## GP-TUE-001 ETHIC AND HEALTH PROMOTION

**L. L. M. Mina***[1], P. Beatini[2]
[1]Pubblic Healt promotion, ASL TO3, Grugliasco, [2]Università di Perugia, Centro Sperimentale per l'Educazione Sanitaria, Perugia, Italy

**Background:** How ethic affects community self-consciousness in public health.
Strategies and practices to improve life conditions and health mean Health Promotion.
The reasons for some rational choices to identify and pursue the aims of such actions are not just effective evidence based, they are also based on socio cultural implications.
Such influences are connected to multi factorial implications in which people live, such as moral factors, values connected to the nowadays socio cultural context and changes.
**Objectives:** The health-promoter should take into account ethical implications. He should be integrated into the social network of public health and supported by acquired knowledge. He should also co-operate with multi functional groups and act in the name of community.
**Underlying values and principles:** Ethical
Fairness
Equality
**Knowledge base/ Evidence base:** Empowerment process
**Context of intervention/project/work:** Should he, besides the deonthological code, take into account the ethical implications too?
Is he a persuader, a model or an integrated member of the community? How does he talk to people to communicate life styles?
Does the health promoter act according to the "Sense of Coherence" as Social-Responsibility?
If considered from an ethical point of view, is empowerment a "goal" or a "means" for health promotion?
If a health promoter is considered a stakeholder and he is part of the community, he shares the profits of his own job. Can he be considered a shareholder?
**Methods:** Textprocessing
**Results and Conclusions:** Our concern is how health promotion can affect peoples choices on the basis of ethic. The challenge is to interpret the changes in the perspective of public health rights.
Ethic will govern future strategies in terms of "Equity" and "Equality".
**Disclosure of Interest:** None declared

## GP-TUE-002 WORKSHOP ON ETHICAL CHALLENGES IN RESEARCHING VULNERABLE POPULATIONS

**H. Nordentoft**[1]
[1]Assistant professor, Aarhus University, Copenhagen, Denmark

**General description:** The ambition to promote health and equity for everybody demands closing the gap in in the difference of health status between groups. This requires that equitable access to health care is possible and also research into how this ambition can be achieved. In this regard, vulnerable populations such as the old, the frail and the poor may experience double stigmatization. Not only do they become stigmatized by hospitals and society. They may also fail researchers' evaluation as being suitable research participants for because of persistent methodological and ethical challenges in the research process
**Rational:** We want to discuss these challenges and illuminate them by listing some of the ethical dilemmas we have experienced in our ph.d.-research with patients with drug addiction and cancer patients in our anticipation to follow the abstract ethical guidelines of the Helsinki declaration.
•The question is how researchers can illuminate the needs and problems of vulnerable populations and - at the same time - respect their integrity without exposing them unnecessarily?
We contend that the Helsinki guidelines need to be appropriated for social and health care research in which purpose and methods often deviate from medical research. We, therefore, want to discuss
•How can a more contextualized approach and empirically informed ethics in research with vulnerable populations be developed?
The workshop participants are seated 10 at each table and asked to reflect on the following questions for 30 min
•When are participants capable of giving informed consent?
•When can participants be classified as vulnerable?
•What are the challenges in illuminating the needs and problems of vulnerable populations, while at the same time respecting their integrity without exposing them unnecessarily?
A chairman at each table summarizes the main points.
Then the participants form two reflective circles: An inner circle with the chairmen and an outer circle surrounding the inner circle seating the rest of the participants. The inner circle has an empty chair which gives participants from the outer circle the opportunity to introduce questions/comments to the discussion. After 20 minutes the discussion shifts to the outer circle where the participants are invited to comment on the first discussion. The two researchers guide the discussions in respectively the inner and outer circle.
To conclude the workshop the researchers summarize main points
**Learning objectives:** To qualify participants' clarification of ethical and methodological challenges in working with vulnerable groups and their work with an empirically and context sensitive informed ethics
**Expected results:** Each participant has
1. identified ethical and methodological challenges in own practice
2. a firmer idea of how vulnerability can be identified, defined and managed in practice and research
3. new perspectives – conceptually and methodologically - on how to conceive and manage these challenges in practice

**GP-TUE-003 GLOBAL HEALTH ETHICS: A FRAME WORK FOR ANALYSING HEALTH INEQUITIES CREATED BY PHYSICIAN MOVEMENTS FROM RESOURCE POOR AFRICAN SETTINGS TO THE DEVELOPED WORLD**

**C. Mpofu***[1]
[1]Faculty of Health Sciences, AUCKLAND UNIVERSITY OF TECHNOLOGY, Auckland, New Zealand

**Background:** Equity and right to primary health care have long been regarded as core features of primary health care. Although it is now three decades after the Alma Ata Declaration set a framework for attaining the equity in health care especially between the developing world and the developed world; access to medicines, vaccination and care is at critical levels in resource poor African continent. One of the threats in this scenario is the mass exodus of physicians to the developed world. In most regions of the developing world, low physician density exacerbates child and maternal mortality rates and hinders treatment of HIV/AIDS (Eyal & Hurst,2008). One of the ways by which global health equity goals could be achieved is by ensuring that there is adequate health workforce in the developing world especially in Africa a continent that is struggling with disease strain and the need to reduce mother and infant mortality. The inadequacy and instability of the physician workforce in Africa, is major impediments to disease-reduction initiatives(Mullan, 2005).
**Objectives:** To examine the ethical issues surrounding the exodus of physicians from resource constrained African region to the developed world under the framework of distributive justice and fundamental principles of global health equity.
**Underlying values and principles:** This work examines the underlying ethical issues surrounding the exodus of physicians from resource constrained African region under the framework of distributive justice and fundamental principles of global health equity. These fundamental principles are tools of achieving primary health care goals as set out in the Alma Alta Declaration 1978. The justice and economic theories will be utilized as can be found in the Alma Ata Declaration which set that social and economic forces should be mobilized together with the health sector as they are "of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries".(WHO, 1978). The underpinning thinking in doing so as set out in this declaration is the spirit of justice and hence justice theories have been used extensively
**Knowledge base/ Evidence base:** Primary health care and workforce planning efforts in the developing world are facing threats as uncertainties created unpredictable movement of physicians to the developed world are rife (Hussey& Hussey,2007).
**Context of intervention/project/work:** The Movement of physicians from low income countries to the developed world creates the further health disparities and this is against calls for global health equity and disease-reduction initiatives in the third world. Also Medical workforce is key to provision of adequate and comprehensive primary health care
**Methods:** A qualitative cross-national case study analysis informed by the emancipatory intents of global health ethics
**Results and Conclusions:** Ethical reasoning at global justice level, wiil posit that in addition to ensuring fair recruitment practice, the developed countries are morally obliged to assist developing countries in meeting critical shortages in workforce in these countries.At a corrective level of justice, corrective action is needed to address inequities that have already been created by unfair recruitment practices. Hence in view of all the above discussed justice theories one would conclude by stating that a better model will be the one that takes into account the principles of social justice and global equity, and the autonomy or freedom of the individual. Another level of justice which raises more complexities is procedural justice, which requires that efforts to achieve equity respect the rights of all who are involved. In this case since procedural justice involves respect and equity for all parties involves it therefore follows that individual autonomy is inherently significant too.
**References:** Hussey, & Hussey, P. S.(2007). International migration patterns of physicians to the United States: A cross-national panel analysis. Health policy, 84(2-3), 298.
Mullan, F.(2005).The metrics of the physician brain drain. New England Journal Medicine, 353(17),1810-1818.
**Disclosure of Interest:** NONE

## GP-TUE-004 THE ETHICS OF EMPOWERMENT

**P. Tengland***[1]
[1]Health and Society, Malmö University, Malmö, Sweden

**Background:** Being empowered has to do with having control over the determinants of one's quality of life (including health) (Tengland 2007). Many things can be changed, on many levels, to increase empowerment in this sense and increasing the empowerment of individuals and groups can be seen as a goal for many kinds of social interventions, e.g. health promotion (WHO 1986).
Empowerment can also be seen as the process of facilitating increased control. This process involves fully engaging the person or group concerned in the change process, so that they controls as much of this process as possible. The professional supports this process, and has no agenda of her own other than to facilitate the individual or group in achieving their aims (Tengland 2007).
Empowerment has a positive ethical ring to it. It is supposedly superior to other ways of working towards health and social change – better than top-down interventions and behavior change projects. But is this so?
**Objectives:** The aim of the paper is to critically discuss the ethical pros and cons of empowerment and relate it to other kinds of goals and interventions within health promotion and public health.
**Underlying values and principles:** Ethical principles and theories, such as utilitarianism, deontology, principalism, virtue ethics and theories of justice are used throughout the discussion.
**Knowledge base/ Evidence base:** The ethical analysis starts from a conceptual theory of empowerment (Tengland 2008) in relation to health promotion (Tengland 2007).
**Context of intervention/project/work:** The general context of the project are the ethical aspects of health promotion and public health (Holland 2007).
**Methods:** Ethical analysis (ethical theories and principles) is used when discussing and evaluating the goals and means of the empowerment approach, and relating it to other approaches (see underlying values and principles).
**Results and Conclusions:** A first conclusion is that empowerment as a process is superior to many behavior change projects, since a) it reduces persuasion, manipulation and coercion of the subjects involved, something that is common in other approaches, b) it (thus) enhances autonomy, rather than reducing it, and c) it is founded on a more accurate theory of human nature, humanistic theory, rather than cognitive theory.
Another conclusion is that many top-down projects are ethically compatible with most empowerment goals (i.e. increased control), e.g. literacy projects in poor countries, although not with all such goals, e.g. requiring drivers to wear seat-belts. However, other ethical concerns are also important, e.g. social justice, equal opportunity, and positive freedom, some of which might not necessarily lead to empowerment of individuals or groups.
**References:** Holland, S 2007. Public Health Ethics. London: Polity.
Tengland, Per-Anders 2007. Empowerment: A Goal or a Means for Health Promotion? Medicine, Health Care and Philosophy, Vol. 10, No 2 (2007), 197-207.
Tengland, Per-Anders 2008. Empowerment: A Conceptual Discussion. Health Care Analysis vol 16, no 2, 77-96.
WHO (1986) Ottawa Charter for Health Promotion. WHO: Geneva.
**Disclosure of Interest:** None declared

## GP-TUE-006 EMPOWERING INVESTIGATORS THROUGH DEVELOPMENT OF AN ETHICS OF RESPONSIBILITY

**S. C. DUTTA***[1]
[1]Ayurvedic Surgery, J.B ROY State Ayurvedic Medical College & Hospital, Kolkata, India

**Background:** Bioethics is not a well known term in Ayurveda. Little training is available regarding ethics during Ayurvedic graduate and post graduate studies. So little ethically sound researches are carried out by Ayurveda researchers. There is curiosity about Ayurvedic treatments throughout the world. The popularity of Ayurveda is increasing day by day. To fulfill this demand Ayurveda science should be explored through extensive ethically viable scientific researches. So training in research ethics is extremely necessary for Ayurvedic researchers. The faculty of the institute/university generally carries out researches. This bioethics training module,focused on research & clinical ethics have been developed to train the faculty of our institute primarily and later on for the faculty of other institutes.
**Objectives:** 1.To assess awareness of bioethics among Ayurvedic Faculty at Gomantak Ayurveda Mahavidyalaya & Research Centre, Goa and then development of bioethics training module mainly focused on research and clinical ethics.
2.To train the faculty of our institute in bioethics, mainly focused on research ethics through the developed bioethics training module.
**Underlying values and principles:** It will develop trained Ayurvedic professional and researchers. Thus it will help to accredited ayurvedic research, ethics committee and better health service to the community.
**Knowledge base/ Evidence base:** It is knowledge base study.
**Context of intervention/project/work:** To assess the awareness of bioethics first among Ayurvedic Faculty at Gomantak Ayurveda Mahavidyalaya & Research Centre, Goa a conventional survey study had been designed having 25 MCQs,in each sitting, based on different aspect of bioethics.
**Methods:** Based on the above said survey, bi-monthly' "Tea Table Chatting(Training)" on ethics from 3pm to 4.30pm was organized. There were pre-assessment and after every 4 sittings there was a post-assessment and the final assessment was conducted after 16 sittings. Within this 16 sittings the following topics were covered e.g. ICMR ethical guidelines to conduct research, importance of SOP, Conflict of interest issue in research, Obstacles in herbal research, Existing laws and Research ethics etc. Two films on research ethics (Constant Gardeners & Lorenges' Oil) were shown. Every faculty had their own choice to join the study. Prior to join the study an informed consent was taken. 28 faculty members of GAM&RC, Goa, had joined in this study
**Results and Conclusions:** Results and Conclusion:- All the assessments contain 25 MCQs (Multiple Choice Questions).There are 3 options in every MCQ-Y-Yes; N-No; DK-Don't Know: All the pre and post training assessment were compared with CHi-Squre Test and the result showed that the training through chatting was effective to develop awareness of bioethics. After this study it was concluded that not only awareness about research ethics was markedly increased among faculty but also help to improve the function of Institutional Ethics Committee.It also helped better clinical approach and thus better health service.
**References:** ( One part of this study was developed by me as a part of compulsory project to complete ICMR-NIH(USA) bioethics training programme in India)
**Disclosure of Interest:** None declared

