

EP-MON-001 INNOVATIONS IN HEALTH LITERACY PRACTICE FOR REDUCING INEQUITIES: IN HEALTH CARE SETTINGS

J. Pelikan¹

¹Keyresearcher, Ludwig Boltzmann Gesellschaft, LBIHPR, Wien, Austria

General description: This is the 3rd Symposium of a 3-part series on Health Literacy (HL). The evidence for HL as a social determinant of health has been recognized, and as such, it clearly influences health equity. Practice, policy, theory and research related to HL are all essential to achieve sustainable change and results. In the past decade, a wealth of global knowledge and experience has promoted HL as significant player in health promotion. Thus, the focus of the series is to provide a special opportunity for exploring the evolving HL concept/definition, measurement, practice in health services and community settings, policy initiatives and research. The sessions will include short presentations and demonstrations from leading experts from diverse regions of the globe, followed by discussion and debate with all participants. Participants will all be invited to join and become involved in an active international network for HL action, policy and research.

This third symposium on HL focuses on HL in Health Services and Health Care Settings especially concerning patients. HL for patients from the beginning has been one of the roots of HL, which in the last decade has been developed successfully.

Objective(s): Within the overarching objective of the Health Literacy Symposia Series, to examine HL as a social determinant and to understand the importance of a whole-systems approach to health literacy in order to promote equity and reduce inequalities, the objectives of symposium 3 are:

1. To present and discuss evolving facets of the concept of HL for patients, as a social determinant
2. To present examples of conceptual and formative research with regard to cultural and social settings
3. To understand the need for capacity building practice and policy with regard to HL in health care settings and the HPH network in particular and to learn of recent initiatives from around the globe.
4. To actively involve participants in debate and dialogue regarding all of the above.

EP-MON-002 HEALTH LITERACY ENVIRONMENT OF HOSPITALS, HEALTH AND SOCIAL SERVICE AGENCIES

R. E. Rudd*¹, O. R. Groene², L. Fleisher³, W. Lawrence⁴

¹Society, Human Development and Health, Harvard School of Public Health, Boston, United States, ²Health Literacy, HPH Catalan Network, Barcelona, Spain, ³Health Education, Fox Chase Cancer Center, Philadelphia, ⁴Professional Development, Literacy Assistance Center, New York, United States

Background: Links between literacy skills and health outcomes are firmly established and health literacy is a recognized social determinant of health. Health literacy, an interaction between the skills of individuals and the demands of health systems, is shaped by the context of public health and health care settings and by the communication skills of health professionals. Little attention has been given to the demand side.

Objectives: The first objective is to describe a mechanism for hospitals to assess their literacy environment and forge new policies to reduce barriers to access and care. The second objective is to report on the findings from measures of the health literacy environment of over 25 hospitals across 4 cities in the U.S. and Spain.

Underlying values and principles: This study is based on principles of social justice. A well documented mismatch between the skills of adults and demands of materials indicate the presence of unnecessary barriers to a wide range of civic activities including those related to health and access to care.

Knowledge base/ Evidence base: National surveys indicate that a majority of adults in most industrialized nations are not able to use everyday print materials with accuracy and consistency to accomplish mundane tasks. Over 1,000 peer-reviewed studies document a mismatch between adults'skills and demands of health materials.

Context of intervention/project/work: Health literacy researchers have been developing new methods to test the skills of patients. However, little if any attention has been given to the demand side of the health literacy equation. As accreditation agencies, such as the Joint Commission, highlight links between patient safety and literacy, a greater focus will be given to the literacy demands placed on the shoulders of patients and visitors.

Methods: Using an environment assessment tool developed by Rudd, researchers in four cities conducted walking interviews in hospitals, assessed a sample of available materials, and examined aspects of the oral exchange.

Results and Conclusions: Across all sites and cities, navigation was difficult and materials were cumbersome. Those involved in the walking interviews faced difficulty finding the main entrance and then lost their way as they tried to navigate to commonly used sites. Maps and signs were not helpful and often made use of technical words. Informants highlighted the good intentions and help of staff but also reported that they used medical terms and were inconsistent in words for places. Print materials were not well-organized, used jargon and scientific terms, and were written at levels that would prove difficult for those without university training.

Disclosure of Interest: None declared

EP-MON-003 HEALTH LITERACY AND BUILDING CULTURAL BRIDGES IN A NATIONAL HEALTHCARE SYSTEM – PRIMARY CARE, HOSPITALS, MEDIA AND BEYOND

D. Levin Zamir*¹, C. Kay², G. Verber³, O. Jacobson⁴, N. Lieberman³

¹National Department of Health Education and Promotion, ²Community Nursing Branch, ³Community Medicine Branch, ⁴Community Division, Clalit Health Services, Tel Aviv, Israel

Background: The systems approach to health literacy is critical in order to achieve results. Few organizations have the opportunity to influence health literacy in a systematic way, on a national basis.

Objectives: To integrate health literacy at all levels - primary care, hospital, community and mass media as a vital component of health promotion and a major vehicle for building cultural bridges.

Underlying values and principles: As health literacy is becoming recognized as a major social determinant of health, more investment must be made in all aspects -functional, interactive and critical.

Knowledge base/ Evidence base: Cultural competence and culturally appropriate health literacy methods are essential for reaching all populations.

Context of intervention/project/work: Clalit Health Services offers comprehensive health care services for over 4 million residents of Israel (54%), within a national universal health care system. The organization runs nearly 1400 primary care clinics, 14 hospitals, a national health information telephone service center and a comprehensive health service and health promotion website. The organization serves Israel's socially and culturally diverse population - 20% Arab speakers, 20% Russian speakers, 90000 are from Ethiopia and speak in Amaharic as well as others.

