

## OP-MON-040 HOW WELL CAN SCHOOLS ASSESS THEIR OWN HEALTH PROMOTING SCHOOL STATUS?

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**Background:** Data collection reflecting how well schools implementing health initiatives can be costly and time consuming. It will be more cost effective if there is a valid tool for schools to collect their own data and interpret it, then take actions to improve their health promoting school status.

This paper reports a study from Hong Kong. Schools used the Health Promoting School Self Evaluation System (SES) to report their health promoting school status. Then the schools were externally audited by using a comprehensive audit tool based on the WHO(WPRO) guidelines and which has been tested with over 100 primary, secondary and special schools over 9 years in Hong Kong<sup>1,2</sup>. The results demonstrated that schools had capacity to quite accurately assess their initiatives in some Key Areas but are less accurate in judging their activities in others by using the SES.

**Objectives:** To find out how well the schools can assess their own health promoting school status by using the SES and externally auditing as reference standard.

**Underlying values and principles:** As Health Promoting School is a continuous process, the schools can use the SES to identify the achievements of their own schools and the direction for improvement.

**Knowledge base/ Evidence base:** Evidence has shown that continuous improvement requires regular monitoring and evaluation, SES would facilities the schools to self evaluate their health promoting status from time to time and identity their strengths and weaknesses.

**Context of intervention/project/work:** Web-based SES was established for the schools to assess their own schools' health promoting school status, to find out their strengths and weaknesses to map out the direction for improvement. Training workshops were conducted to empower the teachers with skills on using the SES to perform self evaluation in schools. External audit was conducted to verify their findings.

**Methods:** Five pilot schools, 1 secondary, 2 primary and 2 special schools, have used the system to perform self evaluation and the external assessments were also conducted.

**Results and Conclusions:** The results suggest that schools have the capacity to assess their initiatives in School Health Policies, School Health Services, School Social Environment and School Physical Environment and fine tuning will be needed in judging their activities in Personal Health Skills, Community Relationships. The presentation concludes by identifying those factors that would empower schools to plan, implement and evaluate more effectively. Specific examples from different schools will be highlighted throughout the presentation.

**References:** 1. A Lee, FFK Cheng, L St Leger (2005). Evaluating Health-Promoting Schools in Hong Kong: Development of a Framework. *Health Promotion International*, Vol 20, No2, p.177-186.

2. A Lee, FFK Cheng and SK Yuen et al (2007). Achieving Good Standards in Health Promoting Schools: Preliminary Analysis One Year After the Implementation of the Hong Kong Healthy Schools Award Scheme. *Public Health*, Vol 121, p.752-760.

**Disclosure of Interest:** None declared

## **OP-MON-041 HOW TO STRENGTHEN THE SCHOOLS CAPABILITIES TO INCORPORATE INNOVATION, SUCH AS THE HEALTH PROMOTING SCHOOL APPROACH, INTO ITS FUNCTIONING?**

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**Background:** Health Promoting Schools (HPS) has been advocated by the World Health Organization as an effective approach to promote health and well-being among school communities and to contribute to the achievement of equity in health. Despite its recognized potential, few studies have evaluated the schools' capacity to implement this approach in an optimal way.

**Objectives:** To present a conceptual model on the process of strengthening the schools' capabilities to integrate innovative intervention such as the HPS approach in their functioning.

**Underlying values and principles:** Because of its multifaceted and concerted nature, HPS presents a challenge with regard to its incorporation into the core business of schools. Building schools' dynamic capabilities is therefore essential to improve their potential of becoming settings conducive to educational achievement, health and well-being of all youth.

**Knowledge base/ Evidence base:** Management theories are used as a foundation to lighten the key components that would increase the capabilities of schools to incorporate innovation into their agenda (Teece et al., 1997; Easterby-Smith et al., 2008). Dynamic capabilities and absorptive capacity are two concepts that hold potential for HPS.

**Context of intervention/project/work:** Empirical basis of the conceptual model builds on the Healthy School approach in Québec, Canada, a whole-school approach equivalent to HPS. The model also draws on the concepts of dynamic capabilities and absorptive capacity. Our findings on the diffusion of Healthy school in Quebec expressed tension between the receptivity to Healthy School and its feasibility in an environment already under pressure. Results shed light on the crucial role of the organizational context.

**Methods:** The model is the result of a dialogue between a theoretical corpus drawn from our literature review on key concepts, i.e. Health Promoting School, dynamic capabilities and absorptive capacity, and findings from our studies related to the diffusion of Healthy School in Quebec.

**Results and Conclusions:** The proposed model is a process model that articulates four strategic levers, i.e. clear strategic vision, strong leadership, trust and organisational learning, with six operational mechanisms, i.e. inner and outer communication, organizational support, professional development, planning, participation and inner and outer collaboration. Dynamic capabilities and its absorptive capacity are anchored in the schools' operational mechanisms and strategic levers. The dynamic capabilities are also determined by the personal absorptive capacity of its members, the organization's prior experience and knowledge and the school's environmental context. The model constitutes a preliminary framework that can serve as a basis for designing future actions and empirical research with regard to Healthy School, with the aim to foster the capabilities of schools, allowing them to become healthy settings for all children and school communities.

**References:** Easterby-Smith, M., Graça, M., Antonacopoulos, E. and Ferdinand, J. (2008). Absorptive capacity: a process perspective. *Management Learning* 39: 483-501.  
Teece, D. J., Pisano, G. and Shuen, A. (1997). Dynamic Capabilities and Strategic Management. *Strategic Management Journal* 18(7): 509–33.

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## OP-MON-042 FROM 'SUICIDE PREVENTION' TO 'POTENTIAL SHOWCASE': A DEVELOPMENTAL APPROACH FOR STUDENT MENTAL HEALTH PROMOTION

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**Background:** In Taiwan, "Suicide Younger" has called much attention in the public. Since 2005, "Suicide Prevention" became the major concern in the school when it was appointed as a health promoting school. With a combination of life education, we expect to create a positive social environment of "Good well & Hope". This project has been launched successfully; but why would a growing child commit suicide? Their mental health status and personality development might be the crux of the matter. To understand how the problem fermented in this society, we have to think beyond school and education system.

Since most of the children are overprotected by parents and teachers throughout their childhood in Taiwan, they lack of the opportunity of self-exploring in common. How should we being the education providers, think of a way to help our child finding their own way without being subsidized by the social expectation?

**Objectives:** The purpose of this research is to review the program development process of a 5-year project and to examine the operation strategies and underlying concepts that how the program initiated from the "risk prevention model" has transformed into the "development model".

**Underlying values and principles:** Although the mental health project was initiated for "suicide prevention", but other than screening risk factors and focusing on the identified target group, we have insisted on the whole school approach. Furthermore, we have developed automatic learning and diligence to accomplish the development task of this Latency stage (Erikson, 1963), while also compensated the development of 'will' and 'purpose' from the previous stages.

**Knowledge base/ Evidence base:** According to vital statistics data released by Department of Health, among the leading causes of death between 15-18 years old in 2003 and 2004, the ranking of "Suicide" has soared to No. 2 from No. 3 position (Department of Health, Executive Yuan, 2004; Department of Health, Executive Yuan).

**Context of intervention/project/work:** Taiwan culture is deeply influenced by Confucianism, thus top-down leadership dominates the society, and the leaders are often the key to innovations and revolutions. However, the education reform in the past years somehow brought in humanistic aspects and voluntarily participating methods, and indeed helped open discussions and possibilities of project development automatically.

**Methods:** This case study adopted ex post facto research by making reference to a spiral framework of an action research model (MacIsaac, 1995). To perform a process evaluation of "Campus mental health program in Ann Ching Elementary School" from 2005- 2009 for exploring the changing strategies and concepts in program planning.

**Results and Conclusions:** Stage 1: The community resources have been integrated to create a multi-learning environment for the students. But the learning process can only create short-term impact without long term effect. Would the input of the physical environment change leads to a continuous social environment change, thus becomes sustainable?

Stage 2: Under a thinking of "Renewable Campus", through teachers' efforts and collaboration, an un-used space in campus has been transformed into the "Bridge Gallery". But how could students' participation be self-stimulated and their potential be inspired?

Stage 3: With various performances made on the stage, children have opportunities to challenge their own courage and determination and built up confidence and self-esteem.

