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**LIFESTYLE COACHING AND A SALUTOGENIC MODEL FOR LIFE SKILL DEVELOPMENT AND TRANSFERABILITY FOR DIABETES AND HYPERTENSION RISK GROUPS, THAILAND**

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**ABSTRACT**

Lifestyle coaching has become one of the most effective lifestyle development programs for the prevention of non-communicable chronic diseases worldwide. This research aims to 1) increase life skill development and transferability of lifestyle coaches, and 2) change lifestyle behaviors of diabetes and hypertension in at-risk groups. The author collected data from 80 lifestyle coaches and 160 diabetes and hypertension people from at-risk groups in Kamphaengphet, Thailand. A salutogenic model was applied in order to reveal influences of optimal socio-cultural conditions on the creation of behavioral changes among the risk groups. A thematic analysis was adopted for 240 in-depth interviews. Four life skill development lessons were presented to the participants during the interviews with several training scenarios. The results indicated that the salutogenic concepts of sense of coherence (SOC) including meaningfulness, comprehensibility and manageability stimulated optimal social conditions for the life skill development. By focusing on establishing little moments of success, general resistance resources (GRRs) provided positive social interactions and opportunities in shared resources to deal with stressors. The lifestyle coaching increased socio-cultural spaces for meaningful moments of successful experiences among the risk groups. Simultaneously, the coaching provided affordable, significant transferability strategies for the coaches and the risk groups.

**KEYWORDS:** Lifestyle Coaching, Salutogenic Model, Transferability

**1. INTRODUCTION**

Overwhelming scientific evidence indicates the relationship between socio-cultural factors and the root causes of non-communicable chronic diseases worldwide (United Nations System Standing Committee on Nutrition, 2018). There are crucial factors related to the lifestyle of the people in at risk groups (incorrect nutrition, insufficient physical activity, stress, alcohol consumption, smoking tobacco). Related factors also include health professionals' practices and organizational culture like ineffective screening, improper counseling, and passive performances (Roberts & Barnard 2005; Gordon, 2013; Gordon et al., 2017).

Researchers highlight that changing both lifestyle behaviors and providing effective intervention can help mitigate the progression of non-communicable chronic diseases and reverse existing conditions

(Gordon et al., 2017). Unfortunately, only a few social science interventions have been developed for potentially preventing lifestyle-related chronic diseases (Gordon, 2013). Additionally, there is very limited knowledge on how lifestyle coaching can establish optimal socio-cultural conditions for life skill improvement and create strategic transferability at the community level (Super, Verkooijen, & Koelen, 2018).

Among non-communicable chronic diseases, type 2 diabetes and hypertension are the most common lifestyle-related chronic diseases (Mozaffarian et al., 2015). World Health Organization (2016) announced that about 422 million people worldwide have diabetes, especially those living in low and middle-income countries. Although there is a globally agreed upon target to halt the rise in diabetes and obesity by 2025, studies show that sugary consumption has risen as well as the number of people living or dying with diabetes. Apart from diabetes, hypertension is another non-communicable chronic disease related to people's lifestyle. Studies revealed that having hypertension could increase risk factors for cardiovascular disease and premature mortality or disabilities of the people in at-risk groups worldwide (Forouzanfar et al., 2015; Mills et al., 2016).

Although lifestyle intervention has become the national health guideline for health professionals, studies reveal that physicians from low-income countries often fail to give proper counseling about these issues. Reasons for this situation include a lack of concern about the significance of lifestyle changing and also because of care providers commonly working with intensely busy schedules, limited resources, little compensation for providing preventive services and working in a poorly equipped infrastructure (Gordon, 2013).