Methods: Health literacy as part of health promotion is integrated into the organization's strategic plan, as it is critical for changes in lifestyle, managing chronic illness, closing health indicator gaps and more. Health literacy needs are recognized and addressed throughout the life cycle, and in accordance with cultural considerations. Maximizing the use of the organizational infrastructure, primary care and hospital based programs provide a basis for individual, group and community programs and services. Mass media is used extensively for introducing and supporting health literacy initiatives, including, but not limited to web-based initiatives. Capacity building for health care staff is integrated into in-service training, with an emphasis on cultural competency and appropriateness.

Results and Conclusions: Process quality control indicates that health literacy is addressed in over 800 community clinics and in many departments in all hospitals. Media initiatives have high participation and exposure and are adapted to non-Hebrew speaking groups. Outcome evaluation of selected indicators have shown that people report better access to care, higher confidence levels in self-care and preventive behavior

Disclosure of Interest: All the authors are employees of Clalit Health Services

EP-MON-004 IDENTIFYING AND SUPPORTING PATIENTS WITH LOW HEALTH LITERACY

K. Sommerhalder*¹, S. Frey², S. Hahn²

¹Health, University of Applied Science, Berne, ² Health, University of Applied Science, Berne, Switzerland

Background: Health literacy facilitates patients in understanding their medical condition, in participating in their care, as well as in exerting greater control over their health and health related decision- making. Health professionals play a crucial role in helping patients to improve their knowledge regarding health related topics and in making healthy choices. However, in order for health education interventions to be effective, they need to be adapted to the patients' health literacy level and should support those patients with low health literacy. In order to accomplish this, a valid instrument is needed to identify patients with low health literacy.

Objectives: This study validates a screening instrument that identifies patients with low health literacy. In addition, this study develops a guideline to assist health practitioners in improving their patients' level of health literacy.

Underlying values and principles: Health literacy supports patients in making informed decisions concerning their health and in having greater control in health related issues. Identifying a patient's level of health literacy assists health professionals in developing tailored interventions to improve the patients' health literacy. In addition, if nurses are aware of the level of their patients' health literacy, they can when required, advocate among other key health professionals for clear patient education and information.

Knowledge base/ Evidence base: Health literacy has a significant impact on health. Patients with low health literacy have a greater risk for poor health and hospitalization, and follow fewer therapeutic and preventive instructions. Currently, there are no German instruments available for identification of patients with low health literacy.

Context of intervention/project/work: The study is in cooperation with two hospitals in Bern, Switzerland. The screening instrument is tested among patients within these two hospitals, and the guideline is developed in cooperation with nurses from these hospitals.

Methods: The chosen English screening tool was translated into German. The translated instrument is currently being tested among 200 patients in acute care hospital settings. The data will then undergo statistical testing and analysis to measure reliability and validity. A literature review about effective interventions to improve patients' health literacy will be undertaken in order to develop the guideline. The guideline will further be developed by integrating knowledge and experiences from hospital nurses. The guideline will describe standardized procedures for utilization of the screening instrument, as well as interventions assisting practitioners in supporting patients to improve their health literacy.

Results and Conclusions: The study is currently in the phase of ongoing data collection. Results of the study will be presented at the IUHPE Conference. The results are an important first step in assisting health care professionals to effectively and appropriately communicate health information and instructions to patients. The concept and relevance of health literacy is, in the Swiss health care system, still relatively unknown. This project increases the awareness of, and establishes a basis for, the central topic of health literacy. With this increased awareness, health care professionals may then become empowered to address the challenge of health literacy.

Disclosure of Interest: None declared

EP-MON-006 THE ROLE OF HEALTH LITERACY IN AN INTEGRATIVE WELLNESS AND PREVENTION PROGRAM: FINDINGS FROM A COLLABORATIVE COMMUNITY-BASED PROGRAM AT A FEDERALLY QUALIFIED HEALTH CENTER IN THE SOUTH BRONX, NEW YORK, U.S.

A. Pleasant^{*1}, R. Warf¹, C. Sardo², J. Cabe³, J. McIntire², Z. Sanchez⁴, D. Lester⁴, P. Izquierdo-Hernandez⁵, R. Carmona⁶

¹Health Literacy and Research, ²Partnerships and Programs, ³Executive Director, Canyon Ranch Institute, Tucson, ⁴Institute for the Advancement of Community Health, ⁵President & CEO, Urban Health Plan, Bronx, ⁶President and 17th U.S. Surgeon General (2002-2006), Canyon Ranch Institute, Tucson, United States

Background: The Canyon Ranch Institute Life Enhancement Program (CRI LEP) is an integrative program to improve health and wellness. The program meets twice weekly, for approximately two hours each session.

Objectives: The CRI LEP curriculum targets creating positive changes in nutrition, physical activity, health behavior, spirituality, integrative medicine, health literacy, and social support.

Underlying values and principles: A core principle is to increase participant engagement with their own health through increased health literacy in order to achieve behavior change producing healthy physical and physiological changes.

Knowledge base/ Evidence base: The CRI LEP is based on over 20 years of experience at Canyon Ranch in Tucson, Arizona, U.S. where this program is a CME accredited curriculum.

Context of intervention/project/work: The first CRI LEP, that this presentation will report on, was developed with and offered by Urban Health Plan (UHP) in the South Bronx, New York, and was conducted in Spanish. Program materials are currently available in English and Spanish with future expansion planned.

Methods: Data collection included validated measures of nutrition, physical fitness, stress, self-efficacy, knowledge, depression, and a set of blood tests to help assess physiological health. Data collection occurred at pre, post, and process evaluation stages.

