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HEALTH PROMOTION/HEALTH EDUCATION AT PHC LEVEL INCLUDING WITHIN HOME SERVICES

Health for All (HAP) Project

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ACRONYMS

CME	Continuous Medical Education
CPG	Clinical Practice Guidelines
HAP	Health for All
HCS	Home Care Services
HE	Health Education
HIF	Health Insurance Fund
HP	Health Promotion
IPH	Institute of Public Health
LUHC	Local Unit of Healthcare
MoHSP	Ministry of Health and Social Protection
NCD	Non-communicable Disease
OH	Operator of Health
PG	Peer Group
PHC	Primary Health Care
QoC	Quality of Care
QoL	Quality of Life
TFL	Together for Life

1. CONTEXT

1.1 Health Promotion and Health Education

According to WHO[1], health promotion (HP) helps people increase control over their health. WHO recognises 3 key elements of health promotion:

- **Policies that support good health** and priorisation of health across all sectors
- **Health literacy** (enhanced personal skills): Health knowledge and skills that help people make better choices.
- **Local leadership** that promotes **healthy environments** in communities and primary health care facilities.

Within this scope, health education (HE) consists in planned learning that helps people get information and skills to make better health decisions.[2]

1.2 HP and HE in the context of HAP

In Phase 1 and 2, HAP implemented health promotion and health education activities through mass media engagement and community-based activities. In Phase 3, HAP shifted focus to support to health education as part of primary health care.

The Quality of Care (QoC) surveys implemented through HAP show that more NCD patients (with diabetes or hypertension) receive proper advice and treatment at service delivery point (Fier and Diber). This is shown by the positive trends of indicators related to “asking questions”, “conducting examinations”, and “advises/explains/instructs” (See Table 1).

Table 1: Percentage of NCD patients (cardiovascular diseases, diabetes) receiving adequate advice and treatment as observed at service delivery point (Fier and Diber). Source: HAP interim progress report, 2023

QoC 2015	QoC 2018	QoC 2022
Patients with Diabetes type II Asks questions 24% Conducts examinations 11% Advises/explains/instructs 25%	Patients with Diabetes type II Asks questions 39% Conducts examinations 22% Advises/explains/instructs 52%	Patients with Diabetes type II Asks questions 47% Conducts examinations 27% Advises/explains/instructs 55%
Patients with hypertension Asks questions 24% Conducts examinations 18% Advises/explains/instructs 38%	Patients with hypertension Asks questions 46% Conducts examinations 24% Advises/explains/instructs 60%	Patients with hypertension Asks questions 51% Conducts examinations 28% Advises/explains/instructs 55%

This progress likely reflects an effort to improve communication and education during consultations.

1.3 Policy context of health promotion and health education

Health education and promotion are embedded in Albania’s health reforms, notably:

[1] https://www.who.int/news-room/questions-and-answers/item/health-promotion

[2] “Any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunity to acquire information and the skills needed to make quality health decisions”. Joint Committee on Terminology (2001). "Report of the 2000 Joint Committee on Health Education and Promotion Terminology". American Journal of Health Education. 32 (2): 89–103.

- **the Strategy on Development of Primary Health Care (PHC) Services 2020–2025**: The strategy emphasizes health education and health promotion in several ways:
    - It integrates health education and promotion into the basic service package at the primary health care (PHC) level, covering activities such as school initiatives, information campaigns, and partnerships with community organizations to scale up access to primary health care (p. 26)
    - It encourages the activation of individuals, families, and communities by providing health education to family members, supporting joint health and social care decision-making, and promoting participation in health-related support groups (p. 26)
    - It encourages local governments to actively organize joint health promotion programs with Local Health Care Units (LHCUs) to improve community health status (p. 17)

- **the National Health Strategy 2021–2030:** The strategy highlights that disease prevention and health promotion should be key components of services provided at primary health care (PHC) facilities, emphasizing that many public health programs — including vaccination, education, surveillance, and screening — reach communities mainly through PHC services. Health education is framed as an integral part of PHC's role in activating individuals, families, and communities. The document also notes that revising the basic PHC service package involves maintaining health promotion and education services as a core element, ensuring they are evidence-based and adapted to the evolving needs and capacities of different health system levels. These strategies recognize preventive care and lifestyle education as central to reducing the burden of non-communicable diseases (NCDs) and improving community health outcomes.

- The **National programme on NCD prevention and its Action Plan(2021-2030)**[3]: this document integrates health education and promotion into both its population-wide strategies aiming to create healthy environments (e.g. Promotion of physical activity, especially in school and workplace settings) and its individual-level interventions (e.g. education of chronic patients and their long-term follow-up). It treats these as essential pillars for the long-term prevention and management of NCDs in Albania

- The **National programme on cancer control:** This programme views health education and promotion as part of primary prevention, setting targets for risk factors reduction like smoking by 20%, alcohol drinking by 10%, declining of obesity, and increase physical activity among children and youth. [4]

Further, there are related national action plans, which further frame the response to health needs of the population:

- **The Action Plan on Health Promotion in Albania (2022-2030)**[5] : The Action Plan structures health promotion interventions around increasing awareness, promoting healthy lifestyles, strengthening enabling environments (especially in schools, workplaces, and municipalities), and fostering intersectoral collaboration. Specific objectives include organizing awareness campaigns, integrating health education into school curricula, developing national networks like Healthy Cities, and empowering health services to deliver systematic health promotion and risk communication activities.

[3] https://portalinjohurive.shkollatpershendetin.al/wp-content/uploads/2022/05/Read-more-Policy-brief-on-NCD-Action-Plan.pdf

[4] https://albania.un.org/en/174226-who-albania-support-albania%E2%80%99s-new-national-cancer-control-programme-2021-2031 ; Koduzi, G., & Celami, R. (2024). How is Performing Cancer Prevention Program in Albania? Implications for Policy Makers. South Eastern European Journal of Public Health, 2510–2524. https://doi.org/10.70135/seejph.vi.3056

[5] https://portalinjohurive.shkollatpershendetin.al/wp-content/uploads/2022/05/Read-more-Policy-brief-on-Health-Promotion.pdf

- **The Mental Health Action Plan (2023-2026)**: The Action Plan prioritizes developing mental health literacy through awareness campaigns in schools, workplaces, and communities, and by training healthcare providers, teachers, and parents. Health promotion is treated as a cross-sectoral responsibility, emphasizing interventions to reduce stigma and discrimination, to promote resilience across the life course, and to create supportive environments in schools and workplaces.