Currently, the lifestyle coaching program (LCP) has been implemented in various public health settings. It is a multidisciplinary approach based on a socio-medical framework. This innovative framework comprises several learning approaches, behavioral change models and sustainable self-care development strategies. Traditionally, the program was monitored by nonphysical health professionals such as social workers, social psychologists and social scientists, however, the LCP has become popular among physicians and other related physical health professionals. Additional research indicates the effectiveness of LCP in terms of its positive modification of social lifestyle behaviors (Tamminen & Holt, 2012; Super et al., 2015). Similar studies from specific sources have exhibited that the LCP reflected the recent advances of social sciences in prevention of risk factors for several chronic diseases (Jakobsson, 2014; Light & Harvey 2015). Therefore, an effective LCP intervention not only results in avoidable human suffering from death and disability it helps save governments money for long term treatment and improving health care services in low income countries (Roberts & Barnard 2005; Gordon, 2013).

At the dawn of the 21st century, the major health threats were non-communicable diseases. In developing countries, the rise of chronic non-communicable diseases such as diabetes, hypertension, stroke and heart disease reflects changes in lifestyle as well as aging. This situation increases the

socio-economic burden for the risk groups as well as national budgeting. Since 2005, Thailand is one of the Asian countries moving closer towards becoming an ageing society faced with the increases in diabetes and hypertension. The National Economic and Social Development Board (NESDB) declared that the number of ageing residents in Thailand has increased to 11.23 million, or 17.13 percent of the total population in 2017. This will make the country become a full-fledged ageing society by 2021 (Office of the National Economic and Social Development Board, 2017). Furthermore, Thailand's current changes in population structure will result in a higher prevalence of non-communicable chronic diseases. These include lifestyle-related chronic diseases; especially type two diabetes and hypertension. The Bureau of non-communicable diseases of Thailand (2019) reported the number of deaths from hypertension had risen to 8,525 persons in 2017 (13.07: 65,204,797 population). The number of diabetes patients who died in 2017 was 14,322 persons (21.96: 65,204,797 population). The Country Cooperation Strategy (CCS) 2017-2021 for Thailand has announced WHO's medium-term strategic vision to Thai state organizations. Among the core components of CCS, non-communicable chronic disease is one of the five priority areas of the work. To overcome this quality of life challenge, increasing partnership engagements, catalyzing positive change and building sustainable institutional capacity are emphasized (World Health Organization, 2017). Therefore, changing the lifestyles of the diabetes and hypertension of at-risk people is not an option. It is an urgent health crisis requiring immediate action at the policy, district and individual behavior levels. To maintain sustainable productivity, a better social policy for non-communicable disease requires both well designed social policy planning and good implementation.

This article applies the salutogenic perspective from the health promotion field to investigate roles of lifestyle coaches. Salutogenesis is associated with the use of life experiences to cope with everyday challenges. In this research, the components of a sense of coherence (SOC), meaningfulness, comprehensibility, and manageability are used as a means to discuss coping with everyday challenges. These components involve the ability of diabetes and hypertension at-risk groups to engage in the general resistance resources (GRRs) in order to cope with stressors. This article offers affordable, evidence-based and comprehensive lifestyle intervention programs for the diabetes and hypertension at-risk groups. These intervention programs have been tested and evaluated as to effectiveness in a district of Thailand. The programs help to develop self-efficacy and managerial skills of the lifestyle coaches as well as increasing positive lifestyle behaviors among the risk groups.

## **2. THEORETICAL FRAMEWORK**

The salutogenic model is a positive socio-medical development paradigm. The model appreciates the assets and abilities of individuals to cope with life's threats and to manage available resources to meet demands of everyday life. According to Antonovsky's (1979; 1987), a salutogenic approach aims to uncover the root cause of people's well-being. The approach is concerned with the relationship between healthy lifestyle, stress and coping. It focuses on the social causes and cultural factors that support human well-being and increases individuals' ability to deal with their own everyday life challenges rather than the disease. By empowering individuals to improve their life

skill management, experiences become the crucial resources. Therefore, stresses or life challenges are not always negative; on the contrary, they can be salutary if individuals have the ability to learn in order to deal with them effectively.

