

OP-MON-001 THE FRAMEWORK CONVENTION ON TOBACCO CONTROL: HOW ARE WE GOING?

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Background: The World Health Organisation's (WHO) Framework Convention on Tobacco Control (FCTC) is a landmark development to address the globalisation of the tobacco epidemic. It is first global health treaty and it consists of a broad range of provisions including: price and non-price measures to reduce the demand for tobacco, reducing the supply of tobacco and mechanisms for scientific and technical cooperation and exchange of information. The FCTC has been ratified by 168 parties, covering 86% of the World's population (Framework Convention Alliance 2009) and to many countries it is very much in the implementation stage. Unless action is taken, tobacco use is set to cause eight million deaths due to tobacco per year in 2030 (WHO 2008), 80% of which will be in developing countries.

Objectives: This study will provide an up-to-date review of the progress of the FCTC. Recent developments will be explored, its successes and failures will be outlined, as well as recommended strategies to ensure the FCTC's progression in the future. The fundamental FCTC Articles that have set deadlines and guidelines for implementation will be emphasised. Attention will be given to developing countries as this is where most progress is needed. The fields of public health, health promotion, policy studies and international relations provide the foundation for this research, as it is interdisciplinary in nature.

Underlying values and principles: The underlying values and principles relate to health equity. Here, it is believed that health is a fundamental human right. We further apply a globalisation gaze, through which we recognise that we live an intimately networked world.

Knowledge base/ Evidence base: Academic literature has substantially contributed to knowledge on tobacco control over several decades. The provisions of the FCTC are based on such knowledge, and its proliferation as an international treaty has been established through consensus on successful ways in which to minimise harm associated with tobacco use.

Context of intervention/project/work: See 'Background'

Methods: In this explorative, qualitative study, key documents will be reviewed. This includes studies from the academic literature, documents from the WHO, FCTC Conference of Party reports, Framework Convention Alliance as well as from other professional organisations, policy makers and researchers in the field.

Results and Conclusions: This study will contribute to what is a dearth of research on the recent developments of the FCTC. Gaps will be filled in relation to exploring challenges, successes and recent progression of the FCTC with emphasis on its implementation.

References: Framework Convention Alliance (2009). "Framework Convention Alliance: The treaty." Retrieved 8th July, 2009.

World Health Organisation (2008). WHO report on the global tobacco epidemic, 2008: The MPOWER package. Geneva, World Health Organisation.

Disclosure of Interest: None declared

OP-MON-002 KNOWLEDGE, ATTITUDES, AND PERCEIVED BARRIERS REGARDING IMPLEMENTATION OF FRAME WORK CONVENTION ON TOBACCO CONTROL (FCTC) PROVISIONS AND TOBACCO CONTROL MEASURES AMONG REPRESENTATIVES OF LOCAL SELF-GOVERNMENT BODIES IN, KERALA, INDIA.

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Background: The Indian state of Kerala has a very strong form of decentralized government. However, knowledge, attitudes and barriers regarding implementation of tobacco control among the representatives of the local self government bodies are not known.

Objectives: To examine the knowledge, attitudes and perceived barriers regarding implementation of FCTC provisions among representatives of Local Self Government Bodies (LSGB) in Kerala

Underlying values and principles: Tobacco use is harmful for the users as well as the non-users in the form of secondhand smoke. The major principle for developing FCTC was the rights of the non-smokers for a tobacco smoke free air.

Knowledge base/ Evidence base: Evidence show that secondhand smoke badly affects the health of populations exposed to it.

Context of intervention/project/work: Decentralized governments will be able to implement the FCTC effectively if the representatives of the local governments are aware of the provisions of FCTC and they have a positive attitude to implement them.

Methods: We surveyed 956 LSGB representatives (mean age 44 years, women 40%), 496 in the southern district of Trivandrum and 460 in the northern district of Kannur district using a pre-tested and structured interview schedule.

Results and Conclusions: In our study 70% LSGB representatives reported that smoking is harmful to health. However, 23% perceived smoking between 1-4 cigarettes or bidis to be not harmful to their health. Up to 82% LSGB representatives were unaware of the WHO FCTC. Among the representatives 76% wanted to ban sale of tobacco products to and by minors and 73% wanted to ban sale of tobacco products within 100 metres of educational institutions. The principal barriers reported by LSGB representatives in implementing tobacco control policies including FCTC provisions were lack of administrative support (31%), lack of political will (28%), lack of financial and human resources (25%) and the fear of public opposition (25%). Most representatives suggested involving community members (74%), non-governmental organisations (73%), levying penalties (66%) and involving LSGB representatives (64%) to effectively enforce tobacco control policies. Overall, 33% (55% men and 1% women) had ever used some form of tobacco and 14.4% were current tobacco users (24% men and 0.8% women). Knowledge of FCTC among LSGB representatives in Kerala was low. However, most of them expressed interest in tobacco control measures and suggested various methods for tobacco control in their local bodies.

Disclosure of Interest: None declared

OP-MON-004 ADVOCATING IMPLEMENTATION OF PICTORIAL HEALTH WARNINGS ON TOBACCO PRODUCTS IN INDIA: A CASE STUDY

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Background: Tobacco is the single largest cause of morbidity and mortality globally and is a risk factor for six of the eight leading causes of death in the world. One of the proven health promotion strategies to reduce this burden is to inform population about the catastrophic consequences caused by tobacco use through depicting pictorial health warnings on all tobacco products. Twenty five countries have successfully implemented this strategy. Though India ratified the Framework Convention of Tobacco Control (FCTC) and notified first set of pictorial warnings in 2006, it took three years of intensive advocacy before the warnings got enforced on May 31, 2009.

Objectives: This presentation would highlight strategic and coordinated advocacy campaigns undertaken, targeting policy makers, media and public in general for early implementation of strong and effective pictorial warnings in India.

Underlying values and principles: Section 7 of the Indian tobacco control legislation corresponds to Article 11 of FCTC.

Knowledge base/ Evidence base: In India 57% men and 11% women use tobacco in some form or the other, with prevalence being higher among the illiterate and low literate groups. This differential in prevalence contributes substantially to health inequity in India. Pictorial warnings are the best way to capture their attention and induce tobacco avoidance. Besides, evidence from countries that have adopted pictorial warnings suggests that it is successful in reducing the smoking frequency and have increased quit attempts.

Context of intervention/project/work: Lack of political will, constitution of Group of Ministers on pictorial warnings, the protracted process of scaling down effective pictorial warnings, and the constant interference of the tobacco industry demanded intensive advocacy.

Methods: An extensive review of scientific evidence and international best practices on pictorial warnings was carried out to design and develop advocacy campaigns to convey strategic messages through:

- Policy makers advocacy: different sets of advocacy cards were developed to inform policy makers and opinion makers to influence implementation of pictorial warnings.
- Media advocacy: considered media campaign was carried out with specific messages supporting and demanding implementation of effective pictorial warnings in India.
- Public opinion building: advocacy initiatives to sensitize public at large and counter industry generated propaganda against use of pictorial warnings were undertaken.
- Legal advocacy: legal research support to litigating NGOs.
- Compliance monitoring: post implementation of pictorial warnings, violations by the industry were recorded and reported to the Government.

Results and Conclusions: On May 31, 2009 India joined the group of nations that have implemented pictorial health warnings on all tobacco products. However, these still do not conform to the FCTC mandates, hence requiring further advocacy efforts.

Disclosure of Interest: "None declared"

OP-MON-005 GRAPHIC WARNINGS ON CIGARETTE PACKAGES IN MAURITIUS: LESSONS LEARNT

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Background: Cigarette packs with graphic warnings are on sale in Mauritius as from October 2009. Mauritius is the first country in Africa to introduce such warnings. It has also introduced the biggest graphic warnings in the world, occupying on average 65% of the total surface area of the pack.

Objectives: - To explore the strategies adopted to introduce graphic warnings in Mauritius.

- To expose the contributing factors, challenges and barriers encountered in the introduction of graphic warnings in Mauritius

Underlying values and principles: The graphic warnings were conceived with due respect to the multi-cultural and multi-ethnic society of Mauritius. They aim to protect human health and life from the harm caused by tobacco use.

Knowledge base/ Evidence base: The cigarette pack is a powerful tool for communicating health messages to smokers. There is ample evidence indicating that graphic warnings on cigarette packs increase awareness of smokers on the harmful effects of tobacco use and encourage smokers to quit smoking. Based on this evidence, Mauritius introduced eight rotating graphic warnings which target smokers with different messages.

Context of intervention/project/work: Data from studies indicate that Mauritius has high prevalence of smoking and non-communicable diseases. The introduction of graphic warnings formed part of a comprehensive tobacco control program. Strong advocacy led to the ratification of the FCTC which, in turn, allowed the development of a comprehensive tobacco control action plan, the adoption of new FCTC-compliant tobacco regulations in November 2008 and the mandatory display of graphic warnings on cigarette packs.

Methods: Extensive research using qualitative techniques measured the appropriateness, acceptance, clarity and appeal of the graphic warnings. Global partnership was a key element that facilitated the search for some of the most powerful images. Representations of the tobacco industry were aimed to weaken the regulations, delay its implementation and to lobby for graphic warnings that were less appealing. Alliances with local anti-tobacco advocacy groups were essential to counteract the lobbying power and tactics of the tobacco industry. The barriers and challenges had to be continuously assessed to create an environment supportive to the tobacco control program and particularly the introduction of the graphic warnings.

Results and Conclusions: The effectiveness of the graphic warnings in improving the knowledge level of smokers and encouraging cessation is being assessed. Mauritius could serve as a model of good practice to other countries in relation to the successful implementation of the FCTC, the introduction of graphic warnings and a holistic approach to the tobacco problem.

References: Not Applicable(NA)

Disclosure of Interest: None declared

OP-MON-006 CAPITALS, CAPABILITIES AND HEALTH PROMOTION : A NEW DIRECTION FOR SOCIAL INEQUALITIES RESEARCH?

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Background: A number of fundamental tensions in health promotion research, practice and discourse continue to thwart its development. Among these issues are how to engender empowerment in individuals and populations, how social inequalities become health inequalities and whether our work should focus on individual behaviour change versus societal, structural change.

Objectives: We critically discuss these fundamental tensions and offer some new theoretical avenues as a basis for health promotion. We argue that health promotion too frequently functions based on the implicit assumptions of utilitarianism (ie. the utility derived from the distribution of goods in society). This particular view of distributive justice has hindered the awareness that individuals have differential capabilities with regard to their ability to convert resources provided by health promotion into health. These differential capabilities are co-determined by individual capitals. Our objective is therefore to introduce and discuss the joint roles that Pierre Bourdieu's capital theory and Amartya Sen's capability approach might play in bringing health promotion beyond utilitarianism and in bringing about a better understanding of how social inequalities in health arise.

Underlying values and principles: People are co-producers of their health. We fundamentally believe that people are active agents in the transforming of their health and we are concerned with better understanding how this comes about in order to enable more equitable health outcomes.

Knowledge base/ Evidence base: A critical analysis of literature from several disciplines.

Context of intervention/project/work: This presentation is the outcome of inter-university collaborative work between Drs. Frohlich and Abel (Montreal, Canada and Bern, Switzerland).

Methods: This presentation is a conceptual, theoretical discussion that brings together literatures from health promotion, sociology and philosophy.