1.4 Scope and approach of the consultancy

The activities of HAP on HP/HE in Phase 3, which started on 1 April 2023, have mostly focused on the following activities:

- The role of PHC in the prevention of NCDs through health education of the patients and their families
- The role of PHC in health education of elderly people
- Health promotion and education during home visits and delivered by nurses to homebound patients and carers (family) in the frame of Home Care Services (HCS)

This consultancy has looked specifically at these activities while also documenting how institutional partners working at PHC and community levels in Albania were addressing HP/HE for NCDs and the elderly.

The approach and methods of the consultancy consisted in a document review (HAP progress reports, other documents produced by HAP such as research reports, health education manuals, TORs), scientific literature review on relevant topics, in a series of meetings/interviews with stakeholders from Operators of Health (OH), Local Units of Health Care (LUHC), PHC staff, and NGOs, in Tirana, Shkodër, and Kavaje as well as the HAP implementation team.

The mission agenda is available in **Error! Reference source not found.**. Findings of the consultancy and recommendations are outlined below.

2. FINDINGS

2.1 HP/HE implemented by selected health system actors (HAP partners)

2.1.1 Community health awareness raising at OH and LUHC levels

The regional Operator of Health Care Services (regional OH) have a Health Education Division located under the Directorate of Public Health and Health Education. Local Units of Health Care (LUHC) usually have one or several health promotion specialists located under their PHC Department[6]

This represents a decrease of health promotion capacity compared with their structure prior to the 2018 reform, when LUHC had dedicated health promotion divisions. Now the LUHC health promotion specialists under the PHC Department have been allocated additional responsibilities/areas of competencies such as general PHC service coordination, which limit their involvement in health promotion.

[6] Regulation on organization and functioning of the Operator of Health Care Services, Order of MoHSP nr.18, date 17.01.2019)

The regional OH HE Division supervises and coordinates the HP specialists of the LUHCs. Together, they function as a HE/HP network that supports the alignment and harmonization of activities across LUHCs.

The role of the regional OH HP Division is primarily managerial, including planning, supervision/coordination of LUHCs activities, aggregating data reports from LUHCs, and transmission of a regional report to the Institute of Public Health (IPH) on a monthly basis. Conversely, the role of the HP specialists of LUHC is to implement community-facing activities.

Under the general guidance of the IPH, the HP networks plan awareness-raising events following a yearly calendar of International Health Days. The HP networks organize their work according to monthly plans of activities related to a selection of International Days. For example, activities would be planned and implemented to raise awareness on health of the elderly on October 1st (International Day of the Elderly). Similarly, on World Diabetes Day, outreach activities are being conducted to propose free-of-charge screening tests. The awareness-raising messages are often relayed on social media platforms as well. Generally, the calendar of International Health Days does not have a particular focus on NCD or the elderly, as maternal and child health topics seem to attract most attention.

The Regional OH coordinates the awareness-raising activities of the LUHCs but the latter retain some autonomy to program and implement community-based activities independently and outside of the frame of the regional OH monthly plan.

The IPH provides guidance to the HP networks in the form of overarching campaign messages, that the HP networks have autonomy to adapt locally. The IPH gathers members of the HP networks each month for capacity building seminars and delivers them (not always) a limited quantity of printed leaflets and/or information material. These events mostly target the dissemination of updated data on specific health issues. Some respondents regretted that these IPH training are not more focused on practical skills-building.

It may happen that the IPH identifies an emerging public health issue (at local or national level) through epidemiological surveillance data, and instructs the HP network to organize related awareness-raising activities on an ad-hoc basis.

The HP Divisions of Regional OH do not have a dedicated budget, unlike the LUHC where a budget is available but is considered minimal by the personnel. The HP networks also report a lack of basic equipment to conduct community activities as well as a lack of transportation.

The HP networks report monthly data related to 3 indicators: number of activities planned, number of activities conducted, and number of beneficiaries reached.

2.1.2 Advocacy for home care services

The NGO Together For Life (TFL) was mandated by HAP in 2024 (10 months contract) to conduct advocacy for a better financing of HCS. TFL mandate is to advocate for patents' rights by ensuring the respect and enforcement of the law in the health sector. It routinely conducts health-related advocacy by collaborating with a network of watchdog institutions such as the Parliamentary Commission on the right to information, the Ombudsman, or the Commission against discrimination. TFL has had several successful lawsuits against the Government for the provision of health services (e.g. cochlear implant, breast cancer chemotherapy, in-vitro procedure) to patients who have been denied care.

In the frame of its collaboration with HAP, TFL has conducted a study on HCS for elderly with mobility challenges.[7] This study highlights among other the difficulties of nurses in providing these

[7] https://www.togetherforlife.org.al/wp-content/uploads/2024/12/Report_Home-based-healthcare-services-for-elderly-individuals-with-mobility-challenges.pdf

services. TFL presented the draft report to a representative of the Ministry of Health and Social Protection prior to a public launch of the report in December 2024 which received media coverage.

TLF also prepared promotional leaflets on HCS and disseminated them in the population of the 20 health centres supported by HAP. TLF has prepared further materials in relation to the study results including a video, infographics and an article, which are currently not disseminated publicly pending the election of a new Parliament in May 2025.

While noting that successful advocacy usually requires a longer period of time than that imparted in their contract with HAP, TLF stated being ready to continue advocating for home care services in a voluntary manner as this falls under their mission. They are particularly interested to advocate for a dedicated budget for HCS, and generally better financing of the PHC services. Currently, the national health budget reflects only one generic line for PHC without further sub-allocations.