This project has definitely raised students and community people's sense about art and beauty, while the prevention has successfully transformed into a sustainable positive development. The whole process has proved that the "Development model" not only positively promotes the mental health of the students, but the students can also be better developed and demonstrate more of their personality strength facing the expectations from parents or the pressure from the society.

**References:** Erikson, E.H. Childhood and society. (2nd ed.). New York: Norton, 1963.

**Disclosure of Interest:** None declared

## OP-MON-043 SUPPORTING STRUCTURES FOR HEALTH PROMOTING SCHOOLS IN AUSTRIA

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**Background:** Since at least the 1990s there have been efforts in Austria to implement the health promoting school (HPS) concept, yet not many schools have been successful in realising it. One possible explanation for this is that there are a number of obstacles for schools that are difficult to overcome. Therefore capacity building – the systematic analysis and development of relevant resources and structures – within schools and their environment is important for sustainable and effective health promotion (HP) implementation.

**Objectives:** This study analyses different forms of supporting structures for schools (like networks, quality criteria and awards for HPS, HP programmes and projects, organisation of teacher trainings regarding HP issues, etc.) and discusses their benefits and limitations.

**Underlying values and principles:** The need for capacity building within the environment of schools is stressed, concerning regional policy development, regional supporting structures, intersectoral collaboration and coordination for sustainable HP in schools.

**Knowledge base/ Evidence base:** This study builds on literature dealing with capacity building for HPS, and also considers governance and school governance literature.

**Context of intervention/project/work:** The context of this study is the school as one of the core settings for health promotion, as well as its environment as an important level for support and capacity building.

**Methods:** The data for this study consists of 12 qualitative expert interviews with actors in school boards and health agencies within 5 of the 9 provinces of Austria, and 11 interviews with school principals in these provinces. The interviews were analysed following a qualitative content analysis approach. Furthermore, an analysis of relevant documents from all provinces in Austria dealing with regional HP interventions and supporting structures has been carried out.

**Results and Conclusions:** All provinces in Austria have developed regional support systems for schools on their way to becoming health promoting, ranging from networks, certificates or awards, special HP programmes, and teacher training. While all of them have underlying assumptions of how schools can be best supported and represent examples of the contextual guidance necessary for school (health) development, none of them can cover all needs and demands of HPS. For example, networks help schools cooperate with each other, but have no reward system, while on the other hand quality seals appreciate a school's effort, but usually don't have resources to support schools in the process of implementation. We conclude that there is no "right" supporting structure, but that a diversity of capacity building measures is important for schools to choose from and meet their individual needs.

**Disclosure of Interest:** none declared

## **OP-MON-044 MAKING HEALTH PROMOTION IN SCHOOLS SUSTAINABLE BY EMPOWERING TEACHERS FIRST? RESULTS FROM A CASE STUDY IN AN AUSTRIAN PRIMARY SCHOOL**

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**Background:** The WHO concept of the Health Promoting School (HPS) – defined as a whole school approach with topics to work on and principles to fulfil - implies major changes in school life. However, evaluation studies show problems of diffusion and quality.

**Objectives:** Similar problems can be observed for the school effectiveness movement. In the related scientific discourse one conclusion is that the importance of teacher empowerment for successful reforms has been underestimated. This study tries to answer the question, if this is also true for the implementation process of the HPS concept.

**Underlying values and principles:** This study relates to the discussions on sustainability of the HPS and empowerment/participation of teachers.

**Knowledge base/ Evidence base:** Relating to empirical evidence coming from school-effectiveness and HP research this study also works with the theories of complex adaptive systems.

**Context of intervention/project/work:** The context of this work is health promotion in schools. It tries to contribute to the development of better implementation strategies.

**Methods:** This case study was carried out in a primary school in Vienna, Austria during the first year of implementation of the HPS-concept. Data come from interviews (principal, teachers, parents, students) and observations (HP-projects, faculty meetings, lessons). Analysis of data was twofold: Organisational structures of the school were identified by hermeneutical methods. Observations during HP-projects were analysed with Grounded Theory. By triangulation of methods and data, group interpretation, respondent validation during a workshop with school staff and a circular research process the quality of results was ensured.

**Results and Conclusions:** During the implementation process the HPS-concept has been changed by the school in various ways, but not always compliant with HPS principles. Three main reasons could be identified: (1) Due to missing resources the school adapted the HPS concept by reducing the number of topics to work on. (2) The lack of adequate structures and a missing culture of cooperation led to the decisions of teachers and principal to carry out projects that were not coordinated between different classes. (3) Therefore realised projects varied widely in terms of size and quality due to variations in resources and HP-knowledge between teachers. Only the projects in line with HP quality criteria led to interactional structures known to have a positive health impact. Based on these results it can be said that teachers influence the HPS implementation process the most. Therefore a conclusion of this study is that the implementation process should start with empowering teachers concerning health literacy. HP for teachers with a focus on team building could also lead to an improvement. Finally the question is raised, if a holistic approach to health promotion with many topics to work on is a realistic goal for schools that have a limited amount of resources available.

**Disclosure of Interest:** None declared

## OP-MON-045 ENGAGING MARGINALIZED WOMEN IN HEALTH POLICY DEVELOPMENT

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**Background:** Extensive research in Canada and abroad on the social determinants of health, demonstrates that factors outside the health care system impact population health, well-being and quality of life. This research will examine the outcomes of community engagement with marginalized women in low-income neighbourhoods in Ontario. I will examine how community engagement (a central feature of deliberative democracy) in policy-making processes should be designed using a combination of participatory research methods and conceptual frameworks, including feminist participatory action research, social justice, and theories of health inequalities. These methods and frameworks speak to the needs of groups in our society that are marginalized, by incorporating the voices and experiences of these individuals in research and policy.

**Objectives:** The following question will guide the discussion: 1) what are effective public participation techniques to involve marginalized women? 2) What are the ways to engage women in deliberative activities? 3) How do marginalized women understand policy, and the factors that contribute to their poor health? 4) What do marginalized women in low income neighbourhoods expect from public involvement experiences?

**Underlying values and principles:** Ideas and values toward citizen engagement in policy-making have been a major tent of health promotion. The 1986 Ottawa Charter definition on health promotion states: "Health promotion is the process of enabling people to increase control over and to improve their health." Community engagement can promote a positive sense of identity, empowerment, community well-being, and positive social change for women marginalized by race, ethnicity, or class, social capital, and healthy environments. The advancement of community engagement with marginalized women will elicit the values these women attribute to living a healthy life, and the ways in which they believe their well-being can be improved. Therefore, participation allows these women to be more involved in decision-making within an emerging decentralized health system in the province of Ontario.

**Knowledge base/ Evidence base:** This research will contribute to evidence regarding inequalities in health, the social determinants of health, and healthy public policy. This will be accomplished by identifying the structural and political barriers to community participation in policy, and increase knowledge translation in women's health research. Structural and political barriers to community engagement include how health is conceptualized or defined in western capitalist societies, existing gender inequalities which have disadvantaged some women, and the political environment in which health policy is formulated and implemented. These barriers combine to influence the extent to which marginalized women's voices are heard by policy makers.

**Context of intervention/project/work:** Disadvantaged women usually experience social and economic barriers to accessing health care, which impact their health. The experience of immigrant women on Canada have been transformed as a result of the difference in the social organization of the two societies. This change and their ability to cope in a new environment impacts their health and well-being.

**Methods:** Focus groups and individual interviews

**Results and Conclusions:** Study is underway, in preliminary stages.

**Disclosure of Interest:** none declared

## OP-MON-046 HEALTH AND GENDER INEQUITIES: CHALLENGES FOR PROMOTING THE HEALTH OF WOMEN LIVING IN POVERTY

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**Background:** In Brazil, HIV has significantly increased among poor women living with a stable sexual partner. For many years, people living in a stable relationship have been ignored by the prevention campaigns given that monogamy was considered a preventive strategy. Couples' most common strategy for HIV prevention is trust each other. In this context, to adopt an additional strategy, such as condom use, could mean the acknowledgement of infidelity.

**Objectives:** In this paper, we present a study about how gender and health inequity impact poor women's ability to exercise power and engage with health promotion strategies in Brazil.

**Underlying values and principles:** This study was based on the social critical paradigm and post-feminist theory.

**Knowledge base/ Evidence base:** Since 1988, date of the new constitution, Brazil has been trying to achieve universal access and equity in health care. In terms of HIV treatment, Brazil is an international reference for offering treatment for those infected by HIV. However, in terms of prevention, primary health care teams still lack preparation in addressing the diverse roles, cultural backgrounds and socio-economic positions of women in Brazilian society.