Results and Conclusions: We conclude that it is through the individual actor that social inequalities are converted into health inequalities. Heretofore individual actors have too often been delegated passive roles in health promotion. We bring the actor back into the discussion through Amartya Sen's capability approach. We propose that health inequalities come about due to unequal capacities to act and that the space for options to act is co-determined by Bourdieu's capitals. Material and non material capitals interact to make up the space for capabilities. In this sense, then, unequal capabilities are formed through differential capitals.

Disclosure of Interest: None declared

OP-MON-007 IS HEALTH PROMOTION REALLY "ALL WORK, NO PLAY"? : THE MISSING DISCOURSE OF PLAY AND PLEASURE IN HEALTH PROMOTION DISCOURSE

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Background: Central to new health promotion discourses is the emphasis on holistic and positive conceptions of health. Originally, this implied a turn away from public health's focus on pathology towards the promotion of social, physical and psychological well-being. While this focus on health promotion relies on implicit assumptions about playfulness and pleasure in public health (Coveney & Bunton, 2003), there is little attention given to these concepts in health promotion discourse. More troubling, is the recent return of a biomedical focus in the public health discourse. Consequently, elements that originally defined health promotion - pleasure and well-being – are relegated or omitted. This is particularly evident in the area of physical activity in which elements of pleasure and play have been all but evacuated as the emphasis on utilitarian activities proliferates, ie. as the 'means' to a more productive health 'end'.

Objectives: The first objective of this presentation is map out the development of a research project that takes as its starting point a critical analysis of the 'field of play.' We interrogate how modern health promotion discourse has conceptualised, structured, normalised and, generally, omitted play as a conceptual and material practice. The second objective is to open up a number of innovative and transgressive avenues for the interdisciplinary study of play and pleasure in current public health discourses, which we hope will have implications for future health promotion activities.

Underlying values and principles: The values underlying this presentation align themselves with the Ottawa Charter: health ought to be a resource for life and not merely an absence of illness. An insertion of play and pleasure elements into health promotion discourse may well be critically needed to refocus health promotion policy on social, psychological and physical health and well-being.

Knowledge base/ Evidence base: The knowledge base for this project is grounded in historical, sociological, psychological studies and public health/health promotion literature on 'play' and 'pleasure'.

Context of intervention/project/work: This work was undertaken as part of an on-line, bi-weekly reading course on play and health promotion undertaken by Drs. Fusco & Frohlich and Ms. Alexander.

Methods: A critical review of literature spanning historical, sociological, psychological and health promotion studies on play and public health in modern society has been undertaken. The texts were discussed and analyzed from the researchers' inter-disciplinary perspectives.

Results and Conclusions: We anticipate that our presentation will: a) show how play has been conceptualized across a broad range of literatures; b) reinvigorate the call to consider pleasure and play and its effects on the construction of social and cultural identities within health promotion discourse; c) demonstrate the missing discourse of play and pleasure in health promotion discourse and encourage researchers to critically interrogate these omissions; d) point towards the ways in which diverse forms of play (transgressive, resistant, pleasurable) could be conceptualised within health promotion.

References: Coveney, J. & Bunton, R. (2003). In the pursuit of the study of pleasure: Implications for health research and practice. *Health*: 7(2), 161-179.

Disclosure of Interest: None declared

OP-MON-008 THE NOTION OF 'CHEERFULNESS' AS A BRIDGE TO COMMUNITY WELLBEING

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Background: The notion of Cheerfulness discusses a unique, organic approach to building well-being and resilience in an Australian rural context. The case study shows how a network of women in middle to senior management across a range of sectors, collaborate to solve community problems. They are connected by place, commitment to community, a sense of fun and trust. Based on the novels of Alexander McCall-Smith, the notion of 'cheerfulness' has been adopted as a core attitude.

Objectives: This paper examines how the elements of Cheerfulness might be a driver for social and cultural change in a rural context. Can non-traditional examples of leadership and informal intersectorial collaborations address problem solving and capacity building in an increasingly challenging environment? The network's approach seems highly effective when measured by the outputs of members. Yet, how attributable are the outputs to this approach? We illustrate how cheerfulness inspired collaborative social action.

Underlying values and principles: The network abides by a commitment to 'cheerfulness' as its core attitude. What does this mean and how has it drawn people together? Members found something was missing in existing (largely patriarchal) approaches to community development. The idea of cheerfulness and its implications of kindness, grace, trust, generosity, respect and good humour has been the catalyst for network members taking on a value-driven approach to make our community work better.

Knowledge base/ Evidence base: Mapping outputs show considerable contribution to social capital (Putnam) and resilience in our community. The conclusions from the mapping exercise show evidence of empowerment, social entrepreneurship (Mawson) and commitment to sustainability can be linked to change agents in our community acting in collaboration.

Context of intervention/project/work: Recognition of the network's contribution to community wellbeing across many sectors led to the mapping exercise. It identified complex issues confronting rural communities and how an informal, motivated and committed group of women operating in goodwill has been highly effective.

Methods: Using an insider practitioner methodology, the group has reflected on how caring for the wellbeing of the individuals led to better wellbeing outcomes for the community through the innovative social actions undertaken by group members. This paper is a case study as well as a participatory learning exercise (Senge).

Results and Conclusions: 'Cheerfulness' has sustained an effective network in a social entrepreneurial approach that leads to community wellbeing in a rural environment. The learning recognizes that community problems are not solved by traditional or linear approaches, but need a multi-faceted set of responses addressing well being at both individual and community level. Such groups lie in the gaps between formal and informal frameworks but this experience shows there may be lessons here for other communities addressing change.

References: Senge, P, 1992 The Fifth Discipline; the art & practice of the learning organisation; Random House, Sydney

Putnam R, 2000, Bowling Alone, the collapse and revival of American Community, Touchstone, NY

Mawson, A 2008, The Social Entrepreneur, making community work, Atlantic, UK

Disclosure of Interest: none declared

OP-MON-009 SPIRITUALITY – THE FOURTH DIMENSION OF HEALTH. AN EVIDENCE-BASED DEFINITION

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Background: In evidence-based oriented Public Health only the physical, mental and social dimensions are widely acknowledged as “empiric” dimensions of health. Research in the past thirty years in different fields of science also outside Public Health has, however, yielded good evidence for the existence of a spiritual dimension of man and therefore also for a spiritual dimension of human health. Despite innumerable attempts there is still no definition of spirituality and spiritual health, which has met the unanimous approval within science.

Objectives: On the basis of past and own research in different fields of science a new basic definition of spirituality is presented. It aims at compatibility with as many value systems, cultural and social backgrounds, types of consciousness – and sciences - as possible. On the basis of this definition the main focus, however, is on defining spiritual health from the point of view of Public health, particularly health promotion and illness prevention.

Underlying values and principles: The basic values and principles of health promotion such as empowerment, participation and equity are fundamental for the presentation.

Knowledge base/ Evidence base: The definition of spiritual health includes a systematic research of the evidence-based public health literature including RCT-studies, meta-analysis as well as quantitative and qualitative studies.

Context of intervention/project/work: Among the various approaches relevant to spirituality and spiritual health Antonovsky’s sense of coherence and Belschner’s model of integral health and health promotion are selected as conceptual points of reference.

Methods: The definitions of spirituality and of spiritual health are based on an interdisciplinary literature research including conventional and alternative medicine, oncology, social and behavioral medicine, gerontology, theology, philosophy, public health and particularly psychotherapy and branches of psychology such as transpersonal psychology.

Results and Conclusions: Spirituality is defined in terms of eight core dimensions which seek universal acknowledgement. These are supplemented with another five evidence-based dimensions to define spiritual health. Due to the usage of universally acknowledged values and simple wording both definitions attempt to qualify for acceptance and use beyond differences in social, cultural and religious backgrounds, gender, age and race.

On the other hand the definitions aim to be clear cut enough to mark-off spirituality from theoretical, pathological or reductionistic tendencies in science as well as from drug-induced heightening of awareness and shallow phenomena in the esoteric and wellness market.

Due to the unfortunate, yet widespread mixing up of spirituality and religion spirituality is also marked-off from extrinsic or institutionalized, normative religiousness or religion.

Furthermore spirituality is established on evidence-based findings as the fourth dimension of health clearly distinguishable from the physical, mental and social dimensions with which it interacts.

Disclosure of Interest: None declared

OP-MON-010 ADDRESSING THE MULTIPLE DIMENSIONS OF HEALTH USING CRITICAL REALISM AND METAPHOR

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General description: The purpose of this workshop is to engage participants in critical dialogue about the complexities of addressing multiple dimensions of health from a continuum of consideration of individual, family, community and beyond. To achieve an understanding of the experience of health, interpretation necessarily arises and understanding of something, therefore, cannot be separated from its context. The human circumstance of health includes, physical, social, occupational, emotional, environmental and spiritual aspects. Furthermore, each dimension of health on its own represents and involves deep and complex biosocial and humanistic aspects of the experience of health. As health care professionals and consumers of health care, we are obligated to understand as many aspects of this experience as possible to allow us to be competent, effective, and compassionate practitioners. This workshop will explore these complexities and introduce participants to how metaphor can be used to understand the biosocial and humanistic aspects of health contextualized within a critical realism framework. Critical realism is a promising meta-theory that is gaining momentum for theorizing in the human health sciences. The utility of the framework has been recognized for its ability to enhance understanding of complex health outcomes by considering the deeper causal mechanisms underlying human health phenomena, inclusive of individual agency and structural factors affecting health outcomes.

Rational: A critical realism framework is adopted to understand the multiple dimensions of health because human social processes and perceptions (including science), as physical phenomena, are imperfect and contextual; that is, dialogue about or perceptions of social phenomena and science are not synonymous with objective truth. Judgments regarding the accuracy of these accounts should be made with alternative perspectives to other arguments, available data and multiple forms of evidence (Clark et al, 2008). Critical realism advocates for the understanding of how dimensions of context (e.g. social environments) and characteristics of an individual (e.g. age, race, sex) interact to influence health outcomes. Such understanding is important to the designing of effective interventions to address the myriad of factors that may affect health outcomes. The use of metaphors to understand the complex social-relational constructs can help to reveal the fundamental and deep issues or conditions within a social determinates of health framework. A metaphor can provide an alternative perspective of a complex concept which has more relevance to an individual, family and community than the knowledge did in its traditional format of interpretation and understanding.

Learning objectives: Participants will learn how a critical realism framework with the use of metaphor can enhance understanding of the interconnectedness of multiple dimensions of health. Participants will consider and construct metaphors to help inform individuals, communities, and government / policies makers about complex health conditions. Participants will re-contextualize discipline specific thinking about health to one which is person-centered, inclusive and interprofessional.

Expected results: As a result of this workshop, participants will have the opportunity to critically analyze their understanding of health and share their ideas and conceptualizations with others. Participants, aided by the tenets and utility of a critical realism framework will gain unique insight into the complexities of health and how to communicate these to diverse audiences through the use of metaphors.

OP-MON-011 FROM BAGHDAD TO BEIRUT: IRAQI REFUGEES' VOICES FOR EQUITY IN TRANSIT

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Background: The representation of the plight of the Iraqi refugees has focused on their experiences and problems in receiving countries of resettlement. An estimated 60,000 Iraqis continue to leave their homes every month to escape violence and threats to their lives and disperse in the Middle East and western countries. Iraqi refugees seeking asylum in industrialized countries cannot reach there before they stop in a neighbouring country in the region to prepare their repatriation papers. Because the Iraqis spend considerable time in neighboring countries, such as Lebanon, their experiences and their conditions should be well assessed to understand their needs.