2.2 Approaches in Health Education at PHC level supported by HAP

2.2.1 Health Education Manuals

Overview

HAP supported the development of several clinical guidelines for PHC providers that contain secondary prevention and treatment-related information, including information on how to prevent the disease and disease complications. The clinical guidelines provide guidance to PHC doctors and nurses on treatment objectives as well as lifestyle change goals and encourage the development of **individual plans of care.**

These guidelines are:

- The clinical guidelines on the 5 main NCDs: Hypertension, Dyslipidaemia, Diabetes, Asthma and Chronic Obstructive Pulmonary Disease
- The clinical guidelines of the most frequent geriatric syndromes (comprehensive geriatric assessment included)
- The clinical guidelines on mental health

To provide more detailed, evidence-based content for counselling/health education on secondary prevention by PHC providers, HAP has developed **two manuals on health education: on Health education on NCD**[8] **and on the health education for the elderly**[9]. At the development stage, the content of these manuals was tested with patients during a meeting with community representatives, representatives of chronic patients and elderly people, facilitated by nurses and doctors.

[8] https://www.hap.org.al/en/manuali-i-edukimit-shendetesor-per-semundjet-jo-te-transmetueshme/

[9] https://www.hap.org.al/en/manuali-i-edukimit-shendetesor-per-te-moshuarit/

Figure 1: Manual "Health Education for Non-Communicable Diseases"

Figure 2: Manual "Health Education for the Elderly"

In these manuals, prevention information is given for each NCD and covers a large range of topics such as knowledge of the disease, complications, guidance on how to perform technical acts such as blood pressure measurement, and lifestyle advice related to nutrition, physical activity and smoking. Both providers and patients can use these manuals.

Health education manuals provide **structured counselling guidance** to meet the specific needs, and circumstances of individual patients, including the co-development with the patient of a shared treatment and lifestyle change plan. This fills a content gap in PHC and empowers providers with structured material for consistent communication and counseling.

These HE manuals are primarily designed for use by family nurses (FN) but they can also be used by family doctors (FDs) during general consultations with NCD patients and the elderly. They lend themselves well for use during the **annual check-up** offered to the population aged over 35 years old where the focus is on screening for NCD risk factors.

Dissemination and sustainability

The HE manuals are well-embedded in the Continuous Medical Education (CME) system at PHC level. They are part of the Training of Trainer, and the Peer Groups, where they are used in particular for the practical case studies.

HAP has also largely disseminated the HE manuals among PHC staff, all participants to Peer Groups, and to the 25 student/physicians of the post-graduate training in Family Medicine. Distribution was both paper-based and electronic. The two manuals are available on the website of HAP. The two manuals have not been formally approved by the MoHSP, despite being in use for over a year. This limits policy-level integration and risks inconsistent recognition or application across the health system. With HAP being in consolidation phase, there is a need for more ownership of the manual by national/local PHC institutions for sustainability.

On the aspect of dissemination/sustainability, we have identified as good practice that the Director of the PHC centre of Rrethina, Shkodër, was approached in 2024 by the local nursing home to train their staff on the clinical guidelines for geriatric assessment. The PHC Director adapted the content on geriatric assessment to a 3-day training tailored to the needs and capacity of the 13 nursing home staff (3 nurses, 1 doctor, 1 social worker, and 8 carers). This 3-day training was provided on December 18, 20, 26, 2024.This contributes to further dissemination of the technical knowledge of the manuals/CPGs while demonstrating leadership from the side of a PHC director.

Another possibility for further dissemination lies with the LUHCs and the onboarding training of newly recruited staff in primary health centers. Both in Shkoder (Rrethina PHC director) and in Kavaje (LUHC), the directors envisaged training the new staff using training content from the Peer Group. In Kavaje, that training programme would target seven new nurses recently recruited. This

approach of an “orientation programme” for new staff based on the clinical guidelines and HE manuals was also discussed at the HAP planning workshop held on February 13, 2025.

Additional opportunities for dissemination of the Health Manuals were identified with the Medical University. The Faculty of Medicine currently offers several training courses on Health Promotion: one 2-day module for students of medicine, and one 1-year long course for students of public health. During the interview, the main course coordinator was open to the idea of integrating the manuals into the reference lists for both courses and possibly include some of the manual content into the courses, with some adaptations to match the respective profiles of students.

HAP could explore this opportunity to adapt the manual content into practical skills-building exercises for integration into academic HP courses, including within nursing faculties across Albania. Furthermore, the Institute of Public Health has started an initiative on motivational counselling training for social workers/psychologists with support from WHO and UNICEF, targeting mental health for children and adolescents. It would be important to create synergies between this activity and other planned activities of HAP with psychologists (see section 3.1.2).

Finally, we identified as a good practice that the Health Centre from Rrethina, Shkodër region, organizes weekly **group-based education** in the community on a range of health topics, including NCDs and risk factors. These education seminars are facilitated by nurses and consist of presentations and discussions of health topics with the audience. According to the health providers interviewed, these sessions are well attended by the NCD patient and elderly members of the community.

2.2.2 Health Education in Home Care Services

In the frame of Home Care Service (HCS), nurses conduct home visits that include direct health education to patients and families. The document package related to the HCS guidelines includes several forms which support the provision and monitoring of health education to patients and families such as:

- The nursing assessment form for the patient during the home visit, which records risk behaviours of the patients (e.g. smoking, alcohol, etc.)
- The nursing chart, which records the individual plan of care

A patient can have on average up to 12 visits/year, each with an education component.

The HCS guidelines, specifically the Manual of HCs Standard Nursing Procedures, provide personalized HE for the various health situations in homebound patients and elderly—e.g., a protein and vitamin C-rich diet, repositioning manoeuvres for pressure ulcers, and active and passive exercises for immobilized patients. For self-monitoring of NCDs at home settings, the HE Manuals for NCDs and the Elderly offer comprehensive information, including advice on healthy lifestyle such as nutrition, quitting smoking/alcohol etc. Nurses should adapt this information, adjusting food portions, or diets for conditions like dysphagia (liquid diets for stroke patients), and tailor physical activities based on the level of patient’s limited mobility or digestive function impairment etc Technical acts are demonstrated to family caregivers for them to perform independently.

While home visits provide an intimate and personalized context for meaningful behavior change support, the informal nature of health education provision (ad-hoc) to patients and family caregivers raises the question of the effective transmission of knowledge and know-how to the family caregivers. It is unclear whether the provision of information to caregivers is sufficient for retention of knowledge and accurate/safe practice of technical acts. It is also unclear whether the current guidelines account for the emotional readiness of family caregivers to support (fatigue, own health conditions).

