurs, most people do not give up, but rather go back to the stage of contemplation before preparing again to take action (McKenzie & Jurs, 1993). Behavioural change in this theory is thus understood to be a dynamic, cyclical process, with people learning from relapse episodes and sometimes making numerous attempts to change behaviour before finally accomplishing their goal and maintaining the desired behaviour over the long term.

To fully appreciate the importance of interventions such as the 5 A’s requires a true population-based perspective (Whitlock et al., 2002). Brief behavioural counselling interventions that are feasible in healthcare settings often have only a modest impact on individual behaviour. For example, smoking cessation interventions in primary care can improve cessation by about 6-15% over usual care. Interventions targeting other behaviours have a similar effect. However, the limited impact of these types of interventions in primary care translates into significant benefits to the health of the population as a whole (and to multiple individuals) when they are systematically applied to a large proportion of those in need. If implemented widely, BBCC interventions have the potential to achieve important reductions in chronic disease and to reduce associated, excess healthcare costs (Whitlock et al., 2002).

### The stages of change:

- **Pre-contemplation**: This initial stage is defined as a time when the person is not seriously thinking about changing their problem behaviour during the next six months. Individuals in this stage are usually not aware of the risks of a specific behaviour or are avoiding thinking about the risks, and so have not considered taking any action.

- **Contemplation**: In this stage, the person begins to think seriously about making a change in the next six months and has formed an intention to change. They are usually aware of the benefits and potential barriers and are weighing these up, but are not ready to change.

- **Preparation**: Individuals in this stage, begin to actively plan to make a change in the next month. Making a change seems possible. Often, they have already made at least one attempt to change behaviour.

- **Action**: This is the six-month period which follows the initiation of a specific change or modification in behaviour. Positive reinforcement and encouragement are very important, as the risk of relapse is still high.

- **Maintenance**: Once the person has performed the new behaviour for more than six months, they are said to be in the stage of maintenance.

- **Termination** is the final stage where the person in no longer tempted by the problem behaviour and feels confident in the ability to resist relapse in all situations.

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**This manual has used the 5 A’s clinical practice guideline as the basis for its proposed intervention. The 5 A’s has several advantages:**

- It provides a unified construct of evidence-based strategies for behavioural change counselling, which can easily be applied across different behavioural domains
- It is well supported in the scientific literature
- It is simple to teach and easy to remember
- It can be used by a range of health professionals
- It is adjustable to the time and resources available
- It can be delivered in a few minutes
- It can easily be delivered using a patient-centred style.
Patient resistance to or lack of compliance with lifestyle advice is commonly reported by healthcare providers as a significant source of occupational frustration (Aveyard and West, 2007; Everett-Murphy et al., 2010, Parker et al., 2010).

The proponents of Motivational Interviewing (MI) (Miller & Rollnick, 1991) argue that such resistance, rather than being an inherent client characteristic, can often be a product of a confrontational counselling style or a sign of damaged rapport resulting from a misunderstanding of the patient’s readiness to change. They suggest that rather than prescribing change, it is more effective to stimulate intrinsic motivation by eliciting the arguments for change from the patient/client themselves and by helping them articulate and resolve their feelings of ambivalence about change. A key component of such an approach is an empathetic therapeutic style, which emphasises the importance of active listening in order to understand the patient’s perspective and experiences (Emmons & Rollnick, 2001).

MI was originally used by psychotherapists in the field of substance abuse, but has since been successfully adapted and simplified into a generic and feasible method to address the challenge of brief behavioural change consultations in the context of primary care (Rollnick et al, 2005). Such adaptations of MI have been found to be effective in the treatment of a broad range of problems, including alcohol and drug abuse, smoking, overweight, physical inactivity, asthma and diabetes. In Rubak’s review and meta-analysis of 72 studies (2005), MI was shown to have significant and clinically relevant effects in 3 out of every 4 studies, outperforming traditional advice-giving in about 80% of the included studies. Further meta-analyses have shown that MI can significantly improve smoking cessation rates above usual brief advice (Lai et al., 2010) and is more efficacious than a range of other treatments for alcohol problems (Vasilaki et al., 2006).

MI can be effective in brief encounters of 10-15 minutes, but more than one encounter with the patient increases the likelihood of an effect. It works in various healthcare settings and can be effectively applied by practitioners from a range of backgrounds (Lundahl & Burke, 2009). Of further interest is that providers have reported that this approach elicits favourable responses from patients, improves the efficiency of the consultation, enhances perceived quality of care and is considerably more personally rewarding (Maguire, 2002; Stewart, 2005; Everett-Murphy et al., 2010; Rollnick et al, 2010).

When using this counselling method, the healthcare provider makes an effort to establish a non-threatening, supportive environment for the patient or client to discuss behavioural risks. Information is provided in a neutral manner and the patient is invited to interpret its personal relevance, express how they feel about possible change and determine their own course of action. In this way, patients are actively engaged in decision making about their health, which gives them a greater sense of personal autonomy and also means that any decisions that may be made are more likely to be both realistic and congruent with their values. In MI, behavioural change such as smoking cessation is understood to be a complex and cyclical process, involving interaction between physical dependence, social factors and motivation, rather than a straightforward decision to change based on information about the health risks.

This varies significantly from the traditional, advice giving approach which casts the provider in a dominant, directing role and the patient merely as a passive recipient of their expert knowledge. In MI, the role of the provider is to facilitate consideration of change in a supportive way and to elicit self-motivational statements, rather than tell the patient what they should do and how they should do it. MI posits that a good collaborative relationship, in which a client is viewed as the expert on his or her own life, serves to minimise resistance to change and thereby enhances motivation (Lundahl and Burke, 2009).

MI offers several strategies to assist providers in negotiating behavioural change (see APPENDIX and Rollnick et al., 2008 & 2010). However, Miller and Rollnick (1995) argue that adherence to the ‘spirit’ of MI and the qualitative change this brings to the interaction is more important than the application of a set of techniques, and that it is this aspect which is likely to be the key to MI’s success.
MI: The guiding style
(Rollnick et al., 2010)

When the topic of behaviour change comes up, it is helpful to shift your stance from being a director to an informed guide and follow three principles: engage with and work in collaboration with the patient/client; emphasise their autonomy over decision making and aim to elicit motivation to change from the patient, rather than to try and instil this in them. You retain control over the direction and structure of the consultation and provide information as needed, but the patient/client retains responsibility for change. Use the skills of asking, listening and informing to draw out your patient/client's ideas and solutions. This shows that you are interested in their experiences and respect their ability to make sound decisions.

Ask open questions – invite the patient/client to enter the conversation and consider why and how they might change.

Listen to your patient/client’s perspective – show you understand by using brief summaries or reflective statements such as “so, what I am hearing is that quitting feels beyond you at the moment.” Such statements convey empathy, encourage patient/client’s to elaborate and are often the best way to respond to resistance.

Inform – ask permission to provide information and then ask your patient/client to interpret what this means for them.

Example of contrasting styles:

Directing style: “I need to advise you that your weight is putting your health at serious risk... you already have early diabetes. You really need to think about losing weight. You need to combine eating less and exercising more. (Patient often responds with a “Yes, but ...” argument against change.)

Guiding style: OK, let’s have a look at this together. From my side, losing some weight and getting more exercise will help your diabetes, but I would like to understand how you think or feel about this... (Patient usually expresses some form of ambivalence at this point). So, what I am hearing is that for you losing weight is important, but it’s difficult because... So where does this leave you now? (Patient usually describes readiness and may ask for further information). OK, look it is up to you to decide when and how to make any changes... Is there anything you feel you can do to make a start? Even small changes can help... (Patient expresses what changes are possible).

Formal training is necessary to achieve optimal results with MI, particularly where providers do not have a background in counselling and communication skills. Competence in using open questions, reflective listening and reflective summarising are essential skills to learn and opportunities for on-going supervision and constructive feedback have proven to be important (Emmons, 2001). There are several online resources available to help clinicians wanting to learn more about MI, including the website: http://www.motivationalinteracting.org.

In the AHA Review, MI is recommended as one of the available evidence based approaches for promoting behavioural change. The level of evidence for MI is deemed sufficiently strong to warrant the strongest level of recommendation ie: Class 1, Category A, reflecting a general consensus that the method is useful and effective (Artinian et al, 2010).

The SNAP 5 A’s Guideline and the Australian Lifescripts Practice Manual urge practitioners to shift away from the prescriptive, advice-giving approach typically used in medical consultations to one which actively engages the patient in decision making and respects patient choice and autonomy. Both manuals include a description of MI. The updated 5 A’s Clinical Practice Guideline (Fiore et al., 2008) also proposes that a patient-centred approach, such as MI, is important in the delivery of the 5 A’s.

The 5 A’s guideline in this manual has therefore been adapted to incorporate simple elements of the Motivational Interviewing approach, in order to assist healthcare providers to deliver the protocol in a patient-centred or guiding style.

The table on page 25 outlines the adapted 5 A’s protocol with an evidence based rationale and a description of how MI has been applied to each of the steps.
Barriers to the delivery of behavioural change counselling in primary care

Healthcare providers report a number of barriers to the systematic delivery of behavioural change counselling in most healthcare settings, which are still mainly organised around acute illness care. These barriers include the fact that they often lack the time, resources, support systems, physical space, knowledge and communication skills to effectively provide such interventions. Additionally, many providers who are unaware of the evidence in support of BBCC are sceptical about its effectiveness (Elford et al., 2001; Katz et al., 2008; Whitlock et al., 2002; Parker, 2010, 2012; Van der Does & Mash, in press). These barriers provide an important rationale for proposing a consistent and overall approach, such as the 5 A’s, for behaviour change interventions across the different behavioural risk factors.

In-service training and on-going support has been shown to be effective in overcoming some of these barriers and improving clinician’s provision of behaviour change counselling in the primary care setting. The inclusion of training modules on BBCC in the curriculum of trainee doctors, nurses and allied health professionals is also important (Emmons & Rollnick, 2001; Whitlock et al., 2002). Training can teach communication skills and change attitudes about the delivery of lifestyle interventions, as well as the style of interaction in behaviour change consultations (Emmons & Rollnick, 2001; Maguire & Pitceathly, 2002; Everett-Murphy et al, 2010). However, clinician training has very limited impact on practice if there is no follow up support and feedback and when it is not accompanied by strategies which support making behaviour counselling an integral part of routine care. Strategies which increase the uptake of BBCC include: the provision of guidelines; risk assessment tools and prompts; patient educational resources and organisational strategies, such as the developing a strong teamwork approach, the delegation of tasks, the implementation of continuous quality improvement processes and developing linkages with referral services (Kinect Australia, 2005; Royal Australian College of GPs, 2006; Harris, 2008).

Policy and health system changes that enable and incentivise clinicians to implement lifestyle interventions are also critical to their widespread adoption. For example, there has been a remarkable increase in the treatment of tobacco dependence by clinicians in developed countries like the US, through the combination of measures taken by health insurers, professional bodies, health administrators and policymakers (see Fiore et al., 2008).

The question of time

Time constraints are often the most significant barrier to the delivery of such interventions in the typical busy primary care setting (Yarnall et al, 2003). However, brief lifestyle interventions like the 5 A’s, which involve screening, interpretation and brief discussion of behavioural risks can often be effectively delivered without requiring more than just a few minutes of extra time (WHO, 2001) (USPSTF, 2009). It is worth noting that the length of time is not always the critical issue in determining the outcome of these types of counselling interventions. For example, MI has been shown to be effective in settings where time constraints are paramount, like accident and emergency departments (Burke, et al., 2003; Hettema et al., 2005 ). In terms of smoking cessation, whilst it is clear that the more intensive the counselling sessions (either in duration or number), the greater the chance of quitting, even a few minutes can still make a difference (Fiore et al., 2008) (See Smoking Pyramid below).

