CASE STUDY

Developing a structured obesity and nutrition training programme for primary care

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ABSTRACT

An optimal format for delivery of obesity training in primary care is still emerging. This article describes a structured training programme designed to overcome common barriers, assumptions of health care professional competence, scope of practice, and how to achieve patient health behaviour change. It covers factual information, behaviour change techniques and communication skills to safely raise sensitive issues, in addition to promoting discussion around local resources and facilitate interprofessional networking. The format proved successful in Malta and Uzbekistan despite their different public health challenges and health care systems. Learning points included appreciation of: motivational interviewing techniques; interactive role play; networking; and opportunity to consider local resource development. Time constraints were partially overcome by creating reusable course materials to support further cascade training. Interactive training involving clinicians from different settings can help engage clinicians who are unfamiliar with obesity prevention and management approaches, explore concerns around obesity stigma and shape the role of different health care professionals to promote a joined up approach across a health care workforce.

Keywords: OBESITY TRAINING, BEHAVIOUR CHANGE THEORY, COMMUNICATION SKILLS, PRIMARY CARE, NUTRITION

BACKGROUND

Training in delivering obesity and nutrition-related healthcare is a relatively new component of health care education, with little consensus over core content across countries, reflecting the recent emergence of obesity as a health priority. The recognition of modifiable lifestyle risk factors affecting noncommunicable diseases (NCDs) has focused attention on improving obesity management *(1, 2, 3)*.

There are many challenges to expanding training across primary care workforces. Firstly, with such a huge scope of subject matter, what exactly should be taught? The clinical positioning of obesity as a shared risk factor for a wide array of metabolic, physical and psychological conditions remains unclear. There is ongoing debate as to whether obesity is most usefully considered as a disease or as a risk factor. At present, only Portugal has officially recognized obesity as a chronic disease (since 2004), although many medical organizations class it as a disease *(4)*. Individual health professional roles and boundaries of responsibility are unclear: what exactly is each professional mandated to do or capable of achieving within their clinical role?

Assumptions around health professional proficiency in nutritional knowledge do not match reported health professional confidence *(5)*. There is lack of consensus and differing academic viewpoints around nutritional approaches (for example which dietary regimes are recommended to support weight loss) *(6)* plus commonly believed myths and misinformation amongst the public (for example: eating for two in pregnancy, the concept of feeding a cold and, "exercise made me breathless so it must be harmful").

Rolling out consistent training across allied health professionals requires time, teaching materials, funding and incentivization mechanisms to develop a pool of trained trainers who can then cascade their training on to more of the workforce. Conveying evidence-based information to patients requires locally-relevant materials to enable effective messaging and signposting.

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Whilst nutritional information is accessible and abundant it is also often conflicting and inconsistent *(7)*. Health professional confidence and ability to influence dietary behaviour change is low *(8, 9, 10)*. Evidence is accumulating around the positive impact of brief interventions, when adequate support is accessible within the community *(11)*. Health professionals in primary care fear causing upset from discussing weight with some justification *(12)* and lack awareness of communication techniques to influence behaviour *(13)*.

Several Member States have recently requested support in developing obesity training from the WHO Regional Office for Europe, a contrast with historical requests for malnutrition training.

LOCAL CONTEXT

The author (a British general practitioner with expertise in obesity training) was invited to develop a training programme, which has now been delivered in Malta and Uzbekistan. Both countries perceive nutrition-related public health challenges, despite very different obesity profiles (Fig. 1):

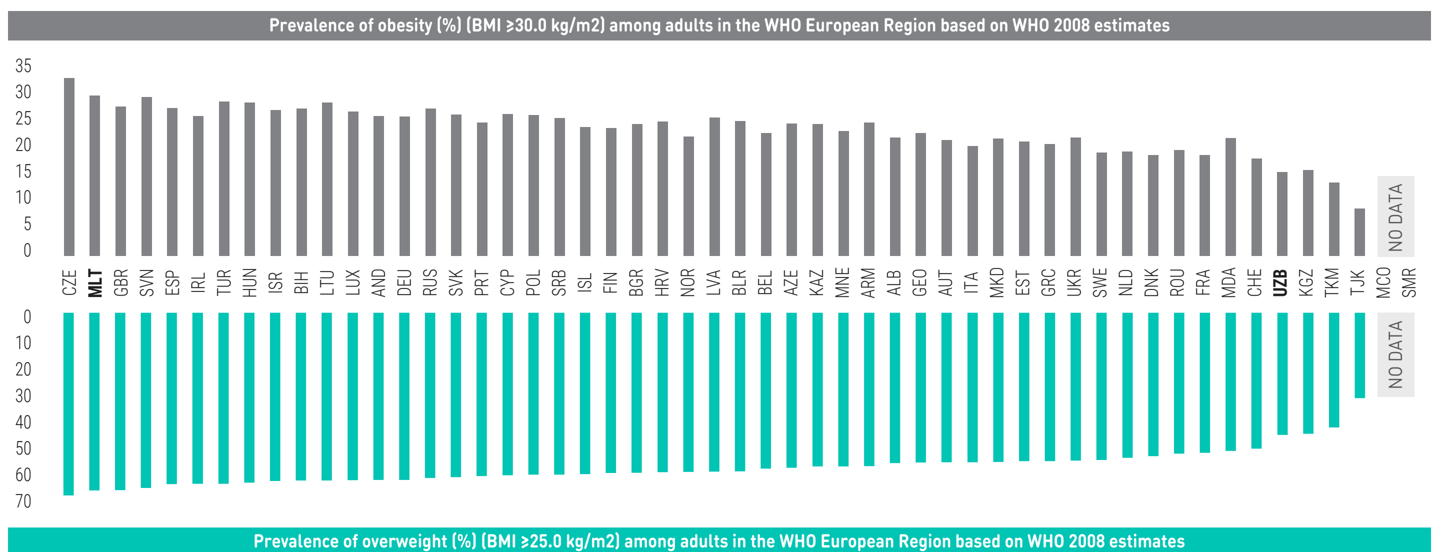
- Malta has high adult and child obesity rates (mean adult body mass index (BMI) of 27.8; 38.3% of 16–19 year olds are overweight or obese) but relatively low NCD mortality of 335 per 100 000 population. Malta has very high population density and is reliant on imported food *(14)*.