## GP-TUE-007 TALLER INTEGRAL PEDAGOGICO EN ETICA CIUDADANA PARA LA PARTICIPACIÓN

Z. R. Franco*[1]
[1]Caldas, Universidad de Caldas, Manizales, Colombia

**Antecedentes:** La carencia de información a los ciudadanos del común sobre lo que constituye su dignidad, sus derechos y sus deberes producen paralisis política que conlleva a la perpetuación de prácticas politiqueras que pervierten el ejercicio gubernamental desconociendo los principios y valores constitucionales y de caracter universal como es la preponderancia del bien común y el ínteres general sobre el particular
**Objetivos:** Concienciar a ciudadanos de instituciones educativas y asociaciones campesinas sobre lo concerniente a la dignidad humana caracteristica de la especie y el sujeto político que se consolida en los principios y valores que la fundamentan. Reflexionar activamente sobre los derechos humanos y los deberes ciudadanos que construyen sociedades más justas y equitativas. Empoderar individual y colectivamente a los ciudadanos para que participen activamente en las decisiones que los afectan en la realización de su proyecto vital para el desarrollo humano armonico
**Valores y principios subyacentes:** Finalizada la realización del taller los participantes estarán en capacidad de pronunciarse en los espacios familiares, sociales y gubernamentales sobre asuntos que atañen al reconocimiento, aceptación y realización de su dignidad y derechos humanos. Asumir las responsabilidades que se derivan de los deberes ciudadanos plasmados en la constitución política de Colombia 1991
**Base de conocimiento / base de evidencia:** Estudiantes de grado 10 de colegios de Chinchina, Palestina, Risaralda y Anserma. Profesores de enseñanza media de estos municipios. Jovenes integrantes de los concejos de juventud; campesinos de las áreas rurales de los municipios citados. Basado en las teorias de Paulo Freire sobre Educación Popular
**Contexto de la intervención / proyecto / trabajo:** Municipios del departamento de Caldas Chinchina, Palestina, Risaralda y Anserma
**Métodos:** Heuristico y participativo. A traves de la conversación identifican el fenomeno de la realidad local para proponer por medio de la participación alternativas a la solución a su problematica local. Decodificación de afiches que permite develar situaciones adversas sobre las cuales es necesario incidir mediante la participación y el empoderamiento individual y colectivo
**Resultados y Conclusiones:** Al aplicar el metodo heuristico se logra la participación activa mediante los mecanismos establecidos en la Constitución Política de Colombia los participantes elevaron derechos de petición a entidades gubernamentales solicitando información para la toma de decisiones en asuntos que les competen
**Referencias:** 1. Freire, P. Pedagogía de la Liberación. Grao. Barcelona. 2004
**Declaración de intereses:** No declarado

## GP-TUE-132 OPERATIONALISING E ARA TAUWHAITI WHAKARAE - MAORI PUBLIC HEALTH WORKFORCE DEVELOPMENT ACTION PLAN

**M. N. Tunks***[1], G. N. Berghan[1]
[1]Research, Hauora.Com, Auckland, New Zealand

**Background:** Hauora.Com is an Indigenous National Maori Health Workforce Development Organisation based in Auckland, New Zealand. Hauora.Com was contracted by the New Zealand Ministry of Health in June 2009 to develop and operationalise E Ara Tauwhaiti Whakarae - A National Maori Public Health Plan of Action.
**Objectives:** This presentation will provide an overview of the six key areas of the plan;
Maori Public Health Career Pathways
Cultural Competencies
Mentoring
Development of Maori Public Health Networks
Developing Whanau, Hapu, Iwi and Maori Communities
Maori Public Health Workforce Intelligence
The presentation will have particular relevance for those working alongside Indigenous Communities.
**Underlying values and principles:** The values informing this project are based on kaupapa Maori - Maori world views and beliefs.
**Knowledge base/ Evidence base:** The project has been informed from national Maori public health workforce development surveys, as well as consultation and meetings with key stakeholders.
**Context of intervention/project/work:** This Maori Public Health Workforce Development project is part of a wider project "Te Uru Kahikatea" - A National Public Health Workforce Development Plan for the New Zealand Ministry of Health.
**Methods:** Qualitative methods have been used in the project. These include face to face interviews and meetings with key stakeholders, hui and review of literature.
**Results and Conclusions:** Progress has been made on a range of actions. These include the development of a Indigenous mentoring programme, national networking forum, stage one cultural competencies and a project which seeks to develop a Maori community cohort for Emergency Disaster Management capability.
**References:** E Ara Tauwhaiti Whakarae - National Maori Public Health Workforce Development Plan (2006) Te Rau Matatini. Wellington, New Zealand.
**Disclosure of Interest:** none declared

**GP-TUE-133 INTERVENTIONS TO ENHANCE FOOD SECURITY FOR MAORI, PACIFIC AND LOW-INCOME NEW ZEALANDERS**

**L. N. Signal***[1]
[1]Health Promotion and Policy Research Unit, University of Otago, Wellington, Wellington, New Zealand

**Background:** Food security is the assured access to sufficient food that is nutritious, of good quality, safe, meets cultural needs, and has been acquired in socially acceptable ways. Despite being a land of plenty, food security is an issue for 20-22 percent of New Zealanders, with higher rates among Maori and Pacific peoples.
**Objectives:** This paper presents findings of a comprehensive research programme that identified interventions to enhance food security among Maori, Pacific, and low-income families in New Zealand.
**Underlying values and principles:** This research was underpinned by commitments to equity in health, to identify the social and economic determinants of food security and to take a comprehensive approach to addressing them.
**Knowledge base/ Evidence base:** Complexity theory frames the research because it acknowledges the multiplicity of factors that impact on social phenomena and focuses on multiple solutions.
**Context of intervention/project/work:** This research was undertaken in New Zealand with Maori, the indigenous people of New Zealand; with Pacific New Zealanders, that is people who have immigrated from the Pacific or were born in New Zealand and are of Pacific ethnicity; and with low-income New Zealanders. The research was multicultural with Maori and Pacific researchers on the research team, Maori and Pacific research advisors and strong representation by Maori and Pacific populations at each stage of the research. Ethical approval was given for each stage of the research.
**Methods:** This research utilises multiple methods including literature reviews, focus groups with communities, stakeholder workshops and key informant interviews.
**Results and Conclusions:** The research identified the need for intervention in three areas: the money available in households, food purchasing influences and the cost of healthy nutritious food. This paper highlights findings and recommendations across these three areas which include healthy public policy, community action and the development of personal skills. The paper concludes with reflections on the value of a comprehensive approach to identifying health promotion interventions to complex social problems.
**Disclosure of Interest:** None declared

## GP-TUE-134 TRADITIONAL KNOWLEDGE AND SELF-DETERMINATION IN INDIGENOUS MENTAL HEALTH

**M. S. Hirch***[1]
[1]Cultural Geography, Center for World Indigenous Studies, Darmstadt, Germany

**Background:** This paper explores the potential of self-determination and revitalizing traditional cultural practice in the healing of individuals and communities suffering from mental disease. The focus is on the resource potential of traditional medicines in the field of mental health.
**Objectives:** Mental health problems, substance use as well as suicide are over proportionately high within indigenous communities who have a significantly lower life expectancy the world over. At the same time indigenous patients are exposed to lack of health care, culturally appropriate services and oftentimes discrimination and institutional racism. Mainstream health care is not properly taking care of indigenous health needs.
Exposed to chronic stress due to historic trauma, poverty and discrimination indigenous people oftentimes feel depressed, helpless, anxious, irritable, and then they blame themselves for feeling that way. These feelings often lead to self medication with sugar and carbohydrates, drugs, alcohol, sex and other activities... these substances exacerbate the trauma and stress and the cycle continues... Until it is stopped.
**Underlying values and principles:** The presentation explores the most fundamental right of self-determination from the view of the healing arts in the context of international policy. Issues concerning indigenous health in this presentation are not only seen in terms of regulations and laws.
**Knowledge base/ Evidence base:** This study directly aims at a comparison of legal standards with the lived realities of indigenous nations on the ground, which thus presents very much a bottom- up perspective. The focus is to determine most appropriate official policies towards traditional medicines for indigenous health care.
**Context of intervention/project/work:** This research is conducted in the frame of a doctoral thesis at the department of Cultural Geography at the university of Cologne, Germany and focussed on experiences from a project "Indian Elder Caregiver Study" funded by the National Institute of Health and conducted by colaboration partners at the Center for Word indigenous Studiess/Center for Traditional Medicine in Oympia, Wa, USA.
**Methods:** Quantitative as well as qualitative methods were used for the project.
**Results and Conclusions:** The project found significant potential of indigenous peoples living in the Pacific Northwest to use and control their own, culturally defined, traditional health system- which is the most fundamental right of self-determination of Fourth World peoples and of immense value for all of humanity
**Disclosure of Interest:** None declared

## GP-TUE-136 WORD OF MOUTH: EVALUATION OF THE 'FILLING THE GAP' INDIGENOUS DENTAL PROGRAM

**L. R. Jackson Pulver***[1], S. A. Fitzpatrick[1], M. Norrie[2], J. Ritchie[1]
[1]Muru Marri Indigenous Health Unit, School of Public Health and Community Medicine, Sydney, [2]Oral Health Unit, Wuchopperen Health Service, Cains, Australia

**Background:** For Aboriginal and Torres Strait Islander people, access to oral health care is complicated by a maldistribution of dentists in regional areas. To address this problem in Far North Queensland, a volunteer dental program 'Filling the Gap' was established in 2006 in partnership with the local Aboriginal and Torres Strait Islander Community Controlled Health Service.
**Objectives:** To understand the efficacy of a volonteer dental programme in a Aboriginal and Torres Strait Islander environment
**Underlying values and principles:** Community empowerment
Capactiry building
Service provision
**Knowledge base/ Evidence base:** Oral health care is complicated by a maldistribution of dentists in regional areas. Oral health is poor in most Aboriginal and Torres Strait Islander populations
**Context of intervention/project/work:** Aboriginal and Torres Straiti ISlander community controlled servce
**Methods:** An evaluation of the program's operation over a two year period was undertaken through a mixed method investigation reviewing the literature, exploring episodes and types of care and patterns of volunteer recruitment through multivariate analysis, and thematically analysing perceptions of the various stakeholders.
**Results and Conclusions:** Key findings revealed that 79 weeks of dental care were provided by 68 volunteer visitors addressing patient needs satisfactorily and eliminating waiting lists. Stakeholders believed that the program met a pressing need, enhanced workforce development, provided a quality service with continuity of care, and enabled cross-cultural relationships to thrive, with the familiarity and trust felt by patients towards the wider health service and its Aboriginal and Torres Strait Islander dental staff extended to the volunteers.
This evaluation demonstrated the need for a sustained public oral health care service for Aboriginal and Torres Strait Islander peoples. Although the program overall was evaluated most positively, its success should not take the place of sustainable oral health care services in regional and remote Australia.
**Disclosure of Interest:** None declared

