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# The Cultural Adaptation Project of Health Education Material for the Finnish Red Cross

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The Cultural Adaptation Project of Health Education  
Material for the Finnish Red Cross

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**Kulttuurinen Adaptaatio -Projektin Terveyden Edistämisen Materiaalista Suomen Punaisen Ristin Käyttöön**

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Projektin tarkoituksena oli valikoida, käännettävä ja arvioida sekä kulttuurisesti adaptoida Punaisen Ristin ja Punaisen Puolikuun Kansainvälisen Liiton (IFRC) tuottamaa terveyden edistämisen materiaalia tarttumattomista sairauksista Suomen Punaisen Ristin (SPR) terveystieteiden käyttöön.

Projektissa käytettiin osallistavia menetelmiä, ja materiaalista kerättiin arvioita mahdollisimman monelta terveystietevapaaehtoiselta ja heidän asiakkaaltaan. Palautetta kerättiin ensin Valtakunnallisilla terveystietevapaaehtoisilla huhtikuussa 2016 pienryhmytyöskentelyllä. Arviointia varten kehitettiin palautelomake, jolla kerättiin palautetta myös terveystieteistä. Palautteet yhdistettiin, avoimet vastaukset ryhmiteltiin teemojen mukaisesti ja palautelomakkeen tulokset analysoitiin SPSS-ohjelmalla. Palautteiden pohjalta tehtiin ehdotus muutoksista materiaaliin. Muutosehdotukset käytiin läpi Suomen Punaisen Ristin terveydenhuollon asiantuntijan kanssa ja hyväksyttiin.

Projektin tuloksena kehitettiin käyttökelpoista ja kulttuurisesti sopivaa materiaalia tarttumattomien sairauksien ehkäisyyn SPR:n terveystieteillä. Lisäksi esitettiin suosituksia terveystieteiden terveyden edistämistyön toteuttamisen tueksi. Materiaalia voidaan hyödyntää myös muissa SPR:n toimintamuodoissa, kuten ensiapukoulutuksessa, ja se tulee olemaan järjestön ulkopuolisten tahojen käytössä. Erityisesti kyselylomake terveystietevapaaehtoisineen on käyttökelpoinen monessa yhteydessä, varsinkin asiakastyössä.

Projektissa käytettiin Terveystietevapaaehtoisuusmallia (McKenzie, Neiger ja Thackeray 2013), jota myös terveystieteet voivat hyödyntää tulevissa projekteissaan. Projektin arvioinnin pohjana käytettiin European Center for Disease Prevention and Control (ECDC) tuottamaa opasta "Translation is not enough - cultural adaptation for health communication materials" (2016) sekä Suitability Assessment of Materials (SAM) -arviointikriteereitä jäsentämään materiaalin arviointia. Teoriapohjana kyselylomakkeen muokkaukselle sekä suosituksille terveyden edistämisen tueksi käytettiin Terveystietevapaaehtoisuusmallia (Health Belief Model) sekä Transteoreettista muutosvaihemallia (Trans-Theoretical Model).

Projektin tuotti tietoa kansainvälisen terveyden edistämisen materiaalin kulttuurista adaptatiota varten. Materiaalit vaativat paljon työstämistä sekä ennen käännoityötä että sen jälkeen. Tätä työtä varten olisi tärkeää saada IFRC:n materiaalit kansallisten Punaisen Ristin yhdistysten käyttöön helposti työstettävässä muodossa. Prosessille tulee varata riittävästi aikaa, sekä seurata mahdollisuuksien mukaan ECDC:n tekemää opasta.

Materiaali ei ole valmis, vaan vaatii jatkuvaa arviointia, palautteen keruuta ja korjausta. Materiaalipakettiin olisi hyvä myös liittää osio muista kroonisista sairauksista, jotka ovat haaste kansanterveydelle Suomessa.

**Asiasanat: Suomen Punainen Risti, kulttuurinen adaptaatio, tarttumattomat sairaudet, terveyden edistäminen, terveyden edistämisen materiaali**

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The goal of the project was to choose, translate, evaluate and culturally adapt health education material about noncommunicable diseases produced by the International Federation of Red Cross and Red Crescent Societies (IFRC) for the use of the Finnish Red Cross Healthpoints.

Participatory methods were used during the process, and the aim was to get feedback of the material from as many Healthpoint volunteers and clients as possible. Feedback was collected first by group work during a national Healthpoint seminar in April 2016. A feedback survey was developed for collecting feedback at individual Healthpoints. The answers were integrated, open answers classified according to theme, and surveys analyzed with SPSS program. Based on the feedback a suggestion list was compiled for making changes in the material. Suggestions were viewed and approved by the Adviser in Health Promotion at FRC.

The project resulted in useful and culturally appropriate health education material about noncommunicable diseases for FRC Healthpoints. Recommendations to support health promotion activities were provided as well. The material can be utilized by other FRC activities, such as first aid training, and by different actors conducting health promotion outside FRC. Especially the Risk Assessment Card is useful in many situations, particularly in individual discussions about health.

A health project plan model was used to structure the project (McKenzie, Neiger and Thackeray 2013), that can also be utilized by Healthpoints in future projects. A guide by the European Center for Disease Prevention and Control (ECDC) called "Translation is not enough - cultural adaptation for health communication materials" (2016) and Suitability Assessment of materials (SAM) -categories were used to aid in the construction of the evaluation. The changes made in the Risk assessment Card and recommendations for health promotion were based on the Health Belief Model and Trans-Theoretical Model.

The project produced information about the cultural adaptation process of international health education material for the future. The text requires a considerable amount of work before translation as well as after. For this reason it would be important to get the IFRC material in an easily editable document form. It is beneficial to reserve enough time for the process, and follow the ECDC guide as closely as possible.

The material is not ready yet, but requires ongoing evaluation, collection of feedback and corrections according to need. It would also be useful to add sections of other chronic diseases which present a challenge for Finnish national health.

**Keywords: Finnish Red Cross, cultural adaptation, noncommunicable diseases, health promotion, health education material**

## Abbreviations

CBHFA	Community Based Health and First Aid
ECDC	European Center for Disease Prevention and Control
FRC	Finnish Red Cross
HBM	Health Belief Model
IFRC	International Federation of Red Cross and Red Crescent Societies
NCD	Non-communicable diseases
SPR	Suomen Punainen Risti, Finnish Red Cross
THL	Terveystieteiden tutkimuskeskus, National Institute for Health and Welfare
TTM	Trans-theoretical Model (Stages of Change)
HQ	Headquarters
WHO	World Health Organization

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## 1 Introduction

Noncommunicable diseases (NCDs), i.e. cardiovascular disease, diabetes, cancer and chronic respiratory disease, present a major threat to public health both in Finland and globally (Terveyden ja hyvinvoinnin laitos THL 2015a; World Health Organization WHO 2014). World Health Organization's (WHO) Global status report on noncommunicable diseases 2014 states, that NCDs cause more deaths than all other causes combined (38 million deaths per year of total 56 million deaths per year in 2012). Globally approximately 42 % of NCD deaths occur before age of 70 years. 82 % of NCD deaths in people under 70 years occur in low-and middle income countries (WHO 2014).

Healthy lifestyles can prevent a major part of noncommunicable diseases. Health behaviors (including tobacco use, diet, physical activity and other health behavior) account for approx. 50 % of all premature mortality (Velicer et.al. 2000). Biggest causes of NCDs globally are alcohol (cause of 3 % of NCD deaths), insufficient physical activity (3.2 million deaths per year; inactivity accounts for 20-30 % of increased risk of all-cause mortality), tobacco (6 million deaths per year), raised blood pressure (9.4 million deaths per year) and obesity (3.4 million deaths per year). (WHO 2014.)

There are large number of studies showing the effect of healthy lifestyle on risk for NCDs and mortality rates. A Japanese cohort study found approximately 8-10 years increase in life expectancy in people with healthy lifestyles (Tamakoshi et.al. 2010). According to an American study among nurses a major part of coronary heart disease and clinical cardiovascular disease risk factors were attributable to poor adherence to a healthy lifestyle (Chomistek, Chiuve, Eliassen, Mukamal, Willett & Rimm 2015).

The FINRISK study in 1972-2012 showed clearly the power of healthy lifestyles in disease prevention. The intervention program was implemented amongst working age population in 1972 first in Eastern Finland (North Karelia and Northern Savo), and subsequent study years in other regions in Finland, to combat one of the highest coronary heart disease (CHD) rates in the world. The program managed to decrease CHD mortality rates by 80% by interventions in vegetable consumption, reduced saturated fat and sodium intake, and reduced smoking rates. However, in recent years' studies, the population cholesterol levels and diastolic blood pressure have shown increases, which is a concern. The researchers emphasize the need for continuous support and efforts for health promotion and disease prevention. (Borodulin et.al. 2014.)

There is evidence about positive effects by interventions designed to change lifestyles to healthier direction. Dietary advice appears to affect risk factors in diet and cardiovascular

disease beneficially (Rees, Dyakova, Wilson, Ward, Thorogood & Brunner 2013). Dietary advice is part of the health promotion work performed by health professionals and volunteers in different organizations, such as the Red Cross.

The International Federation of Red Cross and Red Crescent Societies (IFRC) is a global humanitarian organization, working with 190 National societies in responding to disasters, and supporting programs in, for example development work, disaster preparedness, health and care (IFRC n.d.). The NCDs toolkit, produced by IFRC in 2014 includes a Community toolkit of 82 pages, as well as a Facilitator guide and a Volunteer manual. This health education material is meant as a global tool for thousands of Red Cross volunteers to aid in NCDs prevention and healthy lifestyle promotion.

The Finnish Red Cross (Suomen Punainen Risti, SPR) is a part of the IFRC, and one of Finland's biggest volunteer organizations with 40 000 volunteers and 86 000 members. There are 67 Finnish Red Cross (FRC) Healthpoints in Finland, which offer free services and different activities by volunteer nurses. The volunteers measure for example blood pressure and offer health advice and psychological support. The Healthpoints organize also events and group meetings. (SPR no date a.)

The IFRC toolkit about NCDs cannot be simply translated and distributed to volunteers without adaptation for use in Finland. According to the European Center for Disease Prevention and Control (ECDC), cultural adaptation process is beneficial, in addition to translation, when implementing international health promotion material for national use. The Finnish Red Cross will use the NCDs material as a tool for health promotion at Healthpoints after the cultural adaptation.

## **2 Project goals and objectives**

The project goal is to produce useful material for the prevention of noncommunicable diseases and promotion of healthy lifestyles at FRC Healthpoints. The material can also be used by other Red Cross volunteers, as well as health care professionals with different clients and employments outside the Red Cross.

The objective of the project is to culturally adapt health education material from the IFRC NCDs toolkit to the Finnish Red Cross Healthpoints' use by selecting, translating, evaluating and modifying the material. In addition, recommendations for health promotion at FRC Healthpoints were produced to help guide the activities for NCDs prevention and other health interventions in the future.



### 3 Noncommunicable diseases in Finland

In Finland the NCDs are part of the chronic illnesses that present a major effect on country's economy (THL 2015a). Cardiovascular diseases are the main group of death causes, resulting yearly in over 21 000 cardiac arrests and ischemic heart disease attacks and almost half of the deaths amongst people of working age. The most common cardiovascular diseases in Finland are coronary heart disease, congestive heart failure and disorders of the cerebral circulation. Over 12 000 Finnish people die yearly of coronary heart disease. In 2012 the mortality for cerebral circulation disorders was 1245 cases in Finland. (THL 2015c.)

Every 3rd person in Finland gets cancer at some point in their life. It is the second most common cause of death in Finland. Most common cancers are breast cancer in females, which every 8<sup>th</sup> woman gets at some point in life, and prostate cancer in males. Many cancers could be prevented with lifestyle choices, such as non-smoking and an active lifestyle. Some cancers can also be prevented through vaccinations or medication. Early detection is also important for mortality. (THL 2014a.)

Diabetes causes long term raise in blood glucose, because of the lack of insulin in the body. There are two main types of diabetes: type 1 and 2. There are about 50 000 people suffering from type 1 diabetes, and 500 000 people from type 2 in Finland. Type 2 diabetes is most often preventable by healthy lifestyles. (THL 2014b.)

The most common chronic respiratory diseases in Finland are asthma and chronic obstructive pulmonary disease (COPD). Asthma is suffered by approx. 10% of the Finns, whereas COPD is presented in middle aged and older age group: 12% of men and 3% of women in ages over 64 years old. Smoking is almost always the cause for COPD and also affects onset and symptoms of asthma. (THL 2014c; Salomaa 2016.)

### 4 Health promotion at Finnish Red Cross Healthpoints

When volunteering at the FRC Healthpoints, it is beneficial to consider the different definitions of "health". Health is described in the Constitution of World Health Organization (WHO) in 1946 as a "state of complete physical, social and mental wellbeing, and not merely the absence of disease or infirmity" (WHO 1946).

Health definitions are partly defined by cultural processes. According to Bircher (2005), the presence of symptoms is compatible with health - person might consider himself healthy even

with aches or pains. He suggests the following description of health: “Health is a dynamic state of wellbeing characterized by a physical, mental and social potential, which satisfies the demands of a life commensurate with age, culture, and personal responsibility. If the potential is insufficient to satisfy these demands the state is disease” (Bircher 2005, 336).

It is impossible to give all clients identical advice, since everyone has their own history, definition of health and what they are prepared to do for it. It is the Healthpoint volunteer’s job to find out what each client’s priorities are, what they want help with and how they want to be helped.

There are several levels and perspectives to health promotion. It can be seen as promoting health at individual or community level. Health promotion can also be seen from health service and health politics viewpoint, or as creating environments that promote health. (Pietilä 2012.) The aim of health promotion is to improve people’s capacities in taking care of their health. Many choices, which individuals makes concerning health, are connected to possibilities and values of a certain society at a specific time. It is not only a matter of personal choice. There are many ethical matters and basic values to take into consideration, like value of humanity, self-determination, justice, accountability and participation. (Pietilä, Länsimies-Antikainen, Vähäkangas & Pirttilä 2012.)

Health education can be seen as a part of health promotion (Räsänen 2012). According to WHO’s definition, health education is “any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes” (WHO no date).

There are considerable differences in lifestyles, economic situations, education levels, morbidity and mortality rates, as well as digitalization rates, in different parts of the world. Some things we in Finland (or in other high-income countries) take for granted, such as the possibility to move freely or buy nutritious food, is not at all guaranteed in many places. Health education is also at very different levels in different countries (WHO 2016; Williams et.al. 2015). Education about healthy lifestyles has been offered in Finnish schools since the beginning of the 19<sup>th</sup> century (Lindström & Eriksson 2012). Also the Finnish health services have been quite effective in informing people about healthy lifestyles from child welfare clinics, school health care to occupational health. However, there are big differences in socioeconomic levels in Finland, as well. When considering lifestyle choices and health, morbidity and mortality, there are clearly people more privileged than others. Even when the general well-being of Finnish population has increased, the inequality between the socioeconomic groups has grown. This means inequalities in health as well. (THL 2015b.)

To give people basic information about risk factors and lifestyles it is not enough in Finland (or other high-income countries). It would be more beneficial to concentrate more on giving tools to change behavior, and process of making healthy choices. Basic information can, on the other hand, be important especially with lower socioeconomic status groups.