Objectives: The objective of this paper is to investigate the living conditions and experiences of Iraqi refugee families and children in transit migration in urban areas of Beirut.

Underlying values and principles: human rights, social justice and health equity.

Knowledge base/ Evidence base: Very little is documented in the literature on displacement and forced migration, or special populations about Iraqi experiences, quality of life, or their coping and adaptation in countries of temporary residence, except for disperse anecdotal evidence from welfare agency staff. This may be due to the fact they no refugee camps have been established to receive them and therefore hardly any relevant social and health services are allocated for them in the Arab countries.

Context of intervention/project/work: Lebanon is witnessing fluctuating post-war economic decline, accumulating debt and several social and political problems that need addressing. It is also home for a large population of Palestinian refugees and is influenced by regional tensions.

Methods: In-depth interviews with and observations of Iraqi parents and children, and with staff of relief agencies.

Results and Conclusions: Iraqi refugees in southern and eastern suburbs of Beirut are suffering silently. Stigmatization, psychological disturbances: anxiety, severe poverty and hopelessness are among the recurring themes. Parents' views of themselves as protectors of their children and their families are shaken and this has led to suicidal attempts. Their suffering is exacerbated by deplorable living conditions, state restrictions and persecution, stigmatization and ambiguity on their repatriation papers. Reasons behind this neglect include the lack of state preparedness to host large numbers of refugees, a hesitant political will to develop an equitable policy towards all refugees, scarce resources among relief NGOs and a slack global repatriation process. The families' coping mechanisms and adaptation vary with the conditions they left Iraq in, the urban area they came to, as well as the attitude of welfare agency staff and the social networks the families have developed.

Disclosure of Interest: None declared

OP-MON-014 NETWORK OF MIGRANT FRIENDLY HEALTH CENTRES

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Antecedentes: Collaborative network project developed during 2003-2009 by the Asociación Salud y Familia (ASF) and the public health care system (PHC) in Catalonia (Spain). ASF is a non-governmental, non-profit-making organisation which designs and promotes models for improved accessibility to and use of health services, targeting vulnerable groups as immigrants, in social and cultural disadvantaged positions.

Objetivos: Improve general conditions for the provision of healthcare to the immigrant population.

Increase the availability of cultural competent services.

Improve cultural competent communication between healthcare staff and immigrants.

Reduce unnecessary burdens on workload through reduction of intercultural conflict.

Increase appropriate use of services and the level of satisfaction among patients from the immigrant population.

Valores y principios subyacentes: Cultural accommodation policies.

Migrant friendly policies

Reduction of health disparities.

Cost-effective health care of vulnerable populations.

Base de conocimiento / base de evidencia: Migrant friendly policies in a organizational way and disponibility of intercultural mediators in health centres improve patient satisfaction, cultural competent staff and diminish health disparities.

Contexto de la intervención / proyecto / trabajo: In the period 1999-2009, 1,5 millions of new arrived migrants entered in Catalonia, a country of previous 6 millions of inhabitants with a low cultural and demographic diversity.

Métodos: Broad availability of intercultural mediation services to provide support to immigrants and healthcare staff.

Identifying the needs for intercultural adaptation of the hospital's services, products and routines.

Joint leadership between PHC and ASF to encourage collaboration and the sharing of knowledge, expertise and innovation.

Availability of learning for developing cultural competent skills.

Resultados y Conclusiones: The PHC is actively using the services of 36 intercultural mediators provided by ASF, covering the areas of North Africa, Pakistan, Rumania and Xina and giving direct support to more than 135.000 immigrant patients.

The network is developed in 6 hospitals and 29 primary health centers.

The network is adapting, interculturally, numerous information and health education materials.

The network is providing intercultural learning activities for healthcare staff.

Intercultural organisational development has become part of PHC agenda.

The network experience provides a feasible and innovative model of good intercultural practice which is gradually expanding and adapting to other hospitals and health centres.

Referencias: VVAA "Handbook on integration for policy-makers and practitioners". Directorate General of Justice, Freedom and Security, European Commission, 2004.

Méndez, E "Políticas públicas de acomodación de los inmigrantes en el ámbito sanitario". Quadern CAPS 2004, 32; pp18-23.

Declaración de intereses: NO DECLARADO

OP-MON-015 HOW DO WE GUARANTEE EVIDENCE-BASED MEDICINE IN A SEMI-STATE HEALTHCARE SYSTEM? A LOOK AT THE SITUATION OF TURKISH MIGRANTS IN AUSTRIA

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Background: Turks make up the largest group of migrants in Austria.

Objectives: To improve access to healthcare for Turkish immigrants in Austria.

Underlying values and principles: Since our state healthcare system also covers all Turkish migrants and guarantees evidence-based medicine, there should be no problems.

Knowledge base/ Evidence base: We know from a survey conducted by us at Innsbruck Medical University Hospital that Turks feel they are discriminated and do not receive the same diagnostics and therapy, at least in comparison to "Austrian patients." The reason probably lies in a general dislike of foreigners in our society.

Context of intervention/project/work: Innsbruck Medical University Hospital includes a Women's Health Center that facilitates access to university medicine for women of different ages and walks of life. Its main goal is to provide information and routing within the university hospital.

Methods: To accommodate the female Turkish community a Turkish Women's Medical Office was opened that guarantees the presence of a female Turkish native speaker medical student, at least for first contacts. At the Women's Health Center, first contacts are made in Turkish. Only after the patient's anamnesis has been taken and her medical request has been discussed in detail, are they joined by a female Austrian physician; together, they draw up the further medical program. As far as possible, especially for sensitive disciplines such as gynecology, we provide a women-only setting in the out-patient clinics. We take care to first speak to the patient alone. Later, her family can be included and counseled, if the patient desires. At the initial contact the patient is given the name and mobile phone number of the Turkish staff member, who remains her contact person in all organizational and medical matters and, if desired and needed, can also organize further steps to be taken. This goes beyond purely diagnostic and therapy matters to also provide information on the Austrian health and social system. We generally attempt to create a migrant-friendly setting.

Results and Conclusions: We can state that our Turkish Women's Medical Office, which is very well accepted and relies solely on recommendations from our Turkish women's campaigns, is the best-possible way to meet Turkish women's desire to have a female Turkish native speaker as the first point of contact in the medical university hospital system. We feel this is the best guarantee for evidence-based medicine of the highest standard, also for our female Turkish patients. Nevertheless, we are concerned that using an interpreter, even one of our trained staff, could cause medical quality to suffer. By contrast, we ask ourselves how far parallel care inside the university hospital can go without a major loss of quality. The optimal goal, which is not medical but social, is to ensure that female migrants can access mainstream medical offerings.

Disclosure of Interest: none declared

OP-MON-016 STRESS LEVELS AND DIETARY INTAKE OF HYPERTENSIVE SUBJECTS IN PERI-URBAN COMMUNITY IN ACCRA

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Background: Psychosocial stress/anxiety levels are high in poor peri-urban communities and together with poor dietary intake make inhabitants prone to hypertension.

Objectives: This study therefore intends to bring out the exact association between stress and perseverance of hypertension. It also intends to examine the association between dietary deficiency or adequacy of various food nutrients and hypertension and/or stress.

Underlying values and principles: Several studies have shown some link between stress levels and dietary intake and prevalence or development of hypertension.

Knowledge base/ Evidence base: Hypertension is now being widely reported in Africa and is the most common cause of cardiovascular disease on the continent (Cooper et. al., 1993). It is also a major factor in the high mortality of adults in sub-Saharan Africa (WHO, 2002).

Context of intervention/project/work: This work is part of a larger studies to assess the effect of lysine supplementation on stress and blood indicators.

Methods: Study was a cross-sectional design. About 90 males and females from each household was sampled, and their socio-demographic status was assessed. Ethical clearance was obtained from the Internal Review Board, and concerns of community leaders and subjects was sorted after explaining research to subjects. Subject's height, weight, skin fold measurements was taken. Chronic stress was determined using a Ga and Twi standardized version of the trait and state inventory (T-stai). Blood pressure reading was taken using sphygmomanometer. Three days repeated 24-hour dietary recall was also done on each subject to assess dietary intake.

Results and Conclusions: There was even distribution of males and females. About 28% of the population were hypertensive and 55.5% had high anxiety. Hypertension was higher in males (32.2%) than females (24.4%) while anxiety was higher in females (60.9%) than males (50.0%). Males were at higher risk of hypertension (Odds Ratio 0.933(CI 0.695-1.253)) and anxiety (Odds Ratio 0.809(CI 0.329-1.997)) than females. Hypertensive subjects recorded higher stress (51.02%) and hypertension was more endemic in subjects with high anxiety (32.89%) especially in females (p-value= .036). Hypertension increases with age while chronic stress/anxiety decreases with age. Hypertensive subjects recorded a higher BMI and sodium intake while high anxiety individuals recorded a lower animal protein but a higher cereal protein intake. Other dietary nutrients did not significantly vary in these groups. Hypertension and stress/anxiety levels are closely inter linked with chronic stress/anxiety being more endemic in hypertensive subjects. Dietary intake of sodium predispose individuals to hypertension while intake of low animal protein and high cereal protein increases individuals risk of chronic stress/anxiety.

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Disclosure of Interest: None declared

OP-MON-017 VEGAN DIETS: SOCIAL CHALLENGES, SPIRITUAL BENEFITS, AND ENVIRONMENTAL IMPLICATIONS

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Background: It is becoming increasingly apparent that a shift towards plant-based diets would produce numerous individual and societal benefits. Animal products are widely consumed and are associated with heart disease (Anderson & Smith, 2005; Hu & Willett, 2002). Also, there are troubling environmental problems associated with animal agriculture (FAO, 2006). Vegan diets have the potential to reduce health and environmental problems.

Objectives: Participants will be better able to evaluate the factors that have influenced their own dietary choices and to reevaluate whether their current diet supports their physical, psychological, and spiritual health. Participants will be better able to analyze the ethical, environmental, and health-based motivations that initiated and sustained vegans' diets, and the interpersonal and intrapersonal impact of choosing a vegan diet

Underlying values and principles: Vegans tend to embrace the philosophy of ahimsa or dynamic harmlessness which guides them to not only do the least harm, but to do the most good.

Knowledge base/ Evidence base: Thirty-two vegans were interviewed in two separate phases. Phase I involved seventeen vegans and explored the experience of being vegan. Phase II examined the interpersonal and intrapersonal impact of maintaining a vegan diet and included three vegans in each of the following five professions: medical doctor, registered dietitian, animal activist, philosophy professor, and former farmer.

Context of intervention/project/work: This study involved Americans and Canadians. Phase I interviews took place between November, 2003 and August, 2004 and Phase II interviews were conducted between June, 2007 and February, 2008.

Methods: Critical theory is the frame that guided this qualitative study of vegans. Purposive and snowball sampling techniques were utilized. In-depth interviews, with a semi-structured interview format were used in both phases.

Results and Conclusions: Participants experienced strained relationships as a result of their diet and beliefs; occupational success tended to moderate this effect. Self-reported physical, eudemonic, and spiritual well-being were associated with vegan diets.