<table>
<thead>
<tr>
<th>GP Time</th>
<th>Level of intervention</th>
<th>Increase in quit rates over 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>Minimal: Routine, systematic identification of smoking status; self-help materials in waiting room; Quitline promoted on poster</td>
<td>Twofold</td>
</tr>
<tr>
<td>&lt; 1 minute</td>
<td>Brief: Ask about smoking; assess motivation; brief advice and support; offer self-help materials; refer to Quitline.</td>
<td>Threefold</td>
</tr>
<tr>
<td>2-5 minutes</td>
<td>Moderate: Explore importance, confidence and barriers with patient; brainstorm solutions; offer self-help materials, NRT and on-going support; refer to Quitline and community-based resources</td>
<td>Fourfold</td>
</tr>
<tr>
<td>&gt;5 minutes</td>
<td>Intensive: Further explore patient’s perspective; collaboratively develop a quit plan</td>
<td>Five-sevenfold</td>
</tr>
</tbody>
</table>
Whilst evidence-based approaches like the 5 A’s and MI are no ‘magic bullet’, providers who have used them report they can actually save time by identifying patient's problems more accurately, avoiding unproductive discussion and by using rapid engagement to focus on the changes that make a difference (Rollnick et al., 2010). For example, finding out what the patient already knows about their problem and what they are ready to act on, can avoid wasting time. One can perhaps argue that such approaches use whatever time is available for discussion on lifestyle risk, far more productively. The proponents of MI argue that, in fact, the far bigger challenge for providers with this type of consultation is making the shift to a patient-centred, guiding style and letting go what has been called the “righting reflex”, the tendency to identify a problem and try and solve it for the patient, instead of enabling them to do this for themselves (Rollnick et al., 2008).

The concern about time constraints in the clinic setting can also be resolved by:

- Allocating appropriate roles to various members of the healthcare team. For example, practice nurses can ensure appropriate assessments are done while patients wait for the consultation, which will help speed up the first step in the 5 A’s (ASK). Alternatively, clinicians can complete the first three steps (ASK, ADVISE and ASSESS) and then ask a lay counsellor/dietician/health promoter with more time to assist those patients who are ready to consider change.
- Distributing education materials, which can provide detailed information and teach certain skills, as part of Step 4 (ASSIST)
- Using innovative communication technologies and coordination with outside resources to give patients further support and follow up for Step 5 (ARRANGE).

Patient non-adherence

Many providers in South Africa and elsewhere report that they find lifestyle counselling frustrating because patients tend not to comply with their advice (Parker, 2012; Van der Does, in press). As was mentioned in the discussion of MI, a patient or client’s responses in such interactions can be significantly influenced by the health professional’s relational style and the social climate he or she establishes in the consultation (Rollnick et al., 2002; Stewart, 2005). Often the provider unwittingly provokes resistance by assuming a patient is ready to take immediate action to change, arguing the case themselves for change and prescribing what needs to be done, rather than facilitating the patient’s active involvement in decision making. This resistance is often expressed as passive agreement and subsequent non-compliance, rather than overt disagreement with the health worker at the time.

Research has shown that patients are more likely to adhere to lifestyle recommendations from healthcare providers when they:

- Feel that the healthcare provider has listened to them, understood their concerns and is receptive to their questions
- Believe that lifestyle change is personally important and relevant
- Believe that the provider recognises their autonomy in decision making and treats them like an equal in the consultation
- Can choose from a range of options and determine their own priorities
- Have articulated the reasons for change in their own words (‘change talk’)
- Perceive that the benefits of change outweigh the costs
- Develop positive expectations of future outcomes
- Receive feedback on risk assessment or test results and clear, specific recommendations from the provider in a non-judgemental, neutral manner
- Feel confident that they are able to carry out the advice in their life context

(Kinect Australia, 2005; Rollnick et al., 2005)

Patient circumstances

An individual’s risk for NCDs is determined, not only by their personal choices, but by a wide range of factors relating to the broader economic, social and physical environment in which they live and work. Patients are more likely to adopt healthy lifestyle choices when they are given assistance that acknowledges their individual circumstances and when the healthcare provider has shown an interest in understanding the complexity and burden of the decision from their perspective (Kinect Australia, 2005).

Often patients or clients face seemingly insurmountable difficulties in accessing resources for lifestyle change. For example, they may be unable to afford a varied and healthy diet or do not have access to safe, affordable facilities for regular physical activity. A study in Nigeria illustrates this point: it found several neighbourhood environmental factors that determine walkability to be significantly associated with being overweight. These included the presence of garbage and foul odours, poor neighbourhood aesthetics and feeling unsafe because of traffic and crime (Oyeyemi et al, 2012).

Providers might need to consider that for some individuals, health may be less of a priority than other more pressing concerns, like unemployment or relationship problems, or that there may be disadvantages associated with behaviour change, which are unrelated to health. These difficulties make it all the more helpful to use a patient-centred approach like MI, where the emphasis is on the provider actively listening to the patient’s perspective on the problem and regarding them as the ‘expert’ on if, when and how to implement change in the given circumstances.
Suggested strategies for integrating BBCC into clinical practice

BBCC can be used opportunistically by the general practitioner when a patient presents for some other reason or as part of the management plan when it is relevant to the presenting condition. One or more risk behaviours can be focused on in the consultation, depending on the time available. Although health benefits can be achieved when individual GPs adopt effective strategies, lifestyle interventions are most effective when there is a systematic approach that involves all practice staff. Each member of the primary care team can be trained to deliver different aspects of the intervention, depending on their particular responsibilities and skills (Kinect Australia, 2005; Whitlock et al., 2002).

A practice could choose to proactively address behavioural risks at certain times of the year by marking the various international/national Health Days for smoking, physical activity, diabetes, heart disease etc. each year. At these times, there can be a more intensive focus on delivering the intervention.

A more planned approach, which aims to integrate prevention activities into practice in a more sustainable way, requires appropriate system support. Such support can include:

- posters in the waiting room, prompting patients to discuss lifestyle issues with health professionals
- standardised screening tools for routinely identifying those who need the intervention. These can be self-administered by the patient or administered by a nurse or nurse assistant in the waiting room
- prompts or reminders for staff to routinely ask about risk behaviours during the consultation
- simple protocols (like the 5 A’s) to aid the discussion about behaviour change and ensure that all the necessary elements are covered
- the introduction of complementary activities such as group education sessions, peer support groups or mini clinics
- the introduction or improvement of data management systems to support the effective identification and management of patients at risk and to transfer and consolidate information
- patient records which include space to write down notes on decisions taken or checklists, to ensure efficient follow up and continuity of care
- sufficient, good quality education/self-help resources for distribution to patients/clients in the context of the brief behavioural change consultation
- clear systems and reliable information for referral, both internally within the health system or GP practice and externally to community programmes and services.

(Lifescripts Consortium, 2010).

It may be very helpful for a practice to compile a resource directory specific to the community in which it is located and to develop a detailed knowledge of what local organisations can offer. For example, it may be helpful to find out where the closest Alcoholics Anonymous (AA), Weigh Less or Walk for Life meeting is held every month, which local church groups run health programmes or develop a link with a cadre of community health workers. This integration may increase health system efficiency and impact by creating congruence between clinical interventions and the broader community (Whitlock et al., 2002).

Another suggested strategy for successfully integrating BBCC into a GP practice or primary healthcare clinic is to appoint a staff member such as a practice nurse to be a ‘NCD champion’. The role of such a person would be, first of all, to assess how and to what extent lifestyle risk factors are being identified and managed at present in the practice or clinic, to then consult staff regarding the potential for intervention and to decide on an appropriate and realistic course of action. She/he can then continue to coordinate and monitor NCD prevention activities over time. Performance by the team can be regularly reviewed during staff meetings and feedback obtained from staff and patients (Lifescripts Consortium, 2010).
Brief behavioural change counselling from healthcare providers may successfully initiate the change process, but repeated contact is usually necessary in order to sustain motivation, address barriers and prevent relapse. If this on-going support is not possible from clinic staff, it is important to link patients to available community-based resources which can help fulfil this role. It has been demonstrated that referral to services that provide follow up support have the potential to double the effectiveness of GP advice in smoking, hazardous drinking and physical activity (Lifescripts Consortium, 2010).

An important aspect of the fourth step in the 5 A’s (Assist) is to offer educational/ motivational materials. Self-help print materials can provide additional, detailed information that the provider does not have time to discuss and can assist in self-monitoring, reinforcement and feedback, as well as teach problem solving and coping skills (Artinian et al, 2010). Print materials also have the advantage of being able to be taken home and shared with others. However, it is important to note that such materials are considerably more effective when they are personalised and provided to the patient in the context of counselling, rather than when they are just distributed on their own (Fitzmaurice, 2001; Moore 2002). In the consultation, the healthcare provider can verbally reinforce the main messages, can direct the patient to the information or materials most relevant to their individual ‘stage of change’ and can use the materials as an aid to actively engage the patient in discussion. A further proviso is that educational or self-help materials need to be tailored to a particular target audience’s level of literacy, life circumstances, cultural values and preferred language (Artinian et al, 2010). It has also been demonstrated that there is a greater acceptance and use of materials if they address the concerns and barriers to behavioural change of the specific target group (Artinian et al, 2010). Formative research is therefore essential to develop or adapt effective and appropriate educational materials for diverse communities.

Communication technology is increasingly being used in lifestyle interventions and holds great potential for enhancing intervention efficiency in the future, by automating assessment, aspects of education, follow up and support. Telephone counselling services, computer/web-based programmes and support groups, and mobile phone messaging have all proven to be effective in delivering portions of interventions. Using such technologies has been found to have worked particularly well with low-income populations (Whitlock et al., 2002).

Patient educational/motivational materials on each of the 4 main behavioural risk factors for NCDs are available as part of this package. These have been researched and pre-tested with diverse, local target audiences. Printable versions of these resources are also available for download on the following web site: www.ichange4health.co.za

Section 5 (the appendix of this guide) includes a number of tools to aid the healthcare provider in offering BBCC.

So, in summary, why do Brief Behavioural Change Counselling?

**Opportunity:** A high % of South Africans visit their GP or clinic at least once a year. Chronic patients attend public sector primary healthcare facilities on a monthly basis and comprise the majority of attendees. Local research shows that patients want more information on lifestyle modification from healthcare providers.

**Credibility:** Most patients see doctors and nurses as having a key role in encouraging them to change their lifestyles. They value counselling in the context of a healthcare consultation, take recommendations seriously and have a high degree of trust in the information given to them.

**Feasibility:** Interventions do not need to be long to be effective: even an extra minute added to the consultation can make a positive difference.

**Effectiveness:** Brief, non-judgemental, patient-centred counselling works, is well accepted by patients and improves perceived quality of care.

**Efficiency:** Evidence-based behavioural change interventions are possible in a few minutes and are a productive use of the limited time available.

**Personal satisfaction:** Using effective counselling interventions and a patient-centred approach results in more rewarding interactions with patients, greater job satisfaction, reduced stress and an improved sense of well-being.

section 4: adapted 5 A’s guideline for SA healthcare practitioners
Rationale and methods

The following table outlines the generic 5 A's protocol. It includes a rationale and explanation of how methods derived from Motivational Interviewing have been integrated into each step, in order to assist the healthcare practitioner to use a patient-centred approach.

The adapted 5 A's brief behavioural change counselling intervention, using a patient-centred approach *

**STEP 1: ASK: ± 1 minute**

Ask about and assess behavioural risks:

- Identify and assess risk behaviour.
- Document on clinic record.
- Ask the patient what he/she already knows about the risks associated with the behaviour in non-threatening manner.
- Respectfully affirm what he/she knows.
- Request permission to provide further information on the health risks and the benefits of behaviour change.