**Context of intervention/project/work:** This qualitative research was conducted with 100 women living in poor neighbourhoods in the outskirts of the city of Goiânia, state of Goiás.

**Methods:** The methodology employed was participatory action research and community members participated as co-investigators collecting data within their communities and setting the knowledge translation activities undertaken.

**Results and Conclusions:** Participants have described that if they request condoms in the community centers some professionals find the request unusual. In reality, health care professionals seldom refer to HIV prevention when serving women who are married or in a common law relationship. During the study, the participants too reinforced the notion of expected social roles for men and women, being infidelity more acceptable for males and trust in the partner expected from females. Social discourses tend to relate male sexuality with "biological needs" that could explain some cases of infidelity. For women, trust is a constitutive element of the relationship, but it is presented in varied degrees, from total trust to the absent trust, depending on the particular phase in the couple's relationship. For women living in poverty, the inability to adopt protective measure is explained by the economic dependence on the partner and the consequence that additional deprivation would have on children. To engage in condom use may lead into the suspicion of infidelity by either the man or the woman herself, which in turn may lead to violence in some cases. Health promotion in this case means, among others, access to education, income for women to be able to support the whole family, and training to health care professionals so that they can address the intersections of gender, class, culture and other social determinants of health. Similarly, health policy and programs should favor equity in access to sexual education, community groups that work in sexual health promotion and social marketing to increase awareness on gender equity as key to the health of the population.

**Disclosure of Interest:** None Declared

## **OP-MON-047 THE HOPE PROJECTS: ADDRESSING ECONOMIC AND SOCIAL DETERMINANTS OF HEALTH AMONG LOW INCOME, ETHNICALLY DIVERSE WOMEN IN RURAL NORTH CAROLINA**

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**Background:** The four HOPE Projects build on over 16 years of community based research projects with low income women in rural southern counties. Through a community-based participatory research process, we developed interventions to address women's health within the context of the economic and social circumstances of their lives: poverty, unemployment, racism and lack of access to resources. HOPE (Health, Opportunities, Partnerships, Empowerment) Works (2004-2009) was a successful obesity prevention intervention that drew upon development strategies including loan circles, microenterprise development, and American Indian talking circles. Community women led HOPE Circles of 8-12 women from their social networks which met for 6 months: women set goals and supported each other to make health and social/economic improvements. Threads of HOPE ([www.threadsofhopenc.org](http://www.threadsofhopenc.org)) is a spinoff small business that produces sustainable conference bags, and a non-profit to train low income women in business development. Seeds of HOPE (2009-2014) will disseminate the HOPE Works model through American Indian and African American churches that will have a stronger emphasis on microenterprise development and financial literacy. HOPE Accounts for Women (2009-2011) is funded by the American Recovery and Reinvestment Act; it assists low income women in saving money for starting a business or furthering education through a matched savings incentive.

**Objectives:** To develop, evaluate and disseminate innovative programs to address the economic and social determinants of health and obesity among low income, ethnically diverse women in rural North Carolina.

**Underlying values and principles:** Poverty is hazardous to women's health; unemployed, low income women suffer disproportionate levels of obesity and chronic diseases; women of color are more likely to be poor.

**Knowledge base/ Evidence base:** The conceptual model for the HOPE projects is drawn from the Community Guide for Linking the Social Environment to Health, developed by the CDC Task Force on Community Prevention Services. The model incorporates concepts from the socio-ecologic framework, goal systems theory, and hope theory. Important constructs include self-efficacy to make changes, ability to set and achieve goals, and social support.

**Context of intervention/project/work:** The HOPE projects take place in four rural counties in North Carolina that have suffered structural changes in the economy over the past 15 years, including the loss of tens of thousands of manufacturing jobs, decrease in tobacco production and increase in factory hog farms. Obesity and overweight affect between 70 and 75% of people; African American and American Indian women have the highest rates.

**Methods:** In HOPE Works, written surveys at baseline and 6-months assessed demographics, income, health, diet/PA behaviors, weight control, hope, mental health, and community involvement; weight was measured at each time point. Comparison women completed the same measurements, including wearing pedometers and keeping food diaries. Seeds of HOPE is a randomized control trial to disseminate HOPE Works through community based organizations. HOPE Accounts for Women is a randomized control trial that will compare economic and health changes among the intervention group and a comparison group.

**Results and Conclusions:** Data from the first 3 cohorts (159 Intervention, 118 Comparison) in the HOPE Works study show that 75% of women were African American and most were low income. Outcome analysis demonstrated that HOPE Circle participants lowered BMI more than the comparison group (.5 unit difference), with average weight loss difference of 4.6 pounds. Intervention women also increased 1.7 units in the hope scale. Physical activity and fruit and vegetable intake both increased significantly in intervention group. Seeds of HOPE and HOPE Accounts for women are studies that have the potential to advance research and intervention development to address economic and social determinants of health. The HOPE Projects, including the Threads of HOPE microenterprise, are the result of years of community based participatory research projects to address economic and social determinants of health.

**Disclosure of Interest:** none declared

## **OP-MON-048 MUJERES INDÍGENAS EN EL NOROESTE DE MÉXICO: TRABAJO AGRÍCOLA, SALUD Y PERCEPCIÓN DEL RIESGO.**

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**Antecedentes:** Un estudio preliminar mostró que los trabajadores agrícolas no perciben claramente los efectos de los pesticidas a largo plazo sobre la salud como son las enfermedades crónico-degenerativas y solo le dan importancia a aquellos efectos del tipo agudo.

**Objetivos:** Identificar la forma en que los saberes culturales y percepciones sobre el riesgo de exposición a agroquímicos impactan las prácticas de las mujeres indígenas migrantes que laboran en los campos agrícolas.

Identificar las condiciones laborales de las mujeres indígenas migrantes que laboran en los campos agrícolas.

Conocer los síntomas que refieren las mujeres indígenas migrantes que laboran en los campos agrícolas relacionados al trabajo.

**Valores y principios subyacentes:** Los principios subyacentes son la equidad de salud y mejores condiciones laborales en el contexto de mujeres indígenas migrantes jornaleras agrícolas.

**Base de conocimiento / base de evidencia:** Se manejó la percepción como un proceso cognitivo en el cual convergen creencias, actitudes y saberes bajo un marco cultural y de construcción social.

**Contexto de la intervención / proyecto / trabajo:** El estudio se desarrolló en un poblado conformado por familias principalmente indígenas de diversas etnias. En esta zona hay producción de tomates, fresas y hortalizas que en su mayoría son exportados a Estados Unidos.

**Métodos:** Se realizaron entrevistas semi-estructuradas, aplicadas a una muestra por criterio de 20 mujeres de diferentes edades y pertenecientes a diferentes grupos étnicos, todas jornaleras agrícolas, que dieron su consentimiento de participación. Se utilizó escalas de Likert. Se explicó a las participantes que el motivo de la investigación fue para reportar los hallazgos a los tomadores de decisiones de políticas de salud y trabajo.

**Resultados y Conclusiones:** El promedio de edad fue de 32 años con un promedio de 14 años trabajando. Los malestares relacionados con el trabajo son cansancio, dolor de cabeza, deshidratación, mareo y anemia. Refieren dolor en el cuerpo, especialmente de espalda, cintura, rodillas, pies y huesos; artritis y reumatismo.

Aunque no conocen los nombres técnicos de las sustancias, sí tienen una aproximación de la peligrosidad de éstas.

Se evidenció la situación de precariedad de las condiciones laborales y el impacto a la salud de las mujeres indígenas jornaleras que participaron en el estudio.

**Declaración de intereses:** "No declarado"

## OP-MON-049 PRESERVACIÓN DE LAS MEDICINAS NO HEGEMÓNICAS Y PROMOCIÓN DE UN MEDIO AMBIENTE SALUDABLE. EL PAPEL DE MUJERES LATINOAMERICANAS

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**Background:** América latina es una región altamente diferenciada desde el punto de vista demográfico, socioeconómico y cultural. La población latinoamericana es superior a los quinientos millones de habitantes y forman parte de la misma más de cuatrocientos grupos étnicos.

Tomando en consideración estas complejas circunstancias y las limitaciones de tiempo y presupuestales del presente proyecto, su realización en la región latinoamericana se circunscribió principalmente a obtener y analizar los datos sobre instituciones, organizaciones, redes y bibliografía en cuatro países representativos de diversas culturas de la región: México, Chile, Perú y Brasil.