2.2.3 Health Education in PHC and CGP monitoring visits

In phase 3, HAP continues to support the monitoring of clinical guidelines for 5 NCDs implementation and the monitoring of home care services. HAP has developed manuals and tools to facilitate supportive supervision monitoring visits of health centres by central and regional OH and LUHC, as a team or as a single institution. Monitoring tools include the assessment of the health education component of the guidelines.

To facilitate the supportive monitoring visits of HCs by central/regional OH and LUHCs, HAP has elaborated a monitoring manual with dedicated monitoring tools for various aspects of NCD clinical guideline implementation, including the assessment of the health education component (https://www.hap.org.al/manual-monitorimi-zbatimi-i-protokolleve-per-hta-dislipidemi-diabet-astme-spok/). This manual has been used to train selected professionals from some regional OH and LUHCs. Furthermore, it has been used in 20 monitoring visits conducted by regional HO and LUHCs, coached by HAP.

One monitoring tool in particular, the patient exit interview form, tracks the understanding by patients of their individual plan of care, treatment goal and lifestyle change goals. As the evidence accumulates with these forms, it will be interesting to conduct a review of the data to assess progress in patients' knowledge and understanding of their care plan, as an indirect measure of the quality of health education.

HCS monitoring visits include 4 components: 1) reorganization of work and the functioning of HCS in the HC 2) use of homecare equipment 3) review of the patient's nursing chart 4) observation of the home visit.10 The package of HCS monitoring tools made available by HAP to the monitoring teams contains instructions and checklists related to each of the 4 components, including tools related to the "health education". For example, indicator number 6 supports the verification of health education, such as ''Providing counseling sessions for the patient/family member'', which is referenced in point 4.3 of 'Checklist No. 3: Review of the patient's nursing chart, and point 12 of Checklist No. 5: Observation of the home visit ''Does the nurse provide counseling/instructions to the patient/family member in response to the health situation presented by the patient on the day of the visit?''. This complete set of tools was used during the 35 monitoring visits conducted by regional HO and LUHCs, coached by HAP, during the period January 2024-February 2025.

3. ANALYSIS AND RECOMMENDATIONS

3.1 Strengthening the quality of patient education during PHC consultations with NCD patients/the elderly

HAP contributed to the standardization of NCD patient education by providing evidence based HE content. This material is used for the training of health providers and during patient-provider interactions. The communication skills of health providers, however, are not directly addressed although counselling skills training was provided in earlier phases of HAP. While individualized care plans are promoted, it is unclear to what extent patients are involved in care planning or decision-making or give feedback within the frame of PHC consultations.

The HAP project being in a consolidation phase, it may not be relevant to start a new training programme on communication skills or motivational interviewing which requires extended support to achieve results.

[10]https://www.hap.org.al/wp-content/uploads/2023/11/Manual-Trajnimi-mbi-Monitorimin-e-Jashtem-te-zbatimit-KSHB_2023.pdf

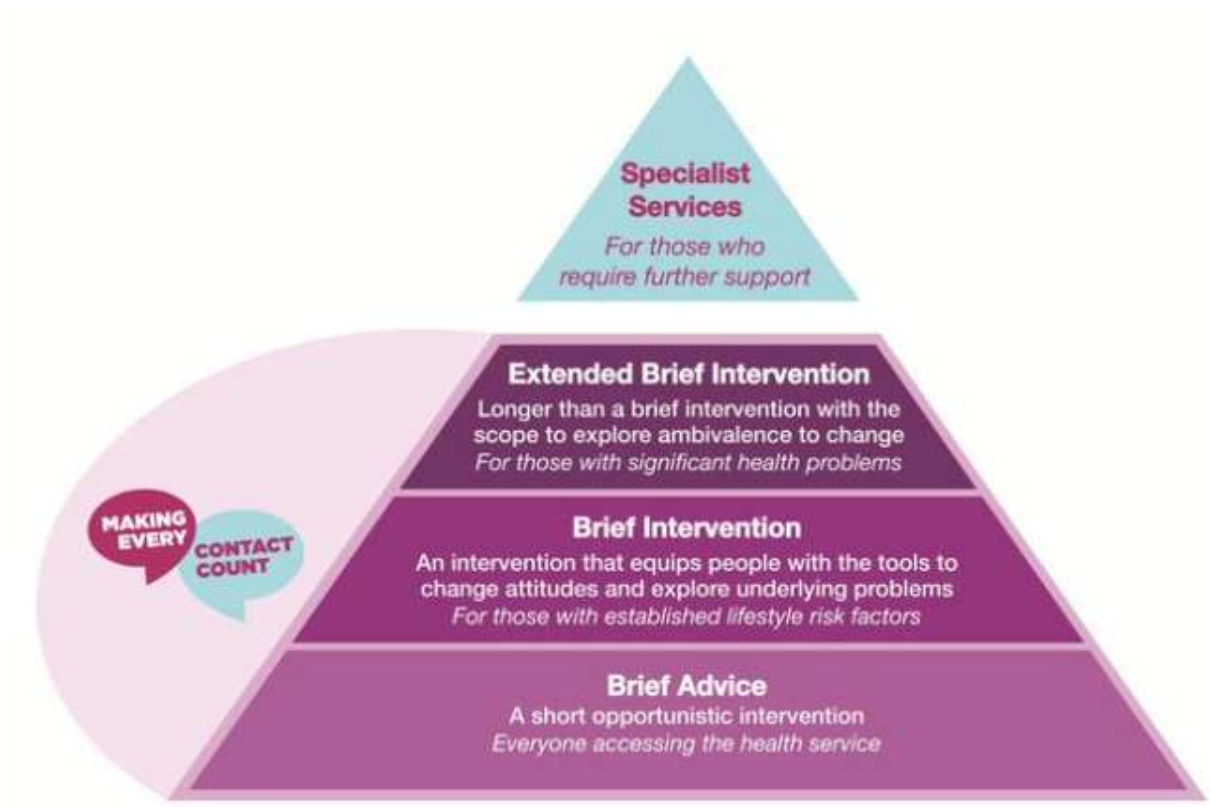
Instead, we can propose the address of this aspect through two main approaches: 1) the introduction of simple tools and techniques ("discussion frameworks") that enhance patient-centered conversations, and 2) tailoring the role of the psychologist at PHC level to support improved health education and behavior change.