**Rationale and methods:**

Step 1 prompts the healthcare practitioner to make the identification and assessment of risk behaviours proactive and routine.

Instead of assuming ignorance and foisting information and advice on a patient, it is suggested that the practitioner starts engaging the patient in a discussion about the risk behaviour by asking what he/she already knows. By acknowledging that the patient might already have some understanding, the practitioner immediately communicates an attitude of positive regard. This also allows the provision of information in the next step to be tailored to the person’s existing level of knowledge and can save time.

Respect for the patient is further reinforced when the practitioner asks for permission to provide further information. This simple change in approach helps establish a non-threatening climate in which to discuss risk behaviour and facilitates collaboration between the healthcare provider and patient from the outset of the consultation.

* Adapted from the 5 A’s protocol in Whitlock et al., 2002 and incorporating MI principles from Rollnick et al., 2008 & 2010.
RATIONALE AND METHODS

STEP 2: ALERT: ± 2 minutes *

Provide relevant information in a neutral manner:

Before giving information, emphasise that your role is to assist the patient in making informed choices, not to compel them to take a particular course of action.

Assist the patient in interpreting results from any test or assessment.

Offer information on the benefits of change in a neutral way, for example:

“Cutting down on salt is a very important way of controlling hypertension and is just as important as medication.”

“Being physically active for just 30 minutes a day can help prevent the onset of diabetes...”

To save time, build on what the patient already knows about the risks.

If there is already a health problem related to the risk behaviour, clearly link the two. For example: “Quitting smoking would be the best way of preventing these frequent bouts of bronchitis.”

Elicit a response from the patient to the information just shared by asking how they feel about it or what they think about it. Offer to answer any questions the patient may have.

Rationale and methods:
Sharing information that establishes behavioural risks as important can be a unique catalyst for change. Using minor qualifications such as, “As your doctor, I would like to explain certain things to you so that you can make informed choices about your health...” for a message and providing information in a neutral way, rather than telling someone what they ‘should’ or ‘must’ do, conveys respect for a patient’s autonomy and can help avoid provoking resistance. Such information is most effective when personalised, by linking it to the patient’s expressed concerns about their health, results from a clinical assessment of some kind or to their personal circumstances.

Asking how the patient feels about the information begins to actively engage the patient in the interaction and allows him/her to assess its personal relevance. It can also help elicit ‘change talk’ (statements of intention to change that come from the patient, rather than the practitioner).

* We have changed STEP 2 from ADVISE to ALERT as this is more consistent with a patient-centred guiding style.
RATIONALE AND METHODS

STEP 3: ASSESS: ± 2 minute

Assess readiness to change:

Assess how important change is for the patient and how confident they feel about possibly making a change.

You can do this by asking the patient to rate importance and confidence on a scale of 1 to 10 (where 1 is ‘not at all’ and 10 is ‘very important/confident’). Most patients can do this verbally, but it might be useful to draw a ruler on a piece of paper and ask the patient where they would place themselves on the continuum. Asking them why they rated themselves as, say a 5 and not a lower number and what, if anything might help increase their ratings can be an effective way of stimulating ‘change talk’.

It is important to listen carefully to what the patient says, as this determines how to proceed in STEP 4. It may be helpful to briefly summarise what they have told you, capturing their own descriptions, as a means of verifying that you have understood their perspective.

Once you have summarised the patient’s view, you can then ask them whether they feel change is a possibility at this time.

If the patient IS NOT READY to change:

Communicate to them that you respect their decision. Offer support if their decision changes in the future. Avoid arguing the case with the patient as this will simply create resistance.

PROCEED TO STEP 4: ASSIST (a)

If the patient IS READY to change behaviour:

Positively reinforce any intentions to change which the patient has expressed, no matter how small they may be.

PROCEED TO STEP 4: ASSIST (b)

Rationale and methods:

In this step, the patient and practitioner negotiate whether behavioural change is to be considered or undertaken. If there is agreement that change is to be attempted, the practitioner works collaboratively with the patient in the next step to identify various options for change and to define realistic behaviour change goals. Having allowed the patient to personally evaluate how important change is and how confident they feel about their ability to make a change, helps to identify the most important issue for further discussion in the following step. For example, those who are still struggling with the importance of change are unlikely to benefit from a discussion about how to change. Similarly, it is unhelpful and a waste of time to talk about why change is important, if the main concern is a lack of confidence.

If a patient expresses a reluctance to change, it is important not to pressurise him/her. Accepting that there may be valid reasons for why a patient is hesitant or apprehensive about change, helps avoid provoking a defensive response and getting involved in unconstructive dialogue. In this moment, rather try to ‘come alongside the patient’, than set yourself up in opposition to him/her and re-emphasise patient autonomy.
RATIONALE AND METHODS

STEP 4: ASSIST: 3-5 minutes

ASSIST (a):
For those NOT READY to change:

Discuss ambivalence to change:
Ask about and acknowledge the patient’s concerns regarding behaviour change with empathy and active listening. Invite them to identify the pros and cons of change from their perspective (see APPENDIX for Decisional Balance tool). In doing so, acknowledge that it is normal and common to feel ambivalent about change and that change can be difficult. Conveying empathy in this way will enable the patient to more openly discuss the way they feel.

Ask the patient if they can think of realistic ways to overcome the difficulties they have identified.

If available, offer materials, which stimulate self-evaluation, enhance motivation and self-efficacy and may assist them in thinking about making a decision in the future. Before distributing such materials, however, ask the patient if they would like to receive a copy to take home with them.

Ask them if they have any more questions. Suggest that they take time to think about the issue and reiterate that help is available when they feel able to make a decision.

ASSIST (b):
For those READY to change:

Provide practical assistance:
Assist the patient to formulate realistic change goals and explore how to practically achieve them. If necessary, brainstorm ideas with them.

Offer materials which teach behavioural change strategies and skills and express confidence that they will help.

If time permits, prompt the patient to anticipate problems and barriers and to consider how to overcome these. Ask the patient to reflect on strategies they have successfully used in past change attempts or with other, similar behaviours.

Prompt patient to seek social support in their social environment.

Prescribe medication, if appropriate.

Rationale and methods:
Offering support if the patient chooses to attempt change, again re-defines the practitioner’s role from that of someone who dictates change towards a health goal, to someone who can assist in achieving a health goal, if and when the patient feels ready to attempt the change. This type of open-ended exchange can successfully engage even the most minimally interested patient in a non-threatening way.

Again, it is important not to pressurise the patient into complying with what you might think they should do, but to rather support any intention to change coming from them. In prompting the patient to formulate their goals, anticipate obstacles and determine solutions, regard the patient as ‘the expert’ on his/her own life. An important means of building motivation is to express the belief in a patient’s capacity to change and in their ability to work out how best to go about it.

In this approach, the practitioner recognises that most people choose to change, not when they are pressurised to, but when they themselves link the desired change to important personal values, have positive outcome expectations and feel sufficiently confident that they can achieve change.

Rather than foisting information onto the patient, offer the materials and explain how they might help. Allowing the patient to decide whether they want the materials or not, communicates respect and equality. Furthermore, it allows you to distribute the materials only to those motivated and interested in engaging with them and avoids wasting expensive resources on those who might just discard them.
RATIONALE AND METHODS

STEP 5: ARRANGE: 1 minute

Arrange for follow up:

Document the decisions or goals the patient has made and the materials given in the clinic record, in order to support continuity of future care with the practice team. This should prompt the healthcare provider to assess progress at the next visit.

Schedule a follow up contact (which could be a visit, phone call/SMS or Email).

Reiterate your own and your clinic staff’s commitment to provide further information and support, both to those attempting change now and to those who may decide to change in the future.

If appropriate and possible, ask the patient if they are interested in referral to community-based resources and/or to other healthcare providers for more intensive counselling. Provide relevant information.

Rationale and methods:

Behavioural change is understood to be a cyclical process, rather than a linear one. It often involves relapse and further change attempts, which require a review and adjustment of the initial behavioural change plan. This makes some form of routine follow up assessment and support necessary. Furthermore, simply notifying a patient that follow up is going to occur is a powerful motivating factor, communicating importance and caring.

During follow up visits, the provider can simply repeat the 5 A’s, taking into account the patient’s change efforts, experiences and current perspective.

Step 5 also involves referring patients for more intensive treatments or support if necessary and if the patient agrees to it. For example, to a social worker, substance abuse counsellor, community health worker, biokineticist or dietician.
section 5: adapted 5 A’s guideline for NCD risk behaviours
Application to four main risk behaviours

The following section includes the 5 A’s clinical practice guideline for brief behaviour change counselling (Whitlock et al., 2002) as applied to the 4 main behavioural risk factors for NCDs.

- Smoking
- Unhealthy diet
- Harmful alcohol use
- Physical inactivity

The original 5 A’s guideline has been adapted to incorporate principles derived from Motivational Interviewing (Rollnick et al., 2008 & 2010) in order to assist practitioners to adopt a patient-client centred approach in its delivery. It is not intended that the guideline be followed rigidly step by step, as this might adversely affect the natural flow of conversation between the health practitioner and patient or client. Rather, it is intended as a guiding structure to help the practitioner deliver the components of lifestyle counselling which are known to be effective and to do so in a manner that actively engages the patient or client in the consultation. Obviously, the constraints of time may determine that not all these components can be delivered by one practitioner or at one time.

Agenda Setting

In a situation where there may be more than one behaviour change that a patient/client could make to achieve better health, it may be helpful to engage the patient in an agenda setting exercise. In such an exercise, the practitioner can give the patient a brief overview and then invite them to select the issue or behaviour they feel most interested in tackling first.

Allowing the patient to determine the focus of the discussion can help give them a sense of autonomy and make them feel more receptive to addressing the need for change, in a way that works for them.

The patient’s iChange4Health: Road to Health Card (see APPENDIX) can be a helpful tool for the purpose of agenda setting. As it contains the patient’s full risk profile, it can firstly help you and your patient evaluate what health behaviours are most relevant for assessment and discussion. Secondly, the illustration of the ‘road to health’ on the card can be used to determine what the patient would most like to focus on in the consultation. You can ask, “Which of these signposts apply to you? What would you like to talk about today?”

It is important to convey the message that a journey towards better health begins with one step, and even small changes can lead to real differences in one’s physical and mental health.

Another simple way of doing agenda setting is with a sheet containing ‘bubbles’ with different topics, including some blank ones with question marks (see APPENDIX). Offering such a sheet, the practitioner can say, “If you like, we can talk about some changes which are important for controlling your condition and which other people in your situation often consider. Would you like to talk about any of these topics? Or perhaps are there other things you would prefer to discuss right now?” (Rollnick et al., 2008).

Lifestyle Assessment Form

See APPENDIX for the iChange4Health: Lifestyle Assessment Form. If the patient/client fills in this assessment form before the consultation, either in the waiting room or with another healthcare provider, STEP 1 of the 5 A’s is already done and more time can be spent on the other steps. This form also prompts the patient to choose the topic they would like to discuss with the healthcare provider.
5 A’s for smoking

STEP 1: ASK

Ask about and assess behavioural risks: Ask the patient if they use tobacco (cigarettes, chewing tobacco or pipe). If the answer is yes, ask if they would mind spending a few minutes discussing smoking with you.

Assess level of risk:

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How soon after waking do you smoke your first cigarette?</td>
<td>Within 5 minutes 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 6-30 minutes 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Within 31-60 minutes 1</td>
<td></td>
</tr>
<tr>
<td>How many cigarettes do you smoke per day?</td>
<td>10 or less 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11-20 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>21-30 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>31 or more 3</td>
<td></td>
</tr>
</tbody>
</table>

Score: 0-2 very low | 3 low | 4 moderate | 5 high | 6 very high

Ask the patient what they already know about the health risks of smoking and/or the benefits of quitting. Respectfully affirm what they know.

