

# Empowerment of individuals with chronic diseases and community through group support approach

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## Background

- Chronic disease is the major health problem in China.
- Chronic diseases are not curable and severely affect the patients' functional capability and quality of life

## NCD prevalence ( % ) in China (2008)

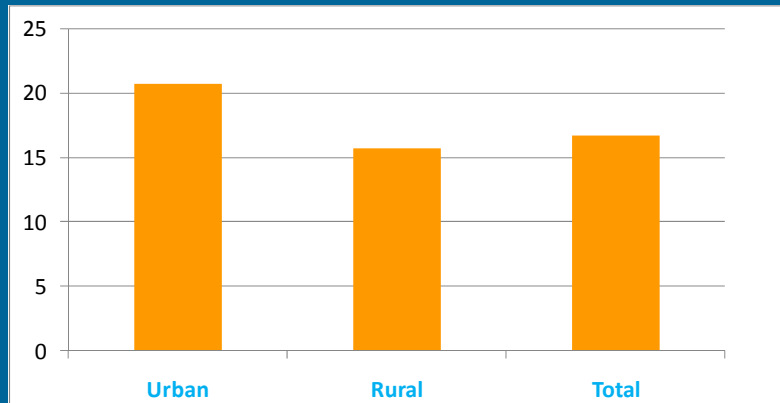


Table 1. Proportion of the elderly with chronic diseases

Number of Chronic diseases	Number of the aged	Number of Proportion(%)
No diseases	462	22.3%
One disease	622	30.2%
Two diseases	499	24.2%
Three and more	476	23.3%

(Resources: community-based survey in Shanghai with 2059 elderly people)

Table 2. The prevalence of the five leading chronic diseases

Disease	Number of patients	
Prevalence(%)		
Hypertension	755	36.7%
Heart diseases	519	25.2%
Peptic diseases	447	21.7%
Arthritis or rheumatics	436	21.2%
COPD	312	15.2%

Table 3. The number of chronic diseases and the rate of ADL impairment

Number of diseases impairment	Number	Rate of patients
Zero	462	10.0%
One	622	13.2%
Two	499	16.0%
Three and more	476	22.9%

$(X^2_{Trend}) = 31.9$  P Value= 0.00

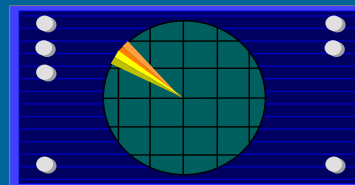
Table 4. The severity of the disease and the rate of ADL impairment

severity Scores of disease impairment	The number of ADL	The rate of patient
1	809	13.3%
2	723	18.8%
3	65	41.5%

$(X^2_{Trend}) = 27.5$       P value = 0.00

## Current situation for NCD care approaches

- For acute condition
- Less attention to patients
- No continuous following up



X



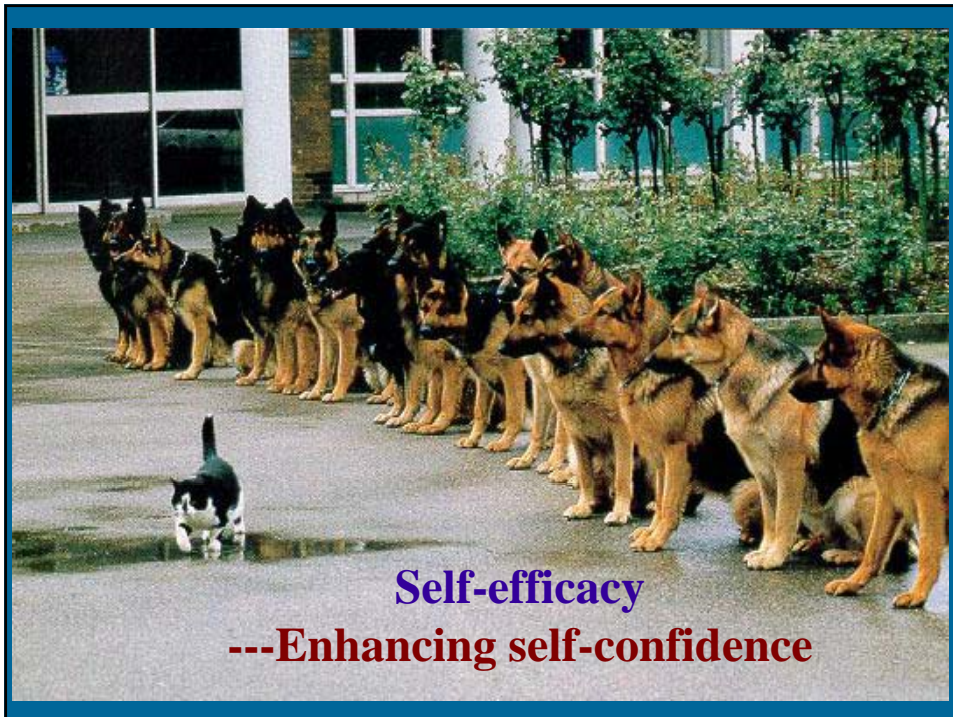
20-50% of adherence

=

Poor quality of life

## Background

- Facing with the challenge, we should explore an innovative approach at lowest possible cost.
  - Theory-directed
  - Focus on empowering skills and confidence
  - Suitable for patients with different kinds of chronic diseases
  - can be taught in any place in the community
  - Lay-led and healthworker-supported group approach