- Uzbekistan has lower obesity rates (Mean adult BMI of 25.8; 21% of 15–19 year olds are overweight or obese) but high rates of NCD mortality at 697 per 100 000 population *(3, 15, 16, 17)*, considered in part to be from high salt intake *(18)*. Whilst they have established nutrition programmes, there are currently no established obesity prevention or management programmes *(16)*.

APPROACH

The 2-day training programme structure was devised to address obesity training barriers at a meeting with colleagues in the Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe. Considering the professional conversation as an interventional tool, the course aimed to teach a conversational structure to address three fundamental questions:

FIG. 1. PREVALENCE OF OBESITY AMONG ADULTS IN THE WHO EUROPEAN REGION BASED ON WHO 2008 ESTIMATES *(17)*



Notes. The country codes refer to the ISO 3166-1 Alpha-3 country codes. Data ranking for obesity is intentionally the same as for the overweight data. BMI: body mass index.
Source: WHO Global Health Observatory Data Repository *(1)*.

1 Report on modelling adulthood obesity across the WHO European Region, prepared by consultants (led by T. Marsh and colleagues) for the WHO Regional Office for Europe in 2013.

The Regional Office is grateful to the European Commission (EC) for its financial support for the preparation of this country profile and the development of the nutrition, obesity and physical activity database that provided data for it.

- What to say: factual nutritional information – potential to highlight either local, national or international nutritional guidelines, for example the Eatwell Plate, the Food Pyramid and tiered weight management options including medication prescribing options.

- How to achieve behaviour change in practice: understanding how eating and activity behaviours develop and are influenced.

- Why me? Why now? Motivational aspects and the importance of goal setting: The course teaches a shared decision making approach and motivational interviewing, to promote patient empowerment and engagement *(19)*, as opposed to traditional advice giving, which can paradoxically result in resistance rather than compliance with advice.

In addition to discussing ways to sensitively raise the topic of weight, the course prompts a review of local resources to assess gaps and explore opportunities for developing local provision: the availability of patient information sources; local networking and incorporation into local health systems; updating on the use of child growth charts in obesity monitoring; and introduction to behaviour change techniques, particularly motivational interviewing *(20)*. It also explores the legitimacy of health professionals who are themselves overweight discussing obesity with their patients. The interactive workbook accompanying the course encourages participants to put learning into practice using role-play and case scenarios.

The workbook and annotated slide sets covering all the teaching approaches (available in English and Russian) were made freely available to delegates to facilitate further cascade teaching to other colleagues not present.

Each country decided which health professional delegates were invited, resulting in a mixed audience of community practitioners, academics, university teachers and public health personnel. Feedback evaluation was designed and collected by local organizers and reports sent to the course organizer.

RELEVANT CHANGES

Course feedback from the two countries showed similar themes even though underlying public health drivers were different in each country. These included:

- Strong interest in motivational interviewing techniques: the interactions during the course and from feedback evaluation highlighted that delegates accepted the need to challenge and move beyond traditional health professional approaches of, "telling patients what to do", and recognized that this approach risks entrenched resistance behaviour – the, "yes, but…" response. Delegates were unaware of evidence for empowering behaviour change, which stems from unlocking patient-directed goals using structured support to overcome barriers to change *(21)*. The motivational interviewing sessions were rated very favourably as this method was unfamiliar to the majority of attendees.

In response to the question "What struck you as interesting, new or meaningful during this workshop?"

  - "The concept of not just lecturing the patient but hearing him/her and leading him to motivate himself to go for change".
  - "The way you ask the question makes a lot of difference."
  - "How to unlock the client's motivation and implement behavioural changes in difficult cases."

- Time limitations: many delegates expressed a desire for more time to practice the techniques and explore the case scenarios. Engaging in role play was a successful introductory format, but any potential to expand the interactive elements of the course to allow embedding of the techniques had to be balanced with limited time to convey the factual elements. Suggestions to overcome time limitations included videotaped case examples, development of pre-course e-learning to enable the array of practical and theoretical material to be conveyed efficiently, and running the course over several half days to improve concentration and participation.