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McDonald, B. (2000). "Once you know something, you can't not know it": An empirical look at becoming vegan. *Society and Animals*, 8, 1-23. DOI: 10.1163/156853000X00011

Disclosure of Interest: None declared

OP-MON-018 FAMILY FACTORS AND EATING BEHAVIOUR OF SCHOOLCHILDREN

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Background: Good nutrition and the establishment of healthy eating habits in childhood and adolescence promote optimal youth health and may prevent long-term health problems. The family and home environment e.g. parental diet and home food availability and accessibility are important influences on the dietary behaviours of youth. Other aspects of the family environment such as parental control, family type, family structure and family communication have also been explored in relation to young people's dietary habits. Ireland has relatively recently undergone considerable change in terms of family size and structure. These changes may influence the eating habits of Irish children.

Objectives: To investigate how family make-up (size, structure and social class) and maternal employment predict dietary habits of children in Ireland.

Underlying values and principles: Access to proper nutrition has been recognized as one of the basic human rights and a key component in the healthy development of children. This study aims to identify promoters and barriers to the development of healthy eating habits within the context of the family environment.

Knowledge base/ Evidence base: The importance of proper nutrition during the early years has been widely presented. Yet, although children living in the high-income countries are constantly exposed to foodstuffs and the majority does not experience food shortage, there is growing evidence for malnutrition in such countries. The family plays a key role in the development of healthy eating habits. In Ireland family size and structure has changed relatively recently and the impact of such changes on the eating habits of children is of interest.

Context of intervention/project/work: This study is based on data collected as part of the Irish Health Behaviour in School-aged Children (HBSC) study. The data set comprises a random sample of schools across the country and this study is based on the analysis of data from 10, 146 students aged between ten and seventeen.

Methods: All participating children completed a questionnaire during class time. The questionnaire included questions on eating habits, frequency of foodstuff consumption, family eating culture and parenting style. Associations between family characteristics and eating behaviors will be expressed in odds ratios from logistic regression models.

Results and Conclusions: Different family factors such as family structure and maternal employment were found to predict aspects of young

Disclosure of Interest: None declared

OP-MON-019 THE RELATION BETWEEN METABOLIC SYNDROME AND THE TYPE OF OCCUPATION

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Background: Metabolic syndrome (MS) has attracted attention as a risk factor for cerebrovascular/heart diseases.

Objectives:

Underlying values and principles: Our study contribute to preventive measures against MS and health promotion at workplace.

Knowledge base/ Evidence base: Evidence

These diseases constantly rank 2nd or 3rd as a cause of workers' death, and, therefore, anti-MS measures are important in occupational health in Japan.

Factors associated with MS include lack of exercise and overnutrition, and improvement of the lifestyle including working environments is indispensable.

Context of intervention/project/work: Contents: The purpose was to evaluate the relationship between the type of occupation and MS as well as its related factors (physical/lifestyle factors)

Subjects: The subjects consisted of 234 male (age: 49.0 ± 6.1 years) and 326 female (age: 47.2 ± 4.9 years) workers in the faculty of medicine of our university and affiliated hospital who underwent health examination in June 2009.

Methods: The subjects were classified according to the type of occupation into clerical workers, teachers, and medical workers, and also according to the presence/absence of MS [diagnostic criteria of the International Diabetes Federation (IDF), 2005] into MS and non-MS groups.

1. Compare the type of occupation with MS

2. Comparison of physical factors (BMI, abdominal circumference, blood pressure, glucose, lipids) and lifestyle factors((1)-(6)) among the types of occupation.

The following (1)-(4) were binary variables (Yes/No).

(1) Body weight: An increase ≥ 10 kg, (2) diet(eating quickly, snack, etc) (3) adequate sleep, (4) smoking

The following (5), (6) were continuous variables.

(5) Drinking score: frequency(1: rarely drink or no drinking, 2: sometimes; 3: every day) \times amount of alcohol/day(1: < 22 g, 2: $22-< 44$ g, 3: $44-< 66$ g, 4: ≥ 66 g).

(6) Amount of physical activities/week(exercise, work, housework, etc): $METs \times time(\text{minutes}) \times frequency$.

Analysis: χ^2 test, one-way ANOVA ($p < 0.05$).

Results and Conclusions: 1. Percentage of subjects with MS according to the type of occupation

In the males, clerical workers(33.3%), medical workers(32.2%), teachers(22.9%). In the females, medical workers(4.8%), teachers(4.0%), clerical workers(3.0%). The percentage of workers with MS did not significantly differ among the types of occupation in the males or females.

2. Comparison of physical/lifestyle factors among the types of occupation

In the males, the blood pressure and glucose as physical factors were significantly higher in clerical workers than in teachers.

In the females, diet(eating quickly) was observed in medical workers(45.0%), clerical workers(24.1%), teachers(16.7%). The amount of physical activity was medical workers(3,379), clerical workers(1,598), teachers(1,316), and the drinking score was medical workers(2.2), clerical workers(1.5), teachers(1.3).

These factors showed significant differences among the types of occupation.

Discussion: In the females, the drinking score in medical workers was slightly higher than that in clerical workers and significantly higher than that in teachers, and the percentage of those diet(eating quickly) in medical workers was significantly higher than that in clerical workers or teachers. Since most female medical workers were nurses, there may be influences of differences in the environment such as the working form (such as nightshift and rotation) among the types of occupation.

In the future, longitudinal studies on the relationship between MS and the type of occupation including factors associated with the working environment are necessary.

Disclosure of Interest: None declared

OP-MON-020 A RANDOMISED CONTROLLED TRIAL OF EARLY INTERVENTION TO PREVENT CHILDHOOD OBESITY IN A DISADVANTAGED POPULATION: RESULTS FROM THE FIRST YEAR FOLLOW-UP SURVEY

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Background: Among Australian children aged 2-3 years, 21% of boys and 18% of girls are currently overweight or obese. Early intervention in the first years of life is essential to prevent the development of overweight and obesity. As yet, however, no such interventions have been effectively implemented or rigorously evaluated. There is a great need to build an evidence-based early intervention.

Objectives: The aim of Healthy Beginnings Trial was to test the effectiveness of an early childhood obesity intervention in the first two years of life.

Underlying values and principles: Health promotion is the process of enabling people to increase control over, and to improve, their health. It supports personal and social development through providing information (Ottawa Charter).

Knowledge base/ Evidence base: Internationally, home visiting intervention has been adopted as one of the strategies that provide social support to mothers, and has been established as effective intervention for improving the health and wellbeing of parents and children. However, there is no systemic model of home visiting published that includes preventing early onset of childhood overweight and obesity as an obligatory part of its content.

Context of intervention/project/work: The intervention has been conducted over the first two years of life to increase healthy feeding behaviours and physical activity, decrease physical inactivity, enhance parent-child interaction, and hence reduce overweight and obesity among children at 2 and 5 years of age in the most socially and economically disadvantaged areas of Sydney, Australia.

Methods: This is a RCT conducted with a consecutive sample of 667 first time mothers with their newborn children. The intervention comprises eight home visits from a specially trained early childhood community health nurse over two years and pro-active telephone support between the visits. Main outcomes include a) duration of breastfeeding measured at 6 and 12 months, b) introduction of solids measured at 4 and 6 months, c) nutrition, physical activity and television viewing measured at 24 months, and d) overweight/obesity status at age 2 and 5 years.

Results and Conclusions: The 6 months follow-up results show promising changes with an increased breastfeeding rate by 10% ($P=0.02$) at 6 months and delayed introduction of solid over 5 months by 14% ($P=0.001$) in the intervention group. The data analysis of one year follow-up is currently under the way. The results will be available for the conference presentation.

The results of this trial will ascertain whether the home based early intervention is effective in preventing the early onset of childhood overweight and obesity. If proved to be effective, it will result in a series of recommendations for policy and practical methods for promoting healthy feeding and physical activity of children in the first two years of life with particular application to families who are socially and economically disadvantaged.

Disclosure of Interest: None declared

OP-MON-021 COMMENT AMELIORER LA QUALITE DE VIE EN MAISON DE REPOS : EXEMPLE D'UNE RECHERCHE-ACTION-PARTICIPATIVE

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Historique / Origines: Prise de conscience de 3 points de vue dans une maison de repos: (1) personne âgée: comment vivre heureux ? (2) membre du personnel, comment s'épanouir dans son travail? (3) directeur, comment assurer une gestion efficiente tout en favorisant la qualité de vie ?

Deux constats: (1) des résidents manifestent tristesse, résignation et insatisfaction. (2) évolution culturelle du personnel marquée par une remise en question progressive de la culture médicale pour une approche plus sociale.

La direction a accepté une recherche-action (RA) pour répondre mieux aux besoins des résidents.

Objectifs: But: analyser la problématique de la qualité de vie, déterminer et mettre en oeuvre des solutions.

Objectifs: (1) assurer l'épanouissement des résidents et du personnel (soignant & d'hôtellerie). (2) soutenir à moindre coût la mise en place d'une politique centrée sur la qualité de vie.

Valeurs et principes sous-jacents: Participation aux décisions des 53 résidents (et famille), 20 membres du personnel. Cohérence entre besoins, objectifs, stratégies et évaluation de la RA.

Empathie : (1) entendre s'exprimer le sujet sur ce qu'il ressent, pense, ou vit (2) être proche et distinct sans être distant (3) entendre et regarder les expériences sans juger, dramatiser ou banaliser, sans avoir de commentaire mental intérieur.

Fondement de connaissance/Fondement de preuve: Modèle de planification systémique et participative PRECEDE-PROCEED de Green & Kreuter et modèle conceptuel de la qualité de vie selon Philippe Corten et al., déjà testés et publiés.

Contexte d'intervention/projet/travail: Amélioration de la qualité de vie dans un cadre de promotion santé et de développement durable. Stratégies: renforcer l'action communautaire, acquérir les aptitudes individuelles, réorienter les services.

Méthodes: Techniques de la RA: (1) Recherche documentaire. (2) Observations pendant 1 an (résidents, soignants). (3) Entretiens non directifs centrés. (4) Brainstormings par groupes (3 groupes de résidents, 2 de soignants et 2 de familles).

Résultats et Conclusions: Une vie de qualité est une vie qui a du sens: (1) les sens « lieux de plaisir » avec affects, besoins, sensorialité et motricité. (2) le sens « signifiant » avec valeurs et spiritualité. (3) le sens « direction » reliant passé et futur. Quelques problèmes identifiés: (1) résidents: crise existentielle, difficultés d'adaptation, régression psychomotrice. (2) personnel: cloisonnement des soins, discordance entre désirs de culture sociale et pratique de culture médicale). Quelques déterminants des problèmes: (1) résidents: méconnaissance des documents administratifs; sentiment d'abandon de la famille; relations quotidiennes médicalisées. (2) personnel: vision restreinte des besoins de l'être humain; représentation négative de la vieillesse. (3) direction: culture médicale, absence de moyens financiers, faible capacité de remise en question. Activités réalisées : suppression de l'uniforme; réorganisation des soins (relation; autonomisation); formation du personnel à la communication; divers microprojets; aménagements des chambres et lieux communs par les résidents et le personnel. Impact: diminution des plaintes; satisfaction du personnel et des résidents, diminution des épisodes de maladies chez les résidents dépendants et diminution de la dépendance sur l'échelle de Katz, absence de régression psychomotrice chez les nouveaux résidents. La qualité de vie, concept multifactoriel, semble déterminée prioritairement par les affects et par la qualité des relations quotidiennes. Améliorer la qualité de vie ne peut se faire sans la participation, à tous les niveaux (information, négociation et prise de décision) de tous les acteurs. Ceci nécessite un changement de représentations et d'attitudes des professionnels de la santé.