There are 67 Finnish Red Cross Healthpoints across the country at the moment. They are part of the volunteer work organized and governed by the local FRC branch. There is always a professional nurse (most often retired) responsible for the Healthpoint, and the client health advice is given by nurses. The Healthpoints offer voluntary and free guidance, support and advice on matters concerning health. (SPR no date b.)

Actual health care is not given at Healthpoints, but the client is referred to official health care if needed. Recommendations from Current Care Guidelines (Käypähoito) are followed. Health promotion includes most often measurement of blood pressure, weight, Body Mass Index (BMI), and sometimes blood glucose. The nurses also give health advice, general support and referrals to further care when needed. (SPR 2013.)

Healthpoints have very diverse activities, from individual guidance to lectures, theme days, groups and events. They may have a fixed location at the Red Cross offices or local service center, or it might be a mobile clinic, moving to where the need is. The services are open and free for all. Most clients are senior citizens or unemployed.

### **Health behavior change theories at the Red Cross**

IFRC's Global Health Team released the Strategic Operational Framework for Health in 2011, contributing to the aims of Strategy 2020. One of the four key initiatives is about further developing Behavioral Change expertise in the Federation, since current health trends are greatly determined by lifestyle factors, and Behavior Change is seen as a crucial component in most health programs. (Claxton 2012.)

IFRC Behavior Change Framework (2012) concentrates mostly on actions for community level behavior change, but also explains individual level change by different theories (Table 1). The explanations of behavior include for example learning and understanding behavior, fear-prompted behavior, attitudes, norms, and self-belief. (Claxton 2012.)

Explanations and theories of health behavior (Claxton 2012)	
Explanation	Evidence-Based Theory
Learning of behaviour	Learning Theories
Understanding of behaviour	Theories of information processing
Fear Prompted Behaviour	Health Belief Model, Protection Motivation Theory & Etended Parallel Process Model
Attitude, Norms & Self-Belief Behaviour	Theories of Reasoned Action, Planned Behaviour & the Integrated Behavioural Model
Goal-setting for Behaviours	Goal-setting Theory
Motivated for Behaviour	Theories of goal-directed behaviour
Automatic and Impulsive Behaviours	Theories of automatic behaviour, impulsive behaviour, and habits
Stages of Behaviour	Transtheoretical Model of Behaviour Change
Stages & Environment of Behaviour	Precaution-Adoption Process Model & Risk Communication
High Barrier Behaviours	Attribution Theory & Relapse Prevention
Persuasively Communicating Behaviour	Communication Persuasion Matrix
Comparisons for Behaviour	Elaboration Likelihood Model
Willpower Behaviours	Theories of self-regulation
Dual-Use Behaviours	Social Cognitive Theory
Stigma Behaviour	Explanations of Stigma & Discrimination
New Behaviours	Diffusion of Innovations Theory
Environmental Behaviours	Systems Theory
Empowering Behaviours	Empowerment Theory
Power in Behaviour	Theories of power
Support Network Behaviour	Social Networks and Social Support Theories
Healthy Organizational Behaviour	Organizational/Diffusion Theories
Stakeholder Behaviour	Stakeholder Theory
Social Norms Behaviour	Social Norms Theories
Problem-solving	Behaviour Conscientization Theories
Community Leaders Behaviours	Social Capital Theory
Community Mobilization Behaviour	Community Organization Theory
Community Influenced Behaviour	Coalition Theory
Behaviour in Policy	Agenda-Building Theory, Multiple Streams Theory , Advocacy Coalition Framework (Societal)

Table 1: Health Behavior explanations

The multiple explanations and models of health behavior explained in the IFRC document require further development to be used by volunteers implementing health promotion interventions at Healthpoints. Health Belief Model (HBM) and Trans-theoretical model are two useful tools when planning health promotion activities.

The Health belief Model (Figure 1) is helpful when trying to understand people's behavior regarding health, as well as planning preventive interventions. There are several factors influencing a person's readiness to take action, such as Individual Beliefs: perceived susceptibility and perceived severity, perceived benefits and perceived barriers, and perceived self-efficacy. Also Modifying Factors have effect, such as age, gender, personality, socioeconomics and knowledge. These lead to Individual behaviors, which are influenced still by Cues to action. (Rosenstock, Strecher & Becker 1988; Glanz no date.)

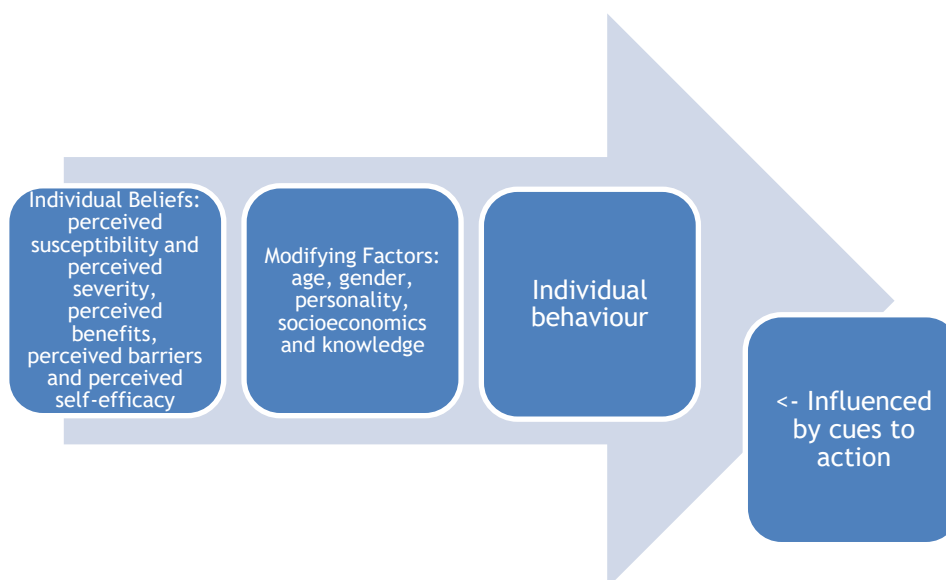


Figure 1: Health Belief Model modified from Glanz (no date)

The theory is beneficial when planning interventions, such as group sessions or individual meetings about NCDs at Healthpoints. The NCDs material influences peoples' perception on susceptibility and severity, as well as barriers and self-efficacy. These aspects are useful when conducting an intervention. It is beneficial to consider the modifying factors especially in individual meetings, but also as far as possible with groups.

The Trans-Theoretical Model (TTM) / Stages of Change emerged in 1980's as constructed by Proshaska and DiClemente, and has been developed further during later years. There are also several versions of the TTM and Stages of Change. Nowadays, it is usually described by 6 stages: precontemplation, contemplation, preparation, action, maintenance and termination

(Table 2). Research among smokers in USA has shown that approx. 40% are in precontemplation, 40% in contemplation and 20% in preparation phase in changing their health behavior. (Prochaska, Redding & Evers 2008.)

Stages of Change (Trans-Theoretical Model)	
Precontemplation	No intention to take action within the next 6 months
Contemplation	Intends to take action within the next 6 months
Preparation	Intends to take action within the next 30 days and has taken some behavioral steps in this direction
Action	Changed overt behavior for less than 6 months
Maintenance	Changed overt behavior for more than 6 months
Termination	No temptation to relapse and 100% confidence

Table 2: Trans-Theoretical Model according to Prochaska et.al. 2008

Without identifying the stage of change, which the client is in when counselling about healthy lifestyles and behavior change, the advice can have very little effect. This also has to be considered when giving health education on FRC Healthpoints.

In addition to Stages of change, there are also ten “Processes of change” identified, which describe the activities people use to process through stages of change. These include Consciousness raising, Dramatic relief, Self-reevaluation, Environmental reevaluation, Self-liberation, Social liberation, Counterconditioning, Stimulus control, Contingency management and Helping relationships. Decisional balance (pros and cons of changing), Self-efficacy and Temptation are also seen as valuable aspects to behavior change. (Prochaska et.al. 2008.)

These processes and aspects can act as guidelines in planning interventions and activities for health promotion, also for FRC NCDs prevention. The recommendations for integrating these theories into practice are described in chapter 6.

## 5 Cultural adaptation project of health education materials

This development project was requested by the Finnish Red Cross headquarters, and was implemented according to the project management model according to McKenzie, Neiger and Thackeray (2013 ) with the phases of

- Needs assessment
- Goal setting
- Choosing methods
- Execution of the project and
- Evaluation

(McKenzie et.al. 2013).

The time table was realized as follows:

1. Reading through the IFRC material, choosing the parts suitable for the FRC, getting approval of the FRC headquarters (by Annika Kaarnalehto, timeframe: January 2016 - February 2016)
2. Initial translation of the material, production of a project plan model (FRC QH/translation, and Annika Kaarnalehto/project plan, timeframe: February 2016 - March 2016)
3. Presentation of the initial material to Healthpoint volunteers, modification of the material and choosing pilot Healthpoints to test the NCDs material (FRC HQ and Annika Kaarnalehto, timeframe: April 2016)
4. Testing the NCDs material at Healthpoints (Finnish Red Cross Healthpoint volunteers, timeframe: May-June 2016)
5. Gathering feedback from the Healthpoint volunteers (post/e-mail), review and analyze of the feedback by SPSS program (Annika Kaarnalehto, timeframe: June 2016 - August 2016)
6. Suggestions for modifications to the material (Annika Kaarnalehto and FRC HQ, timeframe: August- September 2016)

Budget for the development project was 2500 euros, which was used for translation and layout of the material and was covered by the Finnish Red Cross. Research permission was acquired in 9<sup>th</sup> of May 2016 (Appendix 8).

## **Cultural adaptation process**

Culture is challenging to define. In “Communication between cultures” by Samovar, Porter and McDaniel (2010) culture is defined as human-made, learned and subjective part of our environment. It has elements such as values, attitudes, beliefs, history, religion and social organizations. Language plays an important part as a system of symbols. (Samovar et al. 2010.)

Gemignani and Pena (2007, 279) have described culture in social constructionist viewpoint as “shared and ever-changing organization of beliefs, interpretations and practices”. Culture is created by negotiation, internalization and expression of social behavior (Gemignani et.al. 2007). We might have clients from many different countries, age groups and cultural groups, but should not presume anything about a person’s beliefs, habits or identification to a specific culture. We cannot assume anything from a person’s way of clothing, age or education level. Assumptions in general should be avoided as professionals or volunteers, even if it is natural to have them.

When utilizing internationally produced health education materials, cultural adaptation is needed. According to the ECDC guide “Translation is not enough. Cultural adaptation of health communication materials”, this ensures that the end-users can read, understand and apply the material within their own context. The process creates adapted materials which reflect national or local realities, needs and assets without losing the scientific fact base, core concepts or messages of the original version. There are five steps to be followed:

- Careful selection of materials and process coordinators
- Early review by content and linguistic experts
- Translation and quality check
- Comprehension testing and proofreading
- Design, networking and evaluation.

(ECDC 2016.)

The ECDC guideline steps were used to structure the report for project methods and evaluation.

## **Existing health education material for noncommunicable diseases in Finland**

The official recommendations, and much of other information about NCDs, are available at the web pages and materials of the National Institute for Health and Welfare (THL, [www.thl.fi](http://www.thl.fi)). Ministry of Social Affairs and Health (STM, [www.stm.fi](http://www.stm.fi)) has also a number of ma-



terials, projects and recommendations concerning the subject. Official nutrition recommendations can be found from National Nutrition Council (Valtion ravitsemusneuvottelukunta VRN, [www.vnr.fi](http://www.vnr.fi)).

There is a large variety of materials being used for health promotion and NCDs prevention by health workers and volunteers. There are Current Care Guidelines (Käypä hoito -suositukset, [www.kaypahoito.fi](http://www.kaypahoito.fi)) on for example high blood pressure, coronary heart disease, dyslipidemias, diabetes, obesity, asthma, COPD and some cancers. These are independent, evidence-based clinical guidelines by Finnish Medical Society Duodecim ([www.duodecim.fi](http://www.duodecim.fi)), in association with various medical specialist societies. They concentrate on medical treatment, but include also recommendations for prevention and known risk factors.

Duodecim publishes also a website called Terveystieto (for health professionals) and Terveyskirjasto (for the public) with trustworthy information on most subjects on health ([www.terveyskirjasto.fi](http://www.terveyskirjasto.fi)). Most cities have also their own health care guidelines on various subjects in intranet, based on city health care management's recommendations.

Health care workers use different public health organizations materials and websites often, since they are considered reliable and experts in their own field. These include Finnish Heart Association (Sydänliitto, [www.sydanliitto.fi](http://www.sydanliitto.fi)), Finnish Diabetes Association (Diabetesliitto, [www.diabetes.fi](http://www.diabetes.fi)), Finnish Brain Association (Aivoliitto, [www.aivoliitto.fi](http://www.aivoliitto.fi)), Finnish Lung Health Association (Filha, [www.filha.fi](http://www.filha.fi)), Cancer Society of Finland (Syöpäjärjestöt, [www.cancer.fi](http://www.cancer.fi)), and Finnish Red Cross ([www.punainenristi.fi](http://www.punainenristi.fi)). Some of the materials (like brochures) are free, but some have a fee, which makes them more difficult to use.

On top of these, there are a huge number of different materials, presentations, brochures and associations on each subject found by searching the internet. Some of them are very useful and good, some not. This requires a great deal of media literacy and health literacy skills, for example knowledge about trustworthiness, content, sources and how up-to-date the information is (Mustonen 2002).

## 5.1 Needs assessment

The IFRC material about NCDs was developed in English as an international expert co-operation in 2014. It is aimed to be used worldwide, but translated and adapted according to need. The material is quite extensive, and designed to be used by non-professional volunteers as support material as a part of Community Based Health and First Aid (CBHFA) interventions, as an addition to the CBHFA manual. (Implementation and facilitator guide... 2014)

Because of the differences in education levels of Red Cross volunteers (professional or non-professional), and different forms of Health promotion in IFRC and FRC, it was not reasonable to translate the whole NCD package. It would also have been too costly. It was decided that suitable parts of the NCD Toolkit were selected in cooperation with FRC QH to be translated and evaluated at FRC Healthpoints.

The FRC Healthpoints have been working with health promotion and prevention of chronic illnesses for years. They have used material that has been available from different health organizations, as described in more detail previously. It has, however, been up to each individual Healthpoint volunteer to gather the material needed, and there has been large variation in the material use. Depending on each volunteer's professional background (nurses and public health nurses) they have used their own expertise, as well as material gathered over the years.

Not all of the volunteers are skilled at using internet, or have access to computers and/or printers. It takes up much of the volunteer's time to search for reliable and useful materials on each subject, order in brochures (if budget allows), prepare for a lecture and plan a health promotion session. Many volunteers have backgrounds in other types of work in health care besides public health, and not everybody is experienced in doing presentations, facilitating workshops or giving personal advice on healthy lifestyles.

To be able to provide FRC volunteers with reliable, easy-to-use material, with instructions and education on the use, and to guarantee high quality health promotion in all of the FRC Healthpoints, we need a tool such as NCDs toolkit to be translated and culturally adapted to Finland.