**Objectives:** Identificar los principales actores sociales, asuntos y problemas de la región latinoamericana referidos al papel de las mujeres en la producción y conservación del patrimonio cultural intangible, específicamente la protección de los ecosistemas y las medicinas no hegemónicas.

**Underlying values and principles:** En el presente documento adoptamos la definición sobre patrimonio intangible de UNESCO cuando señala que es el conjunto de formas de cultura tradicional y popular o folklórica, es decir, las obras colectivas que emanan de una cultura y se basan en la tradición. Estas tradiciones se transmiten oralmente o mediante gestos y se modifican con el transcurso del tiempo a través de un proceso de recreación colectiva.

**Knowledge base/ Evidence base:** El papel de las mujeres, es decisivo en diversas áreas entre las que se encuentran la socialización de los hijos y la creación y recreación de conocimientos para la preservación de los ecosistemas.

**Context of intervention/project/work:** Centrarse solamente en los roles que desempeñan las mujeres invisibiliza el tema del poder, en otras palabras, cómo se regulan esos roles y la valoración social que tienen. Es decir, no se analizan suficientemente cuáles son los obstáculos que enfrentan las mujeres para participar activamente.

**Methods:** el patrimonio cultural intangible es efímero por naturaleza . Los “tesoros humanos vivos” y la recolección, archivo y grabación de este tipo de cultura son formas efectivas de lograr su protección. Aunque esta aproximación metodológica se reconoce como central, limitaciones señaladas presupuestales y de tiempo, y la extrema extensión y diversidad cultural de la región llevaron a que el presente estudio de factibilidad se basara fundamentalmente en la revisión de fuentes secundarias de información

- ♣ Bases de datos bibliográficas.
- ♣ Publicaciones periódicas secundarias
- ♣ Catálogos, índices, bibliografías.
- ♣ Bases de datos electrónicas sobre redes, proyectos, NGOs e instituciones gubernamentales y académicas.

**Results and Conclusions:** Los documentos y proyectos localizados sobre estos temas responden, en líneas generales, a dos enfoques. El primero de ellos destaca el papel de las mujeres como productoras y transmisoras de conocimientos sobre el uso de los recursos naturales, la medicina tradicional y la elaboración de artesanías pero no analiza ni cuestiona los factores de origen económico, social y cultural (entre los que se encuentra la falta de equidad entre los géneros) vinculados a los problemas principales que se presentan en cada una de estas áreas.

El segundo enfoque utiliza el concepto de género analizando no solo a las mujeres sino a las relaciones sociales que éstas establecen y al sistema de poder en el que están insertas. Esto permite identificar las diferencias existentes entre mujeres enfatizando el carácter sociohistórico y cultural de los procesos de subordinación y negociación en los que se encuentran insertas.

**References:**

**Disclosure of Interest:** "None declared"

## **OP-MON-050 PRIMARY CARE AND PUBLIC HEALTH COLLABORATION: STRENGTHENING HEALTH PROMOTION AND PREVENTION EFFORTS THROUGH INTERORGANIZATIONAL PARTNERSHIPS**

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**Background:** A primary health care (PHC) system is made of up different institutions, professional disciplines, technologies, and forms of practice. Primary care (PC) and public health (PH) are seen as two vital services in Canada's PHC system. PC provides; the first entry point into the health care system; person-focused, episodic care for all but unusual conditions; and coordination of care. PH services aim to promote, protect and improve the health of individuals, groups, or populations. Collaboration with PC and PH can allow us to take more effective action on prevention and health promotion in ways that are more effective than might be achieved alone.

**Objectives:** This study explored professionals' views about barriers and facilitators at the systemic, organizational and interpersonal level of PC and PH collaboration.

**Underlying values and principles:** It is believed that PHC systems can be strengthened by stronger collaborations between PC and PH, which can lead to more integrated systems, more effective health promotion and prevention interventions, and ultimately improved health outcomes.

**Knowledge base/ Evidence base:** Worldwide, health systems are struggling to determine the best ways for PC and PH to collaborate, "a process through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible."(1) Lasker, Weiss and Miller (2) present the notion of the connective power of collaboration, arguing that it can be used to strengthen and combine actions for communities to identify and address health issues.

**Context of intervention/project/work:** This research involved Canadian key informants from PC and PH including: policy-makers, managers, and providers from a broad range of disciplines.

**Methods:** A descriptive qualitative method was used; 70 in-depth interviews of key informant health professionals, having experience in or knowledge about PC and PH collaboration were completed. Informants were identified by the research team and advisory committee, and through a snowball technique. Interviews were audiotaped, transcribed and analysed using NVivo8.

**Results and Conclusions:** Successful collaboration between PC and PH flourishes with support from all levels. Having policies of collaboration bolstered by funding at regional, provincial, and federal levels provides mandates for providers to work across sectors. Leadership who shares common values, beliefs, and motivations towards mutual goals is more successful in creating sustainable collaborations. Providers who value activities carried out by professionals in the other sector initiate and foster collaborative relationships. Collaboration can be resource intensive, requiring more time in relationship building amongst individual providers and agencies, funding, and health human resources. A PC and PH collaboration coordinator may help. PC and PH collaboration has implications for deployment of health human resources, training of new providers, and aligning funding with policy. More work is needed to examine outcomes of successful collaboration.

**References:** (1) CIHR - Institute of Population and Public Health. The Future of Public Health in Canada: Developing a Public Health System for the 21st Century, June 2003. 1-58. 2003. 5-27-0008. (2) Lasker RD, Weiss E.S., Miller R. Promoting Collaborations that Improve Health. *Education for Health* 2001;14:163-72.

**Disclosure of Interest:** None Declared

## OP-MON-051 PARTNERSHIP BETWEEN VILLAGE HEALTH COMMITTEES AND THE GOVERNMENTAL HEALTH SYSTEM IN KYRGYZSTAN

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**Background:** The governmental health system of Kyrgyzstan is engaged in a unique partnership with communities in rural areas. The program is called Community Action for Health (CAH) and has been developed since 2001 with financial support by SDC, Sida and USAID. The Swiss Red Cross is providing technical support.

**Objectives:** CAH has the objectives (1) to enable rural communities to act on their own for improvement of health in their villages, and (2) to enable the governmental health system to work in partnership with village communities for improving health.

**Underlying values and principles:** CAH is grounded in the Ottawa Charter's calls for strengthening community actions through community empowerment and for reorienting health systems towards health promotion.

**Knowledge base/ Evidence base:** CAH draws on principles of community capacity building, Participatory Reflection and Action (PRA), Community-Based Participatory Research, and Salutogenesis.

**Context of intervention/project/work:** Two-thirds of the Kyrgyz population live in rural areas. The program aims at reaching all villages of the country.

**Methods:** At the core of CAH is a collaboration of Village Health Committees (VHCs) with governmental Health Promotion Specialists and Primary Health Care workers. Communities analyse their health priorities and elect members of their VHCs. Government health staff work with VHCs in two areas. They (1) build their organizational capacity to become independent civil society organizations engaged in addressing determinants of health in their villages, and (2) they train them to implement centrally designed health actions on their prioritised health issues, such as promotion of iodised salt, good nutrition, curbing of alcohol abuse, hypertension control and others. VHCs work without any remuneration.

**Results and Conclusions:** CAH has become part of the Kyrgyz health reform program. It covers presently about 1400 villages (85% of the country) and is being extended further. The efforts of VHCs have contributed greatly to the decrease in goiter prevalence among school students, to the increase of exclusive breastfeeding to over 90% and to decreased alcohol consumption, among others. The organizational capacity building has led to many own initiatives related to tackling determinants of health and to the formation of health committee federations on rayon (district) level, which are registered as NGOs. They reach out to other resources for community development. A national federation of VHCs is currently being formed. The Republican Centre for Health Promotion under the Ministry of Health (MoH) is the partner of the VHCs at national level. The MoH is committing increasing resources to CAH to make it sustainable.

**Conclusions:** (1) To build up village organisations for community empowerment and to engage such organisations in centrally planned health actions is mutually fruitful for both of these activities (2) it is possible for the governmental health system of Kyrgyzstan to engage in community capacity building, and (3) the governmental health system recognises the value of such a program and shifts resources to support its extension and sustainability.