Request permission to provide further information on the risks of smoking and benefits of quitting or reducing.
**STEP 2: ALERT**

**Offer information in a neutral way:** Emphasise that your role is to assist the patient in making an informed choice, not to compel them to a particular course of action.

Assist the patient in understanding the results of the Fagerstrom assessment. If their score is very low/low, they should not find quitting too difficult. If their score is moderate to very high, they are much more likely to succeed with the help of medication and further support from health professionals.

If relevant, link smoking to the existing health problem. Provide further information, tailored to what the patient already knows. This will save time.

**Health risks of tobacco use:** Tobacco contains many toxic chemicals, including nicotine, which is the addictive drug in tobacco that makes you dependent on smoking. Tobacco use causes many different types of diseases including cancer, heart disease, chronic bronchitis and emphysema. These diseases can cause premature death. The good news is that quitting works and that it is never too late to stop. Quitting at any age increases life expectancy.

**Benefits of quitting:** Within 12 hours your lungs begin to function better and you can do more before running out of breath. Within 2 days your sense of smell and taste improves. Within 3 weeks exercise becomes easier. After 2 months blood circulation improves. After 3 months the airways begin to recover and start removing the built up mucus. Men become more fertile. After 12 months your risk of lung cancer is reduced and your risk of heart disease is almost halved.

**Key messages:** It does not matter how long you have been smoking, you will feel the benefits of quitting straight away as your body begins to heal itself. Quitting altogether is best, although cutting down does reduce the harm. Some people find quitting easy, others find it very challenging, but most smokers do eventually succeed. Many smokers make up to 7 quit attempts before they finally succeed. Each time they learn something valuable, which helps for the next time.

**Elicit a response to the information** just shared, by asking what the patient thinks and feels about it. Offer to answer any questions the patient may have.

---

**STEP 3: ASSESS**

**Assess readiness to change:** Ask the patient how important change is for him/her at this time and how confident they feel about possibly making a change. You can do this by using the ‘Readiness Ruler’ below:

**Readiness Ruler to assess importance and confidence:**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not important/confident</td>
<td>Unsure</td>
<td>Very important/confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First of all, ask patient why they did not rate themselves a lower number. The answer to this question will be the reasons that the patient sees change as important or the basis of their confidence to change. Then ask what, if anything, could help increase their ratings on the Importance and/or Confidence ruler (for e.g. from 5 to 10).

Summarise the patient’s point of view, using the patient’s own words or phrases.

**Ask the patient if they would like to think about quitting/reducing at this time.**

**If patient is NOT READY to quit/reduce:** Communicate that you respect their decision not to attempt change at this time and offer support if and when they change their mind in the future. Avoid arguing the case, as this will simply create resistance.

**Proceed to STEP 4: ASSIST (a)**

**If patient is READY to quit/reduce:** Positively reinforce any decision to change, no matter how small, and ask if they would like further assistance.

**Proceed to STEP 4: ASSIST (b)**
STEP 4: ASSIST (a)

ASSIST (a) For those NOT READY to change:
Discuss ambivalence to change.
Ask about and acknowledge concerns or difficulties with empathy. Ask them to identify the pros and cons of quitting from their perspective (use Decisional Balance tool in APPENDIX).
Discuss points raised when discussing importance and confidence.
Ask whether they can think of realistic ways to overcome the difficulties they have identified.
Offer patient education materials:
The *iChange4Health: Your Guide to Healthy Living - Smoking Issue* is suitable for those in pre-contemplation or contemplation stage of behaviour change. This material stimulates self-evaluation, enhances motivation and self-efficacy. Before distributing materials, ask the patient if they have any more questions. Reiterate that help is available from you or other healthcare providers, if they were to make a different decision later.

STEP 4: ASSIST (b)

ASSIST (b): For those READY to change:
Provide practical assistance:
Assist the patient in formulating a realistic change goal and explore practical ways of achieving it. For example, would they prefer to go cold turkey or reduce their smoking over time. Prompt them to set a quit date, preferably within 2-3 weeks. Document agreed quit date on the *iChange4Health ‘Road to Health card’*.
Offer self-help materials: The *iChange4Health: Your Guide to Healthy Living - Smoking Issue* and *Guide to Quitting Smoking* contain lots of helpful information on how to quit. Express confidence that using the guide will help. Explain that the materials will assist them work out how to prepare properly and give them tips on how to cope with smoking triggers and cravings. Before distributing materials ask the patient if they would be interested in taking copies home with them.
If time permits, prompt the patient to anticipate problems and barriers and to consider how to overcome these. If the patient has attempted quitting before, ask them to reflect on why they went back to smoking and how they can avoid the same pitfalls this time. If they have quit successfully for any period of time before, ask them to reflect on the strategies that helped them then.
Prompt the patient to identify someone close to them who can offer support during the quitting process. Asking for help from someone who has successfully quit themselves can be particularly helpful. Suggest giving up smoking at the same time as a friend or relative. This can make it easier, because they can support each other.
STEP 5: ARRANGE

Arrange for follow up:

Document the decisions or goals the patient has made and the materials you have distributed in the clinic record, in order to support continuity of care with the practice team. In the record, prompt the healthcare provider to assess progress during the next visit.

Schedule a follow-up contact with the health facility (which could be a visit, phone call/ SMS or Email). Those patients who intend to quit, should come for a follow-up visit a week or two after the agreed quit date. Relapse usually occurs in the first few weeks and patients should be encouraged to keep trying, as it often takes several attempts before quitting smoking successfully.

Reiterate your and the clinic staff’s commitment to provide further information and support, both to those attempting to quit now and to those who may decide to change in the future. Remind the patient to bring their Road to Health card next time they visit the practice/clinic.

If appropriate and possible, ask the patient if they are interested in referral to community-based resources and/or to other healthcare providers for more intensive counselling.

Provide relevant information.

For professional quit smoking counselling, patients can phone:

**Toll free Cancer Association Quitline:**
0800 226622 (9–4pm)

For more information:
[www.cansa.org.za](http://www.cansa.org.za)

**Free online quit smoking support programme:**
[www.ekickbutt.org.za](http://www.ekickbutt.org.za)

**National Council Against Smoking Quitline:**
011 7203145 (9–4pm)

For more information:
[www.againstsmoking.co.za](http://www.againstsmoking.co.za)

NB: Second hand smoke exposure:

Patients should also be assessed for exposure to second-hand smoke. Strong evidence on the harms of passive smoking justifies counselling non-smokers who are exposed to environmental tobacco smoke, especially pregnant women. The 5 A’s procedures can be easily adapted to use with such patients.
## 5 A’s for unhealthy diet

### STEP 1: ASK

**Ask about behavioural risk:** Ask the patient what they already know about a healthy diet. Respectfully affirm what they know.

**Assess level of risk.** Doing the quiz below with your patient, will help you assess their eating habits. This assessment can also be done before the consultation, by the patient themselves or by another healthcare provider, in order to save time (see Lifestyle Assessment Form in APPENDIX).

<table>
<thead>
<tr>
<th>DO YOU USUALLY...?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose wholewheat or brown bread and flour, rather than white bread or flour?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have at least 3 portions of vegetables a day?</td>
<td></td>
<td></td>
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<tr>
<td>Have at least 2 portions of fruits a day?</td>
<td></td>
<td></td>
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<tr>
<td>Choose fat-free or low fat dairy like milk, maas or yoghurt?</td>
<td></td>
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</tr>
<tr>
<td>Eat red meat (like mutton, beef or boerewors) less than 3 times a week?</td>
<td></td>
<td></td>
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<tr>
<td>Include dried or tinned beans, split peas, lentils or soya in your meals at least twice a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove all visible fat from meat before you eat it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove the skin from chicken before you cook it?</td>
<td></td>
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</tr>
<tr>
<td>Avoid eating high-fat foods such as chips, viennas, polony or chocolate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat fish at least twice a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid eating takeaways or street foods like doughnuts, pies, vetkoek, samosas, fried chips, fried chicken, gatsbies or ‘kotas’?</td>
<td></td>
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</tr>
<tr>
<td>Try to cook with less oil and avoid deep-frying foods?</td>
<td></td>
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<tr>
<td>Avoid salty foods like polony, bacon, viennas, crisps, salty biscuits and high salt sauces like soya sauce or barbeque sauce?</td>
<td></td>
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</tr>
<tr>
<td>Avoid adding extra salt to your food at the table?</td>
<td></td>
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</tr>
<tr>
<td>Try to avoid adding high-salt ingredients like soup powders, stock cubes or salty seasonings to your food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choose healthier snacks like fruit, vegetables, low-fat or fat-free yoghurt between your meals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use little soft tub margarine for your bread, rather than butter or brick margarine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid drinking sugary cold drinks or juices?</td>
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</table>

Source: Cooking from the Heart recipe book, produced by the Heart and Stroke Foundation of SA, Pharmadynamics, CDIA, MRC, Cape Town, 2012.

Request permission to provide further information on a healthy diet.
**STEP 2: ALERT**

Offer further information on diet in a neutral way. Emphasise that your role is to assist the patient in making informed choices, not to compel them to take a particular course of action. Assist the patient in understanding the results of the diet assessment.

If patient ticked “No” for any of the questions, their (and possibly their family’s) diet can be improved. The more “No” answers they ticked, the more unhealthy their diet is and the higher the risk of them getting a chronic disease, or getting serious complications if they already have one.

If they ticked “Yes” for some questions, they are making good progress, but can still benefit by making some changes to their eating habits.

If they ticked “Yes” for every question – congratulate them as they are well on their way to preventing chronic disease (or keeping it under control if they already have one). They are choosing healthier options and avoiding the unhealthy foods eaten by many South Africans.

Provide further information. To save time, build on what the patient already knows. If relevant, link information to the existing health problem.

Elicit a response to the information shared by asking what the patient thinks or feels about it. Offer to answer any questions the patient may have.

**Health risks:** Being overweight and eating an unhealthy diet increases the risk of developing diseases such as diabetes, high cholesterol, high blood pressure and cancer. More and more South Africans are eating lots of unhealthy takeaway or street foods which are high in harmful fats, sugar or salt.

A healthy diet: includes plenty of fresh fruit, vegetables, high-fibre foods (like beans, lentils and wholewheat bread) and is low in fat, sugar and salt.

Weight reduction: can be achieved in a variety of ways. Eg, by reducing fat (particularly saturated animal fat), carbohydrate (sugars and starches) and alcohol, or by eating smaller portion sizes and by increasing physical activity.

Key message: Healthy eating does not need to be boring or expensive. The truth is that it can be as simple as making small changes to the way you eat like eating more of this and less of that, or using healthier cooking methods.

If there is time, you can show the patient the Healthy Plate Model below:

The plate is a visual guide to show how much of each food group you should be eating in order to have a healthy, balanced diet. Ideally, you should eat 3 small meals a day, with healthy snacks in-between meals.

What is a healthy balanced meal?

- Half your plate should consist of vegetables, salads or fruit
- A quarter of your plate should consist of high-fibre starchy foods (e.g. brown rice, whole wheat pasta, coarse mielie meal or pap, sweet potato, madumbi or brown/whole wheat/seeded bread)
- The other quarter of your plate should consist of lean protein (e.g. fish, skinless chicken or lean meat, beans or lentils)
- The meal should also contain a small serving of fat (e.g. vegetable oil, soft margarine, avocado or unsalted nuts)
STEP 3: ASSESS

Assess readiness to change: Ask the patient how important change is for him/her at this time and how confident they feel about possibly making a change. You can do this by using the ‘Readiness Ruler’ below:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<th>10</th>
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<td>Very important/confident</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

First of all, ask patient why they did not rate themselves a lower number. The answer to this question will be the reasons that the patient sees change as important or the basis of their confidence to change. Then ask what, if anything, could help increase their ratings on the Importance and/or Confidence ruler (e.g. from 5 to 10).