In Finland we talk more about chronic (national) disease (Kansantaudit), which include other illnesses besides the four NCDs. These aspects are worth combining to the health promotion package in the future. However, since the IFRC has done a huge job in developing tools for NCDs prevention, it is sensible to use them. The problem, and most methods of prevention of NCDs, are global.

## **5.2 Goal setting**

The project started with an inductive approach after a discussion with the FRC Adviser in Health Promotion. She presented a need for IFRC NCDs material adaptation for FRC, and the process of choosing methods and gathering theoretical background begun.

The process of goal setting took place at FRC headquarters (HQ) and with Laurea Thesis supervisors. The goal of the project was to get useful material for FRC Healthpoints for NCDs prevention. The objective was to evaluate the material by as many FRC Healthpoint volunteers and clients as possible, and to make changes according to suggestions, to develop a tool best suited for use in FRC.

### 5.3 Choosing methods

Cultural adaptation and evaluation of materials were chosen as approach methods (ECDC 2016). The project was structured by using the project model of McKenzie et.al. (2013), and the results categorized by applying the Suitability Assessment of Materials (SAM) by Doak, Doak and Root (1996).

The suitability of IFRCs NCDs material was evaluated using participatory methods. According to Robson (2001) active participation of all major stakeholders is needed if a high quality evaluation is wished. The employee/volunteer participation is crucial, since they are using the material in practice. It is also important to get clients' viewpoints of the product. The evaluation method used has elements from participatory evaluation and stakeholder evaluation (Robson 2001).

#### **Suitability evaluation of health education material**

The evaluation of health education material can be seen from three different perspectives: evaluation of the final product, evaluation of the reception of material (pre-testing), or evaluation of effectiveness (Parkkunen, Vertio and Koskinen-Ollonqvist 2001).

Suitability of health education material has been evaluated with several different instruments. The categories of suitability, presented by Doak, Doak and Root (1996) in the Suitability Assessment of Materials (SAM) are:

- Content
- Literacy demand
- Graphics
- Layout and typography
- Learning stimulation and motivation, and
- Cultural appropriateness

(Doak et.al.1996.)

According to a systematic review of suitability of educational materials concerning cancer (Finnie, Felder, Kneupner Linder & Dolan Mullen 2010) only two instruments used for suitability evaluation were described as having evidence of validity; the Suitability Assessment of Materials (SAM) and the Comprehensibility Assessment of Materials (SAM + CAM). For this project, SAM categories were used as a tool to organize evaluations of health promotion material produced by IFRC.

### **Careful selection of materials and process coordinators**

The IFRC's NCDs toolkit material consists of an Implementation and facilitator Guide (88 pages), Volunteer manual (52 pages) and Community toolkit, with 5 toolkits/topics 1-5 (altogether 82 pages) in English. The toolkit is much too extensive to be translated as a whole, at least for Finnish context. It was not considered necessary, or possible for economic reasons, to use Facilitator guide or Volunteer manual, although parts of them would have been beneficial. The project material evaluated during the cultural adaptation project (33 pages of the Community toolkit) was selected in cooperation with the FRC Headquarters.

Selection of process coordinator was simple, since there is only one person nationally in charge of FRC Healthpoints at HQ. Project coordination was conducted in cooperation with HQ adviser in health promotion (Ms. Myllyrinne) and the master student (Ms. Kaarnalehto).

### **Translation and quality check**

The FRC had the material translated from English into Finnish. After that, the material (in preliminary stages of layout) was presented to the FRC Healthpoints' volunteer nurses at a Healthpoint conference 16<sup>th</sup> - 17<sup>th</sup> April 2016 with 60 participants. A workshop was organized, where the volunteers gave feedback about the preliminary material in small groups.

Because of some difficulties in translation and layout of the IFRC material, we did not have the properly selected, translated and laid-out versions of the chosen material at the seminar workshop in April 2016. Despite of the challenges, we got some valuable feedback, as well as inform the Healthpoints of the project.

### **Comprehension testing**

The second stage was to send the translated material with the correct layout for the testing and evaluation at the participating Healthpoints. At the Healthpoint seminar, there were altogether 17 Healthpoints interested in participating in the evaluation of the material. The

material was sent to the Healthpoints contact persons, and the ones who expressed need, made orders by e-mail of the printed material which was forwarded to the FRC Headquarters for material mailing per post.

This e-mailing of material was completed 28<sup>th</sup> of April, and the Healthpoints thus had May-June to test out the material. Most Healthpoints are already on summer holiday in June, so there was quite little time for the testing. Partly because of limited human resources at FRC HQ, and some human errors, there were some Healthpoints which got the requested material in paper form only after delays, and one that did not receive material in paper form at all. Also one Healthpoint did not receive material by e-mail despite of requesting it at the Healthpoint seminar, because of a typing error of the master student.

### **Feedback survey**

In this project the evaluation concentrated on the reception of material as the pre-testing by Healthpoint volunteers and clients was conducted. For the evaluation of material, a feedback survey (Appendix 5) was developed in cooperation with FRC Health Care Expert, and based on the existing NCDs material. The objective of the feedback survey was the evaluation of the NCDs material by Healthpoint volunteers and clients. Suitability was evaluated in the feedback survey on the scale of 1= Not suitable, 2= poor suitability, 3= quite suitable and 4= very suitable. The survey was divided in two parts, one of which was not meant for volunteers. The background information about possible chronic illnesses and Risk Assessment Scores (based on the Risk Assessment Card scores), evaluations of the new information received and changes in conception about NCDs risks were gathered only from the clients. These were evaluated on the scale of 1= not at all, 2= slightly, 3= quite much or 4= considerably.

There were finally 6 Healthpoints that returned feedback surveys (Appendix 5) by the end of June 2016. In addition, one Healthpoint sent general comments in writing, and two others by e-mail. Feedback surveys' open answers were collected and categorized. To help categorize the evaluations, Suitability Assessment of Material (SAM) was used as an aid.

### **Analysis of the evaluations and suggestions for modifications**

The background information and multiple choice answers from the feedback surveys (26 answers) were analyzed with SPSS program (IBM SPSS Statistics Version 22). A written summary was made of all comments combined from Healthpoint seminar in April and the feedback surveys, and a list of suggested changes was produced by the master student based on the answers. The suggested changes were surveyed at a meeting with Ms. Myllyrinne from FRC HQ

on 19<sup>th</sup> August 2016, and a final version of suggestions for the FRC was made by Ms. Kaar-nalehto afterwards (Appendix 1 and 6). The FRC Headquarters will make the changes to the laid-out material during autumn 2016, and an evaluation is planned to take place by an outside expert and a focus group of Healthpoint volunteers after that. The project is continuing with modifications, if needed, and training by FRC headquarters of the Healthpoint volunteers for the use of adapted material during spring 2017. The evaluation of the material will be a continuous process with systematic evaluations, adaptations and updates at least every five years.

## 6 Project outcome

As project outcome, the suitability of the material was evaluated by gathering feedback from Healthpoint volunteers and clients, as well as suggestions for cultural adaptation introduced (Appendix 1 and 6). In addition, recommendations for health promotion at FRC Healthpoints were formed, to help integrate health behavior theories into practice (Chapter 6).

### 6.1 Results of the feedback survey

The feedback survey was completed by total amount of 26 individuals, of which 11 were clients and 14 volunteers (Table 3). 7 of the respondents were males and 19 females. Six different Healthpoints were represented. The information analyzed consisted of background information of the respondents, and their evaluation of suitability and new information received from the NCDs material. The aim was to get evaluations of the material from as many respondents as possible. For example the mean values of the respondents from different groups were not compared further, since this was not the aim of the survey.

Role of the respondents		
	Frequency (n)	Percent (%)
Client	11	40
Volunteer	14	56
Both client and volunteer	1	4
Total	26	100

Table 3: Role of the respondents

Age distribution of the clients and volunteers varied from 51 years to 83 years, with a mean of 70.8 years (Figure 2).

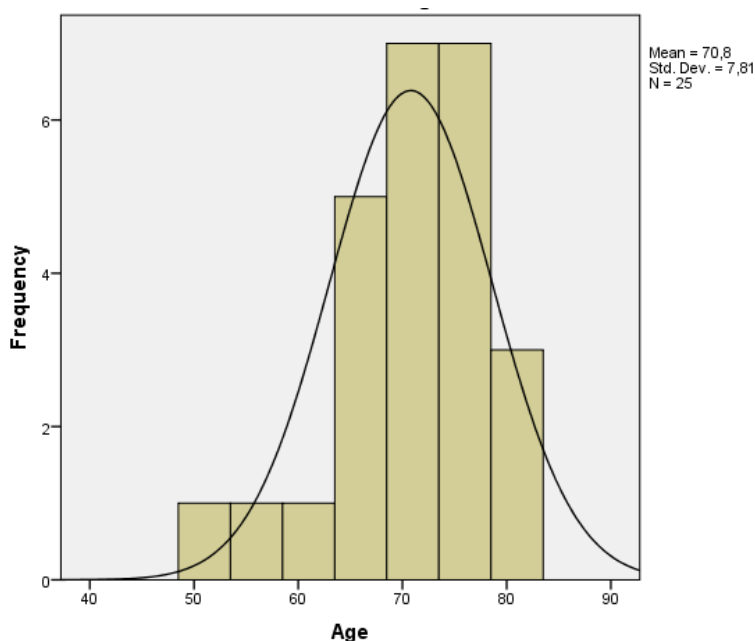


Figure 2: Age distribution of respondents

The answers included one group evaluation (not included in the analyzed surveys), in addition to the individual answers. The group consisted of 10 female Healthpoint volunteers, and evaluated material concerning healthy eating habits as very suitable for use at Healthpoints.

The results of the survey showed that majority of both volunteers and clients assessed the material to be suitable for FRC Healthpoints (Figure 3). Most respondents evaluated material as quite suitable or very suitable. Mean score for suitability was 3.25 at a four point scale. Two Healthpoints also gave feedback by e-mail, and evaluated the material as quite suitable.

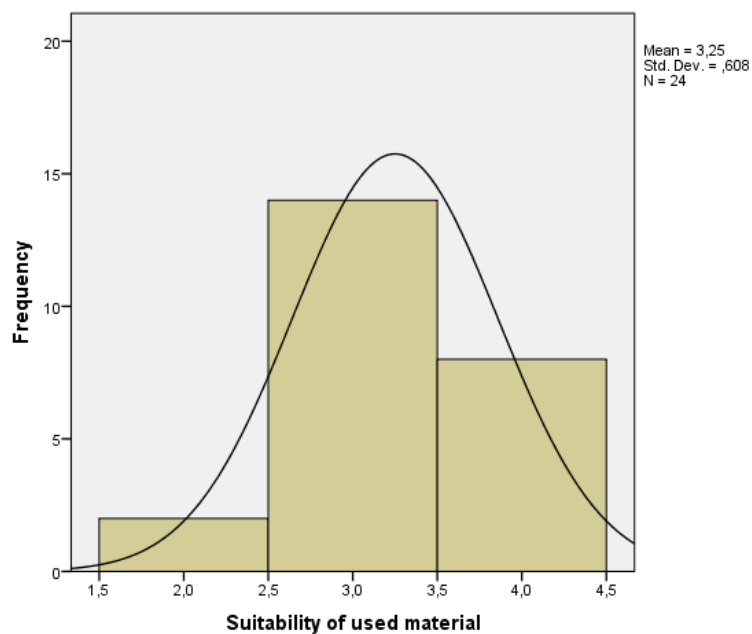


Figure 3: Suitability of material

Suitability assessment of the material varied according to the role at the Healthpoint (Figure 4), from being evaluated as quite poor, quite good or good in the answers by the clients, and quite good or good in the answers by the volunteers.

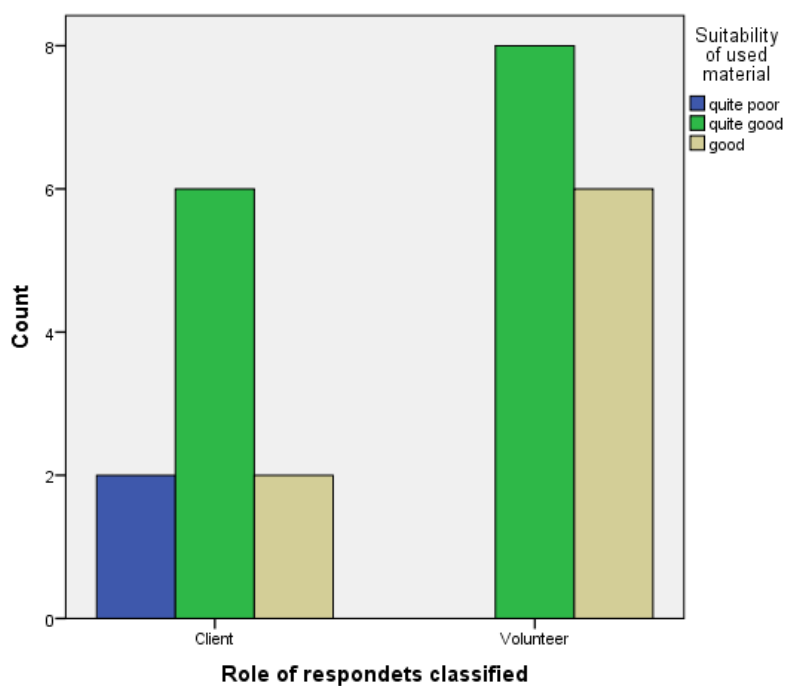


Figure 4: Role and suitability of the material evaluated by the respondents



The Healthpoint clients were asked if they had been diagnosed with one or more NCD or other chronic diseases (Table 4). This information was collected as part of the background information of the respondents. The volunteers were not asked about their possible diagnosis, but some had answered the question. This is why the amount of answers was 13 (instead of 11, which was the number of clients).

Clients diagnosed with a noncommunicable or chronic disease		
	Frequency	Percent
Diabetes mellitus	1	7.7
Cardiovascular disease	4	30.8
Several chronic diseases	3	23.1
No chronic disease diagnosed	5	18.5
Total	13	100

Table 4: Clients diagnoses for chronic disease

There were also some differences in evaluations of clients, depending on whether they were diagnosed with a chronic disease or not (Figure 5).

