A Pilot Study: Developing Big Data Based on a Cross Departmental Data Warehouse for Active Aging in Taiwan

C.L. Lin[1], C.H. Lee[2], Y.T. Yeh[3], H.Y. Ting[2], P.W.Chen[1], S.Y. Cheng[1] and C.Y. Wu[2]
[1]International Integrated Systems, Inc.,[2] Ministry of Health and welfare, Taipei, Taiwan;
[3]Taipei Medical University, Taipei Taiwan

IUHPE
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Background

To ensure the quality of life and dignity of the people after entering the older age. Health Promotion Administration (HPA) in Taiwan construct national and cross-level data warehouse and decision support system (DSS) to assisting making policies.

Method

The system used the concept of polyglot persistence to integrate different sources and types of data from government agencies and related research projects, and the themes supporting decision making are formulated by experts from each department of the HPA and academic institutes **(Figure1)**. In addition, the system introduced a visualization and graphical interface.

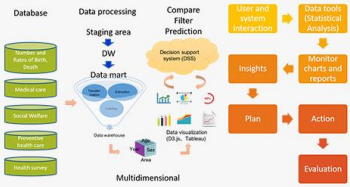

Figure1. The Decision Support System (DSS)

Results

As of 2018, the system has imported 14 datasets. 31 decision themes and 474 indicators were established on the DSS, through the continuous interfacing and storage of the survey data, it can achieve the establishment of predictions models, and can support different levels of data exploration and trend analysis. Users can focus on solving problems rather than data collection and analysis. The systems will help development and implementation of Taiwan's active aging policy **(Figure2 and Figure3)**.

Figure2. Application of Decision Support(1)

Figure3. Application of Decision Support(2)

Conclusions

The DSS can support different levels of data exploration and trend analysis, it would make policy makers easier to understand the context of data, to identify bottle-necks and problems at all levels, and to help turn the data into useful insights for better decisions. This is an ongoing project. We would continue improving the performance of the systems based on users' feedbacks.

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Contact:
Chien-Liang, Lin (peterlin005@gmail.com)

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A prospective study to investigate the relation between Brisk walking, Self-concept ,and Anxiety among Adolescents by utilizing Lazarus and Folkman's coping theory

Hui Jung Chao[1], Ming Yi Hsu[2*]

[1]School nurse; National Experimental High School at central Taiwan Science Park, Taiwan

[2*]Assistant Professor ; School of Nursing, Chung Shan Medical University, Taiwan

Objective: This prospective study aimed at testing the **mediating effect** of self-concept on the relationship between brisk walking and anxiety among high school students living in central Taiwan.

Method: A quasi-experiment using the **time series design** (T1 T2 X T3 T4) was conducted. **Sixty-four** volunteer students were recruited. The Sobel test was utilized to examine the mediation effects of self-concept between brisk walking and anxiety.

Results: Adolescents participating in the brisk-walking program reported **significantly decreases in anxiety and depression as well as increases in self-concept** (See Figure 1).

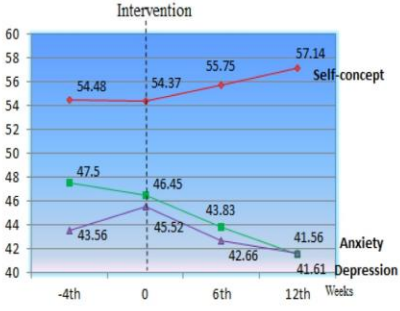

Figure 1. Fluctuation of Self-concept, Anxiety, Depression mean scores prior and post intervention

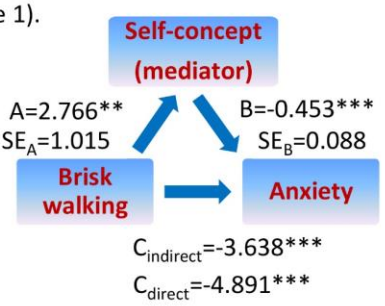

Figure 2. The mediation effects of self-concept

Note. **Sobel Z=-2.41, p=.016*,** A、B、C represented for regression coefficients, SE represented for standard error

The results also indicated that a significant positive correlation between brisk walking and self-concept and a significant negative correlation between self-concept and anxiety. The Sobel test showed **partial mediation** occurred when brisk walking was reduced in association with lower anxiety after self-concept was added in the regression model (See Figure 2).

Conclusion: Brisk walking is an easy and effective way to enhance adolescents' self-concept resulting in improving their anxiety and depression.