## GP-TUE-137 A CONTEXTUAL APPROACH TO BETTER UNDERSTANDING THE HEALTH OF INDIGENOUS POPULATIONS LIVING IN TORONTO

**R. Mehdipanah***[1], M. Cooke[1]
[1]Faculty of Applied Health Sciences, University of Waterloo, Waterloo, Canada

**Background:** The Indigenous (First Nations, Inuit, and Métis) population in Canada is growing. While Indigenous health has improved in the last few decades, life expectancy continues to be lower for Indigenous people compared to the rest of the population. In addition to poorer quality of life, chronic disease rates are on the rise. Furthermore, the focus of current Indigenous health research tends to be on those living in rural or remote Indigenous communities. Yet, more than half of the Canadian Indigenous population currently resides in urban centers. Despite the importance of neighborhood and contextual factors for understanding health in urban areas, the importance of neighborhood characteristic for urban Indigenous health has not yet been examined.
**Objectives:** The study deviates from traditional individual-level approaches to encompass both individual and neighborhood-level variables affecting self-rated health of Indigenous people living in urban areas. We examined Toronto as a city of interest with just over 13,600 Indigenous individuals living in its 140 neighborhoods. The objective of the study was to determine what factors at both the individual and neighborhood level impact self-rated health status.
**Underlying values and principles:** The study aims to better understand social inequalities that may arise amongst Canadian Indigenous populations integrating themselves in urban dwellings.
**Knowledge base/ Evidence base:** The goal of this research was to provide a better understanding of the issues Indigenous populations face in urban settings. We hope policy makers and community groups can use this information for future decisions and allocation of resources.
**Context of intervention/project/work:** This project involves the secondary analysis of survey and other data. It is supported by research funding from the Social Sciences and Humanities Research Council of Canada (SSHRCC).
**Methods:** A series of logistic regression models were constructed in order to understand the effects of the individual and neighborhood-level predictors on self-rated health. Individual-level predictors included gender, age, marital status, education, employment and income, while neighborhood-level predictors included, average yearly income, Gini coefficient, housing, employment and education. Health outcomes indicators included self-reported health, BMI, access to health care and smoking status. Individual-level and health-outcomes data were taken from the 2006 Aboriginal Peoples Survey while neighborhood-level were taken from the 2006 Census and the City of Toronto.
**Results and Conclusions:** Through this study we gained an understanding of neighborhood-level influences on Indigenous health while visualizing of Indigenous urban settlement in Toronto. As expected, Indigenous individuals living in disadvantaged neighborhoods were more likely to have poorer health outcomes. While neighborhood-level predictors such as average household income were significantly associated with health outcomes, individual-level predictors had somewhat stronger effects on predicted health outcomes. By incorporating mapping techniques, the results from our findings will assist policy makers, community groups and researchers to identify and improve health outcomes within the urban Indigenous population.
**Disclosure of Interest:** none declared

## GP-TUE-138 TRANSLATING INDIGENOUS COMMUNITY KNOWLEDGE AND EXPERIENCE TO IMPROVE LOCAL DIABETES STRATEGIES

**K. M. Jacklin***[1], L. Boesch[1]
[1]Human Sciences, Northern Ontario School of Medicine, Sudbury, Canada

**Background:** Diabetes continues to be a significant chronic disease for Indigenous peoples worldwide. Rates of Type 2 Diabetes Mellitus (T2DM) in North America have been found to be up to five times higher for Aboriginal people compared to the overall population. While rates of diabetes continue to increase in this population, health policy, funding and programming have not changed in tandem.
**Objectives:** To identify personal, community, and societal factors which influence Indigenous patients' ability to follow the advice provided through health promotion programs and clinical services in order to achieve glycemic control.
**Underlying values and principles:** The research examines barriers and enablers to clinical diabetes care, self-care, prevention and health promotion activities from patient and provider perspectives.
**Knowledge base/ Evidence base:** Patient and provider explanations and understandings of diabetes are compared to identify divergent theories, gaps in knowledge, and communication issues that may influence effective uptake of diabetes education activities.
**Context of intervention/project/work:** T2DM was designated a priority research area by the Wikwemikong Unceded Indian Reserve (WUIR) in 2005 which lead to a community-academic partnership to begin participatory research concerning diabetes in the community. This paper reports on community-based research conducted from 2007-2009 in partnership with the Diabetes Research Team at the Wikwemikong Health Centre.
**Methods:** Methods include a chart audit of diabetes care received in WUIR to identify patients who achieved glycemic targets and those who did not; in-depth interviews with 50 of those patients and the six family physicians who provide service at the WHC; and focus groups with other health care professionals and paraprofessionals who contribute to the delivery of diabetes care and programming in Wikwemikong.
**Results and Conclusions:** Study findings suggest that on the surface patient and provider explanations for glycemic outcomes are similar more often than not. However, community understandings of the underlying root cause of the epidemic and the complexity of factors influencing progression to secondary complications are much deeper. Patient perspectives reveal that the majority of barriers facing people with diabetes in WUIR are related broadly to issues concerning mental health at the personal, family, community and societal levels. We conclude that community-based participatory approaches to research are effective in increasing awareness of diabetes care issues and creating opportunities to advocate for change. Our analysis suggests that prevention, health promotion, and clinical care concerning diabetes in Indigenous settings can be strengthened by improved understandings of local circumstances, culture and the political-economic realities of life in an Aboriginal community. A final research stage concerned with knowledge translation activities will be necessary to ensure that patient and provider perspectives are used to reframe current approaches and programming to improve care and outcomes.
**Disclosure of Interest:** None Declared
Statement on Indigenous Community Involvement: This research has been conducted in partnership with the Wikwemikong Unceded Indian Reserve. The research was approved by the Wikwemikong Health Centre (WHC) Health Services Committee. The WHC created the WHC Diabetes Research Team in 2005 to work with the academic partners to develop a diabetes research strategy for the community. The WHC Diabetes Research Team has directed all aspects of the research including local ethical considerations, methods, analysis and dissemination. This abstract submission has the full endorsement of the WHC Diabetes Research Team. Contact information for the WHC Diabetes Research Team: Melissa Roy (705) 859-3164 ; email mroy@wikyhealth.ca

**GP-TUE-139 ABORIGINAL AUSTRALIA: NOONGAR HEALTHY LIFESTYLE PROGRAM**

**R. K. Crane***[1], L. N. Garlett[2], I. W. Hill[3], C. F. Yarran[4]
[1]Health Promotion, South Metropolitan Public Health Unit, [2]Noongar Community, [3]Western Australian Police Service, PCYC, [4]Aboriginal Health Team, South Metropolitan Public Health Unit, Fremantle, Australia

**Background:** This paper aims to share the learnings of a three year health promotion and community development project involving a motivated Noongar community in the suburbs of Perth, Western Australia. Aboriginal culture is one of the oldest surviving cultures in the world. Aboriginal cultures are numerous and diverse, comprising hundreds of different kinship and language groups that have adapted to diverse living conditions throughout Australia over thousands of years (Australia's Health Ministers Advisory Council, 20041).

**Objectives:** The program aims to:

1. Increase the physical activity of young Noongar people at the Hilton Police and Citizens Youth Club (PCYC);
2. Increase the awareness and skills in healthy nutrition;
3. Increase the intergenerational opportunities for Noongar people; and
4. Increase the health promoting capacity of the PCYC.

**Underlying values and principles:** From the outset, the program, reflected the seven principles of the Cultural Respect Framework 1.

**Knowledge base/ Evidence base:** The people involved in this project identify with their Noongar heritage and culture. While the Aboriginal population within the South Metropolitan Area Health Service (SMAHS) represent only 1.8% of the total population, this group carries a disproportionate burden of disease.

**Context of intervention/project/work:** The Western Australian Health Promotion Strategic Framework 2007-2011, states the need for increased levels of physical activity for Aboriginal people. It specifically cites the need for "more culturally relevant community-based physical activity programs and services for priority and high risk population groups" (DOH, 20072 pp 32).

**Methods:** Essentially the project was planned, implemented and evaluated through community consultation to deliver physical activity and nutrition outcomes. Basket ball teams and community feasts were initiated and supported for the young Aboriginal people of the community.

**Results and Conclusions:** The results of this program include a variety of physical activity, nutrition, cross-generational and capacity building results. The success of the program includes three National Indigenous Basketball Championships in 2007, 2008 and 2009.

Many other impressive physical activity, nutrition, intergenerational and capacity building outcomes have resulted from the program that has inspired and bonded the community at the local level.

Summary

This program is an innovative, evidence-based program that follows the Cultural Respect Framework1, and has been devised by local Aboriginal people for their community and continues to evolve according to their needs.

In conclusion ten recommendations will be presented that will assist health promoters when working with local Aboriginal communities

**References:** 1. Australia's Health Ministers' Advisory Council. Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (2004 -2009). Standing committee on Aboriginal and Torres Strait Islander Health Working party. Published by Department of Health South Australia. March 2004.
http://www.aboriginalhealth.wa.gov.au/docs/cultural_framework.pdf

2. Department of Health. Western Australian Health Promotion Strategic Framework 2007-2011. Perth, Western Australia: Western Australian Government; 2007.

**Disclosure of Interest:** None declared

**GP-TUE-140 TALKING IT UP!: ABORIGINAL VOICES IN THE FORMULATION OF HEALTH POLICY THAT WORKS**

**A. R. Taket***[1], S. Firebrace[2], R. Blow[3], S. Pollock[4], S. Barter-Godfrey[1]
[1]School of Health and Social Development, Deakin University, [2]Maya Healing Centre, VAHS, [3], [4]Research and Social Policy, Wesley Mission Melbourne, Victoria, Australia

**Background:** Aboriginal and Torres Strait Islander (ATSI) people in Australia experience poor health outcomes, linked to discrimination and a lack of respect for their human rights.
**Objectives:** The study's objective was to undertake a review of current Aboriginal health policy relevant to the state of Victoria in Australia, with particular emphasis on the role and inclusion of indigenous knowledge in policy formulation.
**Underlying values and principles:** Equity, human rights, involvement.
**Knowledge base/ Evidence base:** The study brings two forms of knowledge together: that derived from Aboriginal and Torres Strait Islander people and their families, and that embedded in the research literature and policies that shape the social space in which individual Aboriginal and Torres Strait Islander people exist.
**Context of intervention/project/work:** Urban Aboriginal population in Melbourne, Victoria.
**Methods:** Initially, there were three separate strands to the work: a series of forums involving group interviews/discussions with ATSI people who are consumers of health services; a policy analysis that reviewed policies relating to Aboriginal health at federal and state level; and a literature review. The results of these three separate strands of analysis were then brought together in a fourth strand to the work, a process involving ATSI health service consumers to discuss and agree overall recommendations from the study. The study employed a participatory methodology as the basis for individual and collective empowerment in relation to health outcomes. The need for the study was identified by Aboriginal people, through their own processes of healing, and presented by appropriate figures within their communities, namely community elders. They invited other Aboriginal people to take part through their own communication channels, thus ensuring that responsibility for engagement in the work, and in formulating action for improvement, remained with Aboriginal people and their families. However, the study design also recognised that Aboriginal people exist within broader structural and policy constraints which impact on their ability to manage their own lives successfully or otherwise. Thus the study sought to combine indigenous and non-indigenous knowledge through bringing together the three strands of work in the way described. A Reference Group guided the work at all stages, endorsed the findings, and drafted the recommendations. The two elders who had identified the need for the work formed the core of the group, and were involved from start to finish. Other ATSI people joined the group at different times to assist in its work.
**Results and Conclusions:** Aboriginal health policy is often formulated without the incorporation of indigenous knowledge systems, which would situate policy in a culturally appropriate context. This raises particular issues for Aboriginal people living in urban areas, where the notion of 'community' is marked by diversity of cultures and knowledges. One outcome of this for urban Aboriginal people is inequitable access to services and supports, where some people are shunned by the Aboriginal Controlled part of the system because of their particular associations with mob and country. The three parts of the study present different types of evidence for Aboriginal health, as part of a coherent whole which understands Aboriginal health from a community, research and policy perspective. The themes raised by the Aboriginal participants' voices were strongly endorsed by the evidence in the literature and the 'gold standard' of Aboriginal health policy, the nine principles of the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013. There were seven meta-themes, common themes that emerged from the study as a whole, namely: holism; identity; cultural respect; collaboration; power and control; health sector and services; and reconciliation. The presentation will expand on the conclusions and recommendations formulated within the study.
**Disclosure of Interest:** None declared

