World Health Organization Regional Office for the Western Pacific Region
Healthy Cities Recognition 2018

Community Outreach to Improve Health Literacy and Self-care for Better Management of NCDs

Background

Noncommunicable diseases, which include cardiovascular diseases, diabetes, cancer, chronic respiratory diseases, kill about 40 million people every year and are responsible for 80% of all deaths in the Western Pacific Region. The detection, screening and treatment of noncommunicable diseases (NCDs), as well as palliative care, are essential components of the response to NCDs.

One of the overarching principles in the Western Pacific Regional Action Plan for the Prevention and Control of Noncommunicable Diseases (2014–2020) is: Empower Individuals, families, communities and societies for them to be involved in activities for the prevention and care of NCDs. This should be done based on evidence-based guidelines, patient registries and team-based patient management, including through information and communication technologies (ICT) such as eHealth and mHealth. The importance of empowering people and developing their personal skills and capacity to make informed decisions about health – that is, improving health literacy – is also a key objective in the Regional Action Plan on Health Promotion in the Sustainable Development Goals 2018-2030.

The Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development, endorsed at the 9th Global Conference on Health Promotion, highlighted four transformative pathways – good governance, healthy cities, health literacy and social mobilization – to accelerate action on health and well-being to achieve sustainable development. Health literacy is recognized as a critical determinant of health and countries are called to strengthen health literacy in the population, increase citizen's control of their health and its determinants by tapping on the potential of digital technology, and ensuring consumer environments support healthy choices. To promote health and well-being for all, there is a need to engage and move people to action, mobilize communities and draw on local resources and insights, which can inform appropriate methods and messages.

For the purpose of this Call, applicants could consider actions that reach out to and engage communities to achieve any of the following three levels of health literacy for better management of NCDs:[1]

(1) Core health literacy – communication of health information results in an individual benefit; focuses on conveying understanding of concepts and on teaching basic skills that help the individual function in everyday situations. Examples: reading health information, filling out forms, taking medicine as directed.
(2) Engaged health literacy – individuals are better able to act independently through increased knowledge, motivation and self-confidence; focuses on critical and interpersonal skills. Examples: interacting effectively with healthcare providers, identifying and using community resources, sharing health information with others.
(3) Influential health literacy – individuals gain greater control over their life events and situations; advanced skills impact understanding and action on both individual and

[1] Nutbeam, D. Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. Health Promotion International. 2000; 15(3): 259-267.

community levels. Examples: considering credibility, validity, and reliability of health information, participating in community efforts to improve health literacy, implementing curricula and training programmes focused on health literacy.

Recognition of Best Practice

Cities that have implemented community outreach programmes or tools aimed at improving health literacy and self-care to better manage noncommunicable diseases are eligible to apply for recognition as a best practice. Programmes and tools may address all four main NCDs, cardiovascular diseases (which include stroke and heart attack), diabetes, cancer (including palliative care), chronic respiratory diseases (which include asthma and chronic obstructive pulmonary disease), or may focus on one specific NCDs. Policy documents, studies and photos that demonstrate policy or infrastructure change may be submitted.

For further information, please contact:

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Call for Applications for Best Practice

Title Page

a. **Thematic area**

b. **City and Country name**

c. **Full title of the project**

d. **Contact details**
   i. Responsible person submitting the proposal
   Please provide contact details (name, title, affiliation, email, address, telephone, fax)

   ii. Additional contact person
   Please provide contact details (name, title, affiliation, email, address, telephone, fax)

***[Note: Please keep to the word limits as that will be taken into account in the scoring process.]**

1. **Executive Summary (300 words)**
   Please describe the intervention, who is the target population, what was done (strategies or activities), when was it implemented, and the achievements.

2. **Background (350 words)**
   a. Please describe why this project or intervention was proposed. Please describe the results from surveys, situation analysis, interviews, focus groups, needs assessment or consultation conducted to identify the problem/need being addressed

   b. Please describe the problem being addressed.

   c. Please describe other existing programmes, challenges and impact.

   d. Please describe the social and cultural context in relation to the problem.

3. **Objectives**
   Please specify the proposed objectives (i.e. the anticipated outcome) and the period/timeline of the project.

4. **Planning structure (Maximum 1 page)**
   Please describe the core planning team; the settings where the project was carried out; the target population; and the activities, tasks, milestones, timeline, budget and source of funding.

5. **Multi-stakeholder collaboration (300 words)**
   a. **Community participation**: Please describe how the collaboration with community members including the target population, took place in the planning, implementation and/or evaluation phase of the initiative.

   b. **Other stakeholders (e.g. other government agencies, NGOs, private sector)**: Please describe how the collaboration with other sectors took place in the planning, implementation and/or evaluation phase of the initiative. Please also describe whether resources were shared (i.e. financial or technical).

6. **Equity (200 words)**
   Please provide evidence of the participation of marginalized and/or vulnerable groups (e.g. female or youth) during the planning and/or implementation/evaluation processes; and/or describe interventions that target them.

7. **Replicability or Scalability (300 words)**
   Please describe how the programme (activities, expertise and resources) can be scaled up and be applied and adapted to other settings or sites.

8. **Effectiveness or impact assessment (350 words)**
   a. Please provide evidence of programme achievements in relation to proposed objectives (e.g. improvement in health status, adoption of new law or policy). If possible, show or describe changes from baseline to the current status in 2016. Please provide supporting documents where available.

   b. Please describe how evaluation, surveys, data or routine monitoring were utilized to assess progress and outcomes.

9. **Measures for sustainability (300 words)**
   a. Please describe how the programme is or will be sustained. For example, through city ordinance, city government commitment, community ownership, regular budget allocation, etc.

10. **Bonus (Optional): Theoretical basis (200 words)**
    Please describe how theories of change (i.e., theories of behaviour change, policy development, social marketing, etc) have been utilized for programme development and implementation.