A qualitative study of attitude towards mobile health smoking cessation intervention among Chinese male smokers

Authors: [1]Yitian Feng, [1]Pinpin Zheng, [2]Jidong Huang, [2]Claire Adams Spears, and [2]Michael Eriksen
Affiliations: [1]Fudan University, Shanghai, China; [2]Georgia State University, Atlanta, USA

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Background

China has 316 million smokers, only 17.6% of whom intend to quit smoking within 12 months . Scalable and evidence-based smoking cessation interventions are urgently needed to reduce tobacco use in China. With the exponential increase in mobile Internet users in China (788 million in 2018), mobile health (mHealth) based approach offers unprecedented opportunities for cost-effective dissemination of smoking cessation interventions. However, substantial adaptations are needed to address the unique sociocultural barriers to quitting smoking for Chinese smokers. In this paper, we examine culturally adapted mHealth smoking cessation messages that incorporate mindfulness-based smoking cessation interventions delivered via WeChat, an ubiquitously-used app in China.

Methods

Nine focus groups were conducted among a convenient sample of 47 Chinese male adult smokers, recruited from factories, universities, community centers, and smoking cessation clinics in Shanghai, China in 2018. Thematic analyses were conducted using NVivo.

Focus Groups were conducted separately with each of the following subgroups: (1) Chinese male smokers who are not currently planning to quit (pre-contemplation contemplation stage). (2)Chinese male smokers who are either planning to quit in the next month (preparation stage) or are in the process of quitting or reducing smoking (action stage). The basic information of participants is shown in Table 1.

Table 1 Demographics and quit attempts of the participants

Variable	Subgroup 1 (n=22) Mean(Std) / N(%)	Subgroup 2 (n=25) Mean(Std) / N(%)	*P* value
Age(years)	42.18(14.8)	36.8(13.3)	0.196
Education			
Junior school or below	5(22.7)	3(12.0)	
High school / technical secondary school	5(22.7)	5(20.0)	0.703
Bachelor's degree / college	9(40.9)	14(56.0)	
Master's degree or over	3(13.6)	3(12.0)	
Marital status			
unmarried	8(36.4)	8(32.0)	0.768
married	14(63.6)	17(68.0)	
Smoking status			
Daily	14(63.6)	11(44.0)	0.244
Not daily	8(36.4)	14(56.0)	
Have you tried to quit smoking in the past?*			0.030
No	8(36.4)	2(8.0)	
Yes	14(63.6)	23(92.0)	

Note: *P < 0.05

Results

1. Suggestions for WeChat smoking cessation intervention

Smokers preferred messages delivered via WeChat compared with other delivery modes, such as regular text messaging. Smokers preferred content that comes from government health agencies or health professionals. In addition, they also preferred content that includes practical smoking cessation skills, and incorporates current smoking related events. Additionally, interactive two-way messages that include keywords such as 'I want to smoke', 'take a puff', 'craving', 'secondhand smoke(SHS)', 'pressure', 'irritable', 'words of encouragement' were liked by many smokers. (Table 2)

2. Mindfulness as a Treatment Component

Chinese smokers were less familiar with the concept of "mindfulness," and many equated it with the concept of "meditation". Smokers who had in-person mindfulness training prior to the study indicated that it was an effective way for them to cope with stress and craving. Many smokers, particularly those with higher levels of education, were willing to try mindfulness-based smoking cessation interventions. (Table 2)

Figure 1 Focus group discussion conducted among university students

Table 2 Themes and examples from focus groups with smokers

Theme	Sample quotes from smokers
The form of WeChat message	"It should be rich in forms, including pictures, short videos, texts, cases, which present harsh consequences of smoking."(S1, 50 years old) "The scary smoking pictures have no effect on me, and I would be touched by the cases showing greatly life improvements after successful quitting in smokers."（S1, 22 years old）
WeChat message content	"Since being a smoker, I definitely know the danger of smoking, but I don't care about such long-term harms. I only care about the current influence and symptoms."（S2, 21 years old） "The efficacy of WeChat message depends on who sends it, and I'm willing to receive if CDC send messages to me."（S1, 37 years old）
Keywords	"Hazards of smoking", "perseverance", "harms of secondhand smoke", "craving", "takes a puff", "withdrawal symptom", "irritable", "insomnia", "pressure"
Mindfulness training	"The intervention populations should be stratified. Mindfulness is of no use to people who don't want to quit smoking, and it can be helpful for people who really want to quit smoking or being well educated."(S1, 57 years old) "I have learned about mindfulness in the asthma treatment before, and I keep on doing mindfulness exercise in daily life. It is very useful to practice meditation every morning and evening."（S2, 57 years old）

Note: S-Subgroup

Conclusions

WeChat appears to be a preferred mode for delivering smoking cessation messages among Chinese male smokers. Personalized mHealth messages based on behavior-change theory, originated from government/health professionals, and adapted for Chinese cultures, may be effective in helping Chinese smokers quit smoking. Moreover, mindfulness-based interventions via WeChat may be useful for smokers with higher levels of education.