3.1.1 Introduction of simple "discussion frameworks" to structure and improve the patient-provider communication

Brief interventions are a technique used in patient consultations to initiate change for an unhealthy or risky behavior such as smoking, lack of exercise or alcohol misuse. Brief interventions are recognized by WHO as an effective measure.[11] Brief interventions are typically 5 to 15 minutes and are reinforced over future patients' visits.

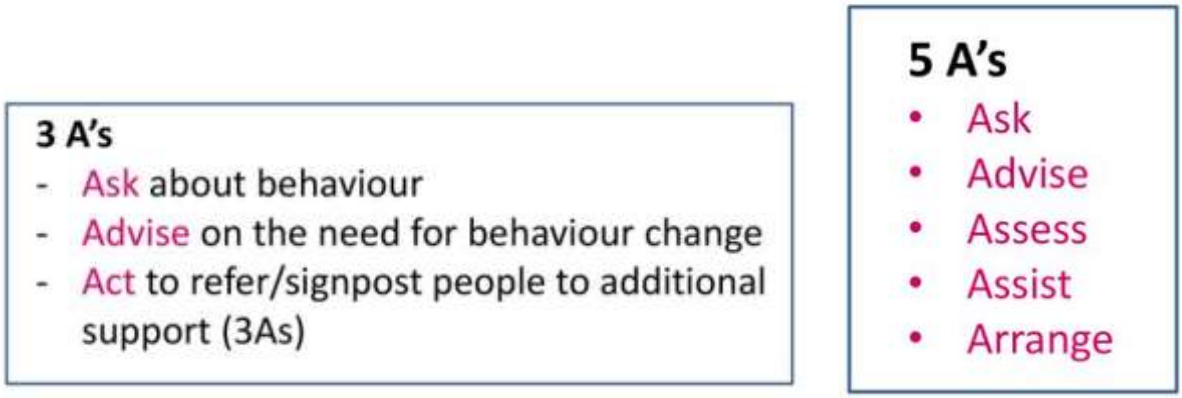
The UK model of Brief Interventions/Very Brief Interventions as part of the "Make Every Contact Count" (MECC) framework is well-documented and provide practical resources and toolkits to adapt these interventions to the Albania context.[12]

Brief interventions or brief advice can be implemented during PHC consultations by following simple "discussion frameworks" such as the 3 A's or the 5 A's, that structure the patient-provider conversation in a way that empowers patient.



[11] Integrated brief interventions for noncommunicable disease risk factors in primary care: the manual. BRIEF project. Copenhagen: WHO Regional Office for Europe; 2022. https://www.who.int/europe/publications/i/item/9789289058551

[12] https://www.e-lfh.org.uk/programmes/making-every-contact-count/ MECC Toolkit



Discussion frameworks help "frame the discussion, allowing for partnership working with the patient and their family and enabling the development of the knowledge, skills and confidence to manage and make informed decisions about their own health."[13] (See Annexe 3 - Article on discussion frameworks and Annexe 4 – Flow diagram for brief advice discussion frameworks).

More information on how to tailor these discussion frameworks to the length of the consultation and local contexts in available in the WHO Brief manual.[14]

These discussion frameworks could be included in the CME system for PHC (Training of Trainers, Peer Groups) for capacity building and adaptation to the local context. The support of psychologists in PHC would be needed to lead on the integration of these tools and training of health provider (see section 3.1.2).

3.1.2 Tailoring the role of psychologists in PHC to HE/support behaviour change as part of individual care plans

HAP is currently preparing the elaboration of a manual for the psychologist operating in primary health care. This manual is meant to help standardise the role, activities and collaboration of the psychologist in PHC, and their interactions and collaboration with other PHC staff. [15] As per the ToRs currently advertised, "the manual will be an instrument for the training of psychologists in PHC enabling them to provide psychological services to patients with emotional and psychological conditions and situations such as depression, anxiety, addictions, chronic stress, adjustment to chronic illness or lack of adherence to medical treatment".

This intervention provides an important opportunity to engage the psychologists at PHC level in the strengthening of the quality of health education. This can be done in two complementary ways:

1) Psychologists' support to improve the patient-provider communication

As seen above, simple tools can be added to the PHC staff training to help frame HE conversations in a way that is supportive of patients (e.g. through the use of discussion framework tools, see section 3.1.1). The psychologist in the PHC team could play a pivotal role in ensuring continuous training of PHC staff on those tools and assisting them to make health communication more effective.

2) Central role of the psychologist for improving behaviour-change elements in the individual care plans.

As the basic package of PHC services is intended to promote individual care plans, psychologists can play a key role in adding more targeted behaviour change elements in the care provided to

[13] Craig L, Senior E, Mitchel M. Public health: PART 4 Behaviour change tools. Br J Nurs. 2019 Feb 14;28(3):152-153.

[14] Integrated brief interventions for noncommunicable disease risk factors in primary care: the manual. BRIEF project. Copenhagen: WHO Regional Office for Europe; 2022. https://www.who.int/europe/publications/i/item/9789289058551

[15] https://www.hap.org.al/wp-content/uploads/2025/03/ToR_Development_Training-Manual_psychologist-final.pdf

patients. Concrete elements will eventually be defined by the psychologists themselves in consideration of context, but one could suggest the following simple, evidence-based techniques:

- **Introducing a "behavioural contract"** as a formal engagement of the patient into his/her care plan and to improve adherence. A behavioural contract is "a written agreement that a patient makes with themselves, with healthcare practitioners, or with carers, where participants commit to a set of behaviours related to the care of a patient. Contracts aim to improve the patients' adherence to treatment or health promotion programmes." [16] Such "contract" helps establish a clear, mutually agreed-upon commitment. The patient and provider outline specific actions and goals which can boost accountability and motivation. This would also serve as a written documentation of the agreed upon goals, that the patient can take home and remind him/herself about. Currently, the CPG on asthma plans for an individual care plan form for patients with asthma. This kind of document, upgraded with targeted behaviour change elements, could be expanded to all chronic patients.
- **Goal Setting and Action Planning**[17]: The behavioural contract is usually accompanied by follow-up plans. Through goal setting and action planning, the psychologist in collaboration with the patient establish small, achievable goals that fit into their daily routine. This might include detailed action plans (e.g., setting specific times for physical activity or meal planning) and tracking progress over time. Regular review of these goals during consultations helps maintain focus and adapt the plan as needed.
- **Encouraging self-monitoring with regular feedback**[18]**:** This approach encourages patients to track key behaviours—such as medication adherence, physical activity, or dietary habits—using simple tools like journals or mobile apps. During follow-up visits, providers/psychologist can review these records with patients, offering constructive feedback and celebrating progress. This method helps patients become more aware of their behaviours, reinforces positive changes, and allows for timely adjustments to their action plans.