The salutogenic model is based on the belief that a strong sense of social coherence (SOC) can help individuals mobilize resources to cope with their stress and cultural risk lifestyle. To maintain healthy lifestyle, sustaining and understanding practical transfer strategies is crucial. First, individuals need to identify and understand the lifestyle challenge they are confronting (comprehensibility). Then, they need to be able to identify root causes and resources to deal with the challenges (manageability). Last, they must feel the meaningfulness of changes in both their perception and behaviors. For Antonovsky (1987), increasing ability to deal with lifestyle challenges is reflected in the sense of coherence (SOC) which consists of three factors: meaningfulness, comprehensibility, and manageability. SOC is defined as 1) stimulation derived from the dynamic feeling of individuals' confidence which arises from internal and external environments in the structured, predictable and explicable course of living; 2) this stimuli has resources available to meet the individuals' demands; and 3) these demands have worth to invest, challenge and engage. The resources are found within each individual and called general resistance resources (GRRs). GRRs include social-cultural capital, empowerment, coping ability, social support, and social network (Antonovsky, 1987).

Although several quantitative studies investigate the correlations between SOC and health behaviors as well as health outcomes (Humphrey, 2013), not many studies apply SOC in the field of socio-medical studies as regards the lifestyle of non-communicable chronic diseases, type 2 diabetes and hypertension. Thus, the researcher adopted the salutogenic approach and lifestyle coaching for increasing optimal social conditions and for lifestyle behavioral changes among the risk groups.

### **3. RESEARCH METHODOLOGY**

The study was conducted in an appropriate setting in order to study optimal social conditions for life skill development and transferability of lifestyle coaches and meaningful experiences for diabetes and hypertension in at-risk groups in coping with everyday lifestyle challenges. Kosumpinakorn district located in Kamphaengphet, a lower northern province in Thailand was chosen because of its significant increase of the diabetes and hypertension people in at risk groups during the last three years (Kosumpinakorn Tambon Health Promoting Hospital, 2018).

#### **3.1 Study design and key informants**

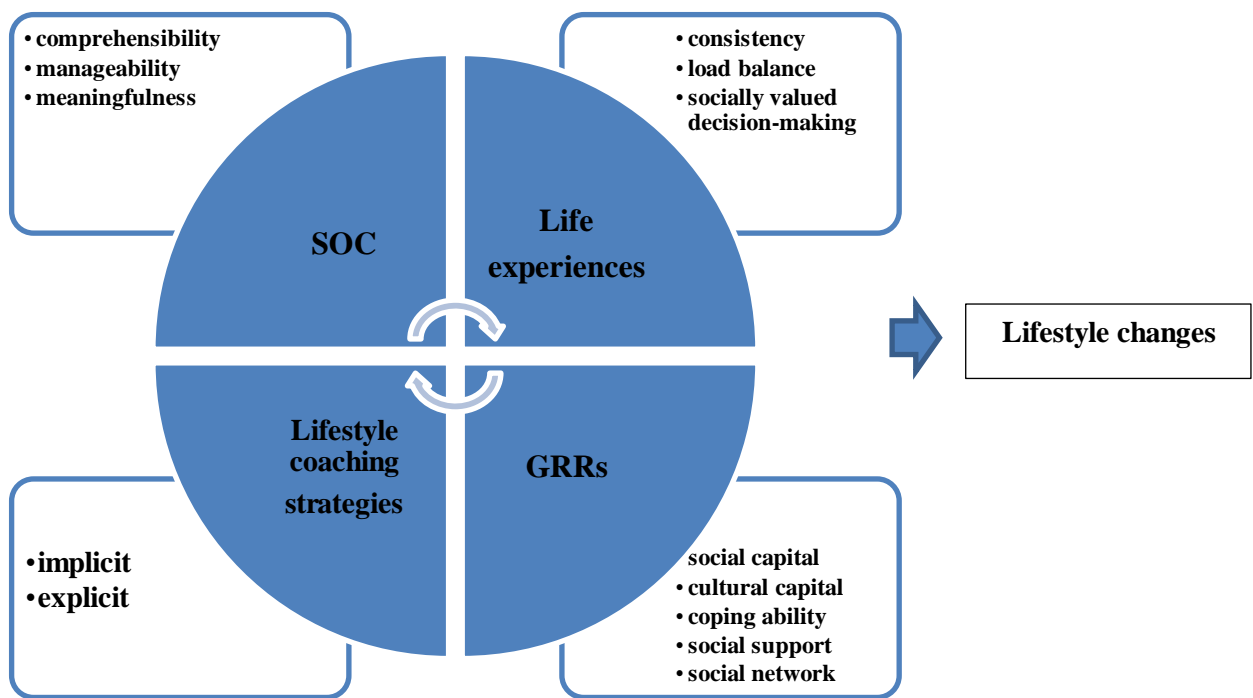
Two groups of key informants were selected respectively. First, 80 district lifestyle coaches were voluntarily recruited. Then, 160 diabetes and hypertension risk groups who had been screened by Kosumpinakorn tambon health promoting hospital were targeted. The risk groups included males and females who had systolic blood pressure (SBP) = 120-139 mmHg., a diastolic blood pressure (DBP) = 80-89 mmHg., or, a fasting plasma glucose test of (FPG) = 100-125 mg/dL.