**GP-TUE-141 CHRONIC DISEASE STORY BOARD: AN INTERACTIVE COMMUNICATION TOOL, ASSISTING ABORIGINAL PEOPLE IN THE NORTHERN TERRITORY (NT) IN THE PREVENTION, DETECTION AND MANAGEMENT OF PREVENTABLE CHRONIC DISEASES**

**B. B. Shields***[1], D. F. Schmitt[2]
[1]Preventable Chronic Disease, [2]Health Promotion Strategy Unit, Department of Health and Families, Casuarina, Australia

**Background:** Chronic Disease prevalence in the Aboriginal population of the NT is high. The Burden of Chronic Disease in the NT Aboriginal population is 3.6 times that of the Australian average. The Chronic Disease Story Board is a portable tool that provides chronic disease information, awareness and education in a culturally appropriate manner to assist NT Aboriginal people prevent, detect and manage preventable chronic diseases.
**Objectives:** This poster describes recent capacity building workshops provided by the NT Department of Health Families (DHF)to Aboriginal community workers, in order to enable them to assist Aboriginal people in the prevention, detection and management of preventable chronic diseases.
**Underlying values and principles:** Culturally appropriate communication and provision of information and education that enables informed decision making.
**Knowledge base/ Evidence base:** Story telling is a powerful cultural appropriate way to provide preventable chronic disease (PCD) information in a non – threatening way.
**Context of intervention/project/work:** Primary Health care is delivered to Aboriginal communities by a diverse workforce, including Aboriginal community workers. The Chronic Disease Story Board is an intertactive communication tool utilised by community workers. Aboriginal Health Promotion officers from the DHF, provide
training and support in the use of the Story Board.
**Methods:** Goal, objectives and strategies of the recent Chronic Disease Story Board workshops will be described. Workshop outcomes,based on participant observations and evaluation feedback, will be identified.
**Results and Conclusions:** The workshops:
Strengthened community workers understanding of PCD,
Increased community workers ability to communicate with their people about PCD and how to prevent and manage it.
Provided community workers with their own Chronic Disease Story Board and increased their confidence in using it.
Since the workshops community workers have used their Chronic Disease Story Boards to share information on PCD prevention, detection and management with their communities. Some community workers have enhanced their Story Boards to share information on glue sniffing
**Disclosure of Interest:** None declared

## GP-TUE-142 THE GUDAGA PROJECT: RESPONDING TO THE HEALTH SERVICE NEEDS OF ABORIGINAL INFANTS.

**L. R. Jackson Pulver***[1], E. Comino[2], J. Knight[2], C. J. Anderson[2], V. Webster[2]
[1]Muru Marri Indigenous Health Unit, [2]CHETRE, School of Public Health and Community Medicine, Sydney, Australia

**Background:** The Gudaga Project is a birth cohort study of Aboriginal infants in an urban environment. The data are being augmented through linkage to administrative data on health services use.
**Objectives:** This paper aims to describe the process of extraction obstetrics data from hospital administrative records and birth outcomes.
**Underlying values and principles:** Health equality, close the gap, healthy babies
**Knowledge base/ Evidence base:** Aboriginal health is poor, infant mortality is worse thatn any other population in Australia
**Context of intervention/project/work:** Hospital (for confinment and recruitment) and community for followup
**Methods:** A brief questionnaire was administered to women on the maternity ward of a large urban hospital to identify mothers of Aboriginal infants. Data on antenatal care and birth outcomes was extracted from obstetrics records. Linkage was complicated due to a change in the electronic record system during recruitment. The major birth outcomes were gestational age and birth weight. The risk factors for birth weight were explored.
**Results and Conclusions:** Of 2047 women surveyed 178 mothers of Aboriginal infants were identified. The mean birth weight of Aboriginal infants was 3281g compared to 3419g for non-Aboriginal infants ($p<0.001$), and 11.8% of Aboriginal compared to 5.8% of non-Aboriginal infants were born at <37 weeks gestation ($p=0.02$). Socioeconomic status, maternal smoking, aboriginality, late antenatal care and vulnerability were risk factors for poor birth outcomes. In multivariate analysis maternal smoking was important predictor of lower birth weight.
This study demonstrated poorer birth outcomes for Aboriginal infants that could be explained by risk factors that have an increased prevalence among mothers of Aboriginal infants. Early results from the Gudaga study have prompted a commitment to enhanced services for Aboriginal families including establishment of a ‘model’ sustained home visiting service beginning during the antenatal period and continuing into childhood.
**Disclosure of Interest:** None declared

**GP-TUE-143 "A DEGREE IN LIFE EXPERIENCE AND A MASTERS IN REALITY": CELEBRATING, VALUING AND SUPPORTING AN ABORIGINAL HEALTH DEVELOPMENT WORKFORCE DURING AN ORGANISATIONAL RESTRUCTURE**

J. A. Smith[1], **B. Shields***[1], M. Liddle[1], J. Daby[1], J. Bonson[1], J. Davis[1]
[1]Health Development Branch, NT Department of Health and Families, Darwin, Australia

**Background:** The Northern Territory (NT) has the highest proportion (approximately 30%) of Aboriginal and Torres Strait Islanders, when compared to other states and territories in Australia. Unemployment rates among this population are extremely high, particularly in sectors requiring formal qualifications, such as health.
**Objectives:** In this paper we will examine strategies that were used during a government organisational restructure to celebrate, value and support an existing Aboriginal health development workforce. We will also identify and discuss key recommendations arising from the engagement with this workforce.
**Underlying values and principles:** A key principle was to provide an environment that was conducive for Aboriginal health development staff to feel valued and supported during a government organisational restructure. This was considered to be a strategy to celebrate and recognise their achievements, and subsequently retain a local Aboriginal health workforce, in a jurisdiction with high unemployment among Aboriginal and Torres Strait Islander people.
**Knowledge base/ Evidence base:** At present, approximately 10% of staff in the NT Department of Health and Families identify as being of Aboriginal and Torres Strait Islander decent. Whilst this is a significant proportion of the health workforce, additional strategies aimed at increasing the Aboriginal health workforce are still required.
**Context of intervention/project/work:** A series of mainstream staff consultation forums were held during an organisational restructure of the Health Development Branch in the NT Department of Health and Families – the largest provider of primary health care in the NT. During this consultation period it was recognised that an additional forum specifically for Aboriginal health development staff was warranted.
**Methods:** The Change Management Co-ordinator organised a meeting with Senior Aboriginal health development staff (four are co-authors) to discuss the possibility of holding a dedicated Aboriginal health development consultation meeting. It was agreed that this was an identified need and a welcome opportunity to raise issues pertinent to this workforce. Consequently, an Aboriginal health development workforce consultation meeting was facilitated by a Senior Aboriginal Health Promotion Officer and other key Aboriginal health promotion staff in July 2009. 12 Aboriginal health development staff participated in this meeting, with subsequent smaller meetings having since been held.
**Results and Conclusions:** Collectively the Aboriginal health development staff had over 120 years experience working in the NT, which spanned government, non-government and Aboriginal community controlled agencies across health, justice, education and primary industry sectors. A series of recommendations resulted from this consultation meeting, with two senior Aboriginal health development staff having already been invited onto a high level Health Development Quality Collaborative.
**Disclosure of Interest:** None Declared

## GP-TUE-146 ABORIGINAL EDUCATION AT UPEI: TRANSITIONING TOWARD A POSITIVE FUTURE IN HEALTH

**J. R. Bull***[1]
[1]Nursing, University of Prince Edward Island, Charlottetown, Canada

**Background:** New and innovative educational approaches are needed to prepare nurses to respond to diverse needs of people from a wide variety of cultural backgrounds. Aboriginal cultures need particular attention as their rich traditions have historically been forced underground or destroyed by Western education and medical practices. The number of Aboriginal individuals entering nursing is low and more needs to be done to attract students to this profession.
**Objectives:** • To increase the number of Aboriginal youth entering into and succeeding in health career studies
• To reduce barriers to admission of Aboriginal students into professional health care programs
• To make UPEI a post secondary institution that is supportive of and conducive to Aboriginal students
• to identify best practices and approaches in order to support policy, planning and program decisions.
**Underlying values and principles:** Dr Alan Seidman has developed a formula which he advocates post-secondary institutions adopt to promote retention of minority students: Retention = Early Identification = (Early = Intensive = Continuous) Intervention
**Knowledge base/ Evidence base:** Successful retention is a result of early identification of support coupled with early and continuous intervention (availability of support) throughout the university experience. He puts the onus on the universities saying institutions “cannot assume that students will take the first step and seek help. The university must be proactive in its approach to students,” (Seidman, 2005).
**Context of intervention/project/work:** The transition program is a support program that will help ensure that Aboriginal students receive the non-monetary supports they need while enrolled in health related studies. It will also reach into the provincial high school to address systematic barriers that may prevent students from being admitted to post secondary education health programs.
**Methods:** This project uses a community based participatory action research method which involves the youth, students, and communities for which the project is being developed.
**Results and Conclusions:** In January, 2009, UPEI established its transition program to help ensure Aboriginal students receive non-monetary supports they will need while enrolled in the School of Nursing and other health related programs. This will then improve the availability of culturally competent health care providers and move toward attaining a sufficient supply and mix of health care workers in Aboriginal communities on PEI.
Chief Frances concluded by saying, “Having an area inside a growing university such as UPEI will only encourage more and more Aboriginal people to choose a post secondary education. When they do that, our citizens, our communities and our province is better for it.
**References:** Seidman, A. (2005). Minority Student Retention: Resources for Practitioners. Retrieved from http://www.cscsr.org/docs/MinorityStudentRetentionResourcesforPractitioners2006.pdf
**Disclosure of Interest:** None declared

**GP-TUE-147 HEALTH INDICATORS AMONG RESIDENTS OF INUIT NUNANGAT, CANADA: A COLLABORATIVE APPROACH TO RESEARCH**

**N. J. Goedhuis***[1], P. A. Peters[2], E. Ford[3], M. Lougheed[3], J. Pennock[1]
[1]First Nations and Inuit Health Branch, Health Canada, [2]Health Analysis Division, Statistics Canada, [3]Health and Environment, Inuit Tapiriit Kanatami, Ottawa, Canada