**Disclosure of Interest:** None declared

## **OP-MON-052 PUBLIC PRIVATE PARTNERSHIP IN HEALTH IN INDIA: CASE STUDY ON MANAGING PRIMARY HEALTH CENTRES WITH HELP FROM PRIVATE SECTOR.**

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**Background:** Public Private Partnership (PPP) in the health sector is seen as an instrument by governments to improve efficiency, reliability and availability of services in health system. PPP is undertaken to improve access of services to the poor and socially vulnerable sections of the population especially in the remote and underserved areas. One such initiative in India which has been prominent since the eighties is the management of Primary Health Centres (PHCs) through PPP with the help of the private sector like private medical colleges and non governmental organization etc.

**Objectives:** The objective of the study was to look into the feasibility of giving two tribal PHCs to be managed by NGO through PPP in Adilabad district, in the state of Andhra Pradesh in India.

**Underlying values and principles:** A major challenge facing developing country policy-makers (including India) is adequate provision of affordable, accessible and good quality health care to their populations, particularly the poor - leading to using private services of mixed quality, typically paid for out of pocket. Although there are now new policy initiatives like National Rural Health Mission there is need for innovative health financing mechanisms, which can enhance pro-poor health systems.

**Knowledge base/ Evidence base:** Numerous countries of the world and even states in India like Orissa, Arunachal Pradesh, Gujarat, Karnataka, Himachal Pradesh etc have allowed the Primary Health Centres to be managed by Public Private Partnership. such initiatives in their states. There have been different models of managing PHCs in India in different states in India.

**Context of intervention/project/work:** India still struggles to see that primary health care is given importance. The problems of lack of manpower, infrastructure in the villages in India are a major concern. This is especially true in the case of marginal communities like the tribal population. Around 92 PHCs in India are for the Tribal population and the health status of these population have been far from satisfactory. In 2008, the Government of Andhra Pradesh considered giving two tribal PHCs to be managed by a Non Governmental Organization through PPP to improve their health status.

**Methods:** A review of the existing models of managing PHCs through PPP was done initially to derive the most suitable model for Andhra Pradesh. Once the model was arrived, it was discussed at the district level with various stakeholders like District Collector, District Medical and Health officer, People's representatives, Medical officers etc in a workshop to get their views on the model. Based on the suggestions from the workshop an NGO was selected which had experience in other states in managing PHCs.

**Results and Conclusions:** The study provided numerous insights into the various models of PPP in managing PHCs in India. There were various issues like retaining/transferring of staff, percentage of government contribution for the PPP, performance indicators for the monitoring of the PHCs. Based on the suggestions from the workshop conducted, the government of Andhra Pradesh selected an NGO which had experience in other states in managing PHCs through PPP and handed over two Tribal PHCs. The study tries to establish the importance of PPP in delivering health care services to the poor. Along with the Government sector, the private and Non-profit sectors are also very much accountable to overall health systems and services of the country and such partnerships could be a tool for augmenting the public health system.

**Disclosure of Interest:** The study was undertaken as a Strategic and Performance Unit Consultant to the Health department, Government of Andhra Pradesh, India.

## OP-MON-053 CAN QUALITY IMPROVEMENT APPROACHES BE APPLIED TO HEALTH PROMOTION IN AUSTRALIAN INDIGENOUS PRIMARY HEALTH CARE SETTINGS?

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**Background:** The focus of performance measurement and quality improvement initiatives in the Australian primary health care context have been largely directed at clinical service delivery, with relatively little attention paid to health promotion.

**Objectives:** The aim of this research is to investigate a systematic approach for improving the quality of health promotion. It involves the development and implementation quality improvement tools and processes in four Northern Territory government and Aboriginal community controlled primary health care services.

**Underlying values and principles:** Our research approach and activities draw on key principles relating to values and ethics in Indigenous health research and action learning principles of participation, collaboration and reflection

**Knowledge base/ Evidence base:** There has not been a systematic approach to planning and monitoring health promotion practice and there is wide variation in workforce capacity for effective practice. This failure to use evidence in practice together with a lack of supportive health centre systems has contributed to the variable success of many Indigenous health promotion programs and consequent lack of impact on health

**Context of intervention/project/work:** Australian Indigenous primary health care centres provide a range of primary health care services to a predominately Indigenous population. The health centres are staffed by multidisciplinary teams (5 to >50 staff) including nurses, Aboriginal Health Workers, doctors and allied health staff. Staffing profiles differ according to the location and size of communities

**Methods:** We have collected data on the scope and quality of health promotion practice and on strengths and weaknesses of health centre systems support for health promotion practice. We have used these descriptive data for before-after analyses. Findings were presented to all staff during a workshop where they were given the opportunity to:

- discuss current system development and patterns of health promotion practice;
- define priorities for improvement; and
- identify goals and strategies relevant to their development priorities.

Interviews with key informants and field notes were used to gain understanding of the feasibility and potential applicability of the CQI intervention more broadly

**Results and Conclusions:** We have seen improvements in systems for documentation and adherence to best practice including community participation and partnerships. Staff report on the educative nature of the process and on the value of the tools as guides for best practice health promotion.

There is early indication that the application of quality improvement tools and processes has supported a systematic assessment on the quality of health promotion and the state of system development in the Australian Indigenous primary health care context, with the potential for more widely generalisable learning.

**Disclosure of Interest:** none declared

## **OP-MON-054 THE IMPLEMENTATION OF HEALTH PROMOTION INTO PRIMARY HEALTH CARE IN AOTEAROA NEW ZEALAND – THE EXPERIENCE AND OUTCOMES DELIVERED BY ONE LARGE PRIMARY CARE PROVIDER IN THE AUCKLAND REGION.**

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**Background:** The New Zealand Primary Health Care Strategy in 2001 saw the formation of Primary Health Organisations (PHOs) and the introduction of health promotion funding to the primary health care sector. The establishment of effective evidenced based health promotion programs within mainstream primary care providers has led to improved access to primary care for some of our most vulnerable populations.

**Objectives:** 1. Expand the primary health care services to include a health promotion perspective and a population health approach. 2. Implement the Health Promoting Practices (HPP) Quality Framework utilising the HPP Tool Kit. 3. Build community capacity, and improve and protect community health and well being of Maori, and reduce health inequalities. (Example programme).

**Underlying values and principles:** The Treaty of Waitangi and values and principles related to the relationship between indigenous Maori and the Government. Medical model and values vs Health Promotion and public health models and values. Reducing inequalities in health.

**Knowledge base/ Evidence base:** ProCare Health has established the capacity and capability to undertake evidence based health promotions programs. This presentation will cover the key processes and structures that ProCare has employed to ensure these programs benefit the populations most in need. Evidence utilised includes: The Ottawa Charter (World Health Organisation 1986), Nutbeam's evaluation framework, Te Pae Mahutonga is a Maori model of health promotion, the Treaty of Waitangi, Laverack's community capacity building domains, Duigan et al's Community Project Indicators Framework are utilised.

**Context of intervention/project/work:** ProCare Health is a Management Services Organisation for three large PHOs in the Auckland Region which serve an enrolled population of 700,000 of whom 60,000 are Maori (the indigenous people of Aotearoa New Zealand) and 75,000 are of Pacific ethnicities.

The policy context is that of the New Zealand Primary Health Care Strategy which has seen the formation of 81 Primary Health Organisations (PHOs) and the introduction of health promotion funding to the primary health care sector.

**Methods:** ProCare set up structures in order to ensure organisation change and a shift in thinking towards prevention, community capacity building, and community participation in primary health care. Other health promotion concepts such as the social determinants of health and the requirement for cross sectoral work have begun to be introduced. The implementation of the Health Promoting Practices (HPP) Quality Framework in family practices has worked towards reorienting the health services.

A health promotion program based on a partnership between the PHO and one mana whenua group (indigenous) in the Auckland region will be presented. The programme utilises community development models to work towards reducing inequalities in health outcomes. Grass roots workers (kaiwhakahaere) are employed and trained to deliver health promotion programmes to their own communities and marae settings. The key findings of the independent Maori evaluation will be discussed. NB: Permission has been gained the Chief Executive Officer of Huakina Development Trust - Tainui. This Trust has developed the programmes in partnership with ProCare Health.

**Results and Conclusions:** A significant shift towards prevention and addressing the social determinants of health within both the MSO and primary health care providers has occurred. Improved access to primary health care for specific populations (including indigenous) in order to address inequalities in health has occurred. Community capacity building indicators have been achieved.