Support

This study was supported by the USA National Institutes of Health (No. R01TW010686).

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Session: Connecting for Health and Wellbeing
Location: Energy Events Centre - Wai Ora Spa Grand Hall
Date: 8:30 AM - 10:00 AM, Thursday, Apr 11, 2019

复旦大学 健康传播研究所 Health Communication Institute, Fudan University

A whole of community response to childhood obesity in an Australian urban setting

Sheree Whittaker, Karen Wardle, Jaimie Tredoux – South Western Sydney Local Health District

The Campbelltown Community

- Located south west of Sydney, NSW, Australia
- Current population: 157, 000[1]
- Undergoing rapid, significant growth
- Diverse CALD and Aboriginal Population
- 28% children (5-12 yrs) overweight/obese[2]
- Below state average for socioeconomic status[3]

The Approach

Change4Campbelltown is translating a community-based systems approach to childhood overweight and obesity previously trialled by Deakin University[4] in rural communities to an urban setting. It's effectiveness in improving environments and health-related behaviours in Campbelltown will be evaluated.

Stakeholder mapping
½ day workshop with project partners

Recruit key leaders
(councillors, NSW members of parliament, government organisations, health, education)

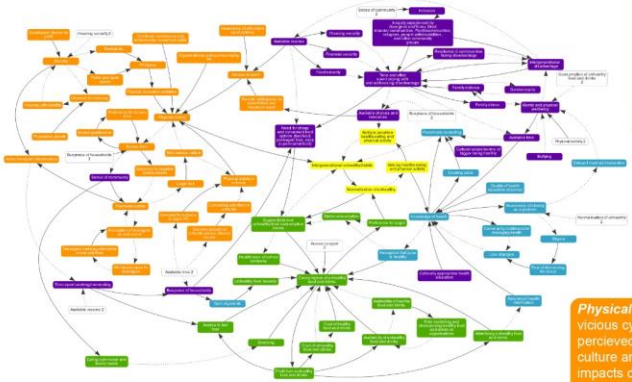
Leaders Workshops
Group model building[4] to develop systems map of childhood obesity

Recruit community champions
(Local council, sport/recreation, local business, NGOs, community leaders)

Change4Campbelltown Workshop
Over 100 leaders and champions worked together to identify community-led actions and formed working groups to implement change

A Systems Map of Childhood Obesity

At the centre of the map there is a vicious cycle between values, priorities, intergenerational habits and normalisation. There was a high level of consensus that these factors underpin childhood obesity and are central to the 4 themes – healthy eating, social factors, education and physical activity.



Healthy Eating example: the density of fast food outlets throughout Campbelltown normalises its consumption. This drives demand & increases advertising.

Social Factors example: the community experiences high rates of financial stress and the time spent coping with disadvantage significantly impacts the communities ability to prioritise healthy choices.

Education example: health literacy, use of jargon and stigma related to obesity identified as barriers to addressing the normalisation of obesity and associated health concerns.

Physical Activity example: vicious cycle connecting low levels of percieved safety with a risk adverse culture and policies which directly impacts on physical activity, social connectedness and screen time.

Where to next

Leaders & Champions identified actions to develop partnerships, improve settings and create community-led programs which impact on safety, access to healthy food, supportive environments and opportunities for physical activity. Action ideas and working groups will be supported to drive change in their community.

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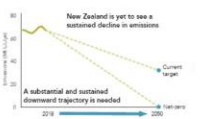
Achieving Certified Emissions Measurement And Reduction Scheme (CEMARS) certification

The need

- Climate change is a serious emerging risk to global public health, development and equity.
- New Zealand's commitment is to reduce its total greenhouse gas emissions by 50% of the 1990 baseline by 2050. The New Zealand government is currently consulting on a target of Carbon Zero by 2050.
- To achieve either of these goals all sectors of New Zealand will need to make significant changes in their sources of energy.
- Climate change is already affecting the health and wellbeing of New Zealanders in adverse ways
- The Health sector needs to lead on mitigation and management of Climate change in New Zealand.



The opportunity

- The Certified Emissions Measurement And Reduction Scheme (CEMARS) is an internationally recognised carbon emissions reporting tool. It is a gold standard tool that uses ISO auditing to provide credible carbon footprint calculation reporting and reduction for large organisations.
- As part of establishing a credible environmental sustainability policy at the Canterbury DHB, greenhouse gas emissions needed to be benchmarked and monitored, with targets for reductions established.
- Gaining CEMARS accreditation is a significant step for developing a strategic and operational plan for reducing greenhouse gas emissions.

The aim

- To identify appropriate and cost-effective areas for carbon reduction.
- To reduce carbon emissions.
- To prepare for the Government's future expectations for the mitigation of climate change.