**Background:** There is a lack of Inuit-specific health information in Canada with which to guide public health programming. Aboriginal identification is not included in vital statistics data, but as the majority of Inuit in Canada live in an area called Inuit Nunangat (the Inuit Homeland), health measures for residents of this geography can be used as a proxy for Inuit.
**Objectives:** The objective was to produce comparable health indicators for Inuit Nunangat to inform health programming for Inuit in Canada, and to measure differences between residents of Inuit Nunangat and the rest of the Canadian population.
**Underlying values and principles:** The principles of this project included ensuring research questions were relevant, and results were interpreted accurately. Research was performed in a collaborative manner, including engaging Inuit stakeholders (e.g. Inuit Tapiriit Kanatami) to interpret and disseminate results.
**Knowledge base/ Evidence base:** Life expectancy estimates for Inuit-inhabited communities have been produced using vital statistics and Census population estimates (Wilkins et al, 2008), but these data are not Inuit-specific. Statistics Canada collects information for Inuit through the Canadian Census, the Aboriginal Children's Survey and the Aboriginal Peoples Survey.
**Context of intervention/project/work:** Health planning at the community and regional levels requires an evidence base on which to base decisions. There is currently a lack of Inuit-specific health information to guide this process.
**Methods:** Using a geographic method adapted from (Wilkins et al, 2008), health indicators were produced for residents of Inuit Nunangat using two sets of Vital Statistics data (1994-1998 and 1999-2003), and Census data from 1996 and 2001. The analysis generated rates for infant mortality, life expectancy (at birth), and mortality rate (by cause). Each of these indicators was produced by sex, for Inuit Nunangat, and for the rest of Canada. The results were age standardized, and rates in Inuit Nunangat and the rest of Canada were compared. Trends were also assessed across the two time periods.
**Results and Conclusions:** Comparing Inuit Nunangat to the rest of Canada, infant mortality was higher (RR=3.3 and 2.8, 1994-1998 and 1999-2003 respectively), and life expectancy was lower (9.5 years lower and 11.8 years lower, 1994-1998 and 1999-2003 respectively). The age standardized mortality rate (ASMR) for residents of Inuit Nunangat was higher than the rest of Canada (RR=2.2 and 2.5, 1994-1998 and 1999-2003 respectively). Rate differences (RD) identified causes of mortality responsible for the greatest number of excess deaths (per 100,000) among residents of Inuit Nunangat as compared to the rest of Canada. In 1994-1998, unintentional injury (RD=70.6), suicide and self-inflicted injuries (RD=60.5), and respiratory disease (RD=44.5) were responsible for the largest difference in mortality. In 1999-2003, suicide and self-inflicted injuries (RD=94.3), unintentional injury (RD=62.7) and malignant neoplasms (RD=48.3) were responsible for the greatest number of excess deaths. This methodology was found to be effective in producing health indicators for this population. The comparisons show that the infant mortality is higher and life expectancy is lower in Inuit Nunangat as compared to the rest of Canada. The profile of death by cause differs between residents of Inuit Nunangat and the rest of Canada, and is changing over time. This work provided key proxy measures for Inuit health, but Inuit-specific health data is still lacking in Canada.
Inuit Tapiriit Kanatami (ITK), Statistics Canada, and Indian and Northern Affairs Canada collaborated on the project described herein. ITK participated in the selection of indicators for the project, and collaborated in both the interpretation of the results and in the dissemination of results to Inuit Regions.
**References:** Wilkins R, Uppal S, Finès P, Senécal S, Guimond É, Dion R. Life expectancy in Inuit-inhabited areas of Canada, 1989-2003. Health Reports (Mar. 2008), V. 19, N. 1, pp 7-19
**Disclosure of Interest:** none declared

## GP-TUE-148 DEFINING OUR 'ETHICAL SPACE': GOVERNANCE OF HEALTH RESEARCH

**J. R. Bull***[1]
[1]Nursing, University of Prince Edward Island, Charlottetown, Canada

**Background:** This study was conceptualized from a partnership between aboriginal communities in Labrador and the researcher as a result of a conference. Based on this and the premise that Aboriginal Peoples have endured a history of exploitation through research, leaving people and communities vulnerable, this research examines the current state of ethical governance of health research with Aboriginal Peoples in Labrador.
**Objectives:** The study objectives are: to examine the current state of knowledge on ethics and governance of research involving aboriginal peoples; to reveal meanings and uses of the concepts of "community" and "population" as they relate to health research, policy, and ethics; to describe how concepts of "ethics" and "research" have been understood and used in relation to the ethical review of health research by community members; and to explain points of convergence or disjunction between meanings perceived by aboriginal peoples in Labrador and those implicit and explicit in national policies
**Underlying values and principles:** Historically, four key false assumptions contribute to the treatment of aboriginal peoples and these continue to be evident in government policies. First, that aboriginal peoples are inferior and are not capable of self-governing; second, that treaties are seen as "a form of bureaucratic memorandum of understanding, to be acknowledged frequently, but ignored often" (p. 4); third, that actions deemed to be of potential benefit to communities do not require consent or consultation; and finally, that non-aboriginal values are sufficient in individual or community development, without the presence of aboriginal values.
**Knowledge base/ Evidence base:** Through a history of colonization and assimilation, aboriginal peoples have been exploited and exoticized in research. The research process itself contributes to contextualizing what it means to conduct authentic research with aboriginal peoples. That is, the relationship building and research negotiation that took place for this study can be seen as an example of a best practice for authentic research involving aboriginal people.
**Context of intervention/project/work:** An important aspect of the movement to decolonize research on aboriginal peoples is scrutinizing the purpose of the research itself. The argument is that westerners, particularly anthropologists, have primarily conducted research that is of an exotic (and essentializing) nature at the expense of research to improve the well-being of aboriginal peoples. For example, much of the research conducted in aboriginal communities has little or no positive impact on health or social well being.
**Methods:** Interviews with key informants have shown that a history of perceived exploitation in research, a shortage of human resource and financial capacity, and past and present relationships with governments, influence the ways in which ethics and research are understood at the community level.
**Results and Conclusions:** A consistent theme is that researchers should engage in authentic relationships with communities, which gives rise to best practises for ethical research involving Aboriginal Peoples.
**References:** Royal Commission on Aboriginal Peoples (1996).
Canadian Institutes of Health Research.(2008). Retrieved on March 10, 2008, from http://www.cihr-irsc.gc.ca/e/193.html.
**Disclosure of Interest:** none declared

## GP-TUE-271 TRUST AND LEADERSHIP: KEY DETERMINANTS OF PARTNERSHIP SYNERGY

**J. M. Jones***[1]
[1]Health Promotion, Health Service Executive West, Galway, Ireland

**Background:** Intersectoral partnerships have been identified as a way of addressing the health challenges facing society. In theory, partnerships achieve synergistic outcomes which are more than can be achieved by individual partners working on their own. It is unclear what factors create this synergy or whether synergy leads to extra and better outcomes.
**Objectives:** This study aimed to determine the key factors that influence partnership functioning and their relationship with partnership synergy.
**Underlying values and principles:** Trust in partnerships.
**Knowledge base/ Evidence base:** Trust in partnerships.
**Context of intervention/project/work:** Partneships.
**Methods:** A mixed methods approach was used which combined findings from a mapping study with chairs/leads of 129 partnerships, five focus groups with 36 partners, a postal survey of 337 partners in 40 partnerships and four workshops attended by 48 partners. The postal questionnaire incorporated a number of specifically designed and validated multi-dimensional scales to assess the contribution of factors that influence partnership functioning and synergy. New validated scales were developed for synergy, trust, mistrust and power. Multiple and logistic regression analysis was used to identify the significance of each factor to partnership synergy and outcomes.
**Results and Conclusions:** Trust and leadership were shown to be the most important determinants of partnership synergy. Community assets, efficiency and boundary-spanning skills were also significant predictors of synergy. Expert assets and mistrust had a negative relationship to partnership synergy. Synergy is predicated on trust and leadership. Trust-building mechanisms need to be built into the partnership forming stage and this trust needs to be sustained throughout the collaborative process. We need to develop systems where the best leaders are put forward for intersectoral partnerships. This should be consistent across all sectors and organisations.
**Disclosure of Interest:** None declared

## GP-TUE-272 HEALTH PROMOTION PARTNERSHIPS: THE RELATIONSHIP OF TRUST TO TEN PARTNERSHIP FUNCTIONING FACTORS

**J. M. Jones***[1]
[1]Health Promotion, Health Service Executive West, Galway, Ireland

**Background:** Intersectoral partnerships have been identified as a way of addressing the health challenges facing society. In theory, partnerships achieve synergistic outcomes which are more than can be achieved by individual partners working on their own. Trust and leadership have been identified as key determinants of synergy.
**Objectives:** This study aimed to identify the relationship between trust and ten independent factors that influence synergy.
**Underlying values and principles:** Health promotion partnerships
**Knowledge base/ Evidence base:** Health promotion partnerships
**Context of intervention/project/work:** Health promotion partnerships
**Methods:** A mixed methods approach was used which combined findings from a mapping study with chairs/leads of 129 partnerships, five focus groups with 36 partners, a postal survey of 337 partners in 40 partnerships and four workshops attended by 48 partners. The postal questionnaire incorporated a number of specifically designed and validated multi-dimensional scales. Multiple and logistic regression analysis was used to identify the significance of each factor to partnership trust.
**Results and Conclusions:** Power was shown to be the most important determinant of partnership trust ($P<.0001$). Synergy and leadership were also borderline significant factors ($P=.06$). Trust-building mechanisms need to be built into the partnership forming stage and this trust needs to be sustained throughout the collaborative process. We need to develop systems where the best leaders are put forward for intersectoral partnerships. This should be consistent across all sectors and organisations.
**Disclosure of Interest:** None declared

## GP-TUE-273 COORDINATED ACTION CHECKLIST: A TOOL TO FACILITATE AND EVALUATE PARTNERSHIPS AND THEIR WORK IN COMMUNITY HEALTH PROMOTION.

**A. Wagemakers***[1], L. Vaandrager[1]
[1]Public Health and Society, Department of Social Sciences, Wageningen University, Wageningen, Netherlands

**Background:** Coordinated action through partnerships is a core approach in community health promotion to deal with the multidimensionality of today's health and societal issues. The number of partnerships is increasing. However, facilitation and evaluation of partnerships is hampered by the lack and/or non-use of feasible tools. As a consequence, health promotion through partnerships is not optimally facilitated and evaluated.

**Objectives:** In this study a tool (the coordinated action checklist) and guidelines were developed and piloted to facilitate and evaluate coordinated action, regardless the level (national or local), phase of the program and the topic addressed by the partnership.

**Underlying values and principles:** Participation and collaboration are principles of health promotion and are core concepts in moderating the social environment of health. Participation and collaboration give insight into the actual dynamics of health promotion practice at multiple levels (individual, organisational and community).

**Knowledge base/ Evidence base:** A conceptual framework and guidelines to facilitate and evaluate supportive social environments in community health promotion were developed by taking participation and collaboration as entry points.

**Context of intervention/project/work:** The checklist was piloted with and in six different partnerships: a national program, an academic collaborative and four local partnerships. The partnerships address different topics such as healthy ageing and overweight.

**Methods:** The conceptual framework and a number of existing tools that address (items on) participation and collaboration were used to develop and pilot the coordinated action checklist. In developing the checklist the principles of appreciative inquiry were applied. Results of the checklist were cross-checked and discussed with partners.

**Results and Conclusions:** Piloting the checklist resulted in a feasible tool helpful to partnerships because its ability to generate actionable knowledge, when used in combination with other methods. The tool combines qualitative and quantitative methods. The positive approach, based on appreciative inquiry, builds on strengths and assets of partnerships and their work and thereby contributes to the partners' enjoyment in using the checklist and to increasing preparedness to action.

The checklist facilitates and evaluates partnerships in community health promotion that differ in context and level (both local and national), phase of the program and addressed topic. Cross-checking results with partners and triangulation of data and discussion increases reliability of the checklist. Piloting in multiple cases contributes to the checklists' external validity.