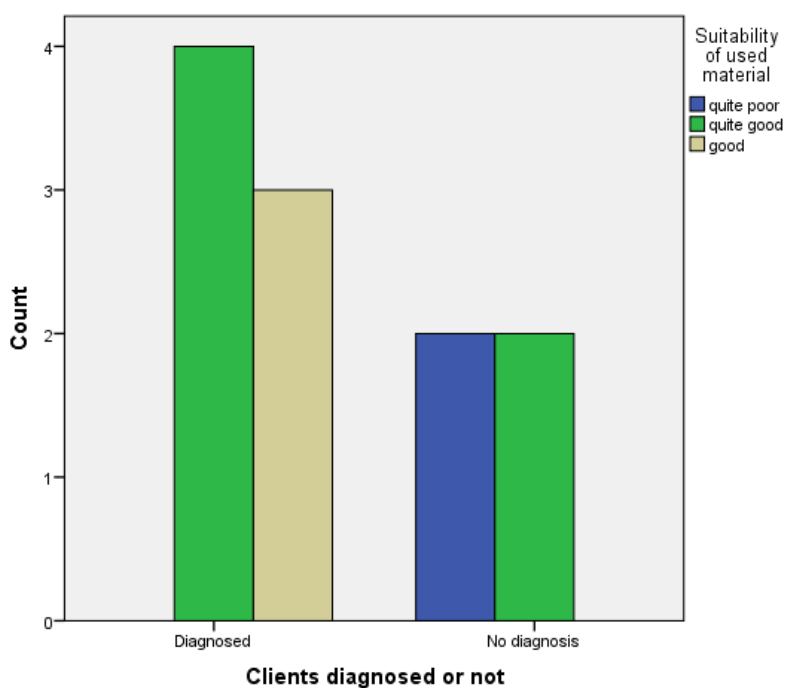


Figure 5: Suitability of the material and diagnosed chronic disease

The clients diagnosed with an NCD or chronic disease evaluated the material to be more suitable, and also assessed to have received more new information from the material compared to those with no diagnosis.

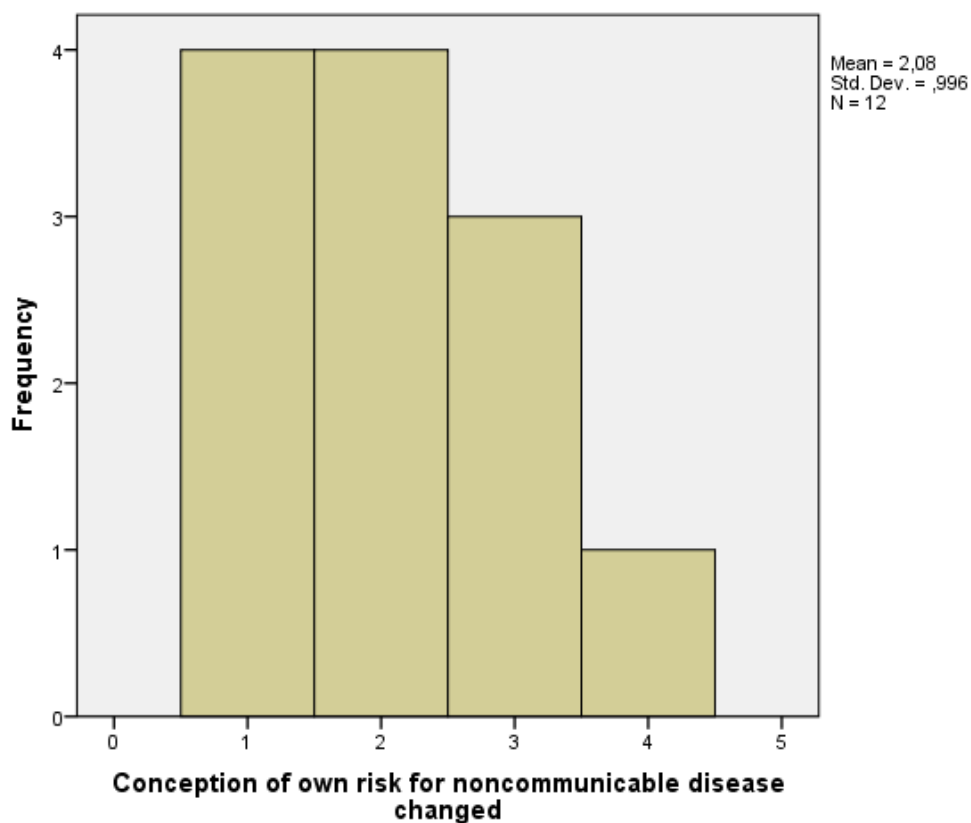


Figure 6: Conception of clients' own risk for noncommunicable disease changed

The clients' evaluations of changes in conception of own risk for noncommunicable diseases was asked at a 4 point scale (Figure 6). Most respondents evaluated no change or slight change in their conception of risks. The mean score for changes in risk conception was 2.08.

The clients were also asked to evaluate the amount of new information about NCDs received from the material (Figure 7) at a four points scale. Most clients assessed to have received new information slightly (6 respondents) or somewhat (6 respondents).

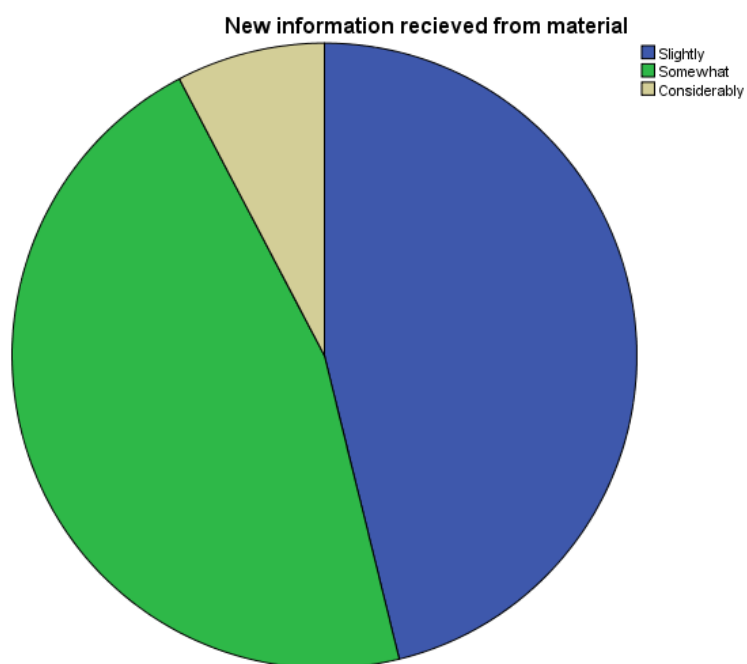


Figure 7: New information received from material

There were some interesting differences in viewpoints of volunteers vs. clients, and also clients diagnosed with chronic diseases vs. non-diagnosed concerning suitability and new information received (Figure 8).

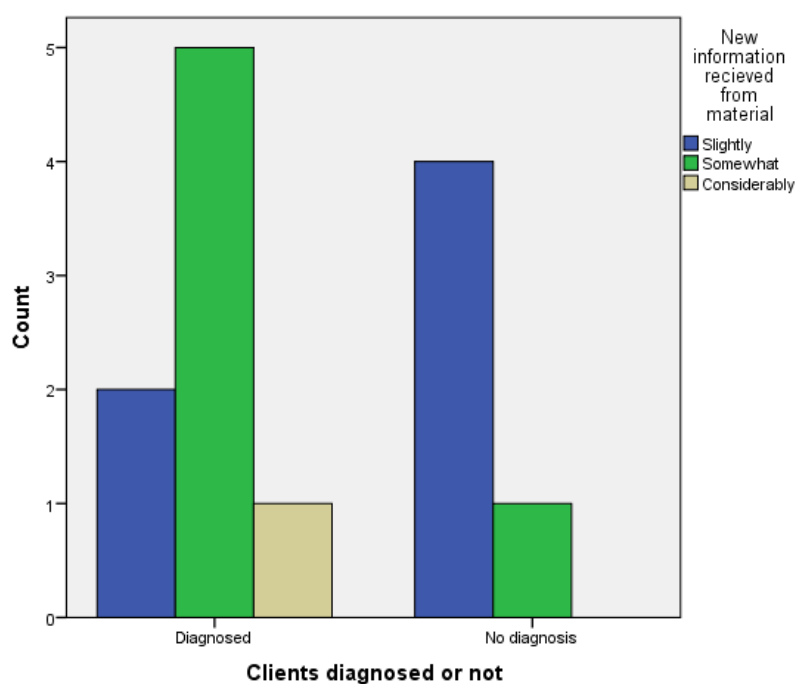


Figure 8: New information and diagnosed NCD/chronic disease

It is possible, that Healthpoint volunteers and clients already diagnosed with an NCD are in general more interested and motivated, since they already know more of the subject and can see the importance of lifestyle and health behavior. The age distribution is also a factor when reflecting the evaluation results - the aged population might recognize the health risks differently, or consider it more difficult to change health habits than younger age groups. The results could have been different if clients were of working age.

## 6.2 Cultural adaptation of the health education material

The suggestions for cultural adaptation of the material were based on the evaluations collected from the feedback at the Healthpoint seminar in April 2016, feedback survey answers, feedback from e-mails, and evaluation by the master student and Ms. Myllyrinne from the FRC.

According to the evaluation, NCDs material was seen by the respondents as generally well made and useful. There were, however, quite a few adjustments needed for the material. The evaluation is categorized according to the Suitability Assessment of Materials (SAM) factor list by Doak et.al. (1996).

### Content

The content was seen as suitable and important for most part. However, there were approx. 97 corrections made to the content of the (directly) translated 33 pages. These included content that was taken out or added. Considering the education levels of most volunteers in FRC activities (especially the targeted professional Healthpoint volunteers), big part of the text was on too basic level. Since the material is primarily targeted to non-professional volunteers for peer-education in developing countries, it must be adapted somewhat to function in higher income countries.

There was some unnecessary repetition in the Community toolkit

e.g. Healthy eating guide, Effects on the body (Appendix 4): Reduces belly fat and risk factors for cardiovascular disease and

Lowers body weight, lowers total fat mass and reduces fat in the liver that can cause obesity and diabetes.

and a few mistakes

e.g. Effects of quitting tobacco: The risk of cardiovascular disease is the same as non-smokers.

It was important to add some country-specific data about illnesses (such as morbidity numbers of NDCs), as well as recommendations on nutrition, alcohol intake and exercise. Otherwise the information is too general. When the material is in electronic form, it is possible to add links to current country-specific recommendations on each subject.

Some parts of the material were seen as questionable

e.g. Healthy eating guide: effects on the body (Appendix 4): Significantly improves learning capacity and motor skills,

or promising too much

e.g. Effects of a healthy diet (Appendix 4): Promotes and heals damaged cells in the brain and nervous system” or

Preserves vision - can prevent or delay all age related eye problems like muscular degeneration, cataract, myopia, dryness and infections.

In such cases it would be very important to have references, e.g. studies used, to verify these statements. Since the references were not available, we could not include some of the statements in the material.

We wanted to add a few statements that were considered important for motivation

e.g. Tobacco use: Increases risk for erection problems for men and

Effects of a healthy diet: Beware of hidden salt/sugar! Where do you think you can get it?

We also wanted to add the recommendations on fat quality, i.e. saturated vs. non-saturated fats. Most comments were given concerning the overall content (approx. 43 comments).

### **Literacy demand**

This section did not come up much in the evaluations, since the material is not meant directly for the clients but as educational resources for volunteers. Writing style of the health promotion materials was, however, in parts seen as overly simplified, which might be associated with cultural issues and literacy levels of different populations (1 comment).

### **Graphics**

The graphics were evaluated mainly as suitable, relevant and illustrative. The pictures were clear, and there was surprisingly little need for corrections on i.e. eating habits or alcohol allowances. The NCD puzzle (Appendix 3) was seen as childish or unnecessary by a few (3 comments), and some pictures as unclear (2 comments). The Risk assessment card with scoring

points at different levels got feedback for being confusing and difficult to fill out (4 comments).

### **Layout and typography**

The Layout was evaluated as partly too overloaded and confusing, full of text with typography too small (12 comments, for example Appendix 4).

### **Learning stimulation, motivation**

The material contains interaction and elements for motivation and self-efficacy. This is the aspect, however, which was seen as an important part to develop more. This is why some adjustments were made to the Risk assessment cards and especially the Health action plan-part (5 comments).

### **Cultural appropriateness**

The cultural factors were considered mostly as appropriate, including pictures. A number of changes had to be made because of e.g. cultural differences in communication.

Some parts were seen as over-simplifying, harsh or scaring people unnecessarily,  
e.g. Unhealthy diet: When your body organs do not work well or stop functioning, you can become very sick or even die.

Also the differences in health care resulted in adjustments needed in some health advice. In First aid instructions some adjustments were made, according to the Finnish standards (SPR 2016).

E.g. Call emergency services or get the person to a doctor or health clinic immediately was changed to “call 112” (Finnish emergency number).

The measurements used were for some part different in Finland, e.g. cups vs. desilitres, inches vs. cm.

Some questions, like “How do you feel?” in the middle of a group discussion about for example alcohol use was not considered suitable. Discussing alcohol consumption habits in a group can be quite challenging in Finland, and was considered more likely to happen in a private discussion.

Some of the expressions were not suited for Finnish discussion with adult clients,

e.g. Effects of a healthy diet: Your intestines are working more effectively and it will be easy to make poo every day, not diarrhea, but normal poo. The phrase was translated to meaning approx. stool gets normalized.

Comments concerning cultural factors were most common (approx. 24 comments) after comments about content.

The NCDs Risk assessment card (Appendix 2) was considered especially useful in the Finnish context, but had to be modified somewhat. The way of calculating scores was thought to be confusing, and also the feed-back for the scores did not match Finnish environment or culture (Appendix 9). We decided not to use Clinical part of the risk assessment card, since our volunteers are not official health care workers, and do not take blood tests, like blood sugar or cholesterol levels in principle. We did not find it necessary to ask if the client is pregnant, since we have an extensive governmental maternal clinic system in Finland, and their health status is checked almost exclusively there.

The blood pressure risk levels were adjusted according to Finnish recommendations, as were the feed-back texts. This left more room for the Health action plan, which is an important part of each client's behavior change cycle. The action plan was modified according to IFRC Behavior Change framework and the Stages of Change-model, especially to support the individuals in stages of contemplation or preparation stages of a lifestyle change. To be able to aid in the decision making, motivation and behavior change process of adapting healthy lifestyles more effectively, some adjustments were made to the Risk assessment card (Appendix 1) and instructions for Tool 4 use (Appendix 6, page 60).

## **7 Project evaluation**

The project process evaluation was conducted by using the five steps suggested by ECDC guide "Translation is not enough. Cultural adaptation of health communication materials" (2016). The project was challenging, since the instructions for this type of work only came out by ECDC in April 2016. It would have been beneficial to follow the guidelines from the beginning. We were able to take advantage of the guidelines at the final stage, after the translation and comprehension testing, primarily for the stages of proofreading and design, networking and evaluation.

In addition, the World Health Organization's Quality of care - document and the Six domains of quality interventions (World Health Organization 2006) was utilized to evaluate the quality aspects of the project.

### **Evaluation by the ECDC guide for cultural adaptation**

According to the ECDC guide, the cultural adaptation process of educational material should follow five steps. First one is “Careful selection of materials and process coordinators”. The materials chosen to be translated and culturally adapted, should be produced by independent authors, evidence-based, tested and evaluated. The material should bridge a gap, or complement existing national resources. (ECDC 2016.) Regarding this step, the project material was considered to be independent and reliable, and is based on evidence about NCDs prevention through lifestyles (e.g. Chomistek et al. 2015).

Evidence-base was, however, sometimes hard to find regarding all recommendations and facts presented in the material, since no references were found by the master student or the FRC adviser in health. The material has been tested around the world, but no information of evaluation was reported. The material was seen as necessary, collective and complimentary to the existing health education material about NCDs in Finland.