Results and Conclusions: Participants reported gains in health literacy. One participant stated, "What impacted me was the talk about how to prepare you for a doctor's visit. I never imagined before. It never crossed my mind that one could prepare themselves for a doctor's visit. I said, 'How can I prepare myself for a doctor's visit?' I ask is my body fat good? Why? I ask everything. He has to find the time because I came to the appointment and it is my time."

Another reported, "I (now) know how to read food labels. Before, I would only look at them, only look at them, but now I pay attention to them."

Participants said that they have integrated their new knowledge into their lives and were sharing the knowledge with members of their family and community. One participant stated, "I am teaching my grandchild. I took her to the supermarket to teach her to read the food product labels. She says to me that she didn't know that; she didn't realize that it was so easy to read the labels."

Sixty percent of the participants decreased their body weight 4.6 pounds on average. All participants reported decreased pain in daily activities, with an average decrease of 3.4 points on a 10-point self-report scale. Overweight or obese participants experienced an average drop in BMI of 0.58 with the highest loss of 1.81. Average weight loss was 3.37 with the highest loss of 11 pounds. Depression scores (PHQ-9) dropped 6.1 points on average on a 23 point scale. The most depressed participants at the program inception experienced an 11 point drop on average.

The CRI LEP is a proven approach to advancing health literacy and improving integrative wellness and prevention of disease.

Disclosure of Interest: None declared

EP-MON-007 THE EFFECTS OF MEDIA HUMOR MESSAGES EXPOSURE AND MEDIA LITERACY ON ADOLESCENTS' NEGATIVE EXPRESSIVE STYLE OF HUMOR

F. Chen¹, L. Yen², W. Wu³, Y. Chiang^{*4}, H. Sheng², Y. Chen¹

¹Department of Public Health, Fu-Jen Catholic University, Taipei County, ²Institute of Health Policy and Management, National Taiwan University, Taipei, ³Department of Nutrition and Health Science, Kainan University, Tao-Yuan, ⁴Department of Public Health, Chung Shan Medical University, Tai-Chung, Taiwan

Background: Adolescents often imitate humor styles from TV programs. It is worthy to pay attention of the impacts of various negative humor messages exposures on humor style.

Objectives: The aim of the study is to explore the relationship of the adolescents humor style and received the humor message contents on TV, and the moderate effects of media literacy.

Underlying values and principles: Negative humor messages will probably cause negative impact on health. The best way to protect adolescents from harmful messages is to enhance individuals' media literacy [1]. Media literacy in humor messages studies were deficient in the past. It needs to be discussed.

Knowledge base/ Evidence base: Mass media always represent some messages, and lead adolescents to imitate the role model behaviors. Media literacy is proved a way to empower individuals to read media texts better [1], It can help viewer to understand the messages embodies in advertising to handling excesses of risk behaviors. [2]

Context of intervention/project/work: This is a three stage projects. The first stage study by using focus group to realize the characteristics of humor messages from media had been completed. The second stage, we developed a questionnaire to explore the influence of negative humor messages from TV on junior high school students. The research results were came from the second stage study.

Methods: Two-staged stratified random sampling and cluster sampling was conducted to choose the study participants from four areas in Taiwan. Five schools in each area and one class of each grade in a school were randomly selected. Among them, 1746 students completed the survey, with an average response rate of 95.7%. Self-devalued and other-devalued humor expressive style, respectively, were regressed on sex, grade, personality at the first step, humor messages exposure at the second step, literacy of humor message at the third step, and the interaction of humor messages exposure and literacy of humor message at the final step.

Results and Conclusions: It was found that humor messages exposure, literacy of humor message, and the interaction significantly predict students self-devalued humor expressive style beyond age, gender, and personality ($\Delta R^2 = 0.27$). Similar results were found for other-devalued media humor expressive style ($\Delta R^2 = 0.16$). According to this research results, it is proposed to encourage adolescents using positive humor style and enhance the ability of adolescents' humor media literacy.

References: 1. Potter, W. J. (2004). Argument for the Need for a Cognitive Theory of Media Literacy. *The American Behavioral Scientist*, 48, 2, 266-272.

2. Badke, W. (2009). Media, ICT, and Information Literacy. *Online*, 33, 5, 47-49

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EP-MON-008 THE IMPACTS OF MEDIA LITERACY ON HEALTH LITERACY OF TOBACCO AMONG CHILDREN

Y. Tsai*¹

¹Communication Studies, Tzu Chi University, Hualien, Taiwan

Background: According to the investigations released from the Bureau of Health Promotion, Department of Health, Taiwan, the prevalence rates of cigarette smoking for the aged 13-15 was 27% during 2004 to 2006 individually in Taiwan(1). It is worthy to concern most of children in the high smoking prevalence area are exposed in the health risk communities and how to solve these health problems through media literacy and other comprehensive programs.

Objectives: First, this study aims to explore how children react to these messages on cigarettes warning labels. Second, the study has conducted an empirical approach to examining and evaluating the extent children have heeded the warnings concerning the prevention from child's consumption of tobacco in Hualien, Taiwan.

Underlying values and principles: This study followed the consent inform principles. Before the subjects were interviewed, the research teams had permission from students' parents.

Knowledge base/ Evidence base: This paper is an evidence base approach.

Context of intervention/project/work: This study lasted for two years. In 2007, we conducted a formative research by interviewing 23 key informants consisting of 5th and 6th graders, and a pilot study collecting 1061 self-reported questionnaires related to tobacco messages and smoking intent and behaviors in Hualien County, located east of Taiwan. In 2008, we used the quasi-experimental design and media literacy intervention for one case and one control groups among 5th and 6th graders in Hualien.