Qualitative data was gathered from both coaches and the risk groups. First, the researcher adopted a salutogenic model. By focusing on the life skill development of the lifestyle coaches, three senses of coherence components (SOC) were investigated (meaningfulness, comprehensibility and manageability). Then, grounded theory was applied to uncover the three characteristics of life experiences, which help empower SOC: consistency, load balance and socially valued decision-making. Using the salutogenic framework, a thematic analysis was conducted of 80 in-depth interviews with the lifestyle coaches. Together with the interviews, the lifestyles coaches were recruited in four learning scenarios. Each scenario concerned not only knowledge but how to cope with the stressors, how to improve life skill, and how to manage resources in order to stay well. To ensure anonymity, pseudonyms were assigned to all key informants. The interview recordings were transcribed verbatim style. Coding categories were derived and formulated from text data. The data was analyzed using software for qualitative data analysis and thematic analysis was conducted based on the guidelines of Braun and Clarke (2006).

The analysis process began with familiarizing oneself with the data and constructing initial codes. The deductive approach led by the salutogenic model was mapped into the data set. The major SOC components of meaningfulness, comprehensibility, and manageability were investigated. After the initial coding, the codes were ordered into themes and then the thematic data mapping was developed. Only codes that fit the themes were reviewed. To ensure that the codes were categorized correctly, a data triangulation approach was applied. The first version of the results was discussed with the key informants until agreement was reached. Then, the second version was examined by the researcher for theoretical soundness to ensure an accurate interpretation. The results were discussed with key informants and lifestyle experts in the regional forum of district health system management development towards SDGs in Phitsanulok, Thailand in 2018.

Quantitative measurements of lifestyle behavioral changes of the risk groups were analyzed using descriptive statistics: mean, percentage, t-test and standard deviation. The achievement of the groups was measured by their lifestyle behavioral changes and their engagement with the coaching team. According to Clear (2018), changing a lifestyle is a habit not an event. Therefore, occasionally participation in some project activities is not enough to change non-preferable lifestyle nor to create optimal conditions for life skill development. Both target groups needed to fully commit to the social process of identity changes, which included 1) meaningfulness as a precondition for engagement and positive learning; 2) comprehensibility as a condition to make health problems insightful; and 3) manageability as a strategy to balance between stressors and resources. To achieve these goals, four learning scenarios were applied. The learning process was continually organized in the community learning platforms at the district level. Dates and times of participation were decided based on participants' convenience.