Second step is “Early review by content and linguistic experts”. Before translation, the materials should be reviewed by local content and linguistic experts, to contextualize the materials by removing inappropriate recommendations and explain challenging concepts. National data, examples and recommendations should be added at this stage. (ECDC 2016.) Unfortunately this step was left aside, because of timetable issues and technical difficulties concerning the project. In retrospect, this would have been an important step, and would have saved time for the translators and at the layout stage. It was also unnecessary for volunteers and clients to evaluate the directly translated version, since it contained so many mistakes/corrections needed.

Step three is “Translation and quality check”. The translation needs to be conceptually equivalent, and not literal. After translation there should be a quality check to notice conceptual errors. Finally, it would be helpful to have an independent and “outsider” reviewer go through the material to notice needs for clarifications or changes. (ECDC 2016.) The translation was made quite literally, because of the timetable issues. It was done by one expert, and reviewed by the project coordinators at the quality check/evaluation phase.

The fourth step is “Comprehension testing” by focus groups, stakeholder discussions, interviews, consensus process or internet-based panels. The group should be representative of the end-user group, to be able to give feedback on content and design issues. Based on this feedback, final modifications can be made. (ECDC 2016.) The fourth step was combined with the third, by making a combined evaluation of the translation, content and design issues. This was done in several stages, first at the workshop in April, then at individual Healthpoints in



May-June 2016 and finally combined by the writer, adding own comments and reviewed together with the FRC QH coordinator. The evaluation step, consisting of the quality check and comprehension testing, was somewhat confusing and challenging, mainly because of the time-table issues and technical difficulties concerning IFRC material layout.

The fifth and last step is “Proofreading, design, networking and evaluation”. Proofreading should be done on the final Word document at this stage, and the second after the text has been placed into a design format (to identify layout issues). After the final designed version is finished, a dissemination plan will be developed to raise awareness and advocate for the use of the materials. Finally, the use of the material will be monitored and evaluated, and adjustments made based on feedback received. Evaluation can be made of, for example, level of awareness, effectiveness and numbers of materials distributed. (ECDC 2916.)

The last step was also combined partly to the evaluation stage, since the material was not available in Word format. This presented problems, since the translation had to be mainly done in the laid-out format, which was then difficult to edit. This project is continuing by making the changes to the laid-out format (when compatible software can be accessed at FRC HQ), expert review, evaluation by a focus group, adjustments made based on feedback and a dissemination plan developed. These are still in the process stage.

### **Evaluation by the Six domains of quality intervention**

The project is examined according to the Six domains of quality interventions, presented in the World Health Organization Quality of care - document (2006): Leadership, Information, Patient and population engagement, Regulation and standards, Organizational capacity and Models of care. The project can be seen as a quality intervention, since it concentrated on the evaluation of the health education material, suggestions for improvements, recommendations for health promotion activities and project planning. This will result in better quality health promotion at FRC Healthpoints.

The initiative for the development project came from the Finnish Red Cross headquarters from the Adviser in Health Promotion. The leadership was divided between the master student and the FRC headquarters. As a nationwide project, it is very important to have strong leadership from the headquarters. The Adviser in Health Promotion has, however, many projects and departments on her responsibility, and was not able to give a great deal of her time for this project. She had luckily other people assisting at the headquarters. The master student had responsibilities in many project management aspects, such as project planning, information matters and contact with volunteers, creating and analyzing the feedback surveys, making suggestions for improvements, evaluation of the project and writing the report.

Information matters are one of the most critical aspects of most projects, and there is always room for improvement. The information about the project has been given at the Healthpoint seminar in Vantaa in April 2016, as well as on an e-mail list for all FRC Healthpoints. There were difficulties in maintaining up-to-date e-mail address lists, and not all Healthpoint volunteers used computers actively. It would be important to get the district offices involved in the future, especially for developing local interventions and use of the material.

The information sharing at the IFRC level was also challenging, since the IFRC employees and national Red Cross society employees are working around the world. Some countries in Europe have tested the NCDs material, and certain employees would have had insight regarding the developed material. Many questions remained unanswered at the international level, however, because of communication challenges.

Population engagement is a crucial aspect of most development projects. Healthpoint volunteers can be considered as population in this project. We involved as many volunteers as possible in evaluation of the IFRC material, by gathering feedback at the Healthpoint seminar, via e-mail and with the feedback survey for the Healthpoints.

During the project it was considered important that the health information distributed through NCDs material is in accordance with the regulations and recommendations used in Finland. It was found necessary to add country specific recommendations for each section, made by proper authorities.

Organizational capacity is a challenge also for the Finnish Red Cross. The headquarters is working with very limited resources with 12 independent districts, 67 Healthpoints and hundreds of volunteers. Healthpoints are only a small part of the volunteer work action within FRC. The time table together with limited personnel resources presented probably the biggest challenge for this project. They resulted in delays in translation process, layout and material delivery to the Healthpoints, as well as some mistakes in sending the material to the participants. Hopefully the resources would be extended according to the clear need within FRC for Healthpoints as well.

The Healthpoints should make most of the current evidence based knowledge about health promotion and the technologies available. The health promotion at FRC Healthpoints is based on volunteering, cooperation and evidence-based care (SPR 2013). Evidence-based care includes different models of care, and for example health behavior theories. These theories are still relatively little used in practice in terms of health promotion and advice at Healthpoints. This project gives some practical tools in regard to the NCDs material using the Health Belief

Model and Trans-Theoretical Model as a basis for health promotion activities. The recommendations formed for health promotion and material use at Healthpoints are integrating the theories into practice.

### **Ethical considerations and limitations**

The project followed ethical principles listed by the ethical board of research (Tutkimuseettinen neuvottelukunta 2009). They have separated three sectors of ethical principles considering human sciences: Respect of research subject's autonomy, avoidance of harm, and privacy and confidentiality (Tutkimuseettinen neuvottelukunta 2009).

The autonomy of participants has been secured by voluntary participation in the project at all levels. The Healthpoint volunteers not willing to participate could refuse at any point. Also the clients at Healthpoints participated voluntarily by filling in the feedback survey (Appendix 5), but had a chance to decline as well.

The project should not have caused any harm by discussing healthy lifestyles or gathering feedback surveys. There are, however, ethical concerns when giving information about risks behavior. It has been shown in several studies (e.g. Borodulin et.al 2014 and Chomistek et al. 2015) that one can decrease the risk of NDCs significantly by lifestyle choices. This is, however, accurate as statistical truth concerning a whole population (e.g. FINRISKI-calculator which calculates each person's risk for chronic diseases based on some individual risk factors and the large FINRISK population study results, THL 2014d). This is not necessarily the case for an individual. Having healthy habits does not guarantee that you do not get a certain disease. Statistically there might be considerably lower risk, but some people still might just be unlucky. It is up to each person to decide what kinds of risks they are willing to take. It is a job for the health care workers and volunteers to ensure that each person has all relevant information to be able to decide for themselves.

Privacy and confidentiality matters were considered. When developing the feedback survey, it was decided that no single person can be identified from the feedback. Some sensitive information about illnesses and risks were asked, but no names or other personal information was collected. Confidentiality is a basic value at FRC Healthpoints, and was also explained in the appendix letter following feedback surveys. This matter was also considered when presenting feedback survey results: the Healthpoints' answers were not reported separately, because of possible identification of respondents considering the small number of answers from many Healthpoints.

The number of feedback surveys received ended up being 26, and 6 Healthpoints were represented out of 67. The results cannot be generalized as the opinion of all FRC Healthpoints' volunteers' opinion. Also the material which was being evaluated at Healthpoints was directly translated, and included quite a few obvious needs for correction. However, the feedback gave a good basis for evaluation, and the volunteers most interested in the subject had a chance to comment. Together with the feedback from Healthpoint seminar workshop with 60 volunteers, there were enough evaluations from volunteers to get their voice heard in the process.

## **8 Recommendations**

The recommendations are divided into recommendations for integrating health behavior theories into practice at FRC Healthpoints, and general recommendations for future cultural adaptation processes and the use of the culturally adapted NCDs material at Healthpoints.

### **8.1 Integrating health behavior theories into health promotion activities**

To be able to integrate health behavior theories and research into practice, there are a number of things to consider when conducting health promotion at Healthpoints. These recommendations are gathered from literature and research concerning health promotion and health behavior change.

#### **Health Belief Model**

When planning a health intervention, it is advisable to consider how the intervention is going to affect client's or target populations' health beliefs. Is the intervention aimed at changing perceptions of susceptibility, severity, barriers, benefits or self-efficacy concerning a health risk? Are the modifying factors, such as age and socioeconomic situations taken into consideration? (Rosenstock et.al 1988)

#### **Stage of change**

It is advisable that the client's motivation and stage of change is clarified at individual level discussions, in relation to each subject. There is no point in giving a much information on how to advance in changing a lifestyle, if the client is still in pre-contemplation stage, i.e. not motivated. In case the client is in contemplation or preparation stage with one of the desired

lifestyle changes, you can fill in the Health action plan -part of the Risk assessment card together. For example you can ask:

“Would you say you are not ready to change in the next 6 months (precontemplation), thinking about changing in the next 6 months (contemplation), thinking about changing in the next month (preparation) or have you already made some progress (action)?” (Norcross, Krebs & Prochaska 2011).

The question will have to be asked several times for patients with multiple problems, since the stages are problem-specific. (Norcross et. al. 2011.)

### Realistic goals according to stage

After identifying the stage of change the client is in, you can design a goal to be realistic, with sufficiently small steps. For example, in case of more physical activity needed, if you set a goal of going for a 1 hour walk every day, it is likely to fail at some point. The person feels like a failure and motivation drops. If instead your goal is to increase physical activity by 10 minutes daily, the person is more likely to succeed, her self-efficacy rises and she thinks it possible to make another step into the right direction later on.

It can be beneficial to plan health discussion topics, once the client’s stage of change is identified (Table 5).

<u>At Precontemplation:</u>	Build trust, wake up concerns or motivation, concentrate on consequences, and examine pros and cons
<u>At Contemplation:</u>	Examine the conflicting interests, present choices, pros and cons of change and support self-esteem
<u>At Preparation:</u>	Help the client to make a plan and a time table, find out what has helped before, aid in prioritizing change
<u>At Action:</u>	Support, give feed-back, follow up the change with visits or calls
<u>At Maintenance:</u>	Give support and positive feedback, make a plan in case of relapse

Table 5: Health discussion according to the stage of change, modified from Marttila 2010 and Miller 1999, cited in Koski-Jännes 2008

### Life context

In health promotion one cannot isolate a single risk behavior or risk factor, but you have to take into an account the environment and life situation of each client. Does he have other health issues? Are there acute social or mental health problems? Does he get support for a

lifestyle change? Is this a priority right now, or is there another matter in need of more urgent care? (Werch, Ames, Moore, Thombs & Hart 2009.)

### **Teachable moments**

If you identify a moment that is critical for taking up a subject, do it. If a client is complaining about an accident he had or relationship problems currently because of excessive alcohol use, it could be a beneficial moment to take up the subject of cutting down the drinking. When a person is suffering from worsened asthma or sleep apnea attacks, he could be motivated to think about stopping smoking. If a relative or friend has just been diagnosed with an NCD, it could help in motivating towards a change in own lifestyle. These can also be described as Cues to action, according to the Health Belief Model. Sometimes a favorite dress not fitting is enough to motivate a lifestyle change; sometimes it takes a diagnosed diabetes. As health professionals it is beneficial to try and listen if this would be a good moment to make an intervention. (Werch et.al. 2009; Glanz no date.)

## **8.2 Cultural adaptation process and use of noncommunicable disease material**

The project of cultural adaptation is in part continuing the large process of IFRCs production of global NCDs health education material. To create a material package with up-to-date information and learning methods for such a huge organization as the IFRC, has been a big challenge. Participants from many different national societies and cultures have contributed to the material. It is meant as a part of Community Based Health and First Aid (CBHFA) material, and can be used either separately or with other materials. (Implementation and facilitator guide... 2014.)

Unfortunately the material was in such a layout format, that the process of translation and layout turned out to be very difficult and expensive. The Finnish Red Cross did not have the program for the layout in question. It is important that the IFRC considers this in the future, so that the translation and cultural adaptation process is made as easy and inexpensive as possible, for more countries to be able to take advantage of materials. The materials should be made available in for example MS Word-format.

In future projects of translation and cultural adaptation of health education material, it is recommended to follow the ECDC guide "Translation is not enough. Cultural adaptation of health communication materials. A five-step guide." (ECDC 2016) as closely as possible. The

text requires a considerable amount of work before translation as well as after. For this reason it would be important to get the IFRC material in an easily editable document form. It is beneficial to reserve enough time for the process.

When developing a global tool for health promotion, such as NCDs toolkit, it would be beneficial to include some variation in content, depending on target population and country: there could be optional parts for higher income countries with additional background information, research, references and assignments.

The particular sections of NCDs toolkit were chosen to be used at FRC Healthpoints to aid in raising awareness, motivation and planning interventions for NCDs prevention. The material can be used in individual health appointments and counselling, as well as in group sessions. Material will be in electronic form, so it can also be used through video projector with groups.

It is advisable to use only part of the material at one meeting, since there is far too much information to absorb at one time. Healthpoints might have a theme evening, where for example healthy eating habits or NCDs as a whole are discussed in a group. Alternatively, the volunteer can discuss individually with clients and find out which risk factors they find most important for themselves, and if they would be willing to change a lifestyle.

The material can also be used in several other Finnish Red Cross activities besides the Healthpoints, as for example a discussion tool about healthy lifestyles and prevention of illnesses at first aid courses, first aid group or friend service meetings etc. It can be utilized in other organizations outside the Red Cross, as well. Especially the Risk assessment card can be used as a tool with clients in for example public health care.

It is important that the material is continuously evaluated, adjusted and developed according to needs and new knowledge. It would be very interesting to conduct a follow-up survey at Healthpoints when the final material is in use. It would be beneficial to add components of health education about other chronic disease, which have serious effects on public health in Finland, such as mental disorders, musculoskeletal diseases and memory disorders.

Health project plan model, which was used for this cultural adaptation project (Appendix 7) can be utilized at Healthpoints, as well. It can be useful in planning new activities or interventions, such as a health education project for a specific group, a theme day or a new place for Healthpoint reception. It is beneficial to consider, before starting new activities, what are the actual needs of a certain group or location, what we want to achieve with the interven-

tion, and how we can verify and measure the outcome. Are we doing something actually beneficial and effective? The model can be used by other Red Cross groups, as well, for planning shorter projects or interventions.

New ways to use the material, taking advantage of modern digital tools and knowledge of health promotion methods should be developed, in forms of e.g. electronic and mobile applications, and innovative ways of health promotion for different individuals and groups. It is important to consider which activities and interventions are offered to which target groups. Are we targeting the most vulnerable in our community? Who are the people most in need of this knowledge and tools about NCDs? How can we reach them? Will the intervention be effective? This is where cooperation with rest of the Red Cross branch, public health care, churches and other organizations plays a large role in the future.



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## Appendix 1: Health action plan

### Suunnitelmani terveempään elämään

Arvioni nykyisestä terveydentilastani kokonaisuutena asteikolla:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Tavoitteeni terveydentilani suhteen asteikolla:

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Tavoitteeseen pääsemiseksi suunnitelmani terveempään elämään:

- Mitä asioita haluan muuttaa:

\_\_\_\_\_

- Mikä on näistä ensisijainen? Miksi?