Summarise the patient’s point of view, using their own descriptions.

Ask if he/she would like to think about changing their eating habits at this time.

If patient is NOT READY to change their diet: Communicate that you respect their decision not to attempt change at this time. Avoid arguing the case, as this will simply create resistance. Proceed to STEP 4: ASSIST (a)

If patient is READY to change their diet: Positively reinforce any decision to change, no matter how small, and ask if they would like to discuss some options for improving their diet. Proceed to STEP 4: ASSIST (b)

STEP 4: ASSIST (a)

ASSIST (a) For those NOT READY to change: Discuss ambivalence to change.

Ask permission to discuss concerns. Invite the patient to identify pros and cons of changing their diet from their perspective (use Decisional Balance tool in APPENDIX). Acknowledge concerns or difficulties with empathy.

Discuss points raised when discussing importance and confidence.

Ask whether they can think of realistic ways to overcome the difficulties they have identified.

Offer patient education materials: The iChange4Health ‘Your Guide to Healthy Living – The Nutrition Issue’ is suitable for enhancing motivation and self-efficacy. Before distributing materials, ask the patient if they would like to have a copy to take home.

Offer support if and when they change their mind in the future.

STEP 4: ASSIST (b)

ASSIST (b): For those READY to change: Provide practical assistance:

Ask the patient how they would like to make a start and if they would like to formulate a change goal. Use the assessment to identify where the patient can make positive changes. For example, they may choose to cut down on takeaways. Assist them formulate a realistic change goal and how to achieve it. Document the goal on the patient retained iChange4Health ‘Road to Health’ card.

Recommend that patients follow the South African dietary guidelines.

Offer patient education materials: the iChange4Health ‘Your Guide to Healthy Living – The Nutrition Issue’ and the ‘Cooking from the Heart Recipe Book’. Explain that the materials include the guidelines, lots of healthy recipes, tips on healthy cooking and shopping and ideas on how to overcome common problems. Before distributing materials, check that the patient would be interested in receiving them.

If time permits, prompt the patient to anticipate problems and barriers and to think of ways to overcome these.

Prompt the patient to identify someone close to them who can offer support during the change process. Asking for help from someone who has successfully changed to a healthier diet or lost weight themselves can be particularly helpful.
Arrange for follow up:

**Document decisions or goals** the patient has made and the materials you have distributed, in the clinic record, in order to support continuity of care with the practice team. This should prompt the healthcare provider to assess progress during the next visit.

**Schedule a follow-up contact** with the health facility (which could be a visit, phone call/ SMS or Email). Reiterate your own and your clinic staff’s commitment to provide further information and support, both to those attempting to change now and to those who may decide to change in the future. Remind the patient to bring their **Road to Health card** the next time they visit the practice/clinic.

Ask the patient if they are interested in referral to community-based resources and/or a dietician or nutritionist for more intensive counselling. Patients with specific conditions or suffering from obesity should have long term contact with health professionals and may require specific advice from a dietician or nutritionist.

Provide relevant information and make referral.

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**For free, professional counselling:**

Heart and Stroke Health Line: 0860 223 222 (9-4pm)

For more information on healthy diet:

www.heartfoundation.co.za OR www.cansa.org.za

Sweetlifemag.co.za
SweetLife Magazine: Fun and informative posts about diabetes in South Africa

South African Society for Obesity: www.sasso.co.za
Screening for alcohol problems is an important preventative activity, which is often avoided by healthcare providers because they fear antagonising patients. However, research has shown that most problem drinkers are cooperative when providers discuss alcohol and value brief interventions when provided in the context of the primary healthcare consultation (WHO, 2001).

Drinking can be conceptualised as harmful when the person experiences adverse physical, psychological or social consequences as a result of their drinking. Alcohol dependence indicates a situation where, in addition, the person is physically addicted and experiences a loss of control, strong desire, tolerance and withdrawal symptoms. Dependence affects only a small proportion of the adult population, but harmful drinking generally affects a much larger proportion of the population (WHO, 2001). Brief interventions should be offered to all patients drinking at potentially risky levels. Early intervention for people who drink at risky levels is important to prevent dependence (Lifescripts Consortium, 2010).
**STEP 1: ASK**

*Ask* the patient if they would mind spending a few minutes discussing alcohol use and health. Take care when assessing alcohol use to be neutral and non-judgemental.

You can briefly *assess* the frequency and quantity of alcohol intake by using the questions below from the Alcohol Use Disorders Identification Test (AUDIT-C, WHO, 2001). The AUDIT-C is a modified version of the 10 question AUDIT instrument, developed by the World Health Organisation (Babor et al., 2001). Practitioners should be aware that AUDIT is a screening tool and should not replace the consideration of mental and social complications, symptoms of dependence and misuse of other substances (Lifescripts Consortium, 2010).

### What is a standard drink? (Lifescripts Consortium, 2010).

<table>
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<tr>
<th></th>
<th>Beer</th>
<th>Wine</th>
<th>Spirits</th>
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<tbody>
<tr>
<td>4.9% alcohol</td>
<td>4.9%</td>
<td>12%</td>
<td>40%</td>
</tr>
<tr>
<td>Medium beer</td>
<td>Medium</td>
<td>Medium</td>
<td>Small</td>
</tr>
<tr>
<td>glass or bottle</td>
<td>285 mls</td>
<td>120 mls</td>
<td>glass</td>
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</tbody>
</table>

It is important to note that often bottles/cans/glasses contain more than one standard drink.

### Alcohol Use Disorders Identification Test (AUDIT-C)

1. How often do you have a drink containing alcohol?  
   - Never 0  
   - Monthly or less 1  
   - 2-4 times a month 2  
   - 2-3 times a week 3  
   - 4 or more times a week 4

2. How many standard drinks do you have on a typical day when you are drinking?  
   - 1 or 2 0  
   - 3 or 4 1  
   - 5 or 6 2  
   - 7, 8 or 9 3  
   - 10 or more 4

3. How often do you have 6 or more drinks on any one occasion?  
   - Never 0  
   - Less than monthly 1  
   - Monthly 2  
   - Weekly 3  
   - Daily or almost daily 4

**Add your score from questions 1—3**  

**Total**

**Scoring:** A score of 5 or more is considered positive for identifying harmful drinking or active alcohol disorders. This score indicates that further assessment, using the complete AUDIT is required (Lifescripts Consortium, 2010).

You can also briefly assess level of dependence using the CAGE questionnaire.

### The CAGE Questionnaire for alcohol use (Ewing, 1987)

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Have you ever felt you should cut down on your drinking?</td>
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<tr>
<td>Have people annoyed you by criticizing your drinking?</td>
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<td></td>
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<tr>
<td>Have you felt bad or guilty about your drinking?</td>
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<tr>
<td>Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?</td>
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**Scoring:** The answers to the questions are scored 0 for “no” and 1 for “yes”. A total score of 2 or greater is considered indicative of harmful alcohol use. 4 positive answers suggests alcohol dependence. A more thorough evaluation is warranted in both cases.

**Request permission from the patient to provide further information.**
STEP 2: ALERT

Offer information in a neutral way. Help interpret assessment results, taking care to avoid labelling someone as a binge drinker or an alcoholic. Rather use terms such as harmful drinking or dependence. If a patient appears to be drinking at harmful levels or experiencing adverse consequences as a result of their drinking, ask them if they are aware of the associated health risks. Respectfully affirm what they know.

If relevant, link to existing health problem as patients are more likely to be responsive to changing their drinking habits if they see a connection. To save time, build on what the patient already knows.

Health risks of harmful alcohol use: Long term problem drinking can cause neuropsychiatric disorders, hypertension, stomach ulcers, cardiomyopathy, cirrhosis of the liver and various cancers, including breast, colon, throat, liver and prostate cancer. Intoxication commonly leads to homicide, traffic accidents, unsafe sex and domestic violence. Harmful drinking also often causes problems at work, at home and with the law.

Immediate effects: Slow reaction time, poor balance and co-ordination, lack of inhibition, nausea and vomiting, blackouts

The benefits of giving up or reducing drinking: besides reducing the risk of many health problems, you will have more money to spend on other things, enjoy a more stable emotional state and have more energy and time to do other things.

Recommendations: In order to avoid the risk:

Women should not have more than one standard drink a day.
Men should not have more than two standard drinks a day.

Elicit a response to the information just shared, by asking what the patient thinks and feels about it. Offer to answer any questions the patient may have.

STEP 3: ASSESS

Assess readiness to change: Ask the patient how important change is for him/her at this time and how confident they feel about possibly making a change. You can do this by using the ‘Readiness Ruler’ below:

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</table>

First of all, ask patient why they did not rate themselves a lower number. The answer to this question will be the reasons that the patient sees change as important or the basis of their confidence to change. Then ask what, if anything, could help increase their ratings on the Importance and/or Confidence ruler (e.g. from 5 to 10).

Summarise the patient’s point of view, using the patient’s own words or phrases.

Acknowledge that changing drinking habits can be difficult.

If patient is NOT READY to quit/reduce drinking: Communicate that you respect their decision not to attempt change at this time and offer support if and when they make a different decision in the future. Avoid arguing the case as this will simply create resistance.

Proceed to STEP 4: ASSIST (a)

If patient is READY to quit/reduce drinking: Positively reinforce their decision and ask if they would like to discuss some options for quitting or reducing their drinking.

Proceed to STEP 4: ASSIST (b)
ASSIST (a) For those NOT READY to change:
Discuss ambivalence to change.
Ask permission to discuss concerns. Invite the patient to identify pros and cons of quitting or reducing their alcohol intake from their perspective (use Decisional Balance tool in APPENDIX). Acknowledge concerns or difficulties with empathy. Discuss points raised when discussing importance and confidence. Ask whether they can think of realistic ways to overcome the difficulties they have identified or the pressures they feel.

Offer patient education materials:
The iChange4Health ‘Your Guide to Healthy Living – The Alcohol Issue’ is suitable for enhancing motivation and self-efficacy. Before distributing materials, ask the patient if they would like to have a copy to take home.

Offer support if and when they make a different decision in the future.

ASSIST (b): For those READY to change:
Provide practical assistance:
Ask the patient how they would like to make a start and if they would like to formulate a change goal. Use the information from the assessment to help identify where the patient can make positive changes. Assist them formulate a specific and realistic change goal and how to achieve it. For example, they might decide to limit the number of drinks per day or decide to commit to a number of alcohol free days per week. Prompt them to set a date to begin implementing their plan, preferably within the next few weeks. Document agreed goal on the patient retained iChange4Health ‘Road to Health’ card.

Offer patient education materials:
The iChange4Health ‘Your Guide to Healthy Living – The Alcohol Use Issue’ teaches strategies and skills for quitting or reducing alcohol use. Express confidence that the leaflet will help. Explain that the material will assist them work out how to prepare properly, give them tips on how to cut down and how to avoid high risk situations. Before distributing the material ask the patient if they would be interested in taking a copy home with them.

If time permits, prompt the patient to anticipate difficulties and to consider how to cope with these (for example, how to deal with common triggers such as social pressure or negative emotions). If the patient has attempted changing before and failed, ask them to reflect on how they can avoid the same pitfalls this time. If they have succeeded in quitting before for a sustained period of time, ask them to recall the strategies that helped them then.