**References:** Duigan et al (2003) "Community Project Indicators Framework – It's use in community projects." Ministry of Health New Zealand. Durie, M. (1999). "Te Pae Mahutonga: a model for Maori health promotion." Health Promotion Forum of New Zealand Newsletter 49(December): 2-5. Nutbeam, D. (1998). "Evaluating health promotion - progress, problems and solutions." Health Promotion International 13(1): 27-44. Laverack, G. and R. Labonte (2000). "A planning framework for community empowerment goals within health promotion." Health Policy Plan. 15(3): 255-262.

**Disclosure of Interest:** None declared

## OP-MON-055 DEVELOPING HEALTH INFORMATION LABELS FOR ALCOHOL PRODUCTS: WHERE SHOULD WE START?

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**Background:** Health information labels on alcohol products, while not currently required in Australia, have a high level of public support and are considered an important component of a comprehensive public health strategy to prevent alcohol related harm. However, to date there has been little research on consumers' views of alcohol health information labels to guide their implementation.

**Objectives:** To undertake a quantitative and qualitative study of consumers views of alcohol information labels to determine the content and style of labels that would most likely to have an impact on consumers' awareness, attitudes and behaviour in relation to alcohol consumption.

**Underlying values and principles:** Consumers have a right to accurate information about the health risks associated with alcohol consumption to enable them to make informed choices. While the provision of health information to alcohol consumers via product labelling is not likely, on its own, to prevent the alcohol related harm it can form an integral part of a comprehensive approach to preventing such harm.

**Knowledge base/ Evidence base:** Evaluations of alcohol information labels are mostly limited to the US experience, where small, text-style labels were implemented in 1989. To date, there is no evidence that such health information labels influence drinking behaviour, but there is some evidence of effects on the knowledge and attitudes of drinkers in relation to consuming alcohol.

**Context of intervention/project/work:** Currently, Australian regulations require alcohol product labels to display only alcohol content (as a percentage of the total beverage volume) and the number of standard drinks in the product. There are no requirements to provide: ingredients; nutritional information; guidelines for low risk consumption; or, information about the health risks of alcohol consumption. However, the Australian Government is currently considering a recommendation from an expert taskforce on preventative health to introduce mandatory health information labels on all alcohol products. Additionally, revised guidelines on low risk drinking for Australians have recently been developed which recommend a limit of two standard drinks (10g ethanol) per day for male and female adults.

**Methods:** The research consisted of two studies: (1) A telephone survey of 1,500 Australians residing within the State of Victoria regarding their opinions of alcohol information labels; (2) a qualitative study involving a series of group discussions with a cross section of drinkers (underage drinkers aged 16-17 years; young adult drinkers aged 18-25 years; and, parents of 15-18 year olds). For the qualitative study, 12 different alcohol health information labels were developed and presented to the discussion groups to obtain their views.

**Results and Conclusions:** The quantitative study found high levels of public support for the introduction of alcohol information labels in Australia. The qualitative study identified the key features of labels which consumers support. These include: simple, clear and direct language; new information/evidence about the health effects of alcohol; a factual and serious tone, rather than humorous; and, a semblance of current or recent televised public education campaigns relating to alcohol and health. The results have implications for how alcohol information labels should be developed and implemented over time.

**Disclosure of Interest:** None declared

## **OP-MON-056 THE NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM RENEWAL PROCESS: HONOURING INDIGENOUS AND MAINSTREAM KNOWLEDGE IN THE RENEWAL OF A NATIONAL ADDICTION PREVENTION AND TREATMENT PROGRAM**

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**Background:** Substance use problems have consistently been identified as priority concern by First Nations communities and leadership in Canada. Canada's primary program to respond to these needs is the National Native Alcohol and Drug Abuse Program (NNADAP). NNADAP is national network of 54 residential treatment centres and more than 500 community-based addiction prevention programs, which are largely controlled and operated by First Nations. NNADAP Renewal process is review of this program that was developed as a result of a partnership between the Assembly of First Nations, the National Native Addictions Partnership Foundation and the Government of Canada.

**Objectives:** To carry out a multi-phased policy development and program revitalization initiative for NNADAP, which is inclusive of both mainstream and Indigenous Knowledge.

**Underlying values and principles:** • Integrity: efforts will be morally sound within the context of an Indigenous World View

- Respect: value for traditional Indigenous knowledge and western knowledge as relevant and appropriate evidence

- Collaboration: consultation and communication with First Nations, at all stages, so as to facilitate collaborative implementation of the renewed NNADAP system

- Choice: nurture choice towards a renewed NNADAP system that honours inherent strengths while identifying the best available evidence.

**Knowledge base/ Evidence base:** This process includes a variety of knowledge sources, including literature reviews, document reviews, expert feedback, needs assessments, and research papers. Activities seek to identify the most effective blend of Indigenous and western knowledge to inform renewal efforts.

**Context of intervention/project/work:** Indigenous cultural meaning is absent from the theoretical foundations that inform addictions and mental health practice. As such, it is recognized within renewal efforts that western world views, perspectives and assumptions have reinforced dominant cultural values and perspectives. While western theoretical frameworks are not without value for Indigenous peoples, this process is designed to ensure that the use of western based approaches is done with cultural competence and is culturally safe. To that end, this initiative seeks to negotiate and create space for translating cultural meaning in addictions services, with an appreciation of Indigenous Knowledge as credible evidence.

**Methods:** Process activities include needs assessments, a national expert's (cultural, research, and service) panel, a national forum with key stakeholders and a series of research papers, which will inform strategic planning efforts for NNADAP. Activities will engage First Nations communities, representative organizations and experts to develop and refine renewal priorities.

**Results and Conclusions:** This presentation will explore the role of Indigenous Culture within NNADAP from a structural, process and outcome perspective, and outline some of the key concepts that set the foundation for establishing the cultural evidence base for cultural practice within addictions services.

**Disclosure of Interest:** None declared

## **OP-MON-058 ON NE DEMANDE PAS LA LUNE. DIALOGUE AVEC DES FEMMES TRAVAILLEUSES DU SEXE DE RUE QUI S'INJECTENT DES DROGUES**

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**Historique / Origines:** Suite à un projet de renforcement des capacités avec des personnes utilisatrices de drogues injectables, un constat s'était imposé : les femmes travailleuses du sexe de rue (TSR-UDI) avaient été peu rejointes malgré leurs besoins anticipés. Sur la base d'un solide partenariat université-communauté, et après consultation auprès de femmes vivant ces situations de précarité, un projet visant la promotion de la santé et la prévention du VIH sur une base d'empowerment a vu le jour.

**Objectifs:** Identifier et comprendre avec des femmes TSR-UDI leurs besoins en matière de promotion de la santé et prévention du VIH puis examiner d'éventuelles avenues de solutions.

**Valeurs et principes sous-jacents:** Construction des capacités, empowerment, collaboration, co-construction des savoirs, équité.

**Fondement de connaissance/Fondement de preuve:** Le projet Lune prend ses assises sur d'autres projets antérieurs menés avec des personnes UDI. Il procède également de groupes de discussion menées avec des femmes TSR-UDI. Il adopte les principes de la recherche action où l'accent est mis sur la participation active des personnes affectées, dans la recherche du problème, en vertu d'une étude à travers un processus cyclique des faits, de l'action et de la réflexion qui mène à une plus grande recherche et une action pour la transformation. Il se réfère aussi à la recherche participative conçue comme un processus de développement de connaissances au travers duquel des citoyens ordinaires, mais tout particulièrement les plus démunis, peuvent produire des savoirs leur permettant de mieux cerner le monde les entourant en vue de promouvoir et défendre leur intérêts.

**Contexte d'intervention/projet/travail:** Le projet LUNE (nom donné par les participantes au projet qui signifie libres, unies, nuancées, ensemble) est une recherche-action participative ancrée dans la communauté. Elle se déroule en étroite collaboration avec des femmes TSR-UDI. Dans sa phase initiale, il s'est agi de collaborer avec les femmes afin qu'elles identifient leurs besoins, envisagent des solutions et construisent leurs capacités pour améliorer leurs conditions de vie et celles de leurs paires.