Methods: The research applied both qualitative and quantitative approaches. Such as in-depth interview, self-reported survey, quasi-experimental design for curriculum interventions, and focus groups.

Results and Conclusions: 1. The results demonstrate that 23 key informants, perceived the negative impressions and cognition of the cigarette smoking. The children's initiation of smoking was affected by the significance of others including family members and friends. The channels of accessing to the cigarette smoking for children consist of television commercials, cartoon, comedies and personal influence. 3. We collected 1086 successful questionnaires. Finally, we analyzed 1061 questionnaires in this dataset. The results show that the both experiences of smoking are significantly related to those who living with among children. The intents of smoking are significantly related to the anti-smoking campaign among non-smoking children. 4. The results of the following quasi-experimental study show that the smoking intervention having not significantly impacts on the health literacy among children. However, the critical thinking and creativeness of some students were observed by school teachers in the experimental group. Based on these findings above, we suggest that use the results as a reference to advocating more anti-smoking media education and campaigns for children.

References: 1. Bureau of Health Promotion (BHP), 2009. Tobacco Control Annual Report. 2009, Department of Health, R.O.C. (Taiwan).

Disclosure of Interest: None declared

EP-MON-010 RAPID MODEL INFLUENCES POPULATION POLICY ORIENTATION FOR THE LAST 5 YEARS IN RWANDA

O. BYICAZA*¹

¹Strategic Information Monitoring and Evaluation, HEALTH POLICY INITIATIVE PROJECT, KIGALI, Rwanda

Background: RAPID (Resources for the Assessment of Population Impact on Development) Developed in 1978, the RAPID model is a computer model that uses up-to-date demographic and economic data to project the impact of rapid population growth on development. RAPID is a user-friendly planning and advocacy tool to help achieve national health and development goals. RAPID was first applied in Rwanda in the 1980s. More recently, a RAPID analysis was developed in 2005 using data from the 2005 Rwanda Demographic and Health Survey and 2002 census data. The resulting advocacy presentation is known to have been one of the critical factors in the Government of Rwanda's commitment to family planning and population issues over the last several years.

Objectives: Intended for leadership groups - political; private sector; district planners; religious; etc

- Illustrates the impact of population factors on social and economic development
- Constituency-building for enhanced RH/FP programs
- Inputs for strategic planning and population policy making

Underlying values and principles: -Characteristics of population

- Interactions between population and economic development and poverty reduction
- Impact of rapid population growth on social and economic development
- Policy response

Knowledge base/ Evidence base: Projections are made using available data on Health sector, Agriculture, Education, Economy, Environment, Urbanization, etc.. and scenarios are made comparing high fertility rate and low fertility rate impact on the social and economic development.

Context of intervention/project/work: The POLICY Project first introduced the RAPID model analysis in Rwanda in 2005, with presentations made to the Parliament, USAID and the Minister of Health by POLICY project staff. In February 2007, the Minister of Health used the RAPID data and the impact of rapid population growth on the economy and other sectors in his presentation to the President and Cabinet at a Government retreat. This presentation sparked renewed Presidential-level commitment to FP and led to all of the advancements named above.

Methods: The methodology used was based on presentation of the RAPID Model to the high level policy and decision makers at National and decentralized level in Rwanda. Rapid was presented to:

- Minister of Health
- Government of Rwanda retreat (in 2005)
- US Ambassador in Rwanda
- Permanent Secretary in the Ministry of Health
- Members of Parliament, especially the members of the parliamentarian commission in charge of population and development
- District Mayors in Kigali city and Rwanda's Eastern Province

Results and Conclusions: For first time, population growth addressed as issue in 2008-2012 EDPRS (Economic and Development and Poverty Reduction Strategy in Rwanda)

- Population Desk created at the Ministry of and Finance and Economic Planning,
- The draft of the population policy is developed and ready to be presented for parliamentarian approval
- President Kagame asks for population action plans from each Ministry,
- Population education integrated into the Rwanda educational system
- Parliament made population issues a priority and created a special commission addresses population and development issues

Disclosure of Interest: None declared

EP-MON-011 LES INTERVENTIONS COMMUNAUTAIRES PEUVENT-ELLES CONTRIBUER AU CHANGEMENT DE COMPORTEMENT VIS-A-VIS DU DEPISTAGE VOLONTAIRE DU VIH ? LE CAS DES ETUDIANTS DE L'UNIVERSITE DE BUEA

J. Matsezou^{*1}, P. Nde¹, R. Seukap¹

¹Service de Planification Delegation regionale de la sante publique du Littoral. Douala., Ministere de la Sante Publique, Douala, Cameroon

Historique / Origines: Les personnes vivant avec le VIH de la ville et les étudiants pairs éducateurs de club santé de l'université de Buéa ont entrepris de sensibiliser leurs congénères sur l'importance du dépistage du VIH. Ces actions de sensibilisation ont duré deux ans (2007-2009). Il est important de relever que les campagnes de dépistage du VIH organisées à l'université n'ont pas souvent mobilisé beaucoup d'étudiants malgré une bonne sensibilisation de ceux-ci sur l'importance du dépistage.

Ce travail a donc pour objectif d'apprécier l'apport de cette sensibilisation dans le changement de comportement des étudiants vis-à-vis du dépistage volontaire du VIH.

Objectifs: Objectifs Spécifique*

- Evaluer l'offre de service et les modalités d'offres de service pendant le dépistage du VIH à l'université.
- Déterminer le niveau des connaissances, les attitudes et les pratiques des étudiants vis-à-vis du dépistage du VIH.
- Analyser les indicateurs et les différents facteurs qui interagissent dans le processus décisionnel de se faire dépister.