3.2 Developing targeted approaches to engage families and carers

Although family members/caregivers may be implicitly involved during home visits, there is no formal mention of approaches or tools to engage families systematically in the care process, especially for elderly or dependent patients. This leaves out a crucial part of the patient's support system.

Family engagement in healthcare is an important part of patient-centred care, especially for people with chronic illnesses, disabilities, or age-related conditions.[19] The HAP project could test models to target a more meaningful engagement of families for both general NCD patient consultations, and for home visits.

3.2.1 For general NCD patients' consultation

[16] Bosch-Capblanch X, Abba K, Prictor M, Garner P. (2007). Contracts between patients and healthcare practitioners for improving patients' adherence to treatment, prevention and health promotion activities. Cochrane Database Syst Rev. 18;2007(2):CD004808. doi: 10.1002/14651858.CD004808.pub3. PMID: 17443556; PMCID: PMC6464838.

[17] Bailey RR (2017). Goal Setting and Action Planning for Health Behavior Change. American Journal of Lifestyle Medicine., 13(6):615-618.

[18] Krukowski, R.A., Denton, A.H. & König, L.M (2024). Impact of feedback generation and presentation on self-monitoring behaviors, dietary intake, physical activity, and weight: a systematic review and meta-analysis. Int J Behav Nutr Phys Act 21, 3.

[19] Barnes MD, Hanson CL, Novilla LB, Magnusson BM, Crandall AC, Bradford G. (2020). Family-Centered Health Promotion: Perspectives for Engaging Families and Achieving Better Health Outcomes. Inquiry. Jan-Dec;57:46958020923537.

As HAP is supporting improved planning/scheduling of PHC consultations, it could be tested to encourage the presence of a family member of the NCD patients during one or several of the consultations and engage them in the care planning and decision-making. Because family members such as a spouse play a critical role in shaping behaviours and the general life environment, it might be strategic to engage them in the discussion on lifestyle modification for the patients. Involving family members in understanding the patient's condition can support patients' adherence and reinforce lifestyle changes discussed during routine PHC consultations. As an example of engagement model, family members can be engaged in the "behavioural contract" technique mentioned above, with a specific section dedicated to the role of the family member. An example of a behavioural contract mentioning the role of the family is included in Annexe 5.

3.2.2 For home care services

Similarly, HAP could test a more structured engagement of family caregivers during home visits. While families do currently receive health education during home visits, it is most likely done verbally and in an ad-hoc manner. It is unclear whether the on-site demonstration of technical acts by the nurse is sufficient for caregivers to perform these acts independently and correctly at home. This could be a case to provide visual, written and structured documentation to the caregivers as a support to the oral information provided during the visits.

Structured discussion frameworks discussed above (section 3.1.1) can also help make the health education more centred to the needs and learning possibilities of the caregivers. A 2021 study by Rojas-Ocana et al., which analysed care education interventions performed by nurses, and the factors that facilitate, or limit, health care training among caregivers, can provide additional insights to select specific educational approaches tailored to the Albanian context. [20]

An educational approach targeting caregivers should recognise and take into consideration the health needs and emotional states of caregivers. Caregivers often experience care provision as a burden affecting their health, emotional state and quality of life.[21] Caregivers often be chronic disease patients themselves. Health education during home visits could thus be provided in a way that does not increase the perceived burden of care and provide solutions to the difficulties they face. Involving the psychologists at PHC in approaches tailored to the Albanian context will be important. Models of engaging local CSOs/NGOs in providing group-based education and/or support to caregivers, either through on-site group counselling or online/phone-based chat group[22], could be tested.

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4. SUMMARY OF RECOMMENDATIONS

Dissemination and sustainability of the HE manuals

1. Promote the use of the Health Education Manuals in the frame of the annual check-up consultations for the general population > 35 years old.
2. Explore the opportunity to adapt the content of the manuals to become part of the HP course content at the Faculty of Medicine, and in collaboration with the current IPH initiative on motivational counselling.

Strengthening the quality of patient education

3. Develop capacity building options for PHC workers, especially nurses, in communication skills and health education during patient interaction, possibly building on motivational counselling skills and the experience of IPH in this domain.
4. As part of the monitoring visits on CPG implementation, conduct a review of the patient exit interview data to assess progress in patients' knowledge and understanding of their care plan, as an indirect measure of the quality of health education.
5. Pilot the introduction of simple tools to structure the patient-provider communication in a way that supports more engagement of the patient in decision-making of the care plan, e.g. "discussion frameworks" as per the Brief Intervention model.
    a. Engage the psychologist at PHC level in this pilot
6. Include in the role of the psychologist at PHC level the following 2 main elements:
    a. Supporting PHC staff in more effective patient-oriented communication, e.g. through the use of patient-centred discussion frameworks
    b. Integrate behaviour change elements as appropriate in the current care provision through for example a behaviour change contract with patients and families
7. Develop and pilot, with support from the health psychologist, targeted approaches to engage families and carers:
    a. In PHC consultations, engage family members in one or several patient's consultations to support adherence to treatment and build upon the patient's support system
    b. In HCS, provide more structured guidance to family caregivers, including through written documentation (e.g. discharge booklet/discharge summary), possibly in electronic format to mitigate budgetary challenge with printing.
    c. Explore the possibility to adapt the HCS guidance to account for the health needs and emotional states of caregivers, and include support to family caregivers as part of the service
    d. Explore the possibility of support to caregivers, through the PHC system or through NGOs/CSOs, either through group-based on-site or online support.