Prompt the patient to identify someone close to them who can offer support during the change process. Asking for help from someone who has successfully changed their drinking habits themselves can be particularly helpful.

Dependent drinkers usually need both further supportive therapy and medication to help with withdrawal symptoms. Mild withdrawal symptoms can be managed by a primary care doctor, but moderate to severe withdrawal/dependency or co-morbidity with other mental or health problems may require admission for more specialist care and supervision. Severe withdrawal symptoms can include fits, confusion and hallucinations. After detox, patients should referred to a rehab programme.

Tips to reduce drinking
It is possible to drink at a level that is less risky and which minimises the possibility of getting drunk.

• Start with non-alcoholic drinks and alternate with alcoholic drinks
• Drink slowly, take small sips
• Add ice, soda, lemonade, coke
• Try drinks with a lower alcohol content
• Eat before or while you are drinking
• Avoid salty foods
• Have alcohol free days
• Avoid situations where you feel pressured to drink
• Go home earlier
STEP 5: ARRANGE

Arrange for follow up:

Document decisions or goals the patient has made and the materials you have distributed, in the clinic record, in order to support continuity of care with the practice team. This should prompt healthcare provider to assess progress during the next visit. Most relapse occurs in the first few weeks. Patients should be counselled to learn from relapses and to keep trying.

Schedule a follow-up contact with the health facility (which could be a visit, phone call/SMS or Email). Arrange for follow up with those patients who intend to quit or reduce alcohol use soon after their quit date (2-4 weeks).

Reiterate your own and your clinic staff’s commitment to provide further information and support, both to those attempting to change now and to those who may decide to change in the future. Remind the patient to bring their Road to Health card next time they visit the practice/clinic.

Patients with acute problems, who drink at risky levels or who are dependent on alcohol should be referred for more specialised intervention. Ask the patient if they are interested in referral to community-based resources and/or specialist health services for more intensive counselling. Where appropriate make referral to addiction specialist, alcohol counsellor or psychiatrist.

Community based resources:

**SA National Council on Alcoholism and Drug Dependence (SANCA)**

Toll Free Number: **086 14 SANCA / 086 14 72622**
Phone: **011 892 3829**
E-mail: sancanational@telkomsa.net
Website: [http://sancanational.org](http://sancanational.org)

**Lifeline South Africa**
A 24 hours professional counselling service for 365 days a year
[www.lifeline.org.za](http://www.lifeline.org.za)
086 132 2322

**Alcoholics Anonymous**
National Helpline: **0861 HELP AA (435-722)**
Website: [aasouthafrica.org.za](http://aasouthafrica.org.za)
5 A’s for physical activity

Define physical activity:
Some people do physical activity in a structured or planned way to get fit. This is called 'exercise', and may include things like: karate, gym, sports, jogging, cycling and aerobics. But to get the health benefits of physical activity it is not necessary that you do these particular kinds of activities: you can do any kind of activity in which you use your whole body to move, such as:
- walking to or from places or taking a flight of stairs
- gardening or housework
- playing outside with your children
- taking part in dance classes.

STEP 1: ASK

Ask the patient what they already know about the benefits of physical activity. Respectfully affirm what they know.

Assess level of physical activity: Asking the questions below, will help you assess your patient or client’s level of physical activity, as well as identify avenues for constructive discussion in the steps to follow. If the assessment can be done before the consultation, by the patient themselves or by another healthcare provider, rather do this to save time (see APPENDIX for Lifestyle Assessment Form).

1. In the past week, did you do physical activity...
   □ as part of your job
   □ to get to and from places
   □ to do housework or gardening
   □ to play sports or dance____________________
   □ in the past week, I did not do any physical activity

2. In a usual week, on how many days do you do physical activity?
   □ none, □ 1 day, □ 2 days, □ 3 days, □ 4 days, □ 5 days, □ 6 days, □ 7 days

3. On any day in which you do physical activity, how many total minutes on average, do you spend being active?
   □ less than 10 minutes
   □ between 10-20 minutes
   □ between 20-30 minutes
   □ between 30-60 minutes
   □ more than 60 minutes

4. On any day in which you do physical activity, how does this activity make you feel?
   □ I feel almost no change in my breathing or heartbeat, and do not sweat (light)
   □ I notice an increase in my breathing and heartbeat, and sweat a little (moderate)
   □ I breathe hard, my heart beats fast, I huff and puff, and I sweat a lot (vigorously)

5. If you had to choose, what kind of physical activity would you most enjoy?
   This can be an open question. For your own records, you can tick off the relevant answers below. Or if the patient needs prompting, you can use the following as examples:
   □ walking to and from places, or in my neighbourhood
   □ playing sport
   □ group exercise classes
   □ playing with my children or grandchildren
   □ gardening
   □ housework
   □ running, jogging, cycling and swimming
   □ dancing
   □ martial arts
   □ other: ________________________

6. What are your top three reasons that make doing physical activity difficult for you?
   This can be an open question. For your own records, you can tick off the relevant answers below. Or if the patient needs prompting, you can use the following as examples:
   □ I don’t have time
   □ I don’t have the support from family or friends
   □ There aren’t enough facilities or I don’t have enough money
   □ I don’t have confidence in my ability
   □ I feel unsafe
   □ I don’t enjoy it
   □ I am too sick or unhealthy
   □ It makes me feel uncomfortable
   □ It’s against my culture
   □ I don’t think it’s important enough in my life
   □ other: ________________________

Request permission to provide further information on physical activity.
**STEP 2: ALERT**

Offer information in a neutral way. Emphasise that your role is to assist the patient in making an informed choice, not to compel them to a particular course of action.

Using the assessment in Step 1, evaluate your patient's current level of physical activity and then alert them to how they compare with current recommendations.

If inactive: You can say something like, “I can see that physical activity isn’t really part of your life. Is this correct? It is important for me to share with you that even small or modest amounts of physical activity has been shown to improve people's health and reduce the risk of disease”.

If moderately active: You can say, “Looking at your answers, it seems that you are doing some physical activity as part of your daily life. It is important for me to share with you that in order for physical activity to be beneficial, you need to do at least 30 minutes of moderate to hard activity on 5 or more days of the week. When doing physical activity, you need to aim to go fast enough so that you huff and puff (breathe faster) and work up a bit of a sweat.”

If sufficiently active in terms of time and levels of intensity: You can say, “Looking at your answers, it seems like physical activity is very much a part of your life. This is great! It is important to maintain these levels of physical activity to keep healthy.

Elicit a response to the information just shared, by asking what the patient thinks or feels about it. Offer to answer any questions the patient may have.

**STEP 3: ASSESS**

Assess readiness to change: If the patient is doing insufficient physical activity or is inactive, ask them if they would like to think about becoming more physically active.

If the patient is moderately physical active, ask them if they would like to discuss adding even more value to their physical activity by increasing time or intensity.

You can also ask the patient how important increasing physical activity is for him/her and how confident they feel about possibly making a change, by using the ‘Readiness Ruler’ below:

<table>
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</tr>
</tbody>
</table>

First of all, ask patient why they did not rate themselves a lower number. The answer to this question will be the reasons that the patient sees change as important or the basis of their confidence to change. Then ask what, if anything, could help increase their ratings on the Importance and/or Confidence ruler (e.g. from 5 to 10).

Summarise the patient’s point of view, using the patient’s own words or phrases.

If patient is NOT READY to increase physical activity: Communicate that you respect their decision not to attempt change at this time and offer support if and when they change their mind in the future. Avoid arguing the case as this will simply create resistance. **Proceed to STEP 4: ASSIST (a)**

If patient is READY to increase physical activity: Positively reinforce their decision and ask if they would like to discuss some options for improving their levels of physical activity. **Proceed to STEP 4: ASSIST (b)**

**Health benefits of physical activity:** Physical activity and fitness are important in preventing obesity and chronic diseases such as diabetes, hypertension, heart disease, lung disease, osteoporosis and certain cancers, especially breast and colon. Regular physical activity also helps with anxiety and depression, reduces the pain from arthritis and helps to manage body weight.

**Current recommendations:**
Research shows that in order to be healthy and fit you need to be getting:

A total of at least 150 minutes of moderate to vigorous physical activity a week

OR

A total of 30 minutes of moderate to vigorous (hard) physical activity on at least 5 days of the week (the 30 minutes can be broken up into for eg, 2x15 minute sessions)

**Moderate to vigorous physical activity means that you work up a bit of a sweat and your heart beats faster than normal.**

**Key messages:** It usually takes time to reach these goals. Starting off by doing something, even if it is a little bit, is better than nothing. The more you do each day, the more you reduce your risk of getting a chronic disease. Even small increases in physical activity can improve health and well-being.

Research has shown that physical activity is beneficial for everyone, even if you are in your senior years, are overweight or already have a chronic condition.
**STEP 4: ASSIST (a)**

**ASSIST (a) For those NOT READY to change:**
Discuss ambivalence to change.

Ask permission to discuss concerns. Invite them to identify pros and cons of changing their levels of physical activity from their perspective (use Decisional Balance tool in APPENDIX). Acknowledge concerns or difficulties with empathy.

Discuss points raised when discussing importance and confidence.

Ask whether they can think of realistic ways to overcome the difficulties they identified in Question 6 so they could do some of the activities that they said they enjoyed in Question 5.

**Offer patient education materials:** The iChange4Health ‘Your Guide to Healthy Living – The Physical Activity Issue’ is suitable for enhancing motivation and self-efficacy. Before distributing the material, ask the patient if they would like to have a copy to take home.

**Offer support** if and when they make a different decision in the future.

**STEP 4: ASSIST (b)**

**ASSIST (b): For those READY to change:**
Provide practical assistance:

Ask the patient how they would like to make a start and if they would like to formulate a change goal. Use the information from the assessment to help identify where the patient can make positive changes. Assist them formulate a realistic change goal and how to achieve it. Something the patient enjoys that is easily integrated into their daily routine and does not require attendance at a special facility involving a cost is more likely to be successful.

Document the agreed goal on the patient retained iChange4Health ‘Road to Health’ card.

**Offer patient education materials:** the iChange4Health ‘Your Guide to Healthy Living – The Physical Activity Issue’. Explain that the materials include the guidelines, lots of tips on how to integrate more physical activity into daily life and ideas on how to overcome common problems. Before distributing the material, check that the patient would be interested in receiving a copy to take home with them.

If time permits, prompt the patient to anticipate problems and barriers and to think of ways to overcome these. If the patient has attempted increased physical activity before and failed to maintain this, ask them to reflect on how they can avoid the same pitfalls this time. Conversely, if they have succeeded in doing physical activity more regularly before, ask them to reflect on the strategies that helped them reach their goals then.

Prompt the patient to identify someone who can perhaps join them in their efforts, for example someone who could walk around the neighbourhood with them.

The following information has been extracted from the iChange4Health ‘Your Guide to Healthy Living – The Physical Activity issue’. For ease of reference for discussion on options for changing with those patients who are willing to try, it is included here.
Walking is an excellent way to keep physically active. Many people walk as part of their everyday life. They walk to work; to get the bus, taxi or train; to the shops; to church; to the clinic, or to visit family and friends. This counts as physical activity, especially if you walk in a way that makes you sweat a little or raises your heart beat.

The following ideas can help you make the most of the walking you are already doing and/or help you add more walking to your day.