Do you feel more confident in your ability to integrate these techniques in your own practice?

  - "Yes, but I will definitely need more practice and courses."

- Awareness of the wider multidisciplinary team: the networking opportunities in meeting allied health professionals was reassuring in conveying a shared sense of responsibility for a challenging issue, as well as highlighting services they were previously unaware of in their region. The group discussions around local service availability generated an evaluation of gaps in provision as well as awareness of available options.

  - "I think it was very well organized and the most important of all is that we met with other professionals and discussed the services."

- "During the course I learnt of services which I did not know existed as I come from the dental field."
- "One change is the way that I will talk to patients and help to motivate them. I will also make contact with other professionals who can help my patients to reach their goals."

- Review of local patient and health professional resources: the course referenced existing WHO resources (where available), or referred to existing web-accessible American or British resources. Creation of professional training materials and local patient information resources that give locality or culturally relevant information were recognized as development priorities in both countries, with delegates making use of networking discussions to explore ideas on their development. Discussions highlighted that delegates in university environments felt empowered to explore resource development, reflecting their educational role, and also that the school curriculum could be harnessed to convey health messages.
    - "As an island we need to map our resources."
    - "We plan to implement development of training materials in the field of nutrition and physical activity."

LESSONS LEARNED AND RECOMMENDATIONS

In any multidisciplinary specialty, each team member should have a defined role to avoid inefficient duplication of work and blurring of accountability. In areas where obesity management is a new element of primary care's remit, training courses provide a mechanism to define specific responsibilities and expectations of local staff *(22, 23)*.

A main focus of primary care weight management discussions is to raise awareness of the relevance of obesity to health and to signpost to ongoing long-term support (such as a community weight management group). Generating repeated conversations over time can help patients to engage, re-engage and modify their goals at different stages of success or disengagement. This facilitates transitioning from short-term effort to long-term behaviour change *(24)*.

An optimal format for obesity training in primary care is still emerging. Despite assumptions that staff are already competent, confidence is currently low and structured training in core topics has been positively received. In addition to factual knowledge, behaviour change techniques and communication skills are fundamental. Future courses should ensure adequate time is allocated to practicing unfamiliar communication techniques alongside didactic teaching. The opportunity to network with allied colleagues, review local resources and brainstorm local solutions was particularly valuable. The flexible, interactive format described here and the resources which enabled further cascade training of local staff was an acceptable format for promoting health professional engagement in front-line obesity management skills in primary care, across different countries.

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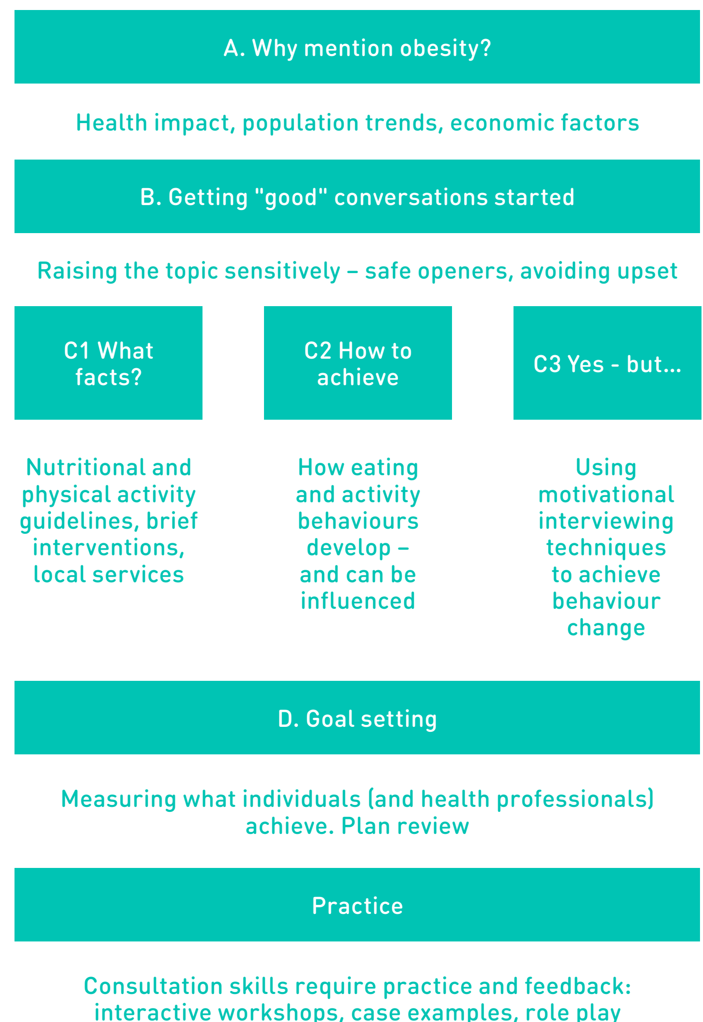
FIG. 2. OUTLINE OF COURSE COMPONENTS *(20)*



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