3.2 Conceptual framework



Picture 1 Salutogenic framework for life skill development and transferability

4. RESULTS

The results are divided into three major parts. The first part displays the optimal conditions based on the salutogenic concepts. The second part shows the life skill development and transferability emerging from the creation of little moments of success during the lifestyle coaching. The last part presents the lifestyle changes of the two risk groups. These included an understanding of the everyday lifestyle challenges and behavioral changes in terms of eating, exercise, and emotional management.

4.1 Creation of optimal conditions for life skill development

The optimal conditions based on the salutogenic concepts have increased the sense of coherence (SOC) among lifestyle coaches including meaningfulness, comprehensibility and manageability. This section summarizes how and why the application of salutogenesis in life skill development practices can create meaningful experiences which help the diabetes and hypertension persons in at-risk groups develop their life skill to cope with their lifestyle challenges.

## **4.1.1 Meaningfulness: the precondition for engagement and social learning**

To increase engagement of the coaches, effective communication is a precondition for meaningfulness. For the lifestyle coaches, communication is a tool for the delivery of health education, an important part of research to support health policy and also essential for lifelong social interaction and commitments. Communications are the key success factors for life skill development.

*We are not only speaking to the risk groups, but we learn to speak their culture. Some of them are our neighbors; many are our friend's parents. They have come to us by motorcycle carrying vegetables or fruits from their garden and giving to us with compliments. These gifts symbolize friendship, a promise for long-term commitment and meaningfulness of life.*

Because of the poverty, the lifestyle coaches are mostly aged and live alone. Some are retired state officers. Many are community health volunteers whose spouses or children are away studying or working in construction sides. The friendly environment during primary care service allowed them to share their skills during their visit and to enhance motivation. This ensured that they would come back for the next learning sessions. The coaches had valuable insights into various aspects of the community. As they remarked:

*We are very lonely...we appreciated the hospital's invitation and permission for showing our vegetables and food during our visits. We felt that we were accepted as a part of the team. Coming to the hospital for training is more enjoyable and meaningful. We don't want to be labelled as "patients" or "useless elderly". We just wanted to be active citizens who are taking parts of meaningful activities.*

During the precondition sessions, meaningful activities for team building are crucial. The traditional "ice breaking games" are useless for these lifestyle coaches. To achieve life skill development goals, it is important to create little moments of sharing experiences, complimenting their active participation, and being supportive when they attempt to take on a new lifestyle challenge.

*Although money is necessary for basic needs but living with dignity is the only compliment, we can manage our own life. It's nice to talk about our successful experiences and know that we are good at something.*

## **4.1.2 Comprehensibility as a condition to make health problems insightful**

Most of lifestyle coaches believe that coaching is a main strategy to create little moments of success for the risk groups. They have realized the value of their experiences (comprehensibility), understood their capacity (meaningfulness), and they are happy that they could use their skills to improve their community (manageability). As one of the coach leaders mentioned that he felt more involved the way the sessions were arranged and presented during the coach trainings. Many coaches felt they were parts of the learning session in a meaningful atmosphere.

*Normally, the health education is boring and time consuming. We usually were informed with such a short notice to come and listening to the experts...paying for our travelling expenses, having 3 in 1 instant coffee breaks with cheap sweet biscuits, having a quick lunch and then go home. These kinds of training go on and on many times a year, especially in September when some annual budgets need to be spent.*

Lifestyle coaches reflected that they love “role play”, group learning, and “show and tell” activities. These techniques stimulated them to be more specific about their problematic lifestyle instead of focusing on teaching and giving instructions. The techniques allowed them to think, to ask specific questions related to their lifestyle, and to take active roles in their wellbeing. As a female coach stated:

*Many of us are retired government officers...some are farmers. We have some successful stories to share. We have learnt via numerous health trainings and social media. We understand the necessity of changes and we want to know how to change.*

All coaches can identify three main lifestyle challenges in everyday living, eating, exercise, and emotional management. Many can quit smoking and alcohol consumption. They can also understand the situation of being unable to transfer a practical knowledge to the risk groups. One volunteer community health worker mentioned:

*As community volunteer health workers, we have been working hard and actively participated in all health promotion activities with the monthly payment of 600 baht (\$U.S.20). Being a coach is not about money, it's about how we can look after our own life and not getting sick because we are too poor to be sick.*

#### **4.1.3 Manageability as a strategy to balance between stressors and resources**

The lifestyle coaches indicated the power of their teamwork. Their management skill was increased. This skill helped them create values, norms, rules, symbols, team structure, and roles among their coaching team. They also included the team as a part of the district health management structure. These lifestyle coaches indicated their team's characteristic conduct as:

*We are active lifestyle coaches who are happy and willing to take action on non-communicable disease, follow up the work we have started, providing useful advice to the risk groups, having a good team work, and playing an important role in lifestyle coaching with friendship and healthy mind.*

Lifestyle coaches mentioned that they shared similar difficulties with the risk groups. While the coaches had to deal with demanding workload, low payment, and uncertain health policy, the risk



groups are dealing with poverty, uncertain natural disasters, and time-consuming health services. Several coaches stated that staying healthy is the best preference. However, better related lifestyle policies are also crucial. These are healthy food, enough public space for exercise, poverty reduction, continual universal health coverage, and enough community lifestyle learning platforms. As a coach stated:

*We are working at the community level, without good support from the policy planner and it's really difficult to reach our goals. Food stalls in schools and in the markets are selling unhealthy food. Lots of sports equipment were rusty left uncared for because of their alienation from the community's lifestyle. All we ask is a competitive social environment that could offer the risk groups extra motivation to perform lifestyle changes.*

## **4.2 Lifestyle coaching and transferability**

Lifestyle coaching is a major strategy for enhancing the capacity of the diabetes and hypertension in at-risk groups. Coaching allows the risk groups to make their own choices and to transform those choices into desired lifestyle behaviors. The lifestyle coaching program (LCP) aims to maximize the benefits of the risk groups in order to apply and to understand useful information, to make decisions and to take a life challenge. This research identified major characteristics of LCP as a continuity of learning strategy and social process that leads to positive transferability of life skill development to a wider domain. LCP begins with engagement, assessing capacity and resources, formulating positive responses, implementation and systematic evaluation. Two coaching strategies are either implicit or explicit. The implicit transfer strategies focus on creating friendly, fun and safe atmosphere for lifestyles. This strategy was well suited for the risk group of retired government officers and middle-class background. Most of them had experienced various training at an educational or a therapeutic workshop. The explicit strategy focuses on self-discipline, lessons of health promotion and therapeutic setting. However, most of lifestyle coaches seemed to love a fun activity organized informally at the community setting. One female peasant who turned herself to a lifestyle coach stated:

*For us, everyday living is already tough. It's not only the inequality, but also changing our lifestyle. We have not many choices, we eat what we are having even it's not a healthy food.*

The life skill transferability from the coaches to the risk groups was related to their social-cultural background such as living condition, social network, social capital and social interactions within their societal domains. Most of the coaches indicated that lifestyle transferability should be a part of the everyday living, based on voluntary mindset and trust. The training sessions reflected the three major concepts of sense of coherence (SOC) of the salutogenic approach (meaningfulness, comprehensibility, manageability) as well as the general resistance resources (GRRs/ socio-cultural capital, social support, social network).

The most practical LCP comprises a set of ideas and practices in four learning scenarios: 1) self-care for the diabetes and hypertension in at-risk groups including the 3 Do's (eating behavior, exercising, emotional management) and the 2 Don'ts (smoking and drinking alcohol); 2) coping with the stressors; 3) improving life skill by creation of a little moment of success; and 4) managing resources based on social capital and networking. For these coaches, health education is useful but not preferable. Full and energetic participations were conducted when using lesson learned, color therapy, team working, and role-playing. Several coaches agreed that: It's not only knowledge but also techniques and explicit strategies that we have learnt during each learning scenario. Role playing, games, demonstration of skill improvement, and exchanging our little moments of success with other lifestyle coaches from different provinces enhanced our network and social support. It helped us to realize our capacity.