**Disclosure of Interest:** None declared

## GP-TUE-274 KEY FACTORS OF SUCCESSFUL COLLABORATION BETWEEN HEALTH EDUCATIONAL INSTITUTE AND HEALTH SERVICE INSTITUTES, ON TEACHING AND LEARNING MANAGEMENT OF COMMUNITY PRACTICES FOR PUBLIC HEALTH STUDENTS: A CASE STUDY IN PITSANULOK , THAILAND

**P. Manorath***[1]
[1]Ministry of Public Health, Health Promotion Center of Boromarajonani College of Nursing,Uttaradit, Uttaradit, Thailand

**Background:** Community setting, a practice site for public health students, is important for managing the subject of community health. Good community practice site requires a strong collaboration between educational institute and healthcare provides (Henneman at al., 1995) in order to together help the students to transfer theoretical knowledge into practices. In addition, a strong collaboration between the college of public health and healthcare provider functions as a bridge that takes public health students to the real world of public health professionals. It can improve not only the quality of community health care but also the quality of public health education (Klomsiri et al., 2007). However, there is lack of evidences that unfolds sustainable key success factor contributing to this alliance.
**Objectives:** This study aimed to explore influencing factors of collaboration between Sirindhorn Collage of Public Health and Primary Care Units in Pitsanulok, Thailand, on teaching and learning management of community practices for public health students.
**Underlying values and principles:** Collaboration between health educational institutes and community healthcare provider is important to improve a quality of community practice for public health student as well as of community health care.
**Knowledge base/ Evidence base:** Good community practice site requires a strong collaboration between educational institute and healthcare provides (Henneman at al., 1995) in order to together help the students to transfer theoretical knowledge into practices.
**Context of intervention/project/work:** Quality of health service is a result of health workers, and public health is a professional career that requires professionals to have a consciousness for professional development. Support a public health college by being a mentor is a kind of consciousness to improve the status of public health professions. In addition, generally public health student are assigned to work in communities within the province whereby a public health college is located. Most of mentors graduated from the college.
**Methods:** This study used a qualitative method with the use of semi-structured interview. Participants were 32 stakeholders who involved in community practice curriculum, including public health collage's director, subject's committees, public health instructors,and community preceptor staffs of primary care units in Pitsanulok. The samples were selected by a method of purposive sampling. Data were collected between 1 and 20 July 2007, and were analyse using thematic analysis.
**Results and Conclusions:** The findings indicated that key success factors for collaboration were the policies of both public health college and primary care units, professional unity of public health staffs, partnership value, and commitment of public health college's alumni. Collaboration between healthcare education and healthcare providers should be promoted and explicitly made because it is necessary to improve a quality of community-practice curriculum. Education managers should promote public health mentors to have skills for effective coaching and training public health students. There are several means to improve collaboration. For example, a plan for practice curriculum should be collaboratively made between education and healthcare institutions. In addition, healthcare providers should provide a structure to service community practice.
**References:** Henneman, E. A., et al. Collaboration: a concept analysis. Journal of Advanced Nursing. 1995; 21 (1) : 103-109.
Klomsiri J.,et al.(2007). Research and development of collaboration model between
Health education Institute and Health service institutes on teaching and
learning management for nurse students: A case study in Uttaradit Hospital.
Wright K, Rowitz L&Merkle A.A conceptual model for leadership development.
Public Health management Practice. 2001 ; 7 (4) : 6-16.
**Disclosure of Interest:** P.Manorath,college of nursing,uttaradit,financial interest

**GP-TUE-276 DEVELOPING THE STRUCTURES OF HEALTH PROMOTION - GOOD PRACTICES OF HEALTH PROMOTION AND COLLABORATION**

**M. Aalto-Kallio***[1]
[1]Quality and evaluation, The Finnish Centre for Health Promotion, Helsinki, Finland

**Background:** Inter-organisational (non-governmental organisatons hereafter NGO, municipalities and companies) and inter- and cross-sectoral (different policy sectors in local governments) collaboration is the key to success in health promotion and its structural development and reinforcement. In Finland the demand of the collaboration of the municipalities and NGOs is written for instance in Policy programme for health promotion. Also the funding organisations encourage NGOs to co-operate together. With co-operation health promotion can be done more effectively and with lower cost. All the potential and relevant knowledge should be combined and activities should be aligned so that the health and wellbeing of citizens are promoted. What kind of collaboration we have in Finland? Do we have some good practices of collaboration to promote health?
In municipalities the health promotion should be seen as a work which take into account the health aspects for everything and in all policy sectors. Naturally the health promotion is the core of the social and health sectors. In other policy sectors the health promotion should be one part of the other tasks. Inter- and cross-sectoral collaboration with different policy sectors for the benefit of health promotion is an investment for the future. The benefits are undeniable. How the health promotion is seen in practice in different policy sectors?
**Objectives:** The main objectives of the questionnaires are to make the work and collaboration of health promotion visible with concrete practices. The aim of the final review is also to define the concepts of health promotion and the structure of health promotion concretily.
**Underlying values and principles:** Values and principles of health promotion
**Knowledge base/ Evidence base:** The knowledge base underly in 1) theory of health promotion, 2) the structure of health promotion and 3)theory of collaboration.
**Context of intervention/project/work:** The questionnaires investigated the health promotion reality (work and collaboration practices) in the context of municipalities and NGOs.
**Methods:** The Finnish Centre for Health Promotion implemented two questionnaires in the end of the 2009. The first questionnaire investigated what kind of health and wellbeing promoted collaboration NGOs have with municipalities, other NGOs and companies. In the questionnaire were asked the concrete descriptions of the collaboration practices. In addition the questionnaire asked to clarify what sort of needs and opportunities there are for the health promotion collaboration. The questionnaire was sent for the representatives of NGOs. Totally 78 of 218 answered to the questionnaire.
The second questionnaire investigated how the promotion of health and wellbeing have been taken into account in different sectors of the municipalities. The questionnaire also asked that how the representatives of different policy sectors perceive the health promotion as a part of their tasks. Like in the first questionnaire also the second one asked about the concrete descriptions of the practices which promote health and wellbeing. The questionnaire was sent for the representatives of different sector (education, social/welfare, health, technical and administration). Totally 154 of 1113 answered the questionnaire.
**Results and Conclusions:** The questionnaires were implemented in October 2009. The results will be gathered in the same report. The report will be a review which bring forth the work and challenges of the developing the structures of health promotion. The report will be finished in January 2010 and it will be published in Finnish on electronic version on the website of the Finnish Centre for Health Promotion.
The results will be gathered in poster which will be presented in IUHPE Conference.
**Disclosure of Interest:** None declared

## GP-TUE-277 BUILDING HEALTH PROMOTION INTO A PROVINCIAL DEPAREMENT OF HEALTH: CHALLENGES AND OPPORTUNITIES

**M. A. Chaudhary***[1], F. Ali[2], S. P. Azariah[3]
[1]Director General Health Services, [2]Director, Health Promotion, Department of Health, Punjab, [3]Project Director, SOHIP, Lahore, Pakistan

**Background:** The CIDA-funded SOHIP project has been working with the provincial Department of Health (DoH) in Punjab province for three years to build commitment to and systems for integration of health promotion (HP) in Punjab. This paper describes the process of mainstreaming HP in a health bureaucracy that has traditionally been organized around separate disease-specific vertical programs.
**Objectives:** The objective of SOHIP is to strengthen management and accountability systems to enable more effective delivery of gender-sensitive, pro-poor health services that mainstream a health promotion approach. The objective of the Punjab DoH in adopting an HP orientation is to improve the effectiveness and efficiency of health programming, and to meet the health MDGs and improve the health status of the population.
**Underlying values and principles:** Embracing a HP approach at the provincial level can also strengthen health sector management systems and structures and improve cost-effectiveness. Helping people to understand the causes of ill-health and how to protect against illness will save resources that might otherwise be spent both by individuals and by health facilities.
**Knowledge base/ Evidence base:** This paper describes a multi-pronged process of interventions including advocacy, departmental restructuring, policy development, promotion of inter-sectoral and intra-sectoral collaboration, strengthening networks, and development of management-oriented tools and resources.
**Context of intervention/project/work:** At the project outset, the DoH equated HP with health education, and took a narrow approach focused on celebrating international days (for safe motherhood, children, etc), and developing BCC materials to support immunization campaigns. The principles, roles and strategies of HP as outlined in the Ottawa and Bangkok Charters were essentially unknown. Little collaboration happened between vertical programs or between the DoH and other institutions.
**Methods:** SOHIP strategies focused on advocacy and capacity development, facilitating policy development and restructuring, and building networks and alliances for HP. A restructuring of the office of Director General Health Services had been planned by the DoH, and SOHIP saw this as an opportunity to mainstream HP by creating a formal HP Department. SOHIP assisted the newly formed department to develop its master plan through an intensively consultative process, helped design a results-oriented logframe and budget, and created an internal market for sustained collaboration across vertical health programs.
**Results and Conclusions:** In 2009, after more than two years of advocacy and capacity building on HP within DoH, a Department of Health Promotion was created. Results of the success of building HP into the provincial department of health will be assessed through consultative workshops and interviews with managers across the department in May 2010, which will then be presented to the Conference.
**Disclosure of Interest:** None declared.

## GP-TUE-278 MULTILEVEL GOVERNANCE OF PUBLIC HEALTH POLICIES: THE CASE OF NORWAY

**M. K. Helgesen***[1]
[1]Department for Welfare, Democracy and, Norwegian Institute for Urban and Regional research, Oslo, Norway

**Background:** Since the mid-1970s, there has been an increased decentralisation of functions to local level, making the Nordic and so-called social democratic welfare states among the most decentralised in the advanced industrialised world. The reforms have been paralleled by an observed ongoing shift from a hierarchical "command and control" governance that followed the sectorised lines of parliamentarian accountability to less hierarchical and non-sectorised structures supported by management by objectives in the terminology of New Public Management or enforced self-regulation and collaboration in inter-organisational networks in a network terminology.
**Objectives:** Objectives are to increase the knowledge on the functioning of the local politico-administrative institutions in initiating, deciding and conducting policy actions on public health in the partnership organisation.
**Underlying values and principles:** Based on the knowledge that cooperation between actors across sectors and levels of formal authority is necessary to reach political objectives the implementation of the new public health is subject to a partnership organisation. This enhances the importance of local politico-administrative institutions as locus for new public health policies.
**Knowledge base/ Evidence base:** Knowledge base is theories on multilevel governance.
**Context of intervention/project/work:** Context of project is the variegated landscape of Norwegian municipalities and their capacities to initiate, decide on and conduct public health policies.
**Methods:** Two surveys sent to all Norwegian municipalities and qualitative interviews in two medium sized municipalities. The first survey is on local government policies on the new public health, the second is on local government political and administrative organisational models. Interviews are carried out with planners, public health officers, leaders of relevant administrative units and politicians.
**Results and Conclusions:** Data show great variation according to whether or not local authorities establish partnerships both vertically with regional authorities and horizontally as inter- organisational networks. Variations are as well large according to the establishment of intersectoral workgroups. The establishment of partnership does not seem to influence local authorities' assessment of the importance of mobilisation of non-governmental actors as well as their cooperation in networks. This includes the levering in of resources to enhance the capacities of non-governmental actors to take part in the policy implementation and conduct measures. Small municipalities (3000 inhabitants or less), to a lesser extent than bigger, initiate, decide and conduct public health policies.
**Disclosure of Interest:** None declared.