Valeurs et principes sous-jacents: La majorité (95%) des étudiants croit à l'intervention divine dans la résolution des problèmes rencontrés par les hommes sur la terre et par extension dans la guérison du VIH/SIDA.

Fondement de connaissance/Fondement de preuve: L'université est par excellence un lieu de dispensation de la connaissance

Contexte d'intervention/projet/travail: Ce projet est mené dans un environnement sociologique où les pasteurs d'églises et les guérisseurs prêchent la possibilité de guérir le SIDA. La conséquence est l'adoption par les étudiants des attitudes et des pratiques qui ne favorisent pas le dépistage volontaire du VIH.

Méthodes: Il s'agit d'une enquête transversale descriptive et d'un Focus group organisés en Avril 2009 .

Echantillonnage aléatoire simple

Effectif des étudiants en 2009= 7923

Taille de l'échantillon = 360 étudiants

Techniques de Collecte des Données

- Le questionnaire auto administré
- Le Focus group

Résultats et Conclusions: - 100% des étudiants connaissent la cause et les symptômes de l'infection au VIH.

- 91% connaissent l'importance du dépistage du VIH

- 16% seulement connaissent que les ARV sont gratuits Cameroun.

- Canaux par lesquels les étudiants sont le plus informés :

- Le mass média (70 %)

- Les pairs éducateurs (65%)

- Les membres de HIRASSO (44%)

- 71 % croient à la séroconversion d'un test positif en test négatif et à la guérison du VIH après des prières/absorption de potions traditionnelles.

- La cause et les symptômes de l'infection au VIH sont connus par la majorité des étudiants ; une minorité seulement (10%) connaît que les ARV sont gratuits au Cameroun.

• 45 % déclarent avoir parlé de l'importance du dépistage à au moins une personne.

• 35 % reconnaissent l'importance du travail des pairs éducateurs et celui des membres des membres de HIRASSO

- 35% de ceux qui n'ont pas encore fait leur dépistage déclarent être dérangé de ne pas connaître leur statut
58 % n'ont pas encore fait leur test de dépistage et 15 % parmi eux déclarent ne pas vouloir connaître leur statut ;

- Raisons évoquées

o peur du résultat positif (31%)

o manque de temps et autres raisons (36 %)

- 39 % déclarent s'être déjà fait dépister .

- Le non respect de l'algorithme décisionnel pendant l'exécution d'un test HIV sont des obstacles qu'il faudra lever le plus rapidement possible car tout résultat d'un test faussement positif, sera facilement mis sur le compte d'une guérison miraculeuse si le candidat au test de dépistage refait le tes dans un autre laboratoire..

- Le suivi régulier de l'exécution des activités de sensibilisation de proximité a permis à plusieurs étudiants de ne plus être réticents au dépistage du VIH malgré un environnement socio culturel dans lequel sont diffusés à longueur de journée, des messages de guérison du VIH par la prière.

- Cette étude nous a permis d'identifier deux maillons faibles dans le processus décisionnel du dépistage volontaire du VIH à l'université de BUEA .Ces deux maillons sont « l'intention de se faire dépister » et « la pratique du dépistage ». Par conséquent, en 2010, le plan d'éducation sanitaire des étudiants devra porter sur ces deux maillons faibles du processus décisionnel

Les actions de changement de comportement à de petites échelles sur des groupes de populations ayant de fortes caractéristiques communes ont un impact important dans le temps si un suivi rigoureux est mis en place.

Conflit d'Interêt: rien a declarer

EP-MON-012 LES INEGALITES FACE À LA SANTE EN VILLE, CAS DE COTONOU

S. H. Kakai*¹

¹Coordination executive, Carrefour Africain de Recherche et d'Echanges pour le Developpement CAREDE, Abomey-Calavi, Benin

Historique / Origines: Depuis toujours, la pauvreté a été un phénomène multidimensionnel qui touche plusieurs aspects de la vie sociale. Historiquement, ce phénomène perçu comme "la négation des opportunités et des perspectives fondamentales sur lesquelles repose tout développement humain, telles que la chance de vivre une vie longue, saine, constructive et de jouir d'un niveau de vie décent ainsi que de la liberté, la dignité, le respect de soi-même et d'autrui" (PNUD, 1997) s'est concentrée dans les zones rurales. A mesure que la masse de la population mondiale migre de la campagne à la ville, la pauvreté devient de plus en plus un phénomène urbain. Selon la Banque Mondiale (Université Johns Hopkins, 2002), dans le monde entier, 30% des pauvres vivent dans les zones urbaines. Ce pourcentage devrait passer à 40% d'ici à 2020 et, d'après les projections, en 2035 la moitié des pauvres du monde devraient vivre dans les villes.

Au Bénin, elle est un phénomène de masse à plusieurs facettes. La littérature sur la pauvreté manque, par ailleurs, de données sûres quant à l'échelle et à l'intensité de la pauvreté urbaine en Afrique et au Bénin en particulier, bien que la proportion des gens qui vivent en-dessous du seuil de la pauvreté soit susceptible d'avoir augmenté du fait de la mauvaise performance macro-économique. L'incidence de la pauvreté rurale est encore nettement plus élevée que celle de la pauvreté urbaine, mais l'écart semble se rétrécir.

