## WHO PEN Protocol 2
### Health Education and Counseling on Healthy Behaviours
(to be applied to ALL)

### Educate your patient to
- Take regular physical activity
- Eat a "heart healthy" diet
- Stop tobacco and avoid harmful use of alcohol
- Attend regular medical follow-up

### Take regular physical activity
- Progressively increase physical activity to moderate levels (such as brisk walking): at least 150 minutes per week
- Control body weight and avoid overweight by reducing high calorie food and taking adequate physical activity

### Eat a heart healthy diet
- **Salt (sodium chloride)**
  - Restrict to less than 5 grams (1 teaspoon) per day
  - Reduce salt when cooking, limit processed and fast foods
- **Fruits and vegetables**
  - 5 servings (400-500 grams) of fruits and vegetable per day
  - 1 serving is equivalent to 1 orange, apple, mango, banana or 3 tablespoons of cooked vegetables
- **Fatty food**
  - Limit fatty meat, dairy fat and cooking oil (less than two tablespoons per day)
  - Replace palm and coconut oil with olive, soya, corn, rapeseed or safflower oil
  - Replace other meat with chicken (without skin)

### Stop Tobacco and avoid harmful use of Alcohol:
- Encourage all non-smokers not to start smoking
- Strongly advise all smokers to stop smoking and support them in their efforts
- Individuals who use other forms of tobacco should be advised to quit
- Alcohol abstinence should be reinforced.
- People should not be advised to start taking alcohol for health reasons
- Advise patients not to use alcohol when additional risks are present, such as:
  - driving or operating machinery
  - pregnant or breast feeding
  - taking medications that interact with alcohol
  - having medical conditions made worse by alcohol
  - having difficulties in controlling drinking

### Adherence to treatment
- If the patient is prescribed a medicine/s:
  - teach the patient how to take it at home:
  - explain the difference between medicines for long-term control (e.g. blood pressure) and medicines for quick relief (e.g. for wheezing)
  - tell the patient the reason for prescribing the medicine/s
- Show the patient the appropriate dose
- Explain how many times a day to take the medicine
- Label and package the tablets
- Check the patient’s understanding before the patient leaves the health centre
- Explain the importance of:
  - keeping an adequate supply of the medications
  - the need to take the medicines regularly as advised even if there are no symptoms

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**Key Points**

- **Salt:** Restrict to less than 5 grams per day.
- **Fruits and vegetables:** 5 servings per day.
- **Fatty food:** Limit to less than two tablespoons per day.
- **Physical activity:** Progressive increase to moderate levels (150 minutes per week).
- **Tobacco use:** Encourage non-smokers, advise smokers to stop, and advise against other forms of tobacco.
- **Alcohol:** Abstinence recommended, with guidelines for safe use.
- **Medication adherence:** Teach patients about their medicines, their purpose, and how to take them correctly.
I. Protocols for primary care

A1: ASK

Do you use tobacco?

NO

Reinforce message that tobacco increases risk of heart disease

A2: ADVISE

YES

Advise to quit in a clear, strong and personalized manner

“Tobacco use increases the risk of developing a heart attack, stroke, lung cancer and respiratory diseases. Quitting tobacco use is the one most important thing you can do to protect your heart and health, you have to quit now.”

A3: ASSESS

Are you willing to make a quit attempt now?

YES

Assist in preparing a quitting plan
Set quit date
Inform family and friends
Ask for their support
Remove cigarettes/tobacco
Remove objects/articles that prompt you to smoke
Arrange follow up visit*

NO

Promote motivation to quit
Provide information on health hazards of tobacco and give leaflet to the patient

A4: ASSIST

A5: ARRANGE

At follow-up visit
Congratulate success and reinforce
If patient has relapsed, consider more intensive follow-up and support from family

* Ideally second follow-up visit is recommended within the same month and every month thereafter for 4 months and evaluation after 1 year. If not feasible, reinforce counseling whenever the patient is seen for blood pressure monitoring.