## GP-TUE-279 INTERSECTORAL COOPERATION AND HEALTH PROMOTION: STRATEGY FOR LOCAL SUSTAINABLE DEVELOPMENT AND PROMOTION OF EQUITY IN HEALTH

**D. G. Rocha***[1], V. C. Marcelo[2], V. P. Alexandre[3], A. A. C. Silva[4], A. B. S. Pereira[5], M. V. C. Carvalho[5], J. R. Lima[6]

[1]Collective Health Department, University of Brasilia, Brasilia DF, [2]Faculty of Dentistry, [3]Faculty of Nutrition, University Federal of Goiás, [4]Unidade de Atenção Básica de Saúde da Família Vila Pedroso, [5]Distrito Sanitário Leste, Secretaria Municipal de Saúde, [6]Faculty of Nursing, University Federal of Goiás, Goiânia GO, Brazil

**Background:** Instersectoral Action on Health Promotion, a project for international cooperation between Brazil and Canada, aims at exchanging knowledge and promoting equity in health services. This action involves Brazilian centers of education located in six different cities, including Goiânia, which is the capital of the state of Goiás, in the Midwestern Region of the country. In Goiânia, the activities were developed in the Eastern Sanitary District, in a partnership with the Municipal Health Secretary (MHS), focusing on Family Health Strategy, with the objective of enhancing local capacity to produce and maintain social-environmental improvements that contribute to promote health and strengthen intersectoral cooperation to achieve sustainable development.

**Objectives:** In the present work, we describe the results obtained emphasizing the effectiveness of the proposed actions, including the influence upon local policies on health promotion (Bottom-up).

**Underlying values and principles:** Planning and execution phases were shared by Universidade Federal de Goiás, MHS, and Health Communitarian Agents (HCA). This project is based on participation, equity in health services, popular and scientific knowledge, and shared management.

**Knowledge base/ Evidence base:** Although primary health care in Brazil is based on health promotion and social participation, on a routine basis, the biomedical model prevails. HCA were the target of this project of intersectoral education and health promotion due to the fact that they work in the health system and are members of the community.

**Context of intervention/project/work:** The capacity building program was developed through 16 workshops and at the end of the process they presented projects of intersectoral action to be carried out in their communities.

**Methods:** A cross-sectional quali-quantitative analysis was performed aiming at identifying signals of the effectiveness of this approach by means of: (1) a self-filled questionnaire, identifying actions and concepts about health promotion and intersectoral cooperation before and after the course; (2) focus groups identifying the main challenges and what they learned during their participation in the process.

**Results and Conclusions:** Comparison between the beginning and the end of the process of education indicated change in understanding health promotion, since initially this was related to disease prevention and health education, and after the course it changed to the concept of better quality of life. Intersectoral cooperation evolved from an abstract definition to “actions between different sectors/partners that have a common cause” and “building up partnerships”. HCA identified: a better capacity of communication and argumentation; the rescue and amplification of their vision about their own roles in the team; the recognition of the importance of partnerships within the services with local businesspeople, universities, community leaderships, and other sectors (sports, leisure activities, public security, environment). We observed that the development of HCA’s argumentative skills and initiatives of intersectoral articulation for health promotion triggered a discussion about autonomy and hierarchy in the process of working in the sphere of the family health team. During this process, we detected that an action that is locally performed has the potential to lead the reorientation of services dedicated to primary health care and mobilize several sectors and levels of management in order to recognize intersectoral cooperation as a strategy that potentializes initiatives on health promotion in the community.

**Disclosure of Interest:** None declared

## GP-TUE-383 THE ROLE OF HEALTH PROMOTION IN SUSTAINABLE DEVELOPMENT

**Y. R. . A. .. Shehada***[1]
[1]Administration, Gaza Health Promotion Centre, Gaza, Palestinian Authority

**Background:** A lot of progress has been achieved in implementing health promotion concept which was addressed at the First International Conference of Health Promotion, Ottawa 1986. Besides, The Bangkok Charter added a positive power to achieve Health for All principle by calling all governments, civil societies and all community sectors to carry out together a global effort in promoting health.

But did we manage to achieve the goals of 'Health for All' and 'All for Health' which were the main principles in Ottawa and Bangkok Charters? A brief look at our achievements shows that we've just partially managed, but we are obviously unsatisfied of those achievements.
**Objectives:** 1- To analyze and find causes of weakness in implementing main goals of Ottawa and Bangkok Charters.
2- To find an approach to bridge the gab between action and needs.
3- To employ all possible efforts towards a global health development.
4- To concentrate on basic needs and global satisfaction.
**Underlying values and principles:** 1- Ensure the global dimension as a value of "Health for All" principle.
2- Expanding the intersectoral action through more collaborative and organized participation at all levels.
3- Developing a unified action to achieve both health and sustainable development goals together.
4- Reforming the world policy including relations within and among nations.
**Knowledge base/ Evidence base:** Health status, weapon,drugs and tobacco trades,
Food, water and energy crisis are evidence based for a serious global action.
**Context of intervention/project/work:**
Trying to find an answer to 'why are we still unsatisfied? It is believed that our action was very limited and we preferred to act on the easy part of the problem and couldn't deal with it in a comprehensive way which covers all fields of health and all needed for it.
In this paper we are trying to find causes of weakness and how could we bridge the gab between action and needs, putting in mind that human well-being and satisfying quality of life should be global priority. In a globalized world all could affect and be affected of what happens on, even positive or negative. This means also that success or fail is global and could be disastrous for all. We also will see the complementary relation between achieving Health Promotion goals and Sustainable Development
**Methods:** Analyze health status on the light of 'Health for all' and 'All for Health' principles and search out methods to join achieving these goals through global successful sustainable development plans.
**Results and Conclusions:** 1- Creating general policy will towards global health policy related to the global sustainable development plans.
2- Developing methods to make major changes towards promoting health for all.
3- Legislations, economical and financial support, social empowerment and ethics are major components for both health promotion and sustainable development
**References:** 1- Ottawa Charter. 2- Babgkok Charter
3- Setting standards in the evaluation of community- based health promotion prgorams, Territory health service, Australia....
4- Ottawa to Bangkok: Changing H.P.discourse, C.Porter.
5- Action for sustainable and Equitable Development
6- Closing the gab in generation...
7- What is Ethics, Manuel Velasquez, et al.
**Disclosure of Interest:** None declared

**GP-TUE-384 BIOCAPITAL AND THE SEARCH FOR ALTERNATIVE RESEARCH & DEVELOPMENT' INCENTIVES IN THE HEALTH SECTOR: AN ANALYSIS OF THE WHO/IGWG ON PUBLIC HEALTH, INNOVATION AND INTELLECTUAL PROPERTY**

**L. T. Morais***[1]
[1]International Affairs Office, Brazilian Health Surveillance Agency, Brasilia, Brazil

**Background:** The emergence of new sort of diseases and the increasing prevalence of diseases that disproportionally affect developing countries represent great concerns and also challenges for global health. It is evident that the modern pharmaceutical industry has been successful in providing the market with a greater number of therapeutical formulas, but it is questionable to what extent those products adequately address real health needs. In addition, issues of intellectual property (IP) and access to these drugs remains a central dilema in many countries. Furthermore, the lack of investments in research and development (R&D) for diseases which mostly affect developing countries reflect the inneficiency of market-driven approach for R&D to provide incentives in order to attend essential health needs of a diverse set of populations. This context highlights the vulnerable scenario and the structural inequalities under which these populations live: unbalanced access to adequate treatments, a prevalence of a market-driven and monopolistic approach to R&D over health-needs oriented efforts.
**Objectives:** Considering the concept of biocapital as a central theoretical framework and through an analysis of the policy process associated with the negotiations under the *Inter-Governmental Working Group on Public Health, Innovation and Public Health* (WHO/IGWG), this study will explore how the dynamics between actors, narratives/discourses and political interests shaped this complex debate and the final document. More specifically, we are interested in the extent to which the IGWG represents a new or alternative framework to address the problems associated with intellectual property rights and their impacts on health, as well as the gaps in health research and development, in order to offer suggestions to realise the goal of a more *health needs-oriented* approach.
**Underlying values and principles:** Intellectual property rights and the current monopolistic model of R&D in the health sector have not improved the affordability and availability of drugs most needed by the world population, although they represent a fundamental discourse to maintain incentives for health R&D.
**Knowledge base/ Evidence base:** It is used the conceptual framework of biocapital in order to understand the co-constitution of technosciences (biotechnology and genomics, especially) with political economy regimes. The root of the dialetic relationship between both categories lies in the conflict around ownership (public and private dimensions) of knowledge production, which represents a great deal for developing countries in their efforts to improve access to medicines and health technologies.
**Context of intervention/project/work:** The research project was designed as an attempt to evaluate and review the whole process of negotiation under the WHO/IGWG, after the approval of the final document (WHA 61.21)
**Methods:** The study made use of the literature available on “biocapital”, "intellectual property and health”, and “policy process analysis”. In order to understand the WHO/IGWG negotiation process, official World Health Organization (WHO) documents have been analyzed. Also, the study benefited of formal interviews with experts in the WHO, international NGOs and Governments.
**Results and Conclusions:** Three main different narratives/discourses shaped the debate and positioned countries in the negotiation process: a) strengthening and enforcement of IPR; b) recognition and support for implementing IP flexibilities; and c) adoption and implementation of alternative funding mechanisms and incentives for R&D. Although the approved final document was successful in translating the claims of developing countries for support in the implementation of IP flexibilities, the language of itens related to alternative R&D models was diluted. Hence, it is suggested that IP flexibilities may be the ‘hard’ currency paid by developed countries and pharmaceutical companies, so as not to face radical changes in the current model of ownership and incentives for health R&D. Also, using the biocapital framework, we support that the possibility of IP flexibilities represents a ‘discourse of hope and hype’ for some developing countries, especially those with manufacturing capacity for drugs.
**Disclosure of Interest:** None declared

## GP-TUE-385 SUSTAINABLE HEALTH SCIENCE AND TOWN OF PUBLIC HEALTH (TOP) PROJECT

**C. Mori***[1], E. Todaka[2], H. Nakaoka[2], M. Hanazato[3]
[1]Bioenvironmental Medicine, Graduate School of Medicine, Chiba University, Chiba City, [2]Center for Environment, Health and Field Sciences, Chiba University, Kashiwa City, [3]Architecture, Graduate School of Engineering, Chiba University, Chiba City, Japan

**Background:** In modern society, rapid economic growth based on mass production, mass consumption and mass disposal has caused global environmental problems and health disorders originating in the environment. If humans continue their current life styles, future generations may be unable to enjoy the life that people do today. It is therefore crucial to study the relationship between the environment and children's health, and to improve the environment to protect the health of children and future generations (Mori 2004; Mori & Todaka, 2009).
**Objectives:** To maintain and improve the health of future generations, we have recently reported the importance of establishing sustainable health science (Mori & Todaka, 2009). In order to spread our idea, we will here introduce the concept of sustainable health science, and the new town planning based on the concept of sustainable health science, called the TOP (Town of Public Health) Project.
**Underlying values and principles:** Sustainable health science is a new scientific field based on preventive medicine or public health focusing on future generations. There are three key points in sustainable health science. First, the focus is on future generations. Second, the "precautionary principle" should be applied. The third is that it should be a transdisciplinary science (Mori & Todaka, 2009).
**Knowledge base/ Evidence base:** In the TOP project, we also proposed preventive medicine in town planning by focusing on continuous recording and evaluation using the "medical records of people", "medical records of buildings", and "medical record of towns".
**Context of intervention/project/work:** Some of the Project's activities such as the chemical contamination health check system and Chemiless-Town Project have already started (Mori et al, in press).
**Methods:** Our previous studies revealed that fetuses are contaminated by multiple chemicals that are transferred through the umbilical cord from the mother (Mori 2001; Mori 2004). Since the health effects of environmental contamination are not easy to recognize, people need to know their own contamination level to make them realize that every single person in the world is actually contaminated. To inform people, a chemical contamination check system using blood samples was developed (Mori et al, 2008). Also, a model of a sustainable health town, Chemiless-Town, was built with chemicals as few as possible to prevent sick-building syndrome in Chiba University (Nakaoka et al, 2007).
**Results and Conclusions:** Sick-building syndrome is a series of symptoms such as headache, throat ache, running nose etc., caused by multiple chemicals indoor air. In modern society, people spend most of the time in indoor air, so indoor air quality is actually a big factor to decide human health. People today are becoming increasingly concerned about the future due to the destruction of the natural environment, environmental contamination, aging of society, increase of health problems, etc. When new towns are planned or old towns are to be rebuilt, the concept of sustainable health science and TOP projects should be considered. This will make towns more attractive because health and the environment will be key issues in the 21st century.
**Disclosure of Interest:** C.Mori, None declared
E.Todaka, None declared
H.Nakaoka, None declared
M.Hanazato, None declared