L'accès aux services de santé est plus amélioré en villes au Bénin du fait du niveau d'instruction élevé des populations, de l'existence de la plupart des hôpitaux de zone, des centres de santé les plus spécialisés (cas du Centre national hospitalier universitaire Hubert Maga de Cotonou par exemple) et des nombreux cabinets et cliniques. De même, l'accès aux médicaments est plus favorisé. Ce fait explique les différences de niveau de vie sanitaire entre les populations urbaines et celles rurales. Ainsi, selon le RGPH3 (2002), le taux de mortalité en milieu urbain est de 9,63% contre 12,8% en milieu rural. Si les conditions sanitaires sont alors maintenues, un individu qui naît en milieu urbain, espère vivre en moyenne 60,7 ans avant de mourir contre 57,3 ans pour le milieu rural. Cette espérance de vie à la hausse dépendra surtout des mesures prises pour la prévalence contre le HIV/SIDA qui malgré, la rareté des statistiques bat son plein dans les villes du Bénin du fait des nouveaux comportements sexuels observés tant chez les adolescents, les adultes et les personnes du troisième âge. A cet effet, ne peut-on pas parler d'une crise de la sexualité en milieu urbain ? Au niveau de la fécondité, selon l'EDSB II (2001) et RGPH3 (2002), une femme du milieu rural pourrait avoir deux naissances de plus que la femme du milieu urbain (6,4 contre 4,4 enfants en moyenne). Malgré les différences de niveau entre les milieux urbain et rural que révèlent ces données statistiques, la disponibilité et la fréquentation des centres de santé en milieu urbain cachent des paradoxes notamment dans les villes secondaires du pays.

Etant donné que les services de santé les plus spécialisés et les plus performants au Bénin (CNHU, Hôpital de zone, CSCS, CHD clinique et autres services) sont concentrés dans les centres urbains, on peut noter malgré cela, l'acuité de certaines contraintes telles que : insuffisance de personnel de santé, sous équipement médicotechnique et roulant, vétusté des infrastructures sanitaires, une amélioration de la qualité des soins. Ainsi ; par exemple, "...le CHD-Zou / Collines (situé dans la ville d'Abomey) spécialisé pour administrer les soins qui dépassent les compétences des CSC (parce que plus équipé) de toutes les communes des départements du Zou et des Collines reçoit de ce fait, aussi bien les patients d'Abomey que ceux venants de toutes les autres localités des deux départements. Le champ d'intervention du CHD – Zou/Collines, ne peut être donc circonscrit à une seule Commune fût-elle celle qui l'abrite ou non" (FIDESPRA, 2004). Quels sont les inégalités de genre en rapport avec la promotion de la santé dans ces villes secondaires du Bénin ?

Objectifs: L'objectif général de cette communication est d'analyser les effets des rapports de genre sur le statut sanitaire des villes secondaires du Bénin. Spécifiquement, nous chercherons à atteindre les objectifs suivants :

- analyser la situation socio-économique des populations concernées ;
- faire une analyse de genre aux questions de santé en s'appuyant sur les quelques cas de morbidité et de mortalité liés aux IST/MST, aux diarrhées, à l'état nutritionnel, à la fécondité, etc.

Valeurs et principes sous-jacents: - Ethique dans la recherche

- Analyse par genre du statut sanitaire des acteurs sociaux

Fondement de connaissance/Fondement de preuve: - Disposant de ressources documentaires et

empiriques issues d'observations participantes

- Capacité à les analyser puisque nous sommes titulaires d'un master recherche et Education et promotion de la santé (Université de Besançon, France).

Contexte d'intervention/projet/travail: Communication issue d'explorations empiriques de recherches.

Méthodes: La méthode adoptée a privilégié la recherche documentaire. De ce fait, plusieurs documents ont été utilisés notamment les cartes sanitaires des zones sanitaires du Bénin, le rapport de l'Enquête démographique et de santé du Bénin (EDSB), etc. Par ailleurs, des enquêtes exploratoires ont été effectuées.

Résultats et Conclusions: - La pauvreté constitue un obstacle à atteindre les objectifs du 3ème millénaire en matière de santé ;

- Les inégalités de genre sont persistantes en matière de santé dans les villes secondaires ;

- Les pouvoirs locaux ont une compétence décentralisée mais les décisions sont toujours centralisées, ce qui ne favorise pas l'atteinte des objectifs de la décentralisation dans le domaine de la santé.

Références: - PNUD, Rapport mondial sur le développement humain, 1997

- Université Johns Hopkins, Revue Population Reports Répondre au défi urbain, numéro 4, 2002

- FIDESPRA, Plan de développement communal d'Abomey, 2004

- INSAE, Recensement général de la population et de l'habitation, 2002

- INSAE, Enquête démographique et de santé, 2002

Conflit d'Intérêt: Rien à déclarer

EP-MON-013 KNOWLEDGE AND PERCEIVED SUSCEPTIBILITY OF MALE ACADEMIC STAFF OF THE UNIVERSITY OF IBADAN ON MALE BREAST CANCER

O. B. PETER-KIO*¹

¹Health Promotion and Education, University of Ibadan Nigeria, Ibadan, Nigeria

Background: Although breast cancer is perceived to be a female phenomenon it does exist among males. Incidence of male breast cancer (MBC) seems to be on the increase with men presenting at an advanced stage. The perception that MBC is a female disease has contributed to its fatality among men with no program in place for awareness and prevention

Objectives: This study explored knowledge and perceived susceptibility of male academic staff of the University of Ibadan, Nigeria to MBC

Underlying values and principles: Healthy health seeking behavioural change

Knowledge base/ Evidence base: The incidence and mortality rates of female breast cancer are stunning that the relatively trifling incidence and mortality rate of male breast cancer are often dismissed from consideration and discussion

Context of intervention/project/work: Descriptive cross-sectional survey

Methods: Four hundred and five (405) male academic staff of the University were selected using a 3-stage sampling technique from the 13 faculties of the University. Data was collected using a validated self administered semi-structured questionnaire. The data were analyzed using descriptive, ANOVA, Logistic regression and Chi-square statistics