Références: 1) PIETTE (D.), Concepts et méthodes en santé publique, notes de cours SPUB 048, ULB/ESP, Bruxelles, 1999-2000.

2) CORTEN & al., Le concept de la qualité de vie vu à travers la littérature anglo-saxonne, in L'information psychiatrique, 1998 ; 9 :9222-932, sur le site <http://homepages.ulb.ac.be/~phcorten>.

Conflit d'Intérêt: Rien à déclarer

OP-MON-022 ADDRESSING SOCIAL CONNECTION... ALMOST UNKNOWNLY

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Background: Caulfield Community Health Service (CCHS) operates within Alfred Health, a major metropolitan health service within Melbourne, Australia. Reflecting identified community need, CCHS focuses much of its health promotion work in the areas of social inclusion and physical activity. The high incidence and impact of social isolation are well known both within Australia and more broadly. Commonly, health services target strategies to increase social connection among community members. In the experience of CCHS, it is physical activity related strategies which are generally most successful in achieving social connection gains (in addition to the desired physical health gains).

Objectives: • To develop a range of sustainable physical activity programs which enable building of social connection

• To measure the social connection changes throughout participation

Underlying values and principles: This initiative is based on efforts to address social connection as a key determinant of health. The principle of building social capital among a population group of older adults enables community members to reciprocate their caring; often a more powerful process than organisations caring for community members through formal structures only. The focus on promoting health and wellbeing, rather than addressing illness is well established within CCHS and the physical activity programs.

Knowledge base/ Evidence base: It is well known that people who are socially isolated generally experience reduced health compared with those who are more socially connected. Evidence within Victoria and Australia highlights that social isolation may be increasing, the number of people living alone is increasing, the amount of time spent alone is increasing and community strength and connection is reducing. In addition, community consultation undertaken by CCHS identifies social isolation as a key priority for the future.

Context of intervention/project/work: This work fits within the context of CCHS' health promotion practice, in the areas of physical activity and social inclusion.

Methods: CCHS directly provides a wide range of physical activity programs to meet the needs of people, particularly older adults, from the local community. Through programs such as Strength Training and Activate, CCHS reaches approximately 700 older adults twice each week on an ongoing basis. In addition, CCHS supports people to participate in existing physical activity opportunities accessible to them. CCHS is committed to providing a range of opportunities for social connection development within such health promotion programs including community participation groups, social gatherings, participant profiling, storytelling and volunteering. Further, the environment in which the physical activity programs are provided aims to ensure inclusion for all and encourage informal social interactions.

Results and Conclusions: Through its model for community based physical activity, CCHS creates opportunities to increase social connection among 700 older adults; many of whom would be considered significantly socially isolated. CCHS has experienced greater effectiveness in building social connection among more people, through physical activity related health promotion strategies, compared with those which focus more specifically on social connection.

Disclosure of Interest: None declared

OP-MON-023 ESTUDIO DE LA EFICACIA DE UN MODELO INTEGRADO DE ATENCIÓN SOCIAL Y SANITARIA A PERSONAS EN SITUACIÓN DE GRAN DEPENDENCIA

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Antecedentes: La sociedad española ha experimentado en los últimos años profundos cambios demográficos, sociales y culturales que han generado nuevas demandas a las que hay que dar una respuesta adecuada

Objetivos: Evaluación del modelo de coordinación sociosanitaria de Castilla y León (España), en grandes dependientes, cuidadores y profesionales que los atienden.

En esta comunicación se presentan resultados de la fase descriptiva inicial del estudio.

Valores y principios subyacentes: El fenómeno de la dependencia, consecuencia del envejecimiento de la población, del incremento de las enfermedades crónicas y degenerativas, así como de las discapacidades es, donde la atención sociosanitaria aparece como una alternativa necesaria al estar conformada por una estructura de asistencia sanitaria y otra de asistencia social, que actúan coordinadamente para proporcionar la mejor calidad asistencial, mas próxima y humana, todo ello en el marco de un sistema con los principios de universalidad y equidad (1).

Base de conocimiento / base de evidencia: La prevención de la dependencia, la detección precoz de las nuevas situaciones de necesidad y su inmediato tratamiento y la promoción de la salud (2) de las personas más vulnerables de la sociedad, exigen una visión integral de la salud, en su triple dimensión, física, mental y social que son base fundamental de la Atención Primaria de Salud (3).

Contexto de la intervención / proyecto / trabajo: Estudio multicéntrico, tipo antes-después realizado en Atención Primaria por 20 Equipos de Coordinación de Base (ECB) (4) de 8 áreas de salud.

Métodos: En una muestra de 200 grandes dependientes que viven en su domicilio, se miden variables relacionadas con problemas de salud, cuidados, plan de intervención y calidad de vida, antes de la intervención. En el cuidador principal, tanto si es familiar como ajeno, se mide la calidad de vida con las viñetas Coop-Wonca (5) y la percepción de carga subjetiva mediante el test de Zarit (6).

Estas mismas variables serán medidas a los 12 meses, tras la aplicación del modelo de coordinación sociosanitaria que evaluamos en el estudio.

Resultados y Conclusiones: Participan 102 profesionales, 48 de los servicios de salud y 54 de los servicios sociales, de 20 ECB urbanos y rurales. Aplicando los criterios de inclusión y exclusión se estudian 149 grandes dependientes con una media de 4,45 problemas de salud. El 60% presenta deterioro cognitivo y el 15,4% ha tenido ingresos hospitalarios en el último año. La media de calidad de vida es de 32,9 en pacientes y 26 en cuidadores sobre 45 puntos. El 91,3% de los cuidadores son familiares (60% mujeres) y acusan sobrecarga el 58,7%.

Podemos decir que un elevado porcentaje de grandes dependientes presenta deterioro cognitivo y un bajo número de hospitalizaciones a pesar de su pluripatología. Los cuidadores son mayoritariamente familiares, predominando las mujeres y destaca la elevada frecuencia de sobrecarga y una percepción subjetiva de mala calidad de vida, más acusada en los pacientes.

Referencias: 1.III Plan de Salud Castilla y León. Consejería de Sanidad. Valladolid 2008

2.Evidencia de la Eficacia de la Promoción de la Salud. Configurando la Salud Pública en una Nueva Europa. Parte dos. Ministerio de Sanidad y Consumo. Madrid 2004

3.Declaración de Alma Ata. Disponible en www.paho.org

4.II Plan Sociosanitario de Castilla y León. Consejería de Sanidad. Valladolid 2003

5.Lizán Tudela L, Reig Ferrer A: Adaptación transcultural de una medida de calidad de vida relacionada con la salud: la versión española de las viñetas COOP/WONCA. Aten Primaria 24: 75-82, 1999

6.Test de Zarit. Disponible en <http://salpub.uv.es>

Declaración de intereses: No declarado

OP-MON-024 COOPERATION AMONG TRIPARTITE ON HEALTH DEVELOPMENT FOR ELDERLY: CASE STUDY IN KANGKOI DISTRICT, SARABURI PROVINCE, THAILAND

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Background: Kangkoi District was once an agricultural area. Due to the Socio-economic and Development Plan, the district is now turned to be an industrial estate. The changing in economic structure affected the well-being of the elderly in the area. It was evident that in many households, the elderly was left alone during day time and many elderly were responsible to take care of young children.

Objectives: It was expected that elderly people should be healthy enough to take care of themselves and the elderly with disability should have caretakers. Chulalongkorn University together with other local governmental organizations and business sectors are tripartite to work hand in hand to initiate health development program for about 2,000 elderly in the area. The activities were constructing data-base on socio-economic and health conditions of all elderly, exercise program and income generating program. This study aimed to elucidate the impact of inter-organizational collaboration on the capacity building for health promotion.

Underlying values and principles: The elderly are asset not the burden of the community. The well-being of the elderly will result in increasing active aging that will benefit the society as a whole.

Knowledge base/ Evidence base: Community members could not work alone due to the lacks of knowledge-based information, leaderships, budget and human resources. Cooperation among people from different fields will result in the progress and success of the health development program.

Context of intervention/project/work: It was suggested that "Adaptive Management" should be adopted to sustain the on-going health development programme. The adaptive approach involves exploring alternative way to meet management objectives, predicting the outcomes of alternatives based on the current state of knowledge, implementing one or more of these alternatives, monitoring to learn about the impacts of management actions. Adaptive management focuses on learning and adapting through partnerships of all stakeholders.

Methods: Quantitative method through survey and qualitative method by using in-depth interview and Focus Groups Discussion were utilized to collect data

Results and Conclusions: The findings suggested that "Adaptive Management" should be adopted to sustain the on-going program because it is a learning-based process to improve management decision. Adaptive management focuses on learning and adapting through partnerships of all stakeholders. In order to maintain long-term sustainable health promotion program for the elderly, full cooperation among tripartite namely: the governmental sectors, the non-governmental sectors and public participation are ultimately required. In order to achieve the application of adaptive management, the six REs namely REvalue, REstrategy, REprocess, REstructure, REcondition and REsearch were proposed as underlying factors determining sustainable development of the health promotion program for the elderly.

Disclosure of Interest: None declared

OP-MON-025 LONELINESS AND SOCIAL ISOLATION IN LATER LIFE: THE USE OF THE DELPHI PROCESS TO IDENTIFY OLDER PEOPLE'S NEEDS AND RESEARCH PRIORITIES

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Background: Loneliness, social isolation and lack of social support have all been associated with poor mental health, especially depression. Loneliness is seen as a specific social problem which accompanies people into later life. Studies have found about a third of older people experience some degree of loneliness. Efforts to promote positive ageing should include strategies to aid social integration and minimise loneliness in older persons.

Objectives: This study used the Delphi technique to determine priorities for interventions and future research to alleviate loneliness and social isolation amongst older people in the Australian context.

Underlying values and principles: Those who are lonely or at greater risk of being isolated, appear to take part in, and benefit from, many types of community activities, the vast majority of which do not aim to alleviate loneliness or isolation. With respect to programs that specifically aim to alleviate loneliness or social isolation, these appear to be relatively few in number and type in the community.

Knowledge base/ Evidence base: Previous researchers have suggested that there are five sets of factors as having been consistently associated with loneliness: Socio-demographic attributes (living alone, being female, having no surviving children, living arrangements, being aged 75 or more years); Material circumstances (poverty, limited education); Health resources (disability, anxiety and depression); Social resources (size of social network, time alone and presence of a confidant); and Life events (recent bereavement and admission of a relative / spouse into care).

Context of intervention/project/work: This Delphi study is part of larger study on loneliness and social isolation.

Methods: The development of a planning and evaluation framework via the PRECEDE/PROCEED model through a two stage Delphi process with a panel of experts was used to construct a model that incorporates the important personal and environmental factors that influence peoples' level of loneliness and/or social isolation and potential initiatives to address the problem. It has provided the direction for further intervention research.

Results and Conclusions: The Delphi panel identified a number of factors that were amenable to assistance or intervention. 'Low level of social participation' and 'having limited social support' were factors / circumstances that were considered as being more amenable to some kind of assistance or intervention. 'Difficulties in accessing transport' and 'being a carer' were also identified by the researcher group in relation to social isolation, and 'having depression' in relation to loneliness.