Advocacy

8. Continue the collaboration with Together For Life, with a specific focus on advocating for a dedicated budget for Home Care Services.

5. ANNEXES

5.1 Annexe 3 - Article on discussion frameworks

Public health: PART 4
Behaviour change tools

Lynn Craig, Subject Lead, Adult Nursing, and Senior Lecturer (L.craig@northumbria.ac.uk), **Emma Senior**, Senior Lecturer/Programme Lead, Adult Nursing, and **Michelle Mitchel**, Graduate Teacher, Northumbria University, Newcastle upon Tyne, discuss tools used to help patients change health behaviours

This article is the last in a series exploring the role of the nurse, midwife or other health professional in public health (Craig and Senior, 2018; Senior and Craig, 2019; Senior et al, 2019). This article will explore the tools that can be used in the Making Every Contact Count (MECC) approach.

As suggested in part 3 (Senior et al, 2019), the accumulation of small changes in individual lifestyle behaviours can create significant improvements in health (National Institute for Health and Care Excellence (NICE), 2014). Nurses are ideally placed to promote, advise on and support these small changes (Lawrence et al, 2016). As with any successful intervention, the nurse–patient relationship and the delivery of person-centered care are fundamental elements. Good communication skills that draw on both verbal and non-verbal communication and listening are paramount, leading to a trusting and supportive relationship whereby delicate and personal issues may be approached confidently by the health professional.

It is worth noting that individuals are more receptive to change during times that seem significant to them. It is beneficial to prompt changes when people are at their most receptive. Such times may be prompted by external events that disrupt prevailing patterns of behaviour. There are many times or events in an individual's life that may offer effective opportunities for intervention, such as religious holidays, or the start of the week, month or year. Positive or negative life events such as becoming a parent or losing a close relative may also be moments that prompt change (Hallsworth et al, 2016).

It is important that nurses understand what motivates people to change behaviours. Behaviour change models are helpful, as suggested in part 3 of this series (Senior et al, 2019) which discussed models set out by Becker (1974); Prochaska and DiClemente (1994) also used by the Royal College of Nursing (2016), and Michie et al (2011). There is also a drive for all nurses and other health professionals to use brief interventions (Public Health England, 2013; NICE, 2014) as discussed in part 2 (Senior and Craig, 2019).

The following tools offer useful guidance. They help frame the discussion, allowing for partnership working with the patient and their family and enabling the development of the knowledge, skills and confidence to manage and make informed decisions about their own health.

The first two discussion frameworks described below are useful when providing a very brief intervention, lasting 30 seconds to 2 minutes. The third tool is useful for brief and more extended interventions.

The three As intervention

This intervention uses the three As: ask, advice, assist (NICE, 2014). 'Ask' refers to asking if the patient is aware of or recognises a health issue. This can include, for example, asking a patient about their smoking status during a routine admission. The 'advice' stage is where the nurse advises them of the risks of their behaviour, for example, the risks of smoking and that smoking-cessation services can offer effective help to quit. Dependent on the patient's response, the nurse may then have the opportunity to 'assist' and refer the patient to other services such as an in-house specialist smoking cessation team, pharmacy staff or a practice nurse for ongoing support.

Motivational interviewing

Motivational interviewing is an effective counselling method that involves enhancing a patient's motivation to change through the resolution of ambivalence (Hall et al, 2012). Devised by Miller and Rollnick (2012), this simplified practice of motivational interviewing offers a solution to the challenge of delivering very brief interventions in healthcare settings as it enables the nurse to 'tailor motivational strategies to the individual's stage of change' as seen in the Prochaska and DiClemente (1994) transtheoretical model (Hall et al, 2012).

RULE is a useful mnemonic to use in motivational interviewing:

- Resist the 'righting reflex'
- Understand the patient's own motivations
- Listen with empathy
- Empower the patient.

The righting reflex relates to the notion that health professionals want to 'fix' problems and tend to advise patients about the steps to take to attain good health. If a patient is ambivalent about making a behaviour change, they will often resist such persuasion and will provide reasons why they must maintain their current behaviour. Resisting the righting reflex requires the nurse to suppress giving advice and instead explore the patient's motivation for behaviour change.

This will lead on to 'understanding your patient's motivations' as, ultimately, a change in behaviour will only be successful if it is underpinned by what the patient wants to do. Exploring the patient's desires and concerns will enable identification of potential barriers.

'Listen with empathy' refers back to the essential communication skills required. During the discussion there should be equal amounts of time spent talking and listening.

'Empowering your patient' requires working in partnership with the patient to identify how they have achieved successful changes in the past and to look at how to achieve the desired behaviour change. The

nurse should be encouraging and be optimistic that the patient can achieve their goal.

The FRAMES model

This model, by Miller and Sanchez (1993), takes the form of an extended intervention, initially created as a model for alcohol treatment. The approach has now been adopted to deliver a brief intervention lasting anywhere from 2 minutes to half an hour. The model, underpinned by motivational interviewing principles, allows for a deeper conversation with the patient in order to gain insight into health-related behaviours and lifestyle choices in order to motivate and support change. The acronym FRAMES means:

- Feedback
- Responsibility
- Advice
- Menu of options
- Empathy
- Self efficacy.

In this approach, giving feedback provides an opportunity to explore the patient's frame of reference, the risks and negative consequences that may arise from the current behaviour. For example, the patient may be unaware of the risks to their health and wellbeing from being overweight.

'Responsibility' brings the focus back to the patient, because the individual must first take responsibility for their health behaviour and then any decisions made about behaviour change.

'Advice' refers to the straightforward advice given to the patient about how to modify their current behaviour, giving the patient a vision of possible change.

The 'menu of options' is simply that—the nurse needs to be able to provide a range of behaviour change options/strategies that the patient can choose from. The nurse should explore with the patient how to manage risk and/or relapse situations and foster participation in the decision-making process.

As eluded to earlier, 'empathy' is fundamental. All interactions require an empathetic, respectful and non-judgmental approach.