Results and Conclusions: The mean age of the respondents was 42.8±1.7years and 88.4% were married. Majority (85.9%) of the respondents were Christians and 89.1% were Yoruba. A higher (63.0%) proportion of the respondents had PhD as the highest educational qualification. Overall 54.1% had heard of MBC. The sources of information about MBC included television (35.2%), health professionals (25.0%), journals (20.2%) and radio (15.8%). Overall mean knowledge score was 19.2±5.9. However, respondents from the medical related faculties had a mean knowledge score of 22.4±4.8 compared with 15.1±4.4 among respondents from the non medical related faculties ($p < 0.05$). Respondents from the medical related faculties are 11 times more likely to know about MBC than those from the non medical related faculties (Odds Ratio (OR) 11.3, 95% Confidence interval (CI) 6.6 – 19.3). Overall, 69.4% of respondents do not perceive themselves as susceptible to the disease. However 53.7% of respondents from the medical related faculties compared with 17.2% of respondents from the non medical related faculties perceived themselves as susceptible to MBC ($p < 0.05$). A high (67.3%) proportion of respondents would gladly go for breast cancer screening if suggested by their doctors (56.0%).

Knowledge and perceived susceptibility of MBC among non medical respondents was low. There is the need for public enlightenment about the disease to increase awareness and uptake of breast screening and other preventive measures among males.

Disclosure of Interest: None declared

EP-MON-015 CONTRACEPTIVE KNOWLEDGE AND COMPLIANCE WITH GUIDELINES FOR PROVIDING CONTRACEPTIVE SERVICES BY PATENT MEDICINE VENDORS IN IBADAN NORTH LOCAL GOVERNMENT AREA, NIGERIA

O. O. Ajayi*¹

¹Health Promotion and Education, University of Ibadan, Ibadan, Nigeria

Background: Although the patent medicine vendors have been recognized as an informal sector in the delivery of contraceptive services, little is known about their knowledge on contraceptives and how well they conform to the FMOH stipulated guideline for the provision of contraceptive services

Objectives: This study explored the extent to which Patent Medicine Vendors comply with the guidelines provided by the Federal Ministry of Health (FMOH) on the delivery of contraceptive services.

Underlying values and principles: Healthy health seeking behavioural change

Knowledge base/ Evidence base: Nigeria is currently faced with high fertility rate (TFR of 5.9), high rates of unwanted pregnancies, unsafe abortion, high maternal mortality rate (MMR of 800 – 1500 deaths per 1000 live births) and unmet need for contraception. The Patent Medicine vendors are an important provider of contraceptive services but their ethics and competence is questionable.

Context of intervention/project/work: Descriptive cross-sectional survey

Methods: All (282) the patent medicine in the study site registered with the local association of patent medicine vendors were recruited. Data was collected using an observational check-list and a validated self administered semi-structured questionnaire. The data were analyzed using descriptive, ANOVA and Chi-square statistics.

Results and Conclusions: : The mean age of the respondents was 32.8±7.0years , 80% were females and 63.5% were West African School Certificate (WASC) holders. Virtually all respondents (98.2%) were trained through the apprenticeship system. Only 17.4% had been formally trained on the provision of contraceptive services. Contraceptive services offered by PMVs as stipulated by the guidelines were: Counseling (98.5%), community sensitization (46.3%) and referral (96.4%). Virtually all (98.6%) the respondents had ever dispensed contraceptives. The contraceptives ever dispensed by respondents include the following: male condom (97.5%), female condoms (3.6%), Duofem (73.4%), Pregnon (18.0%), Spermicide (3.6%) and Intrauterine Device (1.8%). Doufem (62.8%) topped the list of contraceptives sold in the week that preceeded the study. Respondents' overall mean knowledge score was 25.9±5.8. Mean knowledge score on the provision of contraceptive services was higher among males (27.7±5.9) than females (25.6±5.7). Respondents' with bachelors degree had the highest mean knowledge score on the provision of contraceptive services (29.9±5.3) followed by those with WASC (25.6±5.9) $p < 0.05$. The level of compliance with the FMOH guideline on the provision of contraceptive services was higher (65.0%) among respondents' aged 40 years and above than those aged 30 – 39 years (62.0%), less than 30 years (57.5%) ($p < 0.05$). Respondents' who had practiced for fifteen years and above had a significantly higher level (64.0%) of compliance than those with 10 – 14 (50.0%), 5 – 9 (49.5%) and less than five years (31.0%) of experience ($p < 0.05$). Over half (53.9%) of respondents had no copy of the FMOH guideline, 54.6% had no booklet produced by the Pharmacist Council of Nigeria which contain the approved patent medicine list and 50.7% were not licensed.

Compliance with stipulated guidelines by the Federal Ministry of Health on the provision of contraceptive services was low among the study population.

Disclosure of Interest: none declared

EP-MON-016 IQCHART HELPS IN REDUCING LOST TO FOLLOW-UP BY INTEGRATING CLINICAL DATA MANAGEMENT TO COMMUNITY SUPPORT SYSTEMS WITHIN AIDSRELIEF SUPPORTED RURAL HEALTH FACILITIES

O. BYICAZA*¹

¹Strategic Information Monitoring and Evaluation, AIDS RELEIF, KIGALI, Rwanda

Background: AIDSRelief supports health facilities in the Nyamasheke district of Rwanda to rapidly scale up ART services. At these rural facilities in Rwanda that implement the AIDSRelief model of care, health teams collaborate daily to ensure high quality care is provided to patients. The health teams consist of clinical, data, and community staff. Each health facility uses IQChart¹ to electronically manage longitudinal patient records for improved accuracy and timeliness in reporting as well as for informed decision making for program improvement. In May 2008, using key automated reports generated by IQChart the data managers at these health facilities alerted clinicians to a high number of missed ART appointments. Missed refill appointments are a useful predictor of treatment failure in resource-limited settings.