\_\_\_\_\_

- Jos teen muutoksen, mitkä ovat muutoksen hyödyt? \_\_\_\_\_

Entä haitat? \_\_\_\_\_

\_\_\_\_\_

Mitkä asiat auttavat minua onnistumaan (tukiverkostoni, vahvuuteni, kokemukseni, motivaatio):

\_\_\_\_\_

Suunnitelmani elintavan muuttamiseksi:

Mikä muuttuu ja miten? \_\_\_\_\_

Aikataulu: \_\_\_\_\_

Mitkä esteitä/haasteita voi muodostua muutokselle? \_\_\_\_\_

Suunnitelmani esteiden voittamiseksi: \_\_\_\_\_

Ensimmäinen konkreettinen askel: \_\_\_\_\_

\_\_\_\_\_



## Appendix 2: Risk assessment card

## Tarttumattomien tautien riskien arviointi: kyselylomake

Vastaa kaikkiin kysymyksiin elintavoistasi.

**A**

Saat jokaisesta 3 pistettä

Saat jokaisesta 2 pistettä

Saat jokaisesta 1 pisteen

Minä 3 pistettä 2 pistettä 1 pistettä -1 pistettä Laske pisteesi yhteen riveittäin. ▼

<b>Terveellinen ruokavalio:</b> 5 annosta hedelmiä, marjoja ja/tai vihanneksia joka päivä					
<b>Liikunta:</b> 30 min kehon liikkeessä pitävää toimintaa joka päivä, esim. kävelyä, pyöräilyä, venyttelyä.					
<b>Liian suuri määrä alkoholia:</b> Naisilla enemmän kuin 1 annos ja miehillä enemmän kuin 2 annosta alkoholia päivittäin					
<b>Tupakkatuotteiden käyttö:</b> Tupakointi tai esim. nuuskan käyttö, tai asuminen tai työskentely samassa huoneessa tupakoitsijan kanssa					

What your self-assessment score means:

**4-6 pistettä:** Elät epäterveellisesti. Sinulla on **suuri riski** sairastua tarttumattomaan tautiin.

**7-11 pistettä:** Sinulla on joitakin epäterveellisiä tapoja, joiden vuoksi sinulla on **keskinkertainen riski** sairastua tarttumattomaan tautiin.

**12 pistettä:** Elät terveellisesti. Riskisi sairastua tarttumattomaan tautiin on **pieni**. Hienoa!

**B** Elintapapisteesi yhteensä: \_\_\_\_\_

**C** Oletko yli 45-vuotias mies tai yli 55-vuotias nainen?

Kyllä  Ei

**+0 pistettä** **+1 piste**

Esiintyykö suvussasi tarttumattomia tauteja?

Kyllä  Ei

**+0 pistettä** **+1 piste**

**D** Itsearviointisi kokonaispisteet:  
Laske yhteen B- ja C-kohtien pisteet.

<b>4-7 pistettä</b>	<b>8-12 pistettä</b>	<b>13 pistettä</b>	<b>14 points</b>
Hakeudu laboratoriotutkimuksiin.	Hakeudu terveystarkastukseen.	Hakeudu terveystarkastukseen.	Hienoa! Selvitä vielä verensokeri- ja kolesteroliarvossi.

# Tarttumattomien tautien riskien arviointi: kyselylomake

Päiväys: \_\_\_\_\_ Jos olet nainen, oletko raskaana?  Kyllä  Ei

Ikä: \_\_\_\_\_ Tutkimuspaikka: \_\_\_\_\_

## Terveystarkastus

## Lääkäri- ja laboratoriotutkimukset

<b>Vyötärönympäryys:</b> Mittaus kertoo, onko sinulla epäterveellinen määrä rasvaa vyötärölläsi.	Miehet: < 102 cm Naiset: < 88 cm  Miehet: >102 cm Naiset: > 88 cm	<b>Vyötärön- ympäryys:</b> _____ _____ _____	<b>Verensokeri:</b> Sokerien määrä veressä, kun edeltävästä aterialta tai nesteestä nauttimisesta on 8 tuntia. Tulos kertoo, miten hyvin elimistösi käsittelee sokeria.	< 6 mmol/l 6,1-6,9 mmol/l > 126	<b>Veren- sokeri:</b> _____ _____
<b>Painoindeksi (BMI):</b> Mittaus kertoo, oletko yli-, ali- vai normaalipainoinen.	Väliä 18,5 and 25 Väliä 25,5 and 30 Yli 30	<b>Pituus:</b> _____ <b>Paino:</b> _____ <b>Paino- indeksi:</b> _____	<b>Kolesteroli:</b> Mittaa verestä sellaisten rasvojen määrää, jotka estävät tai hidastavat veren virtaamista sydämeästä ja sydämeen.	< 6 mmol/l 6,1-6,9 mmol/l > 126 mg/dl	<b>Kokonais- kolesteroli:</b> _____ _____
<b>Verenpaine:</b> Mittaa miten tehokkaasti veri virtaa elimistöissä ja kuljettaa happea ja ravintoaineita elimiin.	Väliä 90/60 mmHg – 120/80 mmHg Väliä 120/80 mmHg – 140/90 mmHg Korkeampi kuin 140/90 mmHg	<b>Veren- paine:</b> _____ _____			

Huom. Jos verenpaineesi on alle 90/60, mene heti terveysasemalle.

### Terveystarkastuksen tulos:

3

**Hieno!** Käy vielä tarkistuttamassa verenpaineesi ja kolesteroliarvos. Käy vuosittain terveystarkastuksessa.

1-2

**Muuta elintapojasi terveellisempään suuntaan alentaaksesi riskejä.** Käy tarkistuttamassa verenpaineesi ja kolesteroliarvos. Käy terveystarkastuksessa uudestaan 1-3 kuukauden kuluttua.

1-3

**Sinulla voi jo olla tarttumaton tauti tai sinulla riski sairastua.** Käy terveysasemalla tarkistuttamassa verenpaineesi ja kolesteroliarvos.

### Laboratoriokokeiden tulos:

2

Riskisi sairastua tarttumattomaan tautiin on pieni. **HIENO!** Jatka terveellisten elintapojen noudattamista. Tule ensi vuonna uudestaan tarkastukseen ylläpitääksesi hyvää terveyttäsi.

1

Sinulla on **keskin-**kertainen riski sairastua tarttumattomaan tautiin. Sinun pitää tarkkailla elintapojasi välttääksesi tarttumattomat taudit. Käy terveystarkastuksessa ja laboratoriokokeissa vuoden kuluttua.

1

Sinulla voi jo olla tarttumaton tauti tai sinulla on **riski** sairastua. Hakeudu lääkäriin perusteellisempia tutkimuksia varten.

### Suunnitelmani terveempään elämään:

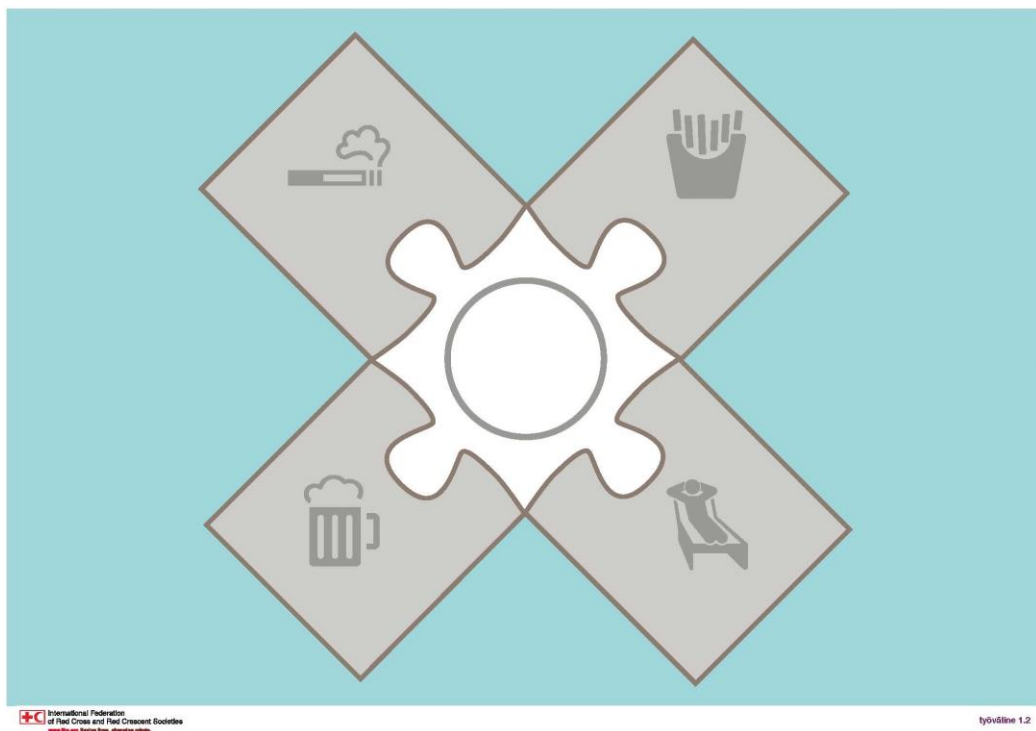
Tavoitteeni elintavoissa: \_\_\_\_\_

Minua motivoi muutokseen: \_\_\_\_\_

Suunnitelmani elintapojen muuttamiseksi: \_\_\_\_\_

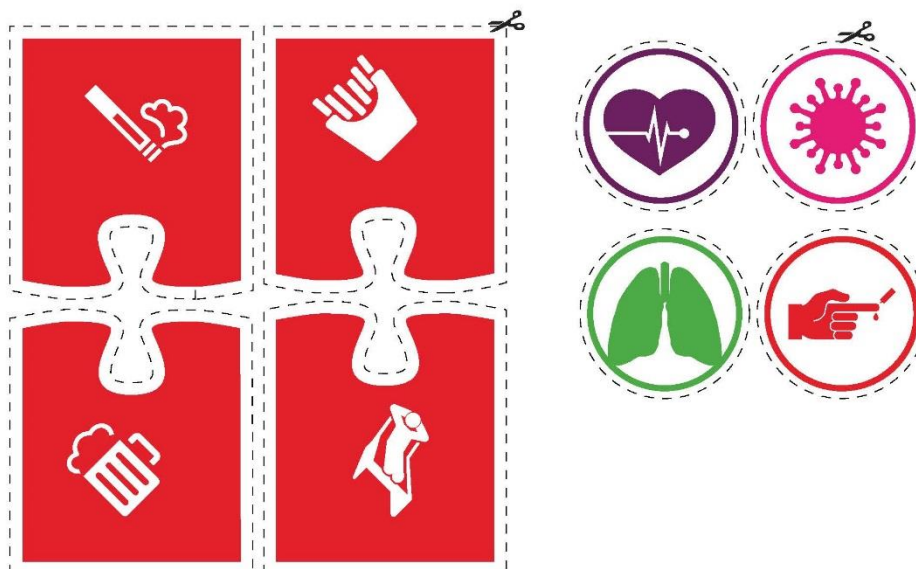
Tukiverkostoni: \_\_\_\_\_

Appendix 3: NCD Puzzle



Työväline 1.2  
**Palapelin palat**

Leikkaa palat irti katkoviivan kohdalta. Tautipalapelin pohjassa asetettavien palojen on yhteensä 6, neljä pyöreää sairautta ja neljä kulmista rakoteltavaa. Käytä toppää käärittämään palat oikeisiin paikkoihin. Irrota palat varovasti aurasäven taudin läpikäyntiä varten.



Appendix 4: Healthy eating habits

## Ohjeita terveelliseen ruokavalioon

Hyvän ruokavalion vaikutuksia elimistöön	Huonon ruokavalion vaikutuksia elimistöön
<ul style="list-style-type: none"> <li>✓ Säilyttää näkökykyä – voi estää tai viivastuttaa ikään liittyviä näköongelmia kuten silmänpohjan rappeumaa, kaihia, likinäköisyyttä, kuivumista ja tulehduksia</li> <li>✓ Korjaa vahingoittuneita soluja aivoissa ja hermostossa</li> <li>✓ Parantaa merkittävästi oppimiskykyä ja motorisia taitoja</li> <li>✓ Hillitsee masennusta</li> <li>✓ Alentaa veren kolesterolia</li> <li>✓ Parantaa verensokerin hallintaa</li> <li>✓ Pienentää sydäntautien ja diabeteksen riskiä</li> <li>✓ Vahvistaa sydämen lihaksia</li> <li>✓ Lisää vastustuskykyä ja voi estää sairastumista tai tulehduksia</li> <li>✓ Auttaa ehkäisemään tauteja ja elimistön vanhenemista</li> <li>✓ Vähentää vatsarasvaa ja sydän- ja verisuonitautien riskiä</li> <li>✓ Laskee painoa ja kokonaisrasvan määrää sekä vähentää maksan rasvaa, joka voi aiheuttaa lihavuutta ja diabetesta</li> <li>✓ Tulehduksia vähentäviä antibioottisia vaikutuksia</li> <li>✓ Estää ummetusta ja parantaa ruuansulatusta</li> <li>✓ Voi estää ja pysäyttää syövän kasvua</li> </ul>	<ul style="list-style-type: none"> <li>✗ Ravintoaineiden puutos saa ihon ja hiukset voimaan huonosti ja aiheuttaa uupumusta, päänsärkyä, alakuloa ja keskittymisvaikeuksia</li> <li>✗ Lisää hampaiden reikiintymistä aiheuttavien bakteerien kasvua suussa</li> <li>✗ Aiheuttaa verensokerin epätasapainoa, mikä aiheuttaa alakuloisuutta ja uupumusta</li> <li>✗ Nostaa adrenaliinin määrää, mikä lisää elimistön stressiä</li> <li>✗ Lisää muiden vaarallisten aineiden määrää veressä, jotka voivat aiheuttaa diabetesta, sydän- ja verisuonitauteja ja maksan sairauksia</li> <li>✗ Aiheuttaa epäterveellistä painonnousua</li> <li>✗ Elimistö saa liian vähän tai ei ollenkaan tarvitsemiaan ravintoaineita</li> <li>✗ Voi aiheuttaa ummetusta kuidun ja veden puutteen vuoksi</li> <li>✗ Saa solut vanhenemaan nopeammin</li> </ul>

## Appendix 5: Feedback survey

### Palautelomakkeen saatekirje

Hyvä Suomen Punaisen Ristin terveystieteen asiakas!

Suomen Punaisen Ristin terveystieteillä testataan Punaisen Ristin ja Punaisen Puolikuun kansainvälisen liiton tuottamaa tarttumattomien tautien ennaltaehkäisyyn ja hoitoon liittyvää materiaalia. Kerään palautetta materiaalista ja sen soveltuvuudesta Suomeen ja SPR:n terveystieteille osana Laurea-ammattikorkeakoulussa tekemääni ylemmän ammattikorkeakoulun opinnäytetyötä. Palaute auttaa meitä kehittämään materiaalia terveystieteiden käyttöön, ja antamaan palautetta myös kansainväliselle liitolle materiaalin toimivuudesta Suomessa.