**Self-efficacy**

**---Enhancing self-confidence**

## Community mobilization

- Community meetings and canvass
- Community training workshop
- Posting Program Post on the community Bulletin Board
- Handing out CDSMP brochure

## Management cycle



## Empowerment skills for self-management

### 1. Problem-solved skill

- 1) What is my problems
- 2) Suggestions
- 3) Self-choose and practice
- 4) Evaluation after practice
- 5) Continue or change another one
- 6) Ask helps
- 7) Accept reality

### 2. Decision-making capacity

### 3. Goal setting and action plan

### 4. Finding community sources

## Implementation

### CDSMP course Leading

- Course leading way:
  - Using “Leaders Manual”, two leaders work in pair to teach a group with 10 to 15 participants
  - CDSMP is a seven-session patient education course given once each week for seven consecutive weeks. And each session takes about 2 hours

## Implementation CDSMP course Leading

- Content of CDSMP course:  
exercise; use of cognitive symptom management techniques; nutrition; fatigue and sleep management; use of medications; dealing with the emotions of fear, anger, and depression; communication with others including health professionals; problem-solving; and decision-making

## Implementation CDSMP course Leading

- Teaching place: the community Senior Center, Patients' house
- Materials needed: small blackboard, chalk, flip Chart, "Leaders Manual" and helpbook
- Process:
  1. Mobilization and course arrangement meeting
  2. Leaders deliver the course
  3. summarizing and reward meeting

## Evidence from our studies

### Randomized studies showed that :

Behaviour change ( exercise... )

Health condition improvement ( pain, fatigue... )

Health services utilization ( seeing doctors, hospitalized days )

SBP and DBP in the intervention groups decreased by 10.77mmHg and 2.20mmHg compared to the control.

The community welcome  
CDSMP

*"After taking Self-management courses, I feel more confident, the life is hopeful again, and I feel the community like a warm big family....."*

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**Best Practices in Health Care for Chronic Conditions**

... Committed to health care improvement

SPOTLIGHT

**Evidence**  
This section presents some examples from the literature on innovative programmes for chronic conditions.  
[More information](#)

**Best Practices Database**  
The best practices database provides examples of care for chronic conditions that have demonstrated positive outcomes from different parts of the world.  
[More information](#)

**The Network of Innovators**  
Links people worldwide to WHO's network of experts, researchers and country teams who are involved in improving health care for chronic conditions.

WHO sites

- [Brazil](#)
- [China](#)
- [Finland](#)
- [Ghana](#)
- [India](#)
- [Iran \(Islamic Republic of\)](#)
- [New Zealand](#)
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The best practices database is designed to promote the exchange of ideas. It provides examples of care for chronic conditions from different parts of the world. The examples presented are either from the literature, or are country experiences that have demonstrated positive outcomes but are not reported in scientific journals.

For studies/cases to be included in the database, the following general criteria were followed:

1. Studies/cases must report objective measures of at least one of the following items:
  - Improvement of patient outcomes (e.g., mortality, adverse effects, pain, etc.).
  - Improvement of professional performance (process measures or professional outcomes).
  - Improvement of resource utilization (economic variables).
2. Studies/cases must be related to chronic conditions or address policy issues that have implications for chronic conditions.
3. Study/case interventions are not standard practice, but they have been introduced to improve processes and outcomes and they have resulted in hypothesized change.

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**Chronic Disease Self-Management in Shanghai**

[printable version](#)

Dango F. et al. Implementation and quantitative evaluation of chronic disease self-management programme in Shanghai, China: randomized controlled trial. *Bulletin of the World Health Organization* 2003;81(3):174-82.

**Objective:**  
To evaluate the effectiveness of the Shanghai Chronic Disease Self-Management Program (CDSMP).

**Methods:**  
A randomised controlled trial with six-month follow-up compared patients who received treatment with those who did not receive treatment (waiting-list controls) in five urban communities in Shanghai, China. Participants in the treatment group received education from a lay-led CDSMP course and one copy of a help book immediately, those in the control group received the same education and book six months later.

**Findings:**  
In total, 954 volunteer patients with a medical record that confirmed a diagnosis of hypertension, heart disease, chronic lung disease, arthritis, stroke, or diabetes who lived in communities were assigned randomly to treatment (n=526) and control (n=428) groups. Overall, 430 (81.7%) and 349 (81.5%) patients in the treatment and control groups completed the six-month study. Patients who received treatment had significant improvements in weekly minutes of aerobic exercise, practice of cognitive symptom management, self-efficacy to manage own symptoms, and self-efficacy to manage own disease in general compared with controls. They also had significant improvements in eight indices of health status and, on average, fewer hospitalizations.

**Conclusion:**  
When implemented in Shanghai, the CDSMP was acceptable culturally to Chinese patients. The programme improved participants' health behaviour, self-efficacy, and health status and reduced the

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## Dissemination

- All communities in Shanghai
- Other cities such as Guangzhou, Dalian, Shenyang in China