## GP-TUE-386 ANALYSIS OF INDICATORS OF MILLENNIUM DEVELOPMENT GOAL ONE - ERADICATE EXTREME POVERTY AND HUNGER - IN SÃO PAULO STATE MUNICIPALITIES THAT DEVELOP SOCIAL AGENDAS

E. Minowa[1], P. R. Nascimento[1], **M. F. Westphal***[1]
[1]Practice in Public Health, School of Public Health, São Paulo, Brazil

**Background:** In order to observe local development and living and health conditions, social agendas have been adopted in Brazil, such as Agenda 21. In the same way, Brazil signed the proposal of the Millennium Development Goals (MDGs) that include targets and indicators for various social areas. Recently, it was found that municipalities with social agendas have made progress on some MDGs, but in others,such as the eradication of hunger, have advanced very little.
**Objectives:** To investigate the influence of Agenda 21 in the city of Piracicaba,São Paulo,Brazil, in the evolution of the indicators of MDG 1 Eradicate extreme poverty and hunger.
**Underlying values and principles:** Equity,solidarity and Intersectoral action
**Knowledge base/ Evidence base:** It is assumed that Agenda 21 can promote the development of actions regarding local problems, reflecting the social indicators. Through the case study of a municipality with Agenda 21 and the positive developments in the indicators of MDG 1, it was possible to verify if it was this agenda that determined the outcome,or other conditions.
**Context of intervention/project/work:** The Food and Agricultural Organization states that the goal of halving the starving population by 2015 will not be achieved due to rising unemployment and deepening poverty. However, it is estimated that Latin America has advanced on the understanding and the pursuit of eradicating hunger, as several countries in the region strengthened their social safety nets.
**Methods:** We conducted a longitudinal, ecological cohort study with a qualitative study of the social experience of government and civil society with the local Agenda 21. The quantitative study followed indicators of MDG 1 in Piracicaba between the years 1997 and 2007 in relation to the Southeast through descriptive studies and statistical models to assess the significance of the results. The MDG 1 indicators were: percentage of families in the municipality served by "Bolsa Família" and malnourished children under 2 years; and municipal revenues per capita taxes and legal and constitutional transfers. In the qualitative study, documents on the municipal experience were reviewed, and interviews with key informants were made.
**Results and Conclusions:** The quantitative results revealed Agenda 21's no significative influence on the development of the MDG 1 indicators, creating a discussion about the ideal time to demonstrate the interaction time/agenda, considering the difficulty in changing health, economic and social indicators. However,as Agenda 21 is a social process, during the fieldwork it was noted that there are many actions for the eradication of poverty and hunger in Piracicaba. The area of social development was reorganized and the Agenda 21 has set itself the role of identifier of the issues and articulating actions. It might be argued that Agenda 21 did not directly influence the indicators, but the development of actions to change them, integrating civil society and private sector with the government.
**Disclosure of Interest:** None declared

**GP-TUE-387 LOCAL HEALTH PROMOTION AND PREVENTION AS AN INTEGRAL PART OF SUSTAINABLE DEVELOPMENT**

**C. I. Fabian***[1]
[1]RADIX, Northwestern Switzerland, RADIX - Swiss Competence Center for Health Promotion and Prevention, Bern, Switzerland

**Background:** According to the Ottawa Charta of 1986 health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.
**Objectives:** How can health promotion and prevention be done in community-oriented work?
**Underlying values and principles:** --
**Knowledge base/ Evidence base:** --
**Context of intervention/project/work:** *Initial status in the communities*
In communities, various problems and challenges arise within public, semi-public or private settings. Mental health, addictions, littering, vandalism, but also violence or social problems are challenges, which the municipalities have to face. Health promotion and prevention in the psychosocial field, especially in a communal setting, have to aim for participation and empowerment as well as to enhance the areas of social justice and equal opportunity emphasized in the Ottawa Charta.
**Methods:** *Practical implementation*
How can these ideas be reduced to practice? An approved method is community-oriented work. In doing so, it is essential to work in and with the setting. This means that the organisational structure and the processes have to be analyzed and if necessary to be developed. It is also crucial to involve the people living and working in the municipality.
Setting-oriented health promotion and prevention has to be understood as an organisational development process. In the communal setting this means that a policy-process has to be started and passed through. Essential phases are initiation, estimation, selection, implementation, evaluation and termination.
**Results and Conclusions:** RADIX works very successfully with this approach and tries to enhance a coordinated coaction under participation of the political responsible persons in the municipalities as well as the health and social sector. Furthermore, RADIX aims to involve people from all other different areas of life. Doing so, RADIX proceeds systematically and follows quality features on the levels of structures, processes and results.
*Sustainable development*
The conditions and topics mentioned above accord with the areas of sustainable development, especially concerning social values and environment.
If the implementation of such processes and the anchoring of the results in the community succeeds, and that in the political culture as well as in the society, a big step towards sustainable development in the communal setting will be achieved.
At the conference 2010 RADIX will present its functioning, in particular the working processes, methods and the quality dimensions developed in pilot schemes.
**Disclosure of Interest:** C. Fabian, RADIX, Consultant

**GP-TUE-388 EMPOWERMENT THE COMMUNITY'S ORGANIZATION THROUGH THE COMMUNITY'S PLAN FOR THE COMMUNITY BASED FOREST MANAGEMENT: EXPERIENCE FROM THAILAND**

**K. Rojpaisarnkit***[1], R. Srimala[2]
[1]Division of Community Public Health, Rajbhat Rajanagarindra University, Chachoengsao, Thailand, [2],

**Background:** In Thailand, the evaluation by Division of Natural Resources and Environment (2009) during 1999 – 2008 showed the damage degree of natural resources in community forest was currently over the level of sustainable development. By the reason that the community forest is the community resources bank, thus the community should have a rule or regulation for conservation the forest as a community forest management that suitable for the need of living and preserve the resources in the community forest forever for all people in the community.
**Objectives:** To empower the community leaders to be capable to determine an agreement of community forest utilization and to prepare appropriate community's plan for community based forest management under community context.
**Underlying values and principles:** The main idea of the study was to persuade five interests Tambon (sub-district)as the leaders of community well-being development group would cooperate through ABC concept (Attitude, Body of Knowledge, and Context). A; change or adapt their attitude through the value of community well-being development, B; develop knowledge and experiences by learning the best practices, C; integrate the data and situation by community's context for set the community's development plan.
5S are used for support the action of group of people as the community's organization, head and staff of local administration, experts from the university, and related stakeholders. 5S, includes, S1 - Situation analysis, S2 - Sharing data, S3 - Setting the priority, S4 - Short term plan, and S5 - Sustainable development.
**Knowledge base/ Evidence base:** The study site is Nongnae Tambon in Chachoengsao province, Thailand. The valuable resource of the community is the "small community bamboo forest" where they earn their livings, for example; young bamboo shoot is for food consumption, and the bamboo tree for selling, etc.
**Context of intervention/project/work:** The project of community empowerment would last 2 years from January 2009 through January 2011. It has been conducted through the cooperation of University, community, and Tambon administration.
**Methods:** The situation analysis (S1) has been processed by community leaders, community technicians and representative of Tambon administrative to study present and past condition of the community forest utilization. The information will be provided to community and sharing on sharing data (S2) basis. Later the community and stakeholders will setting the priority (S3) of the problems and needs to for community forest development, to develop short term plan (S4) to correct community forest problems and to develop community forest. Through sustainable development (S5), community commitment and public policy of community forest utilization will be processed and included into Tambon administration plan for sustainability of community forest conservation.
**Results and Conclusions:** The outcomes of the project includes (1) an information of present situation and utilization of the forest,(2)walk-way for forest study and basic information of forest herbs under leading force of local scholars, (3) tags name and medical quality showing, (4) community commitment to care and utilize bamboo forest(5) plan of community forest management.
The key impact is the community social movement for self-problem management and settlement by the community independent as along with the concept of "triangle that moves the mountain" (creation of relevance knowledge, social movement, and political involvement) by Wasi (2000).
**References:** Division of Natural Resources and Environment, Thailand Development Research Institute. (2009). Community Forest. Online: available. http://www.thaienvimonitor.net/ Concept/order.htm.
Wasi, P. (2000). "Triangle That Moves The Mountain" and Health Systems Reform Movement in Thailand. HRDJ. Vol. 4 No. 2 May - August 2000.
**Disclosure of Interest:** K. rojpaisarnkit, Thai Health Promotion Foundation
R. Srimala, Thai Health Promotion Foundation

**GP-TUE-389 DEVELOPING HEALTHY, SUSTAINABLE COMMUNITIES - CREATING A "GREEN FAN" TO TRACK PROGRESS**

P. J. Reese[1], **P. J. Reese***[1], D. Rousseau[2]
[1]Community Design, Ramsay Worden Architects Ltd, Vancouver, [2]Environmental Consulting and Sustainable Community Design, Archemy Consulting Ltd, Cortes Island, Canada

**Background:** The authors led an expert team commissioned by the Canadian government (CMHC International) to create a guide for developing sustainable, healthy communities in the Shanghai region of China, and now adapted for international use as the Sustainable Community Development Tool (SCD Tool), soon to be available on the CMHC website (www.cmhc.ca)
**Objectives:** The objective of this session is to present the idea of a "Green Fan", a collection of graphic Indicators intended to be universally applicable as a comparative representation of ongoing progress towards sustainability, and to invite feedback on choosing the most appropriate Indicators. The "Green Fan" is intended to stimulate positive competition among communities, and continual progress towards sustainability and beyond, to creating regenerative, healing communities
**Underlying values and principles:** Sustainable communities create healthy living environments, consuming less energy, less resources, and reducing air, water and soil pollution and greenhouse gas emissions. They are complete, compact, walkable communities promoting active, socially engaged, healthy lifestyles. This is particularly important in reducing incidence of obesity, heart disease and type 2 diabetes
**Knowledge base/ Evidence base:** The SCD Tool includes, synthesizes, and makes available the best international practises and precedents, related to sustainability Topics and Indicators. A number of sustainable community experts have been involved in its creation, and it includes a database of information intended to be continually upgraded
**Context of intervention/project/work:** The concept of a "Green Fan", linked to the SCD Tool, to track progress of communities towards sustainability, has been part of the SCD Tool concept from the beginning, but the group of Indicators to be included is not yet finalized. It would be useful to have wide input, including choosing the most memorable and useful Indicators to best track the connection between creating more sustainable urban communities, improving public health and safety, and encouraging healthy lifestyles
**Methods:** The presentation would involve a brief overview of the background of the SCD Tool, ideally including PowerPoint slides, a description of the "Green Fan" and its potential applicability, and an open discussion period to solicit feedback and ideally stimulate an ongoing conversation
**Results and Conclusions:** The intention is to create a graphically memorable and universally useful community sustainability tracking system, informed by relevant and measurable data, which would become widely used by communities internationally to record, display and compare their performance towards sustainability and lead to ongoing improvement in creating healthy, and eventually healing, communities
**Disclosure of Interest:** Peter Reese, Ramsay Worden Architects Ltd, Consultant