Community programs that facilitate social networks emerged as the highest priority for the researcher group, whilst community initiatives targeting depression among older people was the top priority for the policy / practitioner group. Both groups also tended to give higher priority to interventions aimed at broader community level initiatives while a number of more specific program types, for example teleconferencing and computer based programs, were afforded lower priority.

For the researcher group, longitudinal studies to investigate risk and protective factors for loneliness and social isolation among older people was identified as the highest priority, whilst for the policy / practitioner group investigating the association between loneliness, social isolation and psychological resources emerged as the highest priority.

Disclosure of Interest: None Declared

OP-MON-026 A TRIAL OF A TRADITIONAL-STYLE DIET FOR OBESITY AND DIABETES IN A CANADIAN FIRST NATIONS COMMUNITY

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Background: Canadian Aboriginal populations have high rates of obesity and type 2 diabetes. Prior to European contact, First Nations people living on the West Coast ate a traditional diet of game, seafood and edible wild plants. Most of their calories came from dietary fat sources including a unique marine oil derived from one species of fish using an age-old rendering process. The modern diet consists of traditional foods plus market foods of poor nutritional quality.

Objectives: A trial of a modern low-carbohydrate diet based on the traditional diet of the Namgis First Nation was done to determine if it would benefit people with obesity and type 2 diabetes.

Underlying values and principles: The research project was designed to conform with the research ethics guidelines established by the Namgis First Nation. The community was consulted at every stage of the project. The results were shared with the community prior to presenting them in other venues.

Knowledge base/ Evidence base: Most calories in the modern diet are derived from refined carbohydrate foods in contrast to the very low carbohydrate content of the traditional diet. A number of recent studies in generalized populations have demonstrated that low-carbohydrate diets can safely reverse the signs and symptoms of obesity, metabolic syndrome and type 2 diabetes.

Context of intervention/project/work: A diet was designed based on the traditional foods of the Namgis First Nation plus market foods of similar macronutrient value.

Methods: Subjects were recruited from the Alert Bay community on Cormorant Island in British Columbia, Canada. After providing informed consent, subjects had blood drawn to establish baseline measurements for WBC, HgA1c and lipid profile. Measurements of blood pressure, height, weight, waist and hip were taken at baseline and on regular follow-up visits over a 12-month period. Repeat bloods tests were done at 3, 6 and 12 months. Subjects were instructed in the dietary protocol and compliance was encouraged through follow-up visits with the nurse and Community Health Representative, support groups, community dinners and instruction sessions by the lead investigator.

Results and Conclusions: An interim analysis was done on a cohort of 40 subjects that had followed the diet for an average of 7.6 months. Mean weight loss was 10.1% of body weight ($p < 0.0001$) Statistically significant improvements were also achieved in waist hip ratio, HDL, triglycerides, triglyceride HDL ratio and cholesterol HDL ratio. LDL was unchanged. Among diabetics, HgA1c dropped a full percentage point ($p < 0.047$) while they reduced or discontinued hypoglycemic medications.

Conclusion

A dietary intervention tailored to the local traditional dietary pattern is feasible using existing medical clinic staff. Significant improvements from baseline can be achieved in weight, type 2 diabetes and parameters of metabolic syndrome over a 7.6-month period. This type of approach, which correlates a lifestyle change to the local heritage, may be useful in reducing obesity, metabolic syndrome and type 2 diabetes in disproportionately affected populations.

Disclosure of Interest: None declared

OP-MON-027 THE INFLUENCE OF SPIRITUAL, EMOTIONAL AND SOCIAL WELLNESS ON THE MANAGEMENT OF TYPE 2 DIABETES AMONG INDIGENOUS PEOPLE IN CANADA

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Background: Indigenous people worldwide are increasingly affected by an epidemic of Type 2 Diabetes Mellitus (T2DM). Previous research has focused on genetics, local understandings of diabetes and culturally appropriate health education. But many Indigenous people see health as holistic, encompassing more than the physical aspects of health, yet little is known about how spiritual, emotional and social wellness affects T2DM management among Indigenous people.

Objectives: To examine the impact of spiritual, emotional and social wellness on the management of T2DM among the Anishinaabek people in Northern Ontario, Canada.

Underlying values and principles: Euro-western epistemologies have been described as aggressive vis-à-vis Indigenous epistemologies and Indigenous scholars have argued that research is often a manifestation of euro-western cultural narcissism. We intended to bridge the divide between Indigenous views of wellness and illness prevention/health promotion using the concept of “ethical space” by purposefully articulating Indigenous and Western epistemologies.

Knowledge base/ Evidence base: Coping is defined as “the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful”. Research on how people cope has proliferated in the social and health sciences for over three decades and it remains an important research topic today because it can provide explanatory models for why people fare better than others in stressful situations such as the onset of a serious illness.

Context of intervention/project/work: Preliminary research with Indigenous people in Northern Ontario, Canada area indicates that Indigenous patients generally cope with T2DM differently than their non-Indigenous counterparts and that these differences in coping have a serious effect on illness outcomes and quality of life in some.

Methods: Using a participatory action research approach and engaging Indigenous stakeholders in all phases of the research project we conducted unstructured life history interviews with 20 Indigenous people with T2DM whose level of glycemic management was known.

Results and Conclusions: Participants articulated wellness and illness management as a way of life situated within a broader historical, social and political context of Indigenous people and Canadian mainstream culture. Several participants made direct connections between diabetes management spirituality as well as past and present Indigenous cultural practices; all interviewed discussed the impact of the changing life ways of the Anishinaabek on the management of T2DM. Diabetes health intervention efforts must be informed by Indigenous understandings of spiritual, emotional and social wellness to improve people’s responses to the stressful reality of living with T2DM.

Disclosure of Interest: None declared

OP-MON-028 WHANAU ORA HEALTH IMPACT ASSESSMENT AND ITS USE IN MAORI PUBLIC HEALTH

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Background: Hapai te Hauora Tapui Ltd is a Regional Maori Public Health Provider based in Auckland, New Zealand. Hapai is a Indigenous tribally owned and governed Not for profit organisation delivering a range of health promotion programmes to Maori communities in the Auckland Region.

Hapai focuses on four key strategic priorities;

Leadership - including the collection and development of evidence to inform policy and advocacy activities;

Communication and Relationships;

Quality and;

Workforce Development.

Health Impact Assessments (HIA) are currently undertaken in a range of different countries. In New Zealand, we have developed an Indigenous model of HIA based around the National Maori Health Strategy - He Korowai Oranga (HKO).

The aim of HKO is Whanau or family wellbeing.

This presentation focuses on 'Whanau Ora' Health Impact Assessment undertaken for one local and one regional council in Auckland, New Zealand.

Objectives: To outline the key features and results of two Whanau Ora Health Impact Assements carried out in 2009

Provide an over view of key lessons learnt, and application to future Whanau Ora Health Impact Assessment

Underlying values and principles: Hapai Te Hauora Tapui utilises a kaupapa Maori framework -(based on key Maori values and principles) in the delivery of activities with Maori communities in Auckland.

Knowledge base/ Evidence base: Our knowledge based is informed by tribal information and narratives including history, development as well as language and values. We also utilise a range of Western scientific and governmental information, and undertake kaupapa Maori evaluation and consultation to inform our evidence base.

Context of intervention/project/work: Two Whanau Ora Health Impact Assessments (HIA) were undertaken alongside two HIA projects undertaken in partnership with Synergia,a Public health consultancy firm in Auckland.

The first Whanau Ora HIA involved the Draft Auckland Regional Land Transport Strategy. The second Whanau Ora HIA involved the future development of the Manukau City Council Built Form and Spartial Environment.

Methods: The Whanau Ora Health Impact Assessment utilised the four key HIA phases of; Screening, Scoping, Appraisal and Evaluation.

Hapai te Hauora Tapui focused on the qualitative methods for the Whanau Ora HIA, supported by Synergia Ltd with quantitative methods. The key research methods utilised by Hapai included; face to face and focus group interviews, as well as hui.

Results and Conclusions: Both Whanau Ora Health Impact Assessments provided important information to the funders from an Indigenous health perspective, and provided important recommendations in order to reduce the impact of potential negative effects (and increase the likelihood of positive effects) on whanau wellbeing.

Disclosure of Interest: none

OP-MON-030 ADVOCATING FOR INDIGENOUS TOBACCO CONTROL IN AUSTRALIA AND BEYOND

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Background: Successes seen in the broader tobacco control area in Australia over the last 20 years have not been reflected in Indigenous communities, for example reductions in smoking prevalence rates have not been replicated. Around 46% of Indigenous people in Australia smoke tobacco which is just a 4% reduction in smoking rates in the last 16 years (from 50% down to 46%). Mainstream health promotion messages and programs aimed at prevention and cessation are not penetrating Indigenous communities and are having little or no effect.

Objectives: The Centre for Excellence in Indigenous Tobacco Control was funded by Health and Ageing in 2003 for 6 years to conduct research and to advocate for tobacco control in Indigenous populations in Australia.

Underlying values and principles: Any advocacy, research or program delivery initiatives must be culturally sensitive and based in reality to gain acceptance from Indigenous communities. Forming equal partnerships with Indigenous communities and organisations is the key to effective communication and therefore effective advocacy for any health promotion issue including tobacco control.

Knowledge base/ Evidence base: The CEITC initiates, responds to and advocates for a number of Indigenous tobacco control research initiatives and on the ground projects. A project register and scoping paper have been completed and help to shape the work of this Centre.

Context of intervention/project/work: There are many issues and health needs competing for time in Indigenous communities and these issues more often than not have more immediate effects than tobacco and are therefore given priority. The Centre endeavours to raise the profile, priority and immediacy of Indigenous tobacco control in Australia and to contribute to the above in an international context

Methods: The CEITC members are part of many committees, working groups, reference groups and advisory bodies which have both a national and international focus.

Results and Conclusions: Encouraging self determination, sustainability and capacity building are also vital to building effective partnerships. The CEITC endeavours to form respectful partnerships with both Indigenous and non-Indigenous organisations. This presentation will discuss what partnerships might mean to both the Indigenous and tobacco control communities.

Disclosure of Interest: None declared

OP-MON-031 RE-ORIENTING PUBLIC HEALTH AND HEALTH PROMOTION: RHETORIC, CHALLENGES, AND POSSIBILITIES FOR SUSTAINABILITY

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Background: Just as the world is increasingly interconnected, so are some of its most daunting problems. The issue of sustainability is a particularly pointed example of a contemporary problem that has multiple connections. Several interacting unsustainable trends currently exist in the modern world: population growth; the use of fossil fuels; the accumulation of greenhouse gases; and the creation of money.

Objectives: In this presentation we make a case for re-orienting public health and health promotion, based on evidence that societies across the globe are now facing inevitable change for which we remain insufficiently prepared.

Underlying values and principles: Global equity.

Knowledge base/ Evidence base: We draw on a complex body of knowledge and evidence from across the natural, social and behavioural sciences, as well as futures thinking.

Context of intervention/project/work: Not applicable

Methods: We use discourse analysis to focus on the relationship between different sustainability ideals and the reality of a number of challenges in the 'modern' world. A discourse can help to constitute a way of acting in the world, as well as a way of describing it, both opening up and closing down various possibilities for action. This is a useful insight to bring to bear on three key forms of discourse around sustainability: public; policy; and public health/health promotion. We briefly describe elements of public and policy rhetoric around sustainability, as an important background for health promotion efforts. We present two significant public health/health promotion discourses - a reductionist scientific discourse and an ecological discourse.