Olisin erittäin kiitollinen jos täyttäisitte ohjauksen jälkeen lomakkeen (1 A4) ja antaisitte sen terveystieteen vapaaehtoiselle minulle edelleen postitettavaksi. Henkilötietojanne ei kerätä, eikä henkilöllisyytenne paljastu missään tilanteessa. Kaikki lomakkeet ja niihin tallentamanne tiedot käsitellään yksityisyytenne suojaten, eikä tietoja käytetä muuhun tarkoitukseen. Lomakkeet hävitetään silppuamalla opinnäytetyön hyväksymisen jälkeen.

Suuret kiitokset etukäteen!

Ystävällisin terveisin, terveydenhoitaja Annika Kaarnalehto,  
SPR Lounais-Espoon osasto, Laurea ammattikorkeakoulun yamk-opiskelija  
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SPR:ssä kehittämistyön yhteyshenkilönä toimii: Kristiina Myllyrinne,  
[kristiina.myllyrinne@redcross.fi](mailto:kristiina.myllyrinne@redcross.fi)



## Punaisen Ristin ja Punaisen Puolikuun kansainvälisen liiton (IFRC) Tarttumattomat taudit- materiaalin käyttö SPR:n terveysteipiteillä Palautelomake

Päivämäärä: \_\_\_\_\_

Terveysteipite: \_\_\_\_\_ SPR:n piiri: \_\_\_\_\_

### Ympyröi oikea vaihtoehto

1. Sukupuoli: a) Mies      b) Nainen      c) Muu
2. Ikä: \_\_\_\_\_ vuotta
3. Olen terveysteipiteellä a) Asiakas      b) Vapaaehtoistyöntekijä
4. Terveysteipiteellä käytetty materiaali: a) Tarttumattomat taudit      b) Liikunta  
c) Ruokavalio      d) Tupakointi      e) Alkoholi      f) Ensiaputilanteet  
g) Terveysteipiteen käyttämisen muutos      h) Kyselylomake
5. Materiaali soveltuu Suomen Punaisen Ristin Terveysteipiteellä käytettäväksi mielestäni  
a) huonosti      b) melko huonosti      c) melko hyvin      d) oikein hyvin
6. Mikä materiaalissa oli erityisen hyödyllistä tai kiinnostavaa?

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7. Mitä parannettavaa tai soveltumatonta materiaalissa huomasit?

---

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8. Missä muissa tilanteissa/ryhmissä materiaalia voisi mielestäsi hyödyntää?

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### Seuraavat kysymykset ovat vain Terveysteipiteen asiakkaille:

9. Kyselylomakkeen elintapateipiteiden perusteella (kohta B) riskini sairastua tarttumattomaan tautiin on

a) suuri (4-6 p.)      b) keskinkertainen (7-11 p.)      c) pieni (12 p.)

10. Minulla on jo todettu tarttumaton tauti tai pitkäaikaissairaus, joka on:

a) diabetes      b) sydän- tai verisuonisairaus      c) krooninen keuhkosairaus  
d) syöpä      e) muu pitkäaikaissairaus      f) ei ole todettu mitään näistä

11. Käytyäni läpi materiaalin käsitykseni omista riskeistäni muuttui

a) ei ollenkaan      b) hieman      c) melko paljon  
d) huomattavasti

12. Sain materiaalista uutta tietoa

a) ei ollenkaan      b) hieman      c) melko paljon  
d) huomattavasti

**KIITOS OSALLISTUMISESTA!**

## Appendix 6: Modifications

### KORJAUSEHDOTUKSET

#### Aihepiiri 1

##### 1.1

- Nimeksi esim. Työväline 1, 2, jne. (Aihepiirin sijaan), järjestys ja numerointi vasta viimeksi
- Korjaa ”krooniset hengitystiesairaudet ”-> krooniset keuhkosairaudet?

2. Kerro: Korjaa ”..., vaan jotka ovat tavallisesti seurausta...” POIS-> tilalle ”..., vaan ovat usein elintavoilla ehkäistävissä olevia kroonisia kansantauteja.”

##### 3. Lisäys:

- Mihin sairauksiin nämä riskitekijät mielestäsi vaikuttavat?
- Voit käyttää tässä Palapeliä. Palapelin avulla voi havainnollistaa sekä herättää keskustelua neljän elintapatekijän vaikutuksesta kunkin taudin syntyyn.

##### 4. Kerro:

- Lisäys: Olemalla aktiivisia ja liikkumalla säännöllisesti
- Lisäys:

##### Sydän-ja verisuonitaudit Suomessa

- Sepelvaltimotauti, sydämen vajaatoiminta ja aivoverenkiertohäiriöt yleisimmät
- Suurin yksittäinen kuolinsyiden ryhmä
- Aiheuttavat vajaan puolet työikäisten kuolemista
- Kaikki neljä elämäntapaa vaikuttavat
- Mitkä muut tekijät vaikuttavat? (korkea verenpaine, perintötekijät...)
- 80% olisi ehkäistävissä elintavoilla
- <https://www.thl.fi/fi/web/kansantaudit/sydan-ja-verisuonitaudit>

##### Syöpä Suomessa

- Joka 3. suomalainen sairastuu syöpään jossakin vaiheessa elämäänsä
- Toiseksi yleisin kuolinsyy Suomessa
- Yleisimmät syövät Suomessa: Rintasyöpä joka 8. naisella, miehillä eturauhassyöpä
- Kaikki neljä elämäntapaa vaikuttavat
- Mitkä muut tekijät vaikuttavat? (auringon valo, säteilylle altistuminen, tulehdukset, perinnöllisyys...)
- 1/3 ehkäistävissä elintavoilla
- <https://www.thl.fi/fi/web/kansantaudit/syopa>

### Krooniset hengitystiesairaudet Suomessa

- Astma, COPD yleisimmät
- Astmaa n. 10%:lla suomalaisista, COPD ilmenee keski-ikäisillä ja vanhemmilla: yli 64-vuotiaista 12% miehistä ja 3% naisista
- Tupakointi vaikuttaa astmaan ja aiheuttaa lähes aina COPD:n
- Muita kroonisia hengitystiesairauksia mm. krooninen poskiontelontulehdus, nuha, yskä, uniapnea
- Mitkä muut tekijät vaikuttavat? (perinnöllisyys, ympäristötekijät...)
- [http://www.terveyskirjasto.fi/terveyskirjasto/tk.koti?p\\_artik-keli=dlk00029&p\\_haku=keuhkoahauma](http://www.terveyskirjasto.fi/terveyskirjasto/tk.koti?p_artik-keli=dlk00029&p_haku=keuhkoahauma)
- <https://www.thl.fi/fi/web/kansantaudit/astma-ja-allergiat>

### Diabetes Suomessa

- Tyypin 1 ja 2 ovat yleisimmät
- Aiheuttaa pitkäaikaisesti kohonneen verensokerin
- Tyypin 1 diabetesta sairastaa Suomessa n. 50 000 ja tyypin 2 diabetesta n.500 000
- 2-tyypin diabetekseen vaikuttavat kaikki neljä elämäntapaa
- Mitkä muut tekijät vaikuttavat? (perinnöllisyys, ikä, MBO...)
- <https://www.thl.fi/fi/web/kansantaudit/diabetes>

### 1.3

Kuva:

- Soita 112 (tai vie henkilö heti lääkäriin -> POIS), **myös tekstiosuus ja 1.4 ja 1.5 kaikki kohdat**

- Korjaus: Anna henkilön ottaa omaa lääkettään, jos hän pyytää, tai anna ASA 250 mg pureskeltavaksi (sama korjaus tekstiosuuteen)

- Lisäys: Seuraa autettavan hengitystä ja tajunnan tasoa avun paikalle tuloon saakka. (sama lisäys tekstiosuuteen ja 1.4 ja 1.5 kaikki kohdat)

Ensiapu rintakipukohtauksessa:

- Kun veri ei pääse sydämeen...-> Korjaus: Sepelvaltimotautikohtauksessa veri ei pääse sydämeen verisuonten tukkeutumisen vuoksi. Tämän seurauksena osa sydänlihasta menee kuoliin, ja aiheuttaa jopa hengenvaarallisia oireita.

### 1.4

- Aivoinfarkti syntyy...->Korjaus: Aivoverenkiertohäiriöllä (AVH) tarkoitetaan aivoverenkierrossa tapahtuvaa joko tilapäistä, korjaantuvaa häiriötä (TIA) tai pysyvää vauriota aivoinfarktin tai aivoverenvuodon seurauksena.

- Millaisia oireita?



Korjaus: Oireet ilmaantuvat nopeasti, ja niiden tunnistaminen ja varhainen hoitoon hakeutuminen on tärkeää.

Tavallisimpia oireita ovat:

- Halvausoireet: yleensä toispuoleinen käden ja/tai jalan voima- ja/tai tuntoheikkous

\* Suupielen roikkuminen

\* Puhehäiriö

\* Näköhäiriö: molemmilla silmillä nähtävät kaksoiskuvat tai näkökentän puutokset

\* Tasapainohäiriö, kävelyvaikeus ja huimaus yhdessä

Oireet ovat useimmiten kivuttomia.

Aivoverenvuotoon voi liittyä äkillinen ja kova päänsärky.

### 1.5

Kuva:

- Mielialan heilahtelut -> korjaa: vaihtelut
- Otsikosta pois ”tai nousu”
- POIS: Jos henkilö pystyy...
- Korjaus: Jos henkilö pystyy-POIS: -> Auta häntä ottamaan sokeripitoista syötävää tai juotavaa hoidoksi. Tajuttoman suuhun ei laiteta mitään.
- Korjaus: Jos henkilö on tajuton-POIS:-> Jos sokeripitoinen syötävä tai juotava ei auta, oireet eivät helpotu tai jos henkilö on tajuton, soita 112.

Teksti:

- Otsikko ”tai noustessa”-POIS
- Lisäys: 2 virke: Tyypillisimpiä ovat verensokerin laskun oireet.
- Oireet voivat vaihdella...POIS
- Numerointi oireista pois.

Lisäys: Korkea verensokeri voi aiheuttaa happomyrkytyksen eli kooman. Happomyrkytys syntyy hitaasti ja on insuliinisokkia harvinaisempi. Insuliinin puuttuminen johtaa ensin happomyrkytykseen ja lopulta tajuttomuuteen eli koomaan. Tila on hengenvaarallinen ja vaatii aina sairaalahoitoa. Oireita ovat väsymys, pahoinvointi, vatsakivut, punakka iho, syvä hengitys ja asetonin haju hengityksessä, uneliaisuus ja tajunnan häiriöt. Keskustelkaa verensokerin nousun oireista, ja mitä tilanteessa tulisi tehdä.

## Työkalu 2

### 2.3

Kuva:

- Säilyttää näkökykyä...POIS-> Ylläpitää näkökykyä.
- Korjaa vahingoittuneita...POIS
- Parantaa merkittävästi...POIS
- Hillitsee masennusta-POIS-> Parantaa mielialaa ja toimintakykyä
- Vahvistaa sydämen lihaksia -> Vahvistaa lihaksia.
- Auttaa ehkäisemään tauteja...-> Auttaa ehkäisemään tarttumattomia tauteja.
- Vähentää vatsarasvaa jne. POIS
- Lisäys: Auttaa nivelten toimintaa ja lihasmassan ylläpitoa
- Laskee painoa ja kokonaisrasvan määrää (loput pois lauseesta)
- Tulehduksia vähentäviä...POIS
- Voi estää...POIS
  
- Ravintoaineiden puutos... ”alakulua POIS”-> tilalle ”mielialan laskua”
- Aiheuttaa verensokerin epätasapainoa (loput POIS)
- Nostaa adrenaliinin...POIS
- Lisää muiden vaarallisten aineiden...POIS
- Elimistö saa liian vähän...POIS
- Lisäys: Nostaa veren kolesterolipitoisuutta ja altistaa sydän- ja verisuonisairauksille
- Lisäys: Nostaa verenpainetta

Teksti: Ohjeita terveelliseen ruokavalioon:

#### 2. Kerro:

- Kun elimet eivät toimi kunnolla tai lopettavat toimintansa, ihminen voi sairastua vakavasti. (loput POIS)
- Sokeripitoisten juomien... POIS

Tarkastellaan...POIS.

#### 4. Kysy:

- Rajoita rasvan, sokerin ja suolan määrää ruoassa. (loput POIS)
- Lisäys: Yksi annos on esimerkiksi keskikokoinen hedelmä, 1 dl marjoja tai 1,5 dl salaattia tai raastetta.

#### 5. Kysy:

- Miltä tuntuu tietää...POIS
- [http://www.ravitsemusneuvottelukunta.fi/files/attachments/fi/vrn/ravitsemussuositukset\\_2014\\_fi\\_web.3\\_es.pdf](http://www.ravitsemusneuvottelukunta.fi/files/attachments/fi/vrn/ravitsemussuositukset_2014_fi_web.3_es.pdf)

## 2.1

### Tupakointi

- Kurkku: Aiheuttaa kurkun ja äänihuulten syöpää.
- Sydän: Voi tukkia verisuonia, lisää (ei edistää) sydänkohtauksen...
- Sukupuolielimet: Lisää sukupuolielimien syöpäriskiä sekä miehillä impotenssia

### Alkoholi

- Aivot: Lisäys: Voi aiheuttaa mielialan laskua ja unihäiriöitä

### Epäterveellinen ruokavalio-juliste

- Aivot: Korjaus: Voi aiheuttaa uupumuksen ja/tai masennuksen tunteita, päänsärkyä ja keskittymisvaikeuksia
- Lisäys: Suolan, rasvan ja sokerin liiallinen syöminen aiheuttavat riippuvuutta ja lisäävät mielihaluja syödä epäterveellisesti
- Suu ja hampaat: Suolan, rasvan...POIS
- Muut elimet: Korjaus: Mikäli elimet eivät saa syömästäsi ravinnosta kaikkia tarvitsemiin aineksia, elimet eivät suoriudu tehtävästään. Tästä voi seurata niiden sairastumista ja toimintakyvyn heikkenemistä.
- Nostaa adrenaliinin...POIS
- Lisäys (uusi laatikko) Iho: Ravintoaineiden puutos saa ihon ja hiukset voimaan huonosti

### Liikunnan puute-juliste

- Iho-laatikko pois

## Työkalu 3

### Minä:

- Korjaus: kehon liikkeessä pitävää toimintaa-> liikkumista
- Lisäys: (Yksi annos on esimerkiksi keskikokoinen hedelmä, 1 dl marjoja tai 1,5 dl salaattia tai raastetta.)
- Lisäys: (THL 2016: Yksi alkoholiannos on esim. 0,33 l keskiolut/siideri, 12 cl lasi viiniä tai 4 cl viinaa.)
- Naama 2 pistettä: Juon 1-2 annosta-> korjaus: Juon korkeintaan 2 annosta
- Harmaa laatikko: What your self-assessment...POIS koko laatikko
- Punaiset laatikot: B Elintapapisteet yhteensä-Korjaa B->A ( C->B, D->C)
- C (->B): Korjaus: Esiintyykö lähisuvussasi tarttumattomia tauteja (sydän- ja verisuonisairauksia, diabetesta, kroonisia hengityselinsairauksia tai syöpää)?
- D (->C) Itsearviointisi kokonaispisteet: Korjaus: Laske yhteen A- ja B-kohtien pisteet.
- Korjaus: 2-7 pistettä: Sinulla on epäterveellisiä elintapoja, ja suurentunut riski sairastua tarttumattomaan tautiin. Suositellaan hakeutumista terveydenhuollon ammattihenkilön vastaanotolle. 8-13 pistettä: Sinulla on joitakin epäterveellisiä elintapoja tai

muita riskitekijöitä. Mieti voisiko elintapamuutoksesta olla hyötyä riskien alentamiseksi. Hakeudu tarvittaessa terveydenhuollon ammattilaisen vastaanotolle. 14 pistettä: Hienoa, elintapasi ovat kunnossa!