**Méthodes:** Dix-neuf entrevues semi dirigées ont été réalisées avec des femmes TSR-UDI. Leurs analyses ont permis d'identifier leurs besoins collectifs. Un groupe de travail composé de six femmes, une travailleuse de milieu et une universitaire s'est rencontré pendant trois mois. La méthode utilisée pour approfondir les besoins et cibler des objectifs collectifs a permis d'identifier la nature des problèmes rencontrés, leurs causes, conséquences, les solutions possibles et celles qui devraient être développées en termes de faisabilité.

**Résultats et Conclusions:** Sept besoins ont été identifiés dont deux en termes de lieux physiques (un endroit pour dormir en paix et en sécurité ou pour socialiser entre femmes vivant la même situation), trois en lien avec des accès à des biens ou services (accès rapide à des aliments sains et nutritifs, à des dispositifs pour l'hygiène corporelle, à des services médicaux à bas-seuil) et deux en termes de protection (protection contre la violence physique et les ITSS). Ce processus a permis aux femmes de reconnaître leurs besoins, en faire la priorisation, se donner des objectifs de travail concrets puis d'identifier des moyens d'améliorer leur situation de vie et celles de leurs paires.

**Conflit d'Intérêt:** Rien à déclarer

## OP-MON-059 THE RELATIONSHIP OF HOPE TO DRINKING, SMOKING, EXERCISE, AND FAT INTAKE AMONG COLLEGE STUDENTS

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**Background:** Hope is defined as the ability to set challenging goals and exercise the appropriate agency (i.e., motivation and self-efficacy) and pathways (i.e., strategic thinking) in order to reach goals. High hope has been shown to be related to promoting and maintaining good health and preventing, detecting, and treating illness.

**Objectives:** This study examines the relationship of hope to health behaviors, specifically alcohol use, binge drinking, smoking, physical activity, and diet (i.e., limiting fat) among college students.

**Underlying values and principles:** Examining psychosocial factors influencing health behaviors among young adults should help identify intervention targets.

**Knowledge base/ Evidence base:** Hope is related to promoting and maintaining good health as well as preventing and treating illness (Irving, Snyder, & Crowson, 1998; Snyder, 1996, 1998; Snyder, Irving, & Anderson, 1991).

**Context of intervention/project/work:** The current work was conducted among a broad range of college students in the Midwest U.S.

**Methods:** We contacted 8,834 undergraduate students at a two-year college and a four-year university in October, 2008, with 2,700 completing the 108-item online survey (30.6% response rate). Our current analyses focused on the 2,265 undergraduate students aged 18-25.

**Results and Conclusions:** Higher hope was related to being older ( $r=0.05$ ,  $p=0.03$ ), being female ( $39.05\pm 5.91$  vs.  $38.44\pm 6.26$ ,  $p=0.02$ ), and being non-Hispanic White ( $39.01\pm 5.88$  vs.  $37.61\pm 6.86$ ,  $p<0.001$ ), but not to highest parental education. After controlling for age, gender, ethnicity, and highest parental education, higher hope was related to fewer days in the past 30 days for drinking any alcohol ( $F(5, 2229)=30.70$ ,  $p=0.004$ ), fewer days drinking five or more drinks on one occasion ( $F(5, 2227)=30.59$ ,  $p<0.001$ ), fewer days of smoking (even a puff;  $F(5, 2228)=7.58$ ,  $p=0.003$ ), more days engaging in at least 20 minutes of physical activity ( $F(5, 2232)=21.54$ ,  $p<0.001$ ), and more days limiting dietary fat ( $F(5, 2227)=23.15.70$ ,  $p<0.001$ ). Furthermore, hope was related to greater confidence and motivation to engage in healthy behaviors (limiting drinking, quitting smoking, limiting dietary fat, and exercising). Given that hope is an important factor related to engaging in healthy behaviors, using hope as a framework for intervening may be effective in improving health risk profiles of college students.

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**Disclosure of Interest:** None declared

## OP-MON-060 TRANSFERENCE OF LOCAL HEALTH PROMOTION RESPONSIBILITIES? – A STUDY ON MUNICIPAL GOVERNING OF HEALTH ACTIONS IN LOCAL SPORTS CLUBS

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**Background:** The local sports clubs in Sweden receive substantial economical support from the municipalities for the amount of participants that take part in their child and youth activities. The support is regulated in most municipalities (286 of 290) by the use of guidelines for economical support to child and youth activities in the sports clubs. In 89 of these municipalities the guidelines contain requirements on the sports clubs to carry out prevention of substance use.

**Objectives:** To present results from a study of how the municipalities monitor the sports clubs fulfilment of the requirements on prevention of illicit drugs, tobacco, alcohol and/or doping imbedded in the guidelines for economical support and how municipalities use these requirements in governing prevention of substance use in sports clubs.

**Underlying values and principles:** Since Ottawa Charter policy actions have had an important role in health promotion action. The study focuses on the municipalities' administrative governing actions through policy as a health promotion strategy and the sports clubs as a setting for health promotion.

**Knowledge base/ Evidence base:** The study was based on results from a national study that compared the 2007 municipal guidelines for economic support with the guidelines from 2003.

**Context of intervention/project/work:** The sports movement in Sweden involves more than a third of the total population and half of all children and youth, which makes it a viable and attractive setting for health promoting actions. Some of the municipal administrations in Sweden have recognised the possibilities of the setting and tries to influence the sports clubs through the use of regulation in the policy on economical support.

**Methods:** In the autumn of 2009 a questionnaire was mailed to the 89 municipalities that included requirements on prevention of illicit drugs, tobacco, alcohol and/or doping in their guidelines for economical support (response rate: 89 percent (n=70)). The questionnaire focused on municipal governing and monitoring of the requirements and contained both structured and open questions. Analysis of the structured questions was performed in SPSS 16.0 and included both municipal variables (type of municipality, county, political majority and power of taxes) and variables focusing on the contents of the guidelines (type of requirements and concepts: alcohol, tobacco, illicit drugs and doping), which had been identified in the previous study. The open questions were analysed through qualitative content analysis.

**Results and Conclusions:** Preliminary results show that 52 municipalities monitored the sports clubs fulfilment of the guidelines for economical support and in 38 municipalities specific routines were used. Information regarding the monitoring was in most cases communicated through yearly dialogue with the sports clubs. In more than half of the municipalities (n=35) actions to reduce or in other ways influence the distribution of the support had never been taken. The responses to the open questions were detailed and analysis is ongoing. The results will be presented at the conference.

**Disclosure of Interest:** None declared

## OP-MON-061 CYCLING CONNECTING COMMUNITIES - EVALUATION OF A CYCLING PROGRAM TO PROMOTE SUSTAINABLE PHYSICAL ACTIVITY

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**Background:** Encouraging cycling is a sustainable way to increase physical activity in the community. Cycling levels are low in Sydney, suggesting considerable potential for improvement.

**Objectives:** The Cycling Connecting Communities (CCC) Project sought to evaluate a health promotion program designed to increase levels of cycling and encourage the use of off-road cycle paths through south west Sydney.

**Underlying values and principles:** Cycling is considered an equitable and sustainable form of physical activity and transport.

**Knowledge base/ Evidence base:** The intervention included a range of community engagement and social marketing activities, such as organised bike rides and events, cycling skills courses, the distribution of cycling maps of the area and coverage in the local press. All of these strategies have been shown to increase levels of cycling in previous studies.

**Context of intervention/project/work:** An advisory committee of key stakeholders and community representatives advised on project strategies. The Health Promotion Service managed the implementation of community strategies.

**Methods:** The evaluation used a quasi-experimental design that consisted of a pre and post-intervention telephone survey (24 months apart) of a cohort of residents (n=909) in the intervention area (Fairfield and Liverpool) and a socio-demographically similar comparison area (Bankstown). Both areas had similar bicycle infrastructure. Four bicycle counters were placed on the main bicycle paths in the intervention and comparison area to monitor daily bicycle use.

**Results and Conclusions:** The telephone survey results showed significantly greater awareness of the Cycling Connecting Communities project (13.5%) in the intervention area, with significantly higher rates of cycling in the intervention area (32.9%) compared with the comparison area (9.7%) amongst those aware of the project. There was a significant increase in use of bicycle paths in the intervention area (28.3% versus 16.2%). These findings were confirmed by the bike count data. There was a significant increase in cycling among novices/beginners in the intervention area.

Despite relatively modest resources, the Cycling Connecting Communities project achieved sustainable increases in bicycle path use, and increased cycling in some sub-groups. However, social marketing alone will not increase population cycling levels, and there are constraints around and limits to what infrastructure can deliver.