Results and Conclusions: We draw on multiple forms of knowledge and evidence which indicate two major challenges to sustainability. The first relates to the powerful cultural values associated with modernity and its prevailing cultural ethos of individualism, materialism and consumerism. The second challenge is the exponential growth in a number of systems, such as population; fossil fuels; and the economy. We conclude that the potential for collapse lies before us because exponential growth cannot continue indefinitely in a finite system. Widespread anomie and psychological dislocation are amongst the probable outcomes. Conversely, the possibilities for sustainability include a transition to a form of society that could lessen global inequalities, combat emerging problems like obesity, depression and addictive behaviours, and improve individual and social levels of well-being. We argue that the great ecological and environmental challenges of our age will bring change and many threats but also opportunities to reframe our current assumptions and ethos. An example of a tool that can facilitate new thinking about possibilities for sustainability is the 'three horizons' framework, which we explain. Thinking in terms of horizons might help create the new mindset and change in consciousness required by the scope and scale of the challenges presented.

Disclosure of Interest: None declared.

OP-MON-032 SUSTAINABILITY ASSESSMENT: RELEVANCE FOR HEALTH PROMOTION

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Background: In recent years both sustainable development and health promotion actors developed policy assessment methodologies (sustainability [impact] assessment, health impact assessment). Both are being further developed in their respective policy arenas, but there is little exchange. This in spite of the fact that the two methodologies have similarities. The paper aims to bridge this gap.

Objectives: The paper presents the sustainability assessment methodology, in particular a specific method developed by the Swiss government, to the health promotion audience. It confronts this methodology with health impact assessment and analyzes synergies and differences. It then presents two case applications for the sustainability assessment methodology (Federal Spatial Planning Act, Federal Health Promotion Act) and how health promotion objectives were supported. It concludes with considerations about the mutual supportiveness between the two methodologies.

Underlying values and principles: Health promotion (Ottawa Charter 1986, e.g.) and Sustainable Development as laid down in Agenda 21 have similar conceptual backgrounds (material content, new governance paradigms etc.). Consequently the assessment methodologies developed in the two fields and based on their respective background are likely to profit from each other.

Knowledge base/ Evidence base: a) Sustainability assessment debate / fora in European governments and their networks (European Sustainable Development Network ESDN, e.g.) as well as in OECD.
b) Case applications from the Swiss Government

Context of intervention/project/work: Case applications: Switzerland

Methods: Literature analysis, case studies

Results and Conclusions: Sustainability assessment covers most of the health promotion concerns, but has a broader overall policy focus including economic, societal and environmental issues. It can support health promotion objectives, where a health impact assessment does not exist. But the two methods can also be combined. Exchange of experience and cooperation between the two policy arenas have to be improved.

References: Swiss Government: Sustainability Assessment Website

<http://www.are.admin.ch/themen/nachhaltig/00270/03005/index.html?lang=en>

Disclosure of Interest: I am member of the Swiss Scientific Committee, and I was also invited to participate in the abstract review process

OP-MON-033 HEALTH PROMOTION: IS SUSTAINABLE DEVELOPMENT POSSIBLE WITHOUT HEALTH EQUITY?

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Background: While healthcare is personal services applied to individuals aiming to maximize the health of an individual, health promotion is interventions implemented on populations aiming to maximize the health of whole populations. Although that a population is sum of individuals, the two goals are very different. Any health promotion intervention is decision for resource allocation and there always will be winners – people who benefit of it and losers – people who benefit less of it. Choices, or prioritizing competing demands, are inevitable, since resources are limited and less than the needs, i.e. always some claims are declined. The question is: “Which claims will be declined?” and more importantly: “On what basis some claims will be declined?” in order to maximize health of populations.

Objectives: What should be the theoretical basis for research and evaluation in health promotion is fundamental question, since being based on different values there will be different answers. Different values will set up different goals to be achieved, which will use different criteria to determine success, and these in turn will evaluate different evidence.

Underlying values and principles: What should we strive for when allocating resources in health promotion: increasing average health status, or decreasing health inequalities? Is there interdependence between health gain and health equity? Is sustainable development possible without health equity?

Knowledge base/ Evidence base: Usually evidence for clinical efficacy is unambiguous and doesn't depend on the local context, i.e. it can be replicated anywhere. However, effectiveness and especially cost-effectiveness can vary depending on local context in terms of: organization of services provided; considered costs to individuals, families, employers, communities, society; and cultural specificities. For interventions in health promotion there is one important extra aspect of the local context – the distribution of the benefit from an intervention within population. Since it can be different in any different case, the evidence about effectiveness becomes even more equivocal.

Context of intervention/project/work: Focusing on particular individual's health maximization effectively deprives resources from another individual. Does this mean that the right to highest attainable health of the former is greater than the same right of the later? Do people value one more than the other? Does it comply with declared by the society ethics that people are of equal value? The right of an individual to the highest attainable health should not be achieved by denying this right to others. Therefore achieving sustainable wellbeing needs different approach.

Methods: This paper is about theoretical investigation of the correlation between average health status and health inequalities. Average health status will improve, when health of those, who are better-off improves faster than the rest of population, but as result health inequalities will increase. This situation, where health gain and health equity are not interdependent, has supporters, as it complies with Kaldor-Hicks criterion for efficiency.

Results and Conclusions: I've established that evidence in health promotion is relative and depends on the distribution of the benefit in any specific case. The appraisal of any intervention should start with analyzing the distribution of the benefit at local level. I have identified eight combinations of this distribution, leading to very different results. Once this is sorted out, choices should be made in order to maximize the outcome for whole populations in specific cases at local level.

Disclosure of Interest: None declared

OP-MON-034 PROMOTING HEALTH - A KEY TO SUSTAINABLE DEVELOPMENT

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Background: The most important assignment at the moment, beside from action for sustainable development, is to make the issues of sustainable development to a concern that matters to all in the everyday context in a way that will sustain over generations.

Lowered subjective well being is a double load to health, directly from the physiological reactions of the lowered well being and indirectly from unbeneficial behaviors related to bad coping. The risk for a destructive health behavior is higher for people with a low socio-economic status. However, people with high socio-economic status may have access to more financial and other resources to handle stress and strain but in ways more destructive viewed out of sustainability, like excessive material consumption.

Objectives: The paper "Promoting health – a key to sustainable development" investigates the possibility to use health promotion as a strategy for sustainable development.

Underlying values and principles: Using health promotion as a strategy for sustainable development brings a holistic approach to the issues of public health and sustainability. It makes the field of sustainable development accessible to all. It delivers a common ground for planning, policy making and communication. It helps us to take part of and be inspired of each other's work for sustainability.

Knowledge base/ Evidence base: The growing body of knowledge of the salutogenesis and the roots of sustainable development can be gathered into a model for thought and action, here called "Seven landmarks for health and sustainable development". These landmarks are: More body movement every day, More fruits and vegetables in the food, Space for parenthood, Space for human contact, Balancing the stress, Closeness to nature and Closeness to culture.

Context of intervention/project/work: The paper is based on a report by the author (in swedish only and not yet published) financed by The National Board of Health and Welfare and The Environmental Objectives Council.

Methods: Literature review.

Results and Conclusions: The report shows how the factors that promote health mainly are the same that promote sustainable development. "The Seven Landmarks" can be applied in every social, economical or political activity. Examples of applications are: health promoting health care systems, health promoting schools, health promoting public planning, health promoting workplace, health promoting leadership and health promoting policy making.

The major conclusion is that health promotion contains a significant potential to become a universal and including strategy for sustainable development.

Therefore, the interests of the society are:

- a general spreading of the knowledge of health promotion and sustainable development,
- stimulating both public and other sectors to use health promotion as a strategy for higher efficiency and quality in their work,
- further studies of the salutogenesis concerning its hidden driving forces to sustainable development and
- developing methods or models that communicate this knowledge.

Disclosure of Interest: None declared

OP-MON-035 THE MISSING POLICY FOR REDUCTION OF UNDER FIVE MORTALITY RATE IN EGYPT

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Background: Egypt is on road in achieving the health related Millennium Development Goals (MDGs) at the national level. However, it will not do so equally at the rural Upper Egypt level, where 41% of all the poor resides. Data shows that there is slow progress in improving health outcomes, especially those related to under five mortality rate (U5MR). This cannot be blamed alone on weak fragmented health system but is the outcome of interacting social determinants of health that need to be addressed along with shortcomings in public service health delivery. Pro-poor health policies are currently underway through the Health Sector Reform (HSR) and Health Insurance Reform (HIR) adopted by the Ministry of Health (MoH). However, what is still missing a more active involvement of the community for making the national reform policies acceptable/functional, and for promotion of health outcomes of the poor households in Upper Egypt.

Objectives: The objective is to propose a pro-poor policy that will address the persistent U5MR in rural Upper Egypt.

Underlying values and principles: The paper focuses on the untapped policy option of strengthening community based health (CBH) as an integral component to the HSR/HIR, and argues that a policy support for CBH is missing. Such policy would institute the role of community health workers (CHWs) to promote a broader and integrated CBH package through family/community interventions to reach the unreached, address the knowledge gaps on key health and nutrition family practices, strengthen service delivery system, provide quality service at the community level, and empower the community to take ownership. Such a policy should be integrated into the current existing policies, which will ultimately result in improved utilization of health services and will be instrumental to the success of the reform programs

Knowledge base/ Evidence base: The paper analyzes the evidence of CBH, including the cost effectiveness and cost benefit, from the global, regional and local experiences, and refers to UNICEF supported young child survival and development (YCSD) interventions in Upper Egypt. Examples of CHWs interventions are proposed, and estimated costing of adopting the policy per each newborn is made with expected decrease of cost over years by economy of scale. Means to create fiscal space to cover this cost are proposed.

Context of intervention/project/work: UNICEF puts accelerated YCSD as one of its core commitment to address U5MR. The proposed policy aims at linking health promotion with sustainable development; and, practice and policy in Health Promotion. Given that MoH has an extensive network of PHC services and that ultimately 80% of health care needs are covered at this level, CBH therefore should constitute a cornerstone to any sector reform

Methods: The paper analyzes the available data on persistent high U5MR in disparity areas, in terms of size and scope of the problem, direct causes and underlying factors, especially with the current economic/food crisis and escalating child malnutrition. It identifies various policy options, and justifies the rationale for adopting the proposed policy using documented evidence. Desk review and trend analysis of key indicators are main methods used.

Results and Conclusions: Developing a national Policy for CBH is affordable, cost-effective, necessary and timely. Such policy can synergistically be integrated into the current policies for HSR/HIR at PHC level, in a phased strategy, supported by research and evaluation for refined implementation. This policy will ensure social inclusion and equitable access of the most deprived rural communities, and will result in accelerating Egypt commitment toward achieving the MDGs.

Disclosure of Interest: None declared

OP-MON-036 LAS REPRESENTACIONES Y LAS PRÁCTICAS ALIMENTARIAS EN LA CONSTRUCCIÓN DE LA SALUD FAMILIAR FRENTE A LA DIARREA INFANTIL

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Antecedentes: Cuatro años de estudio en una comunidad de Gualeguaychú, evidencian asistencia al Centro de salud de madres con niños con diarreas a repetición, hecho que contrasta con casos que no la presentan, a pesar de tener condiciones de vida similares. Coexisten la prevalencia de infecciones respiratorias agudas, parasitosis, anemia y desnutrición infantil, posibles de prevenir. Son pobres con bajo nivel escolar, precariedad laboral, asistidos con programas sociales.