Delivering such an approach with enthusiasm and positive reinforcement during the discussion will promote self-efficacy. Self-efficacy is a person's belief in their own ability to achieve goals. The nurse should express optimism that the individual can modify their substance use, diet, and so on, if they choose, and express confidence in their plans.

Conclusion

Nurses, along with midwives and other health professionals, are suitably placed to offer interventions that may improve the health and wellbeing of patients and their families. Three discussion frameworks have been explored to aid and assist with the goal of changing a patient's behaviour for the better in the MECC approach.

This series has identified the current drivers for MECC, highlighted the differing approaches to brief intervention, explored the theoretical underpinnings for behaviour change and offered some practical tools that will assist nurses in their routine daily practice. **BJN**

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LEARNING OUTCOMES

- Understand the range of behaviour change tools available to use when Making Every Contact Count
- Be aware of and able to use evidence to underpin practice related to behaviour change

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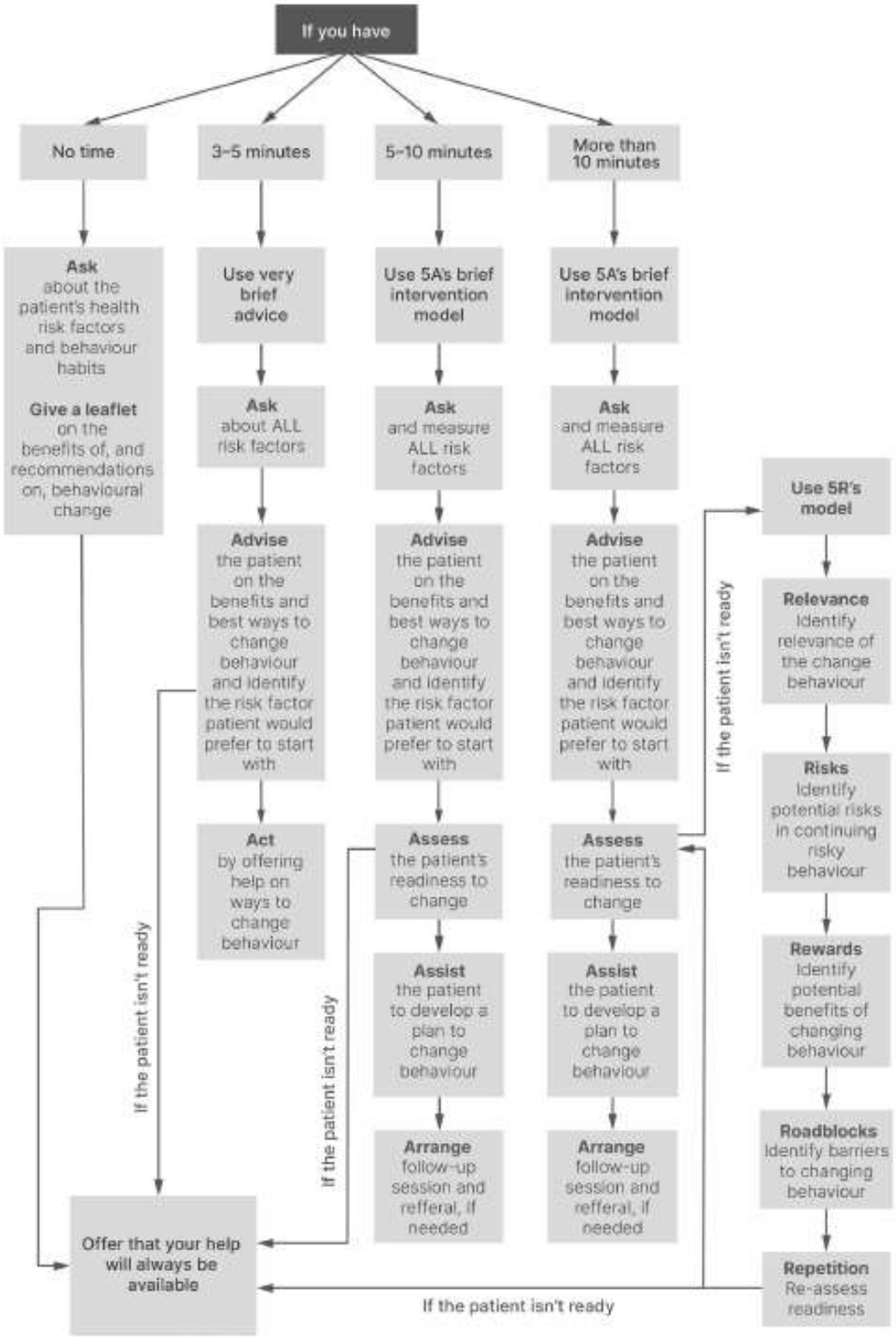
5.2 Annexe 4 – Flow diagram for brief advice discussion frameworks

Fig. A1.2. Flow diagram for helping people change exposure to risk factors – integrated approach



Source: Integrated brief interventions for noncommunicable disease risk factors in primary care: the manual. BRIEF project. Copenhagen: WHO Regional Office for Europe; 2022. Page 91.

5.3 Annexe 5 – Example of a behavioural contract with family role

Family Companion Sheet for NCD Consultations

Patient Name: _____

Family Member Present (Relation): _____

PHC Center / LUHC: _____

Date: _____

1. Summary of Today's Consultation

- Condition Update:

Blood Pressure: _____ Glucose Level: _____ Weight/BMI: _____

- Key Messages for Today (tick as appropriate):

[ ] Medication adherence

[ ] Reduce salt/sugar

[ ] Daily walking

[ ] Foot care

[ ] Smoking cessation

2. Family's Role (Agreed Today)

"What can you do to help?"

[ ] Remind patient to take medication

[ ] Help plan healthy meals

[ ] Join walks or physical activity

[ ] Monitor warning signs (e.g., dizziness, wounds)

[ ] Accompany patient to next visit

Family Note (optional): _____

_____

3. Follow-Up Plan

Next Appointment: _____

What to bring:

[ ] Medication list

[ ] Blood pressure/glucose log

[ ] Questions for the doctor

Signatures (optional, not binding):

Patient: _____ Family Member: _____ Nurse/Doctor: _____