### **4.3 Lifestyle changing**

This study found that the lifestyle coaching which has been developed from Fox's practice-based coaching model (2017) and a salutogenic approach could increase meaningful experiences, comprehensibility, and managerial capacity of the coaches. After the four learning scenarios, the participants had become active lifestyle coaches. They operated 72 community learning scenarios in 7 sub-districts' platforms. These platforms generated an effective cyclical lifestyle coaching process, which included strong lifestyle networks, shared experiences, shared experiences and goals, action planning, an active screening system, positive reflection and feedback.

#### **4.3.1 Social background of participants**

80 lifestyle coaches (100%) voluntarily participated in this project. 45% of these coaches were state health professionals, local administrative officers, school principals and members of civil society groups and 55% were volunteer community health workers. The average age of all coaches was 47 years old. They were low income farmers. Only few males joined the program. 160 diabetes and hypertension in at-risk groups participated in this project. 27.5% were males and 72.5% were females. 79.4% were poor farmers, street hawkers, casual labors who earned US\$ 3-5 per day. Their age was over 50 years old, and most had graduated secondary school level (90.6%).

#### **4.3.2 Changing behavioral lifestyle**

After engaging in the program, the risk groups could: 1) identify the root cause of lifestyle problems and cultural risk behaviors; 2) develop trust, ownership, meaning in life, demonstrate appreciative attitude, collaborative goal setting and public awareness; 3) exchange knowledge, shared experiences, and change social-cultural risk lifestyle. At the end of the program, the Kosumpinakorn tambon health promoting hospital revealed significant changes in four risky lifestyle behaviors concerning the "3 dos and 2 don'ts" (Table 1).

**Table 1 Modification of Lifestyle of the Risk Groups**

Lifestyle Behaviors	Before (n=160)		After (n=160)		t-test	p-value
	$\bar{x}$	S.D.	$\bar{x}$	S.D.		
Eating	2.90	.44	3.09	3.6	4.00*	.000
Exercise	2.83	.77	2.93	.77	1.045	.298
Emotional Management	3.56	.61	3.60	.57	.797	.427
Smoking Tobacco	3.54	.85	3.60	.78	1.185	.238
Alcohol Consumption	3.47	.88	3.62	.70	3.204*	.002
<b>Total</b>	<b>3.07</b>	<b>.32</b>	<b>3.20</b>	<b>.29</b>	<b>4.566*</b>	<b>.000</b>

df = 159\* = significant at 0.05

The findings revealed a more complicated aspect of communication processes between lifestyle coaches and the risk groups. It was not a simple and linear communication but a complex, symbolic dominant code structure. The learning scenarios were divided into four stages; each stage was autonomous but limited the possibilities of the next stage. The first stage was the technical needs production stage, which was influenced by involving institutional power-relations. Choosing the appropriate lines of communication channels, languages and gestures were the keys. Second, the circulation stage was highly related to the socio-economic background and power relations between the coaches and the risk groups. All information related to lifestyle changing was transmitted to communicate and strengthen the bonds between the two change agents informally and naturally. To establish the new social status and power relations, coaching became the symbolic vehicle constituted within the lifestyle changing program. Sets of socio-cultural relations and practices in discursive form were appropriated as a meaningful discourse based on the community's dominant ideologies, social beliefs and values of power relations.

Once achieved, the discourse was interpreted, translated, and transformed into lifestyle behavioral changes. For example, eating, tobacco smoking, and alcohol consumption were perceived as the tools for construction of personal taste with the aim of achieving collective self-esteem, preserving community identity and increasing group solidarity rather than only something to consume. Consumption was the third stage containing meaningful discourses. It was decoded, interpreted and understood based on individuals' experiences and beliefs. Lifestyles were not just actions but having symbolic meanings articulated into everyday practices. Understanding the discursive form of lifestyles provided a deep comprehensibility to life skill development. Drinking coffee or tea with baked goods or dessert, for instance, was perceived as a part of common lifestyle which the risk groups duplicated from the district health organizational culture. Physical activities such as aerobic

dance, running or using a fitness stick represented a new social status which symbolizing urban middle class's lifestyle.