#### **Terveystarkastus:**

- Jos olet nainen, oletko raskaana-POIS
- Tutkimuspaikka-> Vastaanottopaikka
- Lääkäri- ja laboratoriotutkimukset (verensokeri ja Kolesteroli -osuudet) POIS
- Painoindeksitaulukko liitteeksi esim: <http://www.turku.fi/sites/default/files/atoms/files/painoindeksitaulukko.pdf>
- Verenpaine: Korjaa: välillä 90/60-120/80 ->alle 129/84 (sininen naama), välillä 120/80-140-90 -> välillä 130/85-139/89 (oranssi naama)
- Painoindeksi: Yli 30 tai alle 18,5
- Huom. Jos verenpaine on alle..., POIS
- terveystarkastuksen tulos: 3 sinistä: Korjaus: Hienoa! Jatka samaan malliin. 1-2 Oranssia: Hyvä! Arvosi ovat vielä kohtuullisia. Kannattaa kuitenkin tarkkailla elintapoja, ja käydä säännöllisesti terveydenhuollon ammattilaisen vastaanotolla. 1-3 Harmaata: Sinulla voi olla riski sairastua tarttumattomaan tautiin. Suositellaan varautumaan aika terveydenhuollon ammattilaisen vastaanotolle.

Suunnitelmani terveempään elämään: (lisää tilaa) kts. erillinen dokumentti.

#### **Työkalu 4**

##### **Lisää:**

##### **Terveyskäyttäytymisen muutoksen vaiheet: ohjeet**

Taulukkoa voi käyttää apuna elintapamuutosten vaiheiden havainnollistamisessa. On tärkeää tiedostaa, että mikään elintavan muutos ei tapahdu nopeasti tai itsestään, vaan edellyttää mm. tietoa, harkintaa, hyväksyntää, aikomusta ja valmistautumista ennen toteuttamisvaihetta. Muutos ei myöskään useinkaan etene suoraviivaisesti ruudusta toiseen, vaan muutosta yritetään useita kertoja, palaten välillä edelliseen vaiheeseen, ennen kuin pysyvä muutos saadaan aikaiseksi. Monesti motivaatio muutokseen löytyy vasta jonkin taudin tai oireen ilmaantumista.

Vaiheet saattavat olla myös tiedostamattomia, ja kestää vuosikausia. Olisi silti tärkeää takapakeista huolimatta jatkaa muutosta, tiedostaen muutostoiveen, ja sen vaikeuden, syyt. Henkilölle saattaa muodostua epäonnistuneista muutosyrityksistä vääristynyt käsitys omasta pystyvyydestään, eli kyvystään vaikuttaa omiin asioihinsa tai terveyteensä. Pienetkin onnistumiset tukevat pystyvyyttä, ja motivoivat jatkamaan elintapamuutosta.

Voitte esimerkiksi pyytää osallistujia keskustelemaan pienryhmissä tai keskustella asiakkaan kanssa kahden kesken jostakin elintavasta jonka haluaisivat muuttaa, ja missä vaiheessa asian

kanssa ovat menneet. Onko muutos edennyt nopeasti, vai onko jossakin vaiheessa oltu jo vuosia? Onko jokin vaihe hypätty yli? Onko tullut takapakkia ja siirrytty edeltäviin vaiheisiin? Miten päästä seuraavaan vaiheeseen? Mikä on konkreettinen seuraava askel kohti tavoitettasi, jonka toteutat?

**Tutustu myös esim. Muutosvaihemalliin: Esiharkinta - Harkinta - Valmistautuminen - Toiminta - Ylläpito**

<http://www.hyvis.fi/lan/fi/terveysteemat/teemana-painonhallinta/Documents/El%C3%A4m%C3%A4ntapamuutoksen%20vaiheet.pdf>

## Työkalu 5

### 5.2

Tupakkajuliste

- Aivot: Lisäys: Nikotiinivieroitusoireet helpottuvat 3-4 viikon kuluessa.
- Lisäys: Unen laatu ja kesto paranevat.
- Keuhkot: Lisäys: Keuhkot alkavat puhdistua 1 vrk kuluttua
- Korjaus: Keuhkojen värekarvat pystyvät puhdistamaan keuhkoja ja pienentämään tuheludusriskiä 9 viikon kuluessa lopettamisesta
- Suu ja hampaat: Lisäys: Maku- ja hajuaisti terävöityvät 2 vrk kuluttua lopettamisesta
- Sydän ja veri: Sydän- ja verisuonitautien riski on sama...POIS
- Lisääntymiselimet: Lisäys: Miehen erektio-ongelmat vähenevät

Teksti: Tupakoinnin lopettamisen vaikutuksia

- Korjaus: Kymmenen vuoden kuluessa:.....syövän riski on alempi-> vähenee.
- Viidentoista vuoden kuluessa: Sepelvaltimotaudin riski on sama kuin henkilöillä jotka eivät ole koskaan polttaneet yhtään tupakkaa. Loppu eli Riski kuolla... POIS
- <http://www.stumppi.fi/portal/etusivu>

### 5.3

Alkoholijuliste

- Sydän ja veri: Lisäys: Verenpaine alenee.
- Muut elimet: Korjaus: Maksa alkaa toipua ja maksasyöpäriski vähenee
- Lisäys: Suolistosyöpäriski vähenee
- Lisäys: Vatsavaivat vähenevät
- [http://www.julkari.fi/bitstream/handle/10024/129668/TT\\_Alkoholiris-kit\\_PAINO.pdf?sequence=1](http://www.julkari.fi/bitstream/handle/10024/129668/TT_Alkoholiris-kit_PAINO.pdf?sequence=1)

Teksti: Alkoholinkäytön vähentämisen vaikutuksia

2. Vaikka olosi on...POIS
- Tilalle: Painonhallinta helpottuu ja mieliala paranee.

3. Kysy: Muuta kaikki kysymykset sinä-muotoon!

- Miltä sinusta tuntuu?-kysymykset POIS
- Lisäys, 2. kysymys: Oletko huomannut alkoholinkäytöstä haittavaikutuksia?
- Lisäys 3. Kysy -osion loppuun (Suurkuluttajille saattaa tulla vieroitusoireita...): Vapinaa, levottomuutta, sydämen tiheälyöntisyyttä, hikoilua, puhevaikeuksia, sekavuutta, harhoja

#### 5.4

Juliste

- Vatsa ja sisäelimet: Korjaus: Sisäelimesi toimivat tehokkaammin ja ulostaminen normalisoituu.
- Säilyttää näkökykyä...POIS
- Aivot: korjaa vahingoittuneita aivo-ja hermosoluja POIS
- Muut elimet: Maksa toipuu...jne. Kuuluu kohtaan Vatsa ja sisäelimet
- Lisäys: Muut elimet: Ihon kunto paranee.

Teksti: Terveellisen ruokavalion vaikutuksia

1. Kerro: Lisäys 1. kappaleen perään: Suomalaisissa ravitsemussuosituksissa päivittäisestä energiasta suositellaan tulevan 45-60% hiilihydraateista (viljavalmisteet, kasvikset, marjat ja hedelmät), 25-40% rasvoista (2/3 tyydyttymättömistä rasvahapoista), sekä 10-20% proteiinista (liha, kala, kananmuna). Ihminen tarvitsee myös riittävästi nesteitä päivittäin (1-1,5 litraa/vrk). Ateriarytmi kannattaa pitää säännöllisenä, ja syödä ateriat pitkin päivää n. 3-5 tunnin välein.

- Korjaus: auttaa kamppailemaan-> auttaa ehkäisemään sairauksia.
- Numerointi ja aikamääreet pois kaikista (nro 1.-13.)!
- Korjaus: 1. välittömästi -> jo lyhyessä ajassa.
- Korjaus: 9. ...ulostaminen normalisoituu. Verisuonissa oleva haitallinen kolesteroli alkaa hiljalleen poistua.
- 12. Kaikkien on tärkeää...POIS. Tarttumattomien tautien riski vähenee.
- 13. Korjaus: Elimistösi saa tarvitsemiaan vitamiineja ja kivennäisaineita, ja verensokeri ja insuliinitasot normalisoituvat.

2. Kysy:

- söi aiemmin -> syö
- oli->on, söit-> syöt

- Suolansaannin rajoittaminen: Lisäys: Varo piilosuolaa! Missä uskot piilosuolaa olevan?
- Sokerinsaannin rajoittaminen: lisäys: Varo piilosokeria! Missä uskot piilosokeria olevan?
- Rasvansaannin rajoittaminen: Grillaa POIS. Leikkaa rasva pois...POIS. Tilalle: Suosi vähärasvaisia elintarvikkeita.

Lisäys: Rasvan laatuun tulee kiinnittää huomiota, ja suosia tyydyttymätöntä rasvaa (kasviöljyä, pähkinöitä, siemeniä ja rasvaista kalaa) ja välttää tyydyttyneitä rasvoja, kuten eläinrasvoja. [http://www.ravitsemusneuvottelukunta.fi/files/attachments/fi/vrn/ravitsemussuositukset\\_2014\\_fi\\_web.pdf](http://www.ravitsemusneuvottelukunta.fi/files/attachments/fi/vrn/ravitsemussuositukset_2014_fi_web.pdf)

## 5.5

### Juliste

- Aivot: Korjaus: Stressistä palautuminen nopeutuu.
- Keuhkot: Sisään- ja uloshengitystä...POIS. Tilalle: Hengitys tehostuu: hengitysilhakset vahvistuvat ja hengästyminen vähenee.
- Lihakset ja nivelet: Nivelet tulevat vakaammiksi POIS, Tilalle: Nivelrusto ja niveltä ympäröivät kudokset vahvistuvat. Liikelaajuudet säilyvät ja jäykistyminen vähenee.
- Luut: Luiden leveys ja tiheys kasvavat -> Korjaa: Luuntiheys kasvaa, ja alttius murtumille pienenee.

### Teksti: Liikunnan vaikutuksia

1. Kerro: Lisäys 1. kappaleen loppuun: Suomessa terveystieteiden tutkimusten mukaan Suomessa kestävyysliikuntaa (kuten arkiliikuntaa, pyöräilyä tai kävelyä) 2 h 30 min. tai rasittavaa kestävyysliikuntaa (kuten juoksua, hiihtoa tai pallopelejä) 1 h 15 min. viikossa. Lisäksi suositellaan lihaskuntaa ja liikehallintaa ylläpitävää liikuntaa (kuten kuntosalia, jumpaa tai tanssia) 2-3 kertaa viikossa.
2.
  - Luiden leveys ja tiheys -> Luuntiheys
  - Sydänlihas vahvistuu (ja kasvaa POIS)
  - Sinulla on enemmän verta...POIS
  - Korjaus: Keuhkosi ja hengitysilhaksesi vahvistuvat.
  - <http://www.ukkinstituutti.fi/ammattilaisille/terveystieteiden-suositukset>

Appendix 7: Project plan model

**Terveysprojektisuunnitelma**

**MALLI**

1. Tarvekartoitus:

Tiedon keräys ja analysointi tarpeiden määrittämiseksi.

Esim. alueen / väestön riskit, haavoittuvimmat ryhmät, esiintyvät sairaudet/tapaturmat, olemassa olevat interventiot, prioriteettien määrittäminen:

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2. Päämäärän ja tavoitteiden asettaminen:

Mitä halutaan saavuttaa?

Esim. konkreettinen tavoite osallistujamäärästä ja saavutettavasta terveyshyödyistä. Terveyshyödyn vaikuttavuus?

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3. Menetelmän valinta:

Miten yllä olevat tavoitteet saavutetaan? Mitkä ovat toteutusmenetelmät?  
Tarvittavat resurssit?

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4. Terveysprojektin toteutus

Aikataulu: Kuka tekee mitä ja koska?

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5. Arviointi

Miten tulokset saavutettiin? Pystytäänkö tulokset tai vaikuttavuus mittaamaan?  
Miten projektin tuloksia voidaan parantaa seuraavalla kerralla?

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(Lähde: McKenzie J., Neiger, B. & Thackeray, R. 2013. *Planning, Implementing, and Evaluating Health Promotion Programs. A primer. 6th ed. Pearson International edition*)



## Appendix 8: Research permission

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2.5.2016  
TUTKIMUSLUPAPYYNTÖ

Suomen Punainen Risti  
Kristiina Myllyrinne  
Osoite: Tehtaankatu 1 A, 00140 Helsinki

### SPR:N TERVEYSPISTEIDEN MATERIAALIN ARVIOIMINEN JA KEHITTÄMINEN

Pyydän täten lupaa suorittaa arviointitutkimusta SPR:n Terveyspisteillä testattavan Punaisen Ristin ja Punaisen Puolikuun kansainvälisen liiton tuottaman Tarttumattomien tautien materiaalin käytön yhteydessä. Materiaali on valikoitu yhteistyössä SPR:n keskustoimiston kanssa, ja suomennettu ja taitettu Keskustoimiston toimeksiannosta.

Materiaalia testataan eri SPR:n Terveyspisteillä touko-kesäkuun aikana 2016. Sekä Terveyspisteen asiakkaat että vapaaehtoiset saavat vastata palautekyselyyn, joka suoritetaan paperilomakkeella (liite 1, toinen sivu). Opiskelija (A.K.) kerää vastaukset kesän 2016 aikana, analysoi ne SPSS-ohjelman avulla ja tekee tulosten yhteenvedon ja parannusehdotukset SPR:n keskustoimistolle elo-syyskuun aikana.

Palautelomakkeessa ei kysytä nimeä, eikä vastaaja ole tunnistettavissa. Palautelomakkeeseen liitetään tietoisuuden suostumuksen lomake joka jää asiakkaalle (liite 1, ensimmäinen sivu). Palautelomakkeet kerää vaitiolovelvollinen Terveyspisteen työntekijä, ja lähettää allekirjoittaneelle. Palautelomakkeen vastauksia ei käytetä muuhun tarkoitukseen.

Materiaalin valikoinnista, lähettämisestä ja palautteen keräämisestä on sovittu SPR Keskustoimiston työntekijän Kristiina Myllyrinteen kanssa.

### OPINNÄYTETYÖN TIEDOT:

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Ohjaava opettaja: Teija-Kaisa Aholaakko, yliopettaja, Laurea-amk, p. 046-8567348

Ystävällisin terveisin  
Annika Kaarnalehto

Espoo 2.5.2016

Appendix 9: Example of the modified score counting and feedback