Objectives: 1. Reduce HIV patients lost to follow up
2. Promote access to and use of antiretroviral therapy
3. Promote patients data/information use at Health Facility level to improve quality of care
4. Improve HIV patients adherence to treatment.

Underlying values and principles: 1. HIV/AIDS patient's data use at health facility level
2. Antiretroviral Therapy Adherence
3. Community support in HIV patient adherence

Knowledge base/ Evidence base: IQchart (International Quality Clinical HIV/AIDS Registry Tool) is an electronic HIV patients data management system, that helps in identifying on regular basis patients who missed their Antiretroviral therapy pickup appointments.

Context of intervention/project/work: A missing patient list was generated for the community team and a worker (either a coordinator, social worker or a community volunteer) was assigned to each patient. These teams located the defaulting patients and determined the reasons for them missing their appointment.

Methods: The number of patients missing ART appointments for >90 days (definition of "lost-to-follow-up (LTFU)") was analyzed at 10 sites from pharmacy appointment attendance data in the IQChart patient database. An action plan was created and discussed by the teams at the sites. Over the next 7 months, the action plan was implemented, monitored and regular feedback provided. When patients did default the reasons were clearly documented. Descriptive statistics were used in the analysis of reasons for missed appointments

Results and Conclusions: From May to November 2008, the number of patients missing ART appointments from all sites declined by 98% from a high of 650 patients to 11. Further analysis indicated that initially 251 (38.6%) patients had been incorrectly documented as missing due to data entry errors. The benevoles identified the status of the other 399 patients: 232 (58%) had unofficially transferred to other sites; 75 (18.7%) had died; 92 (23%) were LTFU. Of those, 81 (88%) were retrieved and re-enrolled in care. Integrated clinical data management using IQChart and community-based support activities can result in impressive program improvements. In this example there was a significant reduction in the number of missed pharmacy appointments and patients LTFU within a short timeframe. Findings suggest a need for improvement in data flow, entry, and appointment systems, and the patient transfer system. Further studies should evaluate the long-term outcomes of patients re-initiated into care.

Future use of data to investigate, monitor, and evaluate community care activities may lead to similarly effective results, improved quality in patient care, and improved patient outcomes.

References: 1. Bisson GP et al. Pharmacy refill adherence compared with CD4 count changes for monitoring HIV-infected adults on antiretroviral therapy. PLoS Medicine 5 (5): e109. doi:10.1371/journal.pmed.0050109 23 Apr 2008.

Disclosure of Interest: None Declared

EP-MON-017 FROM EXPERIENCES TO REFLECTION- A HEALTH PROMOTION STRATEGY FOR COMMUNITY EMPOWERMENT

C. N. KASYOKA*¹

¹HEALTH AND SOCIAL SERVICES, KENYA RED CROSS SOCIETY, NAIROBI, Kenya

Background: The Kenya Red Cross Society, Nairobi branch has been implementing a HIV/ AIDS Peer education project since November 2006. The project targets in and out of school youth aged 10 to 25 years. The project employs various strategies such as training of peer educators, community outreaches, sports, theatre, mobile VCT and referrals and reflection process.

Objectives: The objectives for the HIV/AIDS peer education project is to reduce the HIV prevalence amongst youth ages 10 to 25 years through behaviour change communication.

Underlying values and principles: WHAT IS A REFLECTION?

A reflection is a process that enables people to identify and analyze lessons learnt from the finished action and its messages regarding community action and empowerment.

Reflection is concerned with how people can sustain their collective action through the development of appropriate positive knowledge, values, attitudes and consciousness for improved health.

Knowledge base/ Evidence base: OBJECTIVES OF DOING A REFLECTION PROCESS

1. To enable people to have a deeper commitment and higher levels of consciousness to sustain their collective action towards sustainable development.
2. To make them aware of the positive and negative attitudes, value and consciousness resulting from their experiences that may hinder health promotion.
3. To institute mechanism for attitude formation at both the individual and group community level
4. To relate peoples experiences/situation to bigger social realities on the ground.

Context of intervention/project/work: The target group carries out a reflection process once a month to review their experiences and take stock of lessons learnt. The bottom line here is that for a reflection process to take place the target group must have engaged in health promotion activities. This means health promotion takes a deeper meaning and is no longer regarded as a donor project.

Methods: Each reflection process is carried out using a reflection module which has the following elements:

- Theme (What are we reflecting on, what do we need to address in health promotion or sustainable development?)
- Objective of doing the reflection (What values is the community trying to 'catch?')
- Content area (Questions that guide participants/facilitator into the reflection)
- Methodology (Role plays, team building, quiet time, group work, plenary and /or video shows and analysis.

Results and Conclusions: 1. The target group has a deeper commitment and higher levels of consciousness to sustain their collective action towards health promotion.
2. The target group becomes aware of the positive and negative attitudes, value and consciousnesses resulting from their experiences hence become effective agents of change.
3. The reflection process has aided the target group to institute mechanism for attitude formation at both the individual and group community level.

CONCLUSIONS: It has been established that lessons and insights from experiences are drawn out best through a reflection process. Indeed, experiences without reflection become mere memories. If reflection is not done, the community tends to forget their collective power in influencing behavior change in health promotion.

Disclosure of Interest: Employee of Kenya Red Cross Society