Lastly, the reproduction stage included interpretation and reaction. Since the lifestyles represented tastes, class and preferable social status, both lifestyle coaches and the risk groups agreed that lifestyles were socialized, learned, and changeable. They also were considered as additional signs to interpret individual self and class identification representing their new patterns of social relationship in a wider social domain. Changing negative lifestyle was thus associated with good adaptation strategies and perceived as being a member of state organizations. Understanding roles and social functions of lifestyle opened cultural codes for a better life skill development.

## 5. CONCLUSION AND DISCUSSION

This article proposed two crucial arguments. First, the researcher emphasizes application of the salutogenic model as an affordable and effective transferability strategy for life skill development. She highlights transferability process based on friendly, meaningful shared experiences, fun and motivational climate for life skill development. She stressed that little moments of success and a sense of cohesion during each of the learning scenarios created comprehensibility and manageability among lifestyle coaches. This finding supports Antonovsky's concept of "meaningfulness" which highlights that "the demands are challenges, worthy of investment and engagement" (1979, p. 19).

According to Cronin and Allen (2015), the sense of meaningfulness increases a high level of engagement in life skill development activities. By providing community lifestyle learning platforms, a safe, natural and friendly climate generates little moments of success for the coaches. In a developing country where SOC is often obstructed by a passive learning culture, the three characteristics of life experiences: consistency, overload-underload balance and socially valued decision-making (Antonovsky, 1987) could be established by coaching actions. SOC reflects the ability of the coaches to orient themselves toward stressors and to deal with everyday lifestyle challenges. A clear structure during learning sessions creates consistency of trust. Lifestyle changing challenges coaches' capacity in manageability. It also helps them to realize their abilities and other challenges in their lifespan. Team working and the social network of multi-disciplinary coaches increases shared experiences of personal and life skill in terms of goal setting, initiative, self-confidence and leadership.

In sum, a salutogenic approach offers crucial transferability strategies as well as tools for life skill development among these coaches. Nonetheless, longitudinal studies are needed to confirm that the approach can improve life skill in other social domains. Second, the researcher challenges the linear relational framework of conventional health education. She suggests that lifestyle coaching provides a new and affordable framework of lifestyle changing. It increases an awareness of meaningful living and offers a better management of resources with the creation of a little moment of success in community learning platforms.

The Kosumpinakorn tambon health promoting hospital's Annual report (2018) assures the findings (Table 1). These findings differ from those of the Stanford Coronary Risk Intervention Project (Stanford Coronary Risk Intervention Project, 1994; Winkleby et al., 1996) in three aspects. First, they are more focused on the community's leverage instead of the SCRIP's one-on-one counselling by nonphysical health professionals. Second, the two interventions of this study highlight community engagement rather than individual self-help programs. Third, the study operates on grounded approach instead of Web enabled. The findings support the latest report of the World Economic Forum (Thornton & Hess, 2009) which shows one of the reasons for Spain's becoming the world's healthiest county is because of its effective public health policy based on screening and prevention strategy. Furthermore, this study outlines effectively managing the risk population is not only adhering to treatment recommendations, but also introducing them to healthy lifestyle behaviors (Wong-Rieger and Rieger, 2013); as well as strengthening district-level management (Fetene et al., 2019).

Applying the lifestyle coaching to the risk groups increases community awareness of preventable factors involving everyday lifestyle behaviors. This finding differs from others studies (Fox, 2017; Wong-Rieger & Rieger, 2013; Fetene et al., 2019) because the approach brings new actors into the community learning platforms. Therefore, it is not only the volunteer community health workers nor district health professionals but also the lifestyle coaches and the risk groups who become the active actors in the lifestyle changing challenges.

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