**Adding steps to your day**
- Walk to visit a friend instead of phoning them (this also saves money)
- Walk with your child to school (this way you get to spend more quality time with them too)
- Get off the bus / taxi / train one stop earlier and walk the rest of the way
- Deliberately choose a longer route to the place where you are going
- Walk instead of taking a taxi (this also saves money)
- Walk to the shop with your child, instead of sending them on their own
- Take the stairs instead of the lift
- Walk somewhere during lunch time at work
- If you use a car, park far away from the entrance to the shopping mall
- On a weekend, walk along the beach for pleasure and relaxation

**Making your steps count more:**
- Swing your arms when you walk
- Whenever you walk anywhere, walk as fast as you can (this can also save time)
- Carry your shopping bags, instead of using a trolley
- Take fewer rest breaks and walk fast enough so that you are out of breath (huff and puff), your heart beats faster, and you are sweating

There are also other ways to increase physical activity:

**Reduce your inactivity**
- Take opportunities to stand more, e.g. when speaking on the phone
- Sit less
- Watch less TV
- Move while sitting, e.g. do chair exercises
- Play with your children or grandchildren
- Take a lunch break at work and go for a walk

**Get moving to music**
Doing physically activity to music can make it much more fun, especially when you are doing it with others.
If you have access to the internet, you can download songs and music videos and use them to dance to.

**Take up a new hobby or sport**
- Get together with friends to play a regular ball game over the weekend
- Join a dancing group
- Take up a hobby that will get you physically active, like hiking, swimming or fishing
- Visit museums, parks, the botanical gardens or other popular places of interest and walk around

**Feel unsafe on your own?**
- Walk around at your nearest shopping mall
- Start an exercise group at your place of worship or work
- Walk in the grounds of a school in your neighborhood with a group of friends
- Go for a short walk during your lunch break at work, if you feel safer there than at home

**No facilities where you live?**
- Take one or two old phone books, wrap some cello tape around them to secure the pages. Now step up and down for 1 minute at a time at your own pace. Rest for one minute. Then slowly increase the time you spend stepping and decrease the rest periods in between.
- Take a short walk around the block, or up and down the road
- Join the neighborhood watch, and walk with them
- Dance to your favourite song in your home
- Join the scholar patrol at your local school

**Overcoming common difficulties:**

**No support from friends or family?**
- Do physical activity at home while doing chores or dance to music
- Join a neighbourhood watch or the scholar patrol at your local school and walk with them

**No time to be active or exercise?**
- Do small bits of activity throughout the day, like climbing stairs, walking, cycling to the shop or dance to songs while you are cleaning or cooking. All these add up and can be counted as physical activity.
- Cook enough food for 2 days. This can give you enough time to be active. You can play with your children or go for a walk at the time you usually cook.
- Start an exercise group at work and exercise during the lunch break.
For free, professional counselling on lifestyle change:

Heart and Stroke Health Line:
0860 223 222 (9-4pm)

For more information on healthy lifestyle:
www.heartfoundation.co.za OR www.cansa.org.za

Arrange for follow up:

Document decisions the patient has made and the materials you have distributed, in the clinic record, in order to support continuity of care with the practice team. This should prompt healthcare provider to assess progress during the next visit.

Schedule a follow-up contact with the health facility (which could be a visit, phone call/ SMS or Email). Reiterate your own and your clinic staff’s commitment to provide further information and support, both to those attempting to change now and to those who may decide to change in the future. Remind the patient to bring their Road to Health card next time they visit the practice/clinic.

Ask the patient if they are interested in referral to community-based resources and/or a biokineticist, if available for more intensive counselling. Provide relevant information and make the referral.

Refer patients to:
Toronto Doctor’s magic pill, 23 and a half hours.
Walking is our best medicine.

If you have access to the internet, take some time to look up this brilliantly illustrated video on YouTube. It has received over a million hits, much to the delight of the doctor who created it, Dr Mike Evans from St Michael’s Hospital in Toronto, Canada.

It contains a simple message: if physical activity were a medicine it would be the most miraculous medicine ever invented. Citing research from around the world, Dr Evans shows that just half an hour of activity a day, even if it is just walking, is very effective in preventing or reducing the risk of many different health problems. He urges us all to try and limit sitting and sleeping to 23 and a half hours out of every 24 and to ensure that we are active for at least half an hour each day.

The CHIPS programme – a community-based physical activity programme funded by the Sports Science Institute of SA.

- ‘OptiFit Outreach’ classes for adults aged between 18 - 55. There are 11 branches in communities in the Western Cape.
- ‘Live it Up’ classes specifically for men and women over the age of 55. 19 branches in the Western Cape.
- Classes are held in community centres or places of worship

Contact Person: Zulfah Gierdien-Abrahams
Phone: 021 659 5608
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Run/Walk for Life
Tel: 0861 005566
E-mail: info@rwfl.co.za • Website: www.rwfl.co.za

Siyadlala Mass Participation Programme (SMPP)
Sport and Recreation Services • Department of Cultural Affairs and Sport
Telephone: (021) 483 9629 • Fax: (021) 483 9666
E-mail: mjosephs@pgwc.gov.za

Pedal Power Association
Telephone: (021) 689 8420 • E-mail: info@pedalpower.org.za

National Department of Sports and Recreation
Telephone: (012) 304 5000 • Website: www.srsa.gov.za
section 6: appendix
SECTION 6: APPENDIX

Tools for the healthcare provider

Lifestyle Assessment form

This can be administered by a practice nurse, a receptionist or by the patients themselves while they are waiting for the consultation. For convenience, it combines all the rapid assessment tools outlined in Step 1 (ASK) of the 5 A Protocols for each of the 4 risk factors. This form also prompts the patient to think about their priorities and what risk behaviour/s they would most like to discuss with their healthcare provider at that time. If it is possible for patients to fill in the Lifestyle Assessment form while waiting to be seen, the practitioner can then spend more time in the consultation discussing patient concerns or assisting them in problem solving.
Do you want to do something positive to improve your health and get more out of life? Would you like to discuss your lifestyle with your health practitioner today? If yes, please answer the questions below.

Your answers will help guide the conversation between you and the practitioner about your health. If more than one of these health behaviours applies to you, it would be helpful if you could think about what you feel most interested in talking about today and tell your healthcare provider when you see him/her. In this way you can discuss what you feel most ready to change at this time.

Your answers will be kept confidential.

Today, I would most like to discuss:

- [ ] Smoking
- [ ] Nutrition
- [ ] Alcohol
- [ ] Physical Activity

**SMOKING**

Do you use tobacco (cigarettes, pipe, chewing tobacco): [ ] YES [ ] NO

Short Fagerstrom test for nicotine dependence

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How soon after waking do you smoke your first cigarette?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 5 minutes</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Within 6-30 minutes</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Within 31-60 minutes</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>How many cigarettes do you smoke per day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 or less</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>11-20</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>31 or more</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

Score: 0-2 very low, 3 low, 4 moderate, 5 high, 6 very high

If your score is very low/low, you should not find quitting smoking too difficult. If your score is moderate to very high, you are much more likely to succeed with the help of medication and support from health professionals.

**NUTRITION**

DO YOU USUALLY...?

<table>
<thead>
<tr>
<th>Yes/No</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choose wholewheat or brown bread and flour, rather than white bread or flour?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have at least 3 portions of vegetables a day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have at least 2 portions of fruits a day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choose fat-free or low fat dairy like milk, maas or yoghurt?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat red meat (like mutton, beef or boerewors) less than 3 times a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Include dried or tinned beans, split peas, lentils or soya in your meals at least twice a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove all visible fat from meat before you eat it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remove the skin from chicken before you cook it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid eating high-fat foods such as chips, viennas, polony or chocolate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat fish at least twice a week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid eating takeaways or street foods like doughnuts, pies, vetkoek, samosas, fried chips, fried chicken, gatsbies or ‘kotas’?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try to cook with less oil and avoid deep-frying foods?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid salty foods like polony, bacon, viennas, crisps, salty biscuits and high salt sauces like soya sauce or barbeque sauce?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid adding extra salt to your food at the table?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Try to avoid adding high-salt ingredients like soup powders, stock cubes or salty seasonings to your food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choose healthier snacks like fruit, vegetables, low-fat or fat-free yoghurt between your meals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use little soft tub margarine for your bread, rather than butter or brick margarine?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoid drinking sugary cold drinks or juices?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Cooking from the Heart recipe book, produced by the Heart and Stroke Foundation of SA, Pharmadynamics, CDIA, MRC, Cape Town, 2012.
If you ticked “No” for any of the questions, your (and possibly your family’s) diet can be improved. The more “No” answers you ticked, the more unhealthy your diet is and the higher the risk of you getting a chronic disease, or getting serious complications if you already have one.

If you ticked “Yes” for some questions, you are making good progress, but can still benefit by making some changes to your eating habits.

If you ticked “Yes” for every question - congratulate yourself as you are well on your way to preventing chronic disease (or keeping it under control if you already have one). You are choosing healthier options and avoiding the unhealthy foods eaten by many South Africans.

### PHYSICAL ACTIVITY

**Read this definition of physical activity before answering the questions below:**

Some people do physical activity in a structured or planned way to get fit. This is called ‘exercise’, and may include things like: karate, gym, sports, jogging, cycling and aerobics. But to get the health benefits of physical activity it is not necessary that you do these particular kinds of activities: you can do any kind of activity in which you use your whole body to move, such as:

- walking to or from places or taking a flight of stairs
- gardening or housework
- playing outside with your children
- taking part in dance classes.

Below are some questions about physical activity in your life.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 1. In the past week, did you do physical activity... | □ as part of your job  
□ to get to and from places  
□ to do housework or gardening  
□ to play sports or dance  
□ other: |
| 2. In a usual week, on how many days do you do physical activity? | □ none  
□ 1 day  
□ 2 days  
□ 3 days  
□ 4 days  
□ 5 days  
□ 6 days  
□ 7 days |
| 3. On any day in which you do physical activity, how many total minutes on average, do you spend being active? | □ less than 10 minutes  
□ between 10-20 minutes  
□ between 20-30 minutes  
□ between 30-60 minutes  
□ more than 60 minutes |
| 4. On any day in which you do physical activity, how does this activity make you feel? | □ I feel almost no change in my breathing or heartbeat, and do not sweat (light)  
□ I notice an increase in my breathing and heartbeat, and sweat a little (moderate)  
□ I breathe hard, my heart beats fast, I huff and puff, and I sweat a lot (vigorous) |
| 5. If you had to choose, what kind of physical activity would you most enjoy? | □ walking to and from places, or in my neighbourhood  
□ playing sport  
□ group exercise classes  
□ playing with my children or grandchildren  
□ gardening  
□ housework  
□ running, jogging, cycling and swimming  
□ dancing  
□ martial arts  
□ other: |
| 6. What are your top three reasons that make doing physical activity difficult for you? | □ I don’t have time  
□ I don’t have the support from family or friends  
□ There aren’t enough facilities or I don’t have enough money  
□ I don’t have confidence in my ability  
□ I feel unsafe  
□ I don’t enjoy it  
□ I am too sick or unhealthy  
□ It makes me feel uncomfortable  
□ It’s against my culture  
□ I don’t think it’s important enough in my life  
□ other: |
Research shows that in order to be healthy and fit you need to be getting:

A total of at least 150 minutes of moderate to vigorous physical activity a week

OR

30 minutes of moderate to vigorous (hard) physical activity on at least 5 days of the week

**Moderate to vigorous physical activity means that you work up a bit of a sweat and your heart beats faster than normal.**

Even small or modest amounts of physical activity has been shown to reduce the risk of disease.

- If in Question 2 you ticked less than 5 days a week
- in Question 3 you ticked less than 30-60 minutes
- in Question 4 you ticked that you feel no change in your breathing or heartbeat when doing physical activity

You need to talk to your healthcare provider about how you can introduce more physical activity into your life or to make your physical activity more vigorous, so that you huff and puff (breathe faster) and work up a bit of a sweat.

If physical activity is very much a part of your life, congratulate yourself! It is important to maintain these levels of physical activity to keep healthy.