**Disclosure of Interest:** None declared

## **OP-MON-062 LES EFFETS DE LA CONCERTATION SUR LA PRISE EN COMPTE D'ENJEUX DE SANTÉ PUBLIQUE : LE CAS DU PREMIER PLAN STRATÉGIQUE DE DÉVELOPPEMENT DURABLE DE LA COLLECTIVITÉ MONTRÉALAISE**

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**Contexte:** La Ville de Montréal a adopté en avril 2005, en collaboration avec un ensemble d'organismes partenaires issus de divers secteurs d'activité, le Premier plan stratégique de développement durable de la collectivité montréalaise (Plan). Alors que ce Plan couvre la période de 2005 à 2009, un deuxième pour la période de 2010 à 2015 est en cours d'élaboration. À ce jour, près de 180 organismes sont engagés à titre de partenaires du Plan. Il participent aussi bien à son élaboration qu'à sa mise en œuvre, ce qui constitue un des éléments singuliers de la démarche.

**Objectifs:** L'objectif de la présentation est de démontrer que, tout au long de l'élaboration de ces deux plans, la démarche de concertation mise de l'avant a permis, voire stimulé, l'émergence d'enjeux et de mesures n'ayant pas été prévus à l'origine. C'est notamment le cas des enjeux de santé publique.

**Valeurs et principes sous-jacents:** Le principe de concertation multi-acteur, au cœur de la démarche, a favorisé les délibérations entre les organismes associés au Plan. L'association entre la Ville de Montréal et la Direction de santé publique de Montréal a été particulièrement fructueuse. De cette collaboration ont émergé des éléments, au départ inattendus, qui sont présentés ci-après.

**Fondement de connaissance/Fondement de preuve:** Cette approche renvoie à la perspective selon laquelle « la gestion de l'environnement prend aujourd'hui de plus en plus la forme d'une action concertée reposant sur l'interaction et la délibération entre les acteurs ». (Lepage et al., 2003 ; Salles, 2003 in Gauthier, 2006)

**Contexte d'intervention/projet/travail:** Des enjeux de santé publique et les actions spécifiques qui en découlent ont été intégrés au Plan, dont les îlots de chaleur urbains, les mesures de modération de la circulation ou l'agriculture urbaine. Ces actions permettent de s'attaquer à des problématiques importantes de santé, telles les maladies cardio-respiratoires, les traumatismes routiers ou l'insécurité alimentaire, en agissant sur l'environnement bâti.

De plus, la collaboration entre les deux organisations a donné naissance à un programme innovateur; Quartiers 21. Il vise à mettre en œuvre les orientations prioritaires du Plan et à expérimenter des pratiques novatrices en développement durable à l'échelle d'un quartier ou d'un voisinage, en misant sur la prise en charge citoyenne et la mobilisation de divers secteurs de la société.

**Méthodes:** Diverses instances de concertation ont été mises en place par la Ville de Montréal pour arriver à échauffer un Plan qui soit partagé par un ensemble de partenaires, dont des groupes d'orientations, des comités de travail ou des outils de sondage.

**Résultats et Conclusions:** La présentation montrera comment la concertation, à différents niveaux et sur plusieurs objets, peut permettre l'émergence et la prise en compte d'enjeux communs à la santé publique et à l'aménagement urbain, dans le cadre d'un exercice de planification municipale.

**Références:** Gauthier, Mario. 2006. « Débat public et gestion de l'environnement : bilan de l'expérience québécoise de médiation environnementale ». In « Le débat public en apprentissage : Aménagement et environnement ». Sous la direction de L. Simard, L. Lepage, J.-M. Fourniau, M. Gariépy et M. Gauthier. L'Harmattan, Villes et entreprises, pp. 171-183.

**Conflit d'Intérêt:** Rien à déclarer

## OP-MON-063 INDICATORS OF THE HEALTH PROMOTION TARGETS

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**Background:** The theory of health promotion is characterized by many different views of what is an appropriate outcome measure of any health promotion intervention, and therefore what will be an appropriate performance indicators.

**Objectives:** The aim of the current presentation is to analyze the conceptual and practical issues emerged during the health promotion measurement indicators development process.

**Underlying values and principles:** Based on definition of health promotion, concept of empowerment, and principles of inclusion, inter-sectorality, and participation, the large ring of different sectors and stakeholders were involved.

**Knowledge base/ Evidence base:** There are many complex conceptual and practical problems which influence the choice of performance indicators.

**Context of intervention/project/work:** Usually cities development assessment plans do not fully consider health promotion activities and objectives. To fill this gap and to support the evaluation of health promotion targets identified in City Health Policy document, the indicators development process was initiated and indicators package elaboration guided by the Tallinn City Social Welfare and Health Care Department and Health Coalition.

**Methods:** A working group was established which focused to four tasks. First, consensus in theory was needed before any consensus on what is most suitable to measure, is reached. Second, the review of relevant literature and assessment of the feasibility, problems and possible uses of health promotion performance indicators was conducted. Third, a compilation of existing sources of national and local health and its determinants surveys, and statistics, to assess the extent and comparability of information collected from different sources, was conducted. Fourth, the wide discussions among stakeholders from different sectors was initiated.

**Results and Conclusions:** After reviewing the strengths and weaknesses of those health promotion models currently proposed for indicator development, a health development model was agreed, as a common frame of reference, and a rational basis for the selection, organization and interpretation of health promotion indicators. Eleven domains of indicators were identified within three groups – outcome, impact and process indicators.

Health promotion theory-, policy and practice- and data-driven discussions resulted agreed set of indicators, and furthermore, it enriched the common understanding of health promotion indicators measurement among stakeholders in city setting. Nevertheless, the open discussions demonstrated the differing view about the understanding of health promotion essence and scarce knowledge at the inter-sectoral level about measurement indicators and also modest sense of responsibility to identify these and meet the targets.

**Disclosure of Interest:** None declared

## **OP-MON-064 STRENGTHENING LOCAL GOVERNANCE TO IMPROVE EARLY CHILD DEVELOPMENT AT SIX MUNICIPALITIES IN BRAZIL: THE EXPERIENCE OF A DONOR**

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**Background:** In Brazil in 1991 became public law the Statute for Childhood in Brazil. However, the age group zero to three was neglected in those laws till recently when the municipalities became responsible for the delivery of services to protect those rights. But, the municipalities are not prepared to do so.

**Objectives:** 1) Contribute to generate comprehensive and effective care during pregnancy, birth, postnatal and child care to 3 years by health, educational and human services; 2) Train and educate community leaders, professionals, families and caregivers to the importance of emotional bond during those critical period of children lives; 3) Foster local governance to build effective public policies that make sustainable the quality care for ECD

**Underlying values and principles:** Maria Cecilia Souto Vidigal Foundation is a family foundation ([www.fmcsv.org.br](http://www.fmcsv.org.br)) that established as a mission "to generate and disseminated knowledge for early childhood development"

**Knowledge base/ Evidence base:** Generate the proper actions from local authorities and gain the required participation of professionals and families.

**Context of intervention/project/work:** Main principles that are the core of the program: to promote the establishment of a local network involving participants from public, private non-profit and private for-profit sectors to serve as a forum and a level of governance; and to deliver a set of educational opportunities to professionals, and community leaders in order to strengthen their capacity to make a better contribution for the ECD

**Methods:** Seventeen municipalities in the State of São Paulo were invited to present their own projects and after a selection process six were chosen to receive technical and financial support from the Foundation.

**Results and Conclusions:** Six cities (from 40,000 to 300,000 inhabitants) signed a partnership agreement with FMCSV to develop comunitary projects. Each project established their own governance structure and processes that resulted in two levels: political and technical. The first guarantees the participation of the three sectors of the society, including decisions affecting the financial resources to sustain their projects. The second guarantees the knowledge and practice that should be introduced by local services and families to provide quality care to children zero to three. It was developed a preparatory phase in which the selected municipalities were assisted by the Foundation to recognize their assets and problems, to identify their selected strategies to operate the local project, to write their proposals, to identify the members of the political and technical committees, and to establish their own terms for partnering with the Foundation. Now, the projects are been progressively implemented with a important component of accessing available knowledge and practices offered by a group of advisors that are supported by the Foundation. During the two phases the Foundation accumulated lessons learned that are the essence of this participation.

**Disclosure of Interest:** No conflicts of interest