Objetivos: Conocer las representaciones y las prácticas alimentarias de las madres relacionadas con la diarrea infantil

Valores y principios subyacentes: Es necesario indagar en las familias sobre representaciones y prácticas que construyen para solucionar la experiencia de una enfermedad o la posibilidad de padecerla. En la familia se expresan resultados en salud enfermedad y se dan respuestas de los actores a su cuidado y/o atención. Se trabajó en diarrea infantil por ser una patología prevenible y prevalente e involucra la alimentación.

Base de conocimiento / base de evidencia: En la familia se toman decisiones en el proceso alimentario, en la construcción de interacciones, y en la reproducción biológica y social. Asisten al Centro de Salud superando visitas recomendadas y no garantiza mejor salud.. La situación plantea que el proceso de la diarrea transcurre en el contexto familiar, y es ahí donde se previene, se produce y/o reproduce, sin desconocer que operan las determinaciones sociales y las condiciones de vida.

Contexto de la intervención / proyecto / trabajo: El estudio se ubica al sur de Gualeguaychú. Las familias provienen de zonas inundables, relocalizadas, extensas, extendidas y monoparentales, expuestas a: hacinamiento, promiscuidad, alcoholismo, violencia, madres con bajo nivel escolar, pobreza, desocupación, sedentarismo, alimentación inadecuada, falta de higiene personal y de la vivienda.

Métodos: Estudio exploratorio de corte transversal cuali-cuantitativo. Universo. familias de niños de 0 a 6 años de edad. Unidad de observación: la familia. Muestreo intencional. Técnicas: observación. Encuesta semiestructurada y entrevista en profundidad. Marco operacional: episodios diarreicos percibidos por la madre, representaciones que construye, prácticas dirigidas a la búsqueda de su solución.

Resultados y Conclusiones: Las familias poseen información sobre cuidados en salud. Existe entre grupos diferencias en sus hábitos, en prácticas alimentarias y en la construcción de salud familiar. Es preciso generar espacios de socialización entre las familias. Abrir su participación como sujetos sociales autónomos con capacidad de decisión respecto de las gestiones en salud. Si la familia constituye la microestructura que más peso tiene en la constitución de las representaciones y las prácticas de los sujetos en el proceso salud-enfermedad-atención, si la salud resulta delvínculo de los seres humanos con sus prácticas y saberes, se recomienda:

Revisar las políticas alimentarias y de salud, que puedan ser pensadas desde los registros alimentarios a nivel familiar con énfasis en sus prácticas, más que en sus representaciones.

Declaración de intereses: "No declarado"

OP-MON-037 “PROGRAMA DE REDUCCIÓN DE LA DESNUTRICIÓN CRÓNICA INFANTIL”

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Antecedentes: La empresa Minera Yanacocha en cumplimiento del Decreto Supremo 071-2006-EM ha creado el Programa Minero de Solidaridad con el Pueblo de Cajamarca conocido como el Fondo Solidaridad Cajamarca, gestionado en forma conjunta por representantes de la empresa minera Yanacocha, del Gobierno Regional, la Municipalidad Provincial de Cajamarca y el Obispado en representación de la sociedad civil, formando la Comisión Técnica de Coordinación, quien ha decidido desarrollar una intervención que disminuya la desnutrición crónica en menores de 3 años, denominado “Programa de Reducción de la Desnutrición Crónica Infantil”

Objetivos: Objetivo general: Reducir en 8 puntos porcentuales la desnutrición crónica infantil en la región Cajamarca, al cabo de 4 años de intervención

Objetivo específico: Mejorar las prácticas, comportamientos nutricionales y de cuidado de la salud durante el embarazo y la infancia, en las familias con niños menores de 3 años y madres gestantes.

Valores y principios subyacentes: •Prevención de la desnutrición crónica infantil con abordaje integral y multisectorial.

•Participación y empoderamiento ciudadano.

•Articulación con otras intervenciones sociales en salud y nutrición.

•Enfoque de género e interculturalidad.

Base de conocimiento / base de evidencia: La desnutrición infantil es un problema de salud pública, que debido a su estrecha vinculación con la pobreza ha sido priorizada como parte del primer Objetivo de Desarrollo del Milenio. Provocando efectos irreversibles e intergeneracionales en el potencial y las capacidades cognitivas y físicas de los niños y niñas, comprometiendo su desarrollo, el de sus familias y de la sociedad, al traducirse en menores logros y mayores costos de salud, educación y productividad, repercutiendo negativamente en el crecimiento económico de los países, lo cual perpetúa la pobreza, las inequidades sociales y conforma un círculo vicioso

Contexto de la intervención / proyecto / trabajo: Beneficia a familias pobres de 453 comunidades de 19 distritos en 12 provincias de la Región Cajamarca (Cajamarca, Hualgayoc, Celendín, Chota, Cutervo, Jaén, Contumazá, San Pablo, Santa Cruz, Cajabamba, San Marcos y San Miguel) con énfasis en los niños y niñas menores de 3 años y mujeres gestantes

Métodos: La estrategia principal consiste en la educación personalizada a gestantes y madres de niños menores de 3 años; dicha educación se realiza a través de las sesiones de consejerías personalizadas y sesiones demostrativas en preparación de dietas para niños y gestantes enfatizando el consumo de proteína animal y productos locales disponibles, y estimulación psicoafectiva, realizados por facilitadores que son contratados por el proyecto, articulándose a los diferentes actores, programas y proyectos sociales locales

Resultados y Conclusiones: •Se ha incrementado la cobertura de CRED en los niños de 1 y 2 años gracias al trabajo de educación del facilitador

•Acortamiento de la brecha entre la oferta y la demanda en salud, debido al incremento en 32% de los recursos humanos disponibles para el trabajo comunitario, que complementan la labor de los 207 trabajadores del sector salud en los ámbitos de intervención

•Incremento progresivo de la atención integral de niños y niñas en el PREDECI; de 1,915 en enero a 6,421 a setiembre del presente año, incrementándose también el monitoreo del estado nutricional en 32.16% y 42.39% respectivamente, a razón del trabajo de vigilancia y seguimiento comunitario realizado.

Referencias: Objetivos de Desarrollo del Milenio (ODM), el estado nutricional de los niños menores de 5 años y el porcentaje de la población que no alcanza el nivel mínimo de consumo de energía alimentaria. CEPAL.PMA. MIMDES. 2008. El Costo del Hambre. Impacto Social y Económico de la Desnutrición Infantil en el Perú

Declaración de intereses: L. Castaneda, Asociación Los Andes de Cajamarca (ALAC), Empleada.

OP-MON-038 TEETH TALES: ADDRESSING CHILD ORAL HEALTH INEQUALITIES IN REFUGEE AND MIGRANT COMMUNITIES

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Background: Refugee and migrant children experience significantly poorer oral health than the non-migrant population. There is limited community based intervention research addressing oral health inequalities in these vulnerable communities.

Objectives: To employ culturally competent methodologies to explore the sociocultural determinants of child oral health. Representatives from the Iraqi, Pakistani and Lebanese communities are involved at every stage of the research process.

Underlying values and principles: Teeth Tales is a community-based participatory research study working in partnership with local cultural organisations. Existing cultural groups were accessed as well as employing a community member to recruit participants.

Knowledge base/ Evidence base: Refugee and migrant communities experience up to 60% more caries than the mainstream community. Past research often excludes these communities from research due to perceived methodological difficulties.

Context of intervention/project/work: Community partnerships and participation are essential in ensuring that research is useful, meaningful and produces sustainable changes for the community.

Methods: A wide range of people including community leaders, parents, grandparents, health care providers and cultural organisations participated. Focus groups (n=11) and semi-structured interviews (n=7) were conducted with community members and semi-structured interviews were also conducted with five health care professionals who work with these communities.

Results and Conclusions: Four broad categories were identified: 'Child Oral Health', 'Service Use', 'Migration and Settlement', and finally 'Community Solutions'. These came together as a result of the data analysis process, which was conducted in partnership with the different cultural groups. This was a key stage of the cultural competence framework. Consequently the themes follow a logical pattern of issues associated with knowledge and beliefs about child oral health and the facilitators and barriers involved in accessing appropriate services; the impact that migration and settlement has on these two issues; and finally the community's view on resolving the issues at hand.

This is the first research of its kind internationally to work collaboratively with these communities to identify the sociocultural determinants of this highly inequitable childhood disease. Through this project we have been able to establish and strengthen strong community partnerships with key cultural organisations. Teeth Tales has been successful in generating new knowledge about sociocultural differences in child oral health using culturally competent methods. This in turn has informed the development of a controlled community intervention and evaluation trial and will inform policy and practice to improve the health of preschool aged children through the prevention of dental caries, reorientation of universal primary health and social health systems to address these inequalities.

Disclosure of Interest: None declared

OP-MON-039 RISK ROLES AND THE ROLE AS INVOLVED. IMPACT ON CHILDREN'S AND ADOLESCENTS' HEALTH

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Background: An important feature of contemporary welfare state management is initiating partnerships for developing public health policies and practices that positively impact on the health of people. Health promotion has been replaced by new managerial institutions and new cross-professional partnerships (Christensen & Lægheid 2007). For children and young people, this managerial revolution (Kettl, 2005) has meant new roles. The premises for their inclusion into health promotion have changed.

Objectives: The topic is welfare management and involvement of children in health education activities. The paper aims to identify different role modalities of present health semantics aimed at children and young people.

Underlying values and principles: The matter of inclusion becomes a question of both the communication about people as certain role bearers and a question of the ways people as persons react towards generalised role communications (Luhmann 1995; Stichweh 2005).

Knowledge base/ Evidence base: System theory by the German sociologist Niklas Luhmann and value reflected health education theory (Wistoft, 2009) are combined in order to grasp different semantic modalities of inclusion of children and young people.

Context of intervention/project/work: Point of departure is a cross-municipality quantitative-qualitative study. A joint project between Department of Management, Politics and Philosophy, at the Copenhagen Business School and the Danish School of Education, Aarhus University (Wistoft et al., 2007).

Methods: I) Literature review, II) Pilot study, III) Survey: telephone interviews with the danish health managers (N=72 (98)), IV) Focus group interviews with pupils aged 13-15 years in 19 school classes (N=108), V) Case studies: focus group interviews in five selected municipalities (N=34).

Results and Conclusions: A new kind of identity - the risky child - is attributed to the children as they are involved in health promotion. Being confronted with different risks of childhood coming for example from eating fatty food, drinking alcohol, smoking cigarettes or having sexual relationships, the children are brought into a moral, political and lifestyle oriented discourse on risks. In this discourse their identity (as children) is at stake as they are expected to participate as well-experienced information consumers. They are expected to be rational, qualified, and future oriented participants. Often the health promotion information concerns a distant future in which the children risk invisible threats.

This turns children into roles as risky people, potentially risk bearers, risk information consumers, risk prioritisers and choosers. The paper concerns a thesis for further development, that present welfare management is accompanied by certain requests concerning the use of health information. Risk reflexivity is promoted. To the individuals, this means that the role as healthy involves information processing and reflexive activities modulating between being a risk-taker and risk avoider. Already in childhood, the risk-mode of relating to oneself is promoted. The role as healthy is also a role of risk reflexion.

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