**ALCOHOL**

Do you drink alcohol? YES NO

If yes, understand what a standard drink is before answering the questions below:

<table>
<thead>
<tr>
<th>Beer</th>
<th>Wine</th>
<th>Spirits</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.9% alcohol</td>
<td>12% alcohol</td>
<td>40% alcohol</td>
</tr>
<tr>
<td>Medium beer glass or bottle</td>
<td>Medium wine glass</td>
<td>Small glass</td>
</tr>
<tr>
<td>285mls</td>
<td>120mls</td>
<td>30mls</td>
</tr>
</tbody>
</table>

It is important to note that often bottles/cans/glasses contain more than one standard drink.

**Alcohol Use Disorders Identification Test (AUDIT-C)**

1. How often do you have a drink containing alcohol?
   - Never 0
   - Monthly or less 1
   - 2-4 times a month 2
   - 2-3 times a week 3
   - 4 or more times a week 4

2. How many standard drinks do you have on a typical day when you are drinking?
   - 1 or 2 0
   - 3 or 4 1
   - 5 or 6 2
   - 7, 8 or 9 3
   - 10 or more 4

3. How often do you have 6 or more drinks on any one occasion?
   - Never 0
   - Less than monthly 1
   - Monthly 2
   - Weekly 3
   - Daily or almost daily 4

Add your score from questions 1–3 Total

**Scoring:** A score of 5 or more is considered positive for harmful drinking

**The CAGE Questionnaire for alcohol use (Ewing, 1987)**

<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever felt you should cut down on your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have people annoyed you by criticizing your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you felt bad or guilty about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoring:** The answers to the questions are scored 0 for “no” and 1 for “yes”. A total score of 2 or greater is considered indicative of harmful alcohol use. 4 positive answers suggests alcohol dependence.
5 A’s Poster/prompt

You can copy the 5 A’s poster opposite and put it up in your consulting room as a reminder of the 5 steps for behaviour change counselling.
THE 5 A’s

An effective, but quick way to promote lifestyle change in routine primary care

STEP 1
ASK
about risk behaviour

STEP 2
ALERT
patient to health risks and benefits of behaviour change

STEP 3
ASSESS
readiness to change behaviour

STEP 4
ASSIST
in attempt to change behaviour

STEP 5
ARRANGE
follow-up and referral
AGENDA SETTING TOOL

For patients who need to address more than one risk behaviour, it may be helpful to allow them to choose what they would most like to focus on first.

One simple way of doing this is to use the bubble sheet (see below). Each bubble contains a possible topic for discussion. The blank bubbles give the patient the opportunity to raise other issues. In offering such a sheet, the practitioner can say something like: “Here are some areas that we can talk about which are important in controlling your illness. Would you like to discuss any of these topics today, or is there perhaps something else that you feel is more important to talk about right now?” If there is something else the patient wants to discuss, it is usually feasible to move on the other topics after a few moments. This brief strategy usually takes only a minute or two. It allows the patient to agree on a focus for discussion and address anything else that may be of greater importance to him/her and which may distract from a constructive discussion on behavioural risks (Rollnick et al., 2008).

The illustration on the iChange4Health: Road to Health card (see page 61) can also be a useful tool for agenda setting. You can ask the patient which of the signposts on the ‘road to health’ they would most like to discuss at that time.

Sample agenda setting ‘bubble’ sheet

(Rollnick et al., 2008)
DECISIONAL BALANCE TOOL

In MI it is important to acknowledge that, from the patient’s perspective, there may well be costs and benefits of maintaining current behaviour or of behavioural change. The Decisional Balance exercise is a particularly useful tool for helping those patients who seem uncertain about change. First ask the patient about what is good about the way things are at the moment, for eg. “What is good about smoking for you?” This question needs to be asked with genuine curiosity about the perceived benefits of smoking. Any trace of judgement or sarcasm will simply engender defensiveness. Then you can follow up with a question like, “What is the down-side for you/what are the things about smoking that you don’t like?” By asking both questions, you will elicit both arguments against change (question 1) and arguments for change (question 2). Inviting patients to explore their feelings of ambivalence in this way can be the first step in encouraging them to reflect on change. It can also possibly help them see discrepancies between their behaviour and what they really value (Rollnick et al., 2008).

A useful way to conclude the conversation is for you to briefly summarise the patient’s account of the pros and cons. Concluding with a question like, “So, where does this leave you now?” or “So, how does that leave you feeling?” invites the patient to take things a step further and to be in the driver’s seat of change in their lives (Rollnick et al., 2008).

Sample Decisional Balance tool for patient drinking at harmful levels

<table>
<thead>
<tr>
<th>Decision</th>
<th>Likes</th>
<th>Dislikes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stay the same</td>
<td>Helps me relax after work, tastes nice, enjoy drinking with friends, makes me more sociable</td>
<td>I feel out of control, makes me sleep badly, have put on weight, conflict with wife, feel ashamed with children</td>
</tr>
<tr>
<td>Change: cutting down on drinking</td>
<td>Fewer arguments at home, no hangovers, work better, feel good about gaining control, children will be relieved</td>
<td>Will have to explain to friends, loss of enjoyment, unsure how to cope with stress</td>
</tr>
</tbody>
</table>

(The Royal Australian College of GPs, 2006)

Motivational tension: Inside the mind of a smoker – the desire to stop versus the need to smoke

A smoker may feel a desire to stop, which varies from moment to moment depending on:
- Worry about health
- Dislike of financial cost of smoking
- Guilt or shame about smoking
- Disgust with smoking
- Hope for success at stopping

The desire or need to stop, conflicts with physical urges to smoke and the desire to smoke:
- Anticipated enjoyment of cigarette
- Need for the forthcoming cigarette
- Concern about loss of self esteem if the quit attempt fails
- Concern about unpleasant short term effects of stopping
- Wanting or needing to hold on to the perceived benefit of smoking

Depending on the strength of the competing desires and needs, the conflict may result in:
- Putting the idea of stopping out of his or her mind
- Forming an intention to stop at some vaguely conceived future time point
- Forming a definite plan to stop at some future time point
- Deciding to stop immediately

Offering BBCC and treatment can change this balance - small things can have a big effect on actions

**Road to Health Card for adults**

**Standard Operating Procedure for MY ROAD TO HEALTH CARD**

**BACKGROUND**

**PURPOSE**

The ‘Road to Health’ card is intended to be a tool to assist healthcare providers to discuss LIFESTYLE RISK BEHAVIOURS with their patients/clients. The card is designed to be a personal record which the patient takes home and brings back every time they attend a health service for care. This will allow for different healthcare providers over time, to monitor and reinforce progress towards a healthier lifestyle.

**SCOPE**

- Health professionals
- Community Based Workers

**PREREQUISITES**

NB: It is intended that, after the initial assessment, the healthcare provider engages the patient/client in a discussion about how they feel about their scores, whether they have any questions about them and whether they would like to think about setting any health goals to improve them (or maintain them, if they are good). It is important that the healthcare provider asks permission to discuss these issues and supports patient autonomy in decision making. In other words, the healthcare provider needs to avoid making the decisions and telling the patient/client what to do, as this often merely provokes resistance to behaviour change.

1. The goals on the right hand side of the card represent the optimum health goals that a patient/client can work towards, in order to achieve good health and wellness.

2. The red, amber and green dots are intended to indicate whether the scores imply high, medium or low risk of chronic disease and their complications. The little faces are intended to indicate progress towards the healthy goals: a neutral face for inconsequential or no progress and a happy face for evident progress or behavioural change, no matter how small.

3. If the patient/client is literate, they can fill in the section on ‘My Personal Plan’ themselves. They can also tick or colour in the little faces to indicate assessment of their own progress. There is also space for them to write down comments or changes to their plans as they go along.

4. If they have been screened for the various cancers listed, HIV or TB, they can simply tick the box.

5. There is enough space in the box to also write down a date.

**PROCEDURE**

Page 1 informs the patient/client what actions are needed in order to lead a healthy lifestyle, to achieve wellness and prevent chronic disease.

Page 2 allows the health care provider to assist the patient/client in understanding certain key indicators of health, set personal goals for behaviour change and chart their progress over time.

After a full assessment by health professional, the patient’s baseline scores are recorded on the Road to Health Card i.e. weight, waist circumference, BP, Blood glucose etc.

A plan is discussed with the patient/client on how to reach the targeted milestones that will address the modification of lifestyle

The patient/client needs to be informed of the health risk factors pertaining to him/her and realistic milestones discussed before decisions are made

The patient/client should be asked to bring the Road to health card with them every time they visit the service so that the health team can monitor progress and assist in plotting future milestones.
### Health Risks

<table>
<thead>
<tr>
<th>Health Risk</th>
<th>My Score</th>
<th>My Plan</th>
<th>3 Months</th>
<th>6 Months</th>
<th>12 Months</th>
<th>Healthy Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large waist measurement</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Men: less than 94 cm (size 36)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Women: less than 80 cm (size 38)</td>
</tr>
<tr>
<td>Overweight</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>5-10% weight loss if overweight</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Less than 140/90 mmHg</td>
</tr>
<tr>
<td>High blood sugar</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Fasting glucose: 5.5 mmol/L or less HbA1c; less than 7%</td>
</tr>
<tr>
<td>High blood cholesterol</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Less than 5 mmol/L</td>
</tr>
<tr>
<td>Unhealthy diet</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>5 veg and fruit per day Low fat, low sugar, low salt</td>
</tr>
<tr>
<td>Physical inactivity</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>At least 150 minutes per week</td>
</tr>
<tr>
<td>Smoking</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Non-smoker</td>
</tr>
<tr>
<td>Harmful alcohol use</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>Men: limit to 2 drinks a day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Women: limit to 1 drink a day</td>
</tr>
<tr>
<td>Depression</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
<td>⭕️⭐️⭐️</td>
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<td>Coping well</td>
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### My Chronic Disease Medical History

I am being treated for:

### Screening

- Cervical cancer
  - DATE:
- Breast cancer
  - DATE:
- Prostate cancer
  - DATE:
- HIV
  - DATE:
- TB
  - DATE:
Recommended Reading

GUIDES FOR HEALTH PROFESSIONALS ON BBCC USING THE 5 A’s:


MOTIVATIONAL INTERVIEWING


Ten things that Motivational Interviewing is not. Miller WR and Rollnick S. Behavioural and Cognitive Psychotherapy, 2009 (37) 2: 129-140.


OTHER RECOMMENDED READING


The role of primary healthcare in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol. Harris M. Commissioned paper for the National Preventative Health Task Force, 2009.


section 7: references


Harris M (2009). The role of primary healthcare in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol. Commissioned paper for the National Preventative Health Task Force, 2009.


Van der Does AMB & Mash B (in press). Evaluation of the “Take 5 School”: An education programme for people with Type 2 diabetes in the Western Cape, South Africa.


Thank you to all our partners involved in compiling this manual, a first in South Africa!

The manual forms part of the iChange4Health 2013 campaign, which is a joint initiative between the Chronic Disease Initiative for Africa (CDIA) and Pharma Dynamics. Pharma Dynamics has become SA’s leading supplier of cardiovascular medicines and has, by making many life-changing medicines more affordable, significantly increased the accessibility to hundreds of thousands of South Africans. We do however feel that prevention is better than cure, and has therefore put our full weight behind this social investment.

The aim of the campaign is to educate the public regarding healthy lifestyle changes and to provide healthcare professionals with the skills, knowledge and tools to assist patients in making these changes.

Pharma Dynamics invites all healthcare professionals to partner with us in our quest to educate South Africans about lifestyle changes needed to improve the health of our nation.

Let’s all change for good!

Paul Anley
Founder & CEO, Pharma Dynamics

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