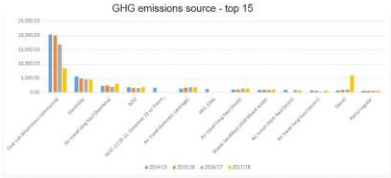
Implementation

- The coal boilers at Burwood were replaced with biomass boilers in 2016.
- Further plans are underway to make similar changes at Christchurch and Ashburton so that Canterbury DHB can eliminate this fuel and achieve the desired carbon reductions outlined in the CEMARS project.
- The Canterbury DHB's carbon footprint enables us to effectively target where our future activity should take place.

Measuring CDHB's Carbon emissions:

The CEMARs analysis revealed that

- 50% of Canterbury DHB's emissions came from coal burned in the Ashburton, Christchurch and Burwood boilers.
- Replacing the coal boilers with a climate-friendly option was a priority.



Results:

- Canterbury DHB has achieved a 23.5% reduction in carbon emissions over the past 4 years.
- An audit of four financial years identified an overall emissions reduction of 23.5% from 2014/15 to 2017/18.
- This was a reduction in emissions of 9,737 tonnes of CO2.
- Canterbury DHB was recognised by Enviro-Mark Solutions as among the top 20carbon reducers in their carbon certification programmes (carboNZero & CEMARS) for the year 2017/18.
- The CEMARS certification process revealed that targeting the coal boilers was the most cost-effective approach to reducing the greenhouse gas emissions.

In 2019

- The New Zealand government has asked DHBs to address adaptation and mitigation of climate change.
- All DHBs are required to undertake an audit of environmental sustainability measures they are already engaged in.
- There are indications that CEMARS will be a required activity for all DHBs in NZ.
- Canterbury DHB is well prepared to achieve what is required of them by Government

Canterbury District Health Board
Te Poari Hauora ō Waitaha

[1]https://www.productivity.govt.nz/sites/default/files/A3%20Summary%20Briefing_Low-emissions%20economy%20Draft%20report.pdf

Actuación de la cooperación internacional Sur-Sur brasileña hacia el fomento de prácticas para promoción de la salud ambiental y saneamiento

Autor: Isabela Coelho Moreira
Instituicion: Fundación Nacional de Salud, Brasília, Brasil

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Antecedentes/Objetivos

La cooperación internacional y los Objetivos de Desarrollo Sostenible

En el siglo XXI, la Organización de las Naciones Unidas, con la Agenda 2030, incluyó en sus Objetivos de Desarrollo Sostenible (ODS) el acceso de las poblaciones al agua y al saneamiento. Según esta propuesta, la Fundación Nacional de Salud (FUNASA), órgano ejecutivo del Ministerio de Salud de Brasil actúa en la promoción de la salud pública y la inclusión social con acciones de saneamiento y salud ambiental en comunidades rurales, ribereñas, indígenas y pueblos remanentes de comunidades de negros que resistieron a la esclavitud - conocido como "quilombos". También realiza acciones de Cooperación Internacional promoviendo el intercambio de prácticas exitosas en Brasil para países en desarrollo.

La Cooperación Sur-Sur, practicada en el mundo desde la década de 1970, trae en sus principios la horizontalidad, primando por acciones estructurantes y desarrollando las capacidades endógenas de cada país. En este sentido, FUNASA realiza proyectos con poblaciones extranjeras, que en muchas características se asemejan a las realidades brasileñas en condiciones de escasez, o privadas de recursos e infraestructuras sanitarias.

Métodos

Los proyectos de cooperación internacional Sur-Sur

FUNASA desarrolla proyectos de Cooperación Sur-Sur hacia la promoción de la salud ambiental y saneamiento, con países del Caribe, África y Medio Oriente, basada en los principios del desarrollo de las capacidades locales, intercambio horizontal de saberes y promoción de agentes multiplicadores.

Resultados

Proyecto de Cooperación Trilateral Sur-Sur Brasil/Etiópia/Unicef

Empezó en 2014, el proyecto de cooperación trilateral entre el Fondo de las Naciones Unidas para la Infancia (UNICEF) y los gobiernos brasileño y etíope para la formación del marco regulatorio de servicios de agua y saneamiento, mejora del saneamiento urbano e higiene de la población con la construcción de un sistema de tratamiento de aguas residuales en un condominio en la ciudad de Wukro.

Proyecto de Cooperación Bilateral Sur-Sur Brasil/República de Haiti

Las tratativas del proyecto de cooperación bilateral con la República de Haití empezaron en 2016, con el objetivo de lograr la transferencia de Solución Alternativa Colectiva para Tratamiento y Suministro de Agua potable para comunidades de bajos ingresos a partir del uso del filtro con el elemento Zeolita, y procesos de decantación y cloración del agua. Esta solución fue desarrollada por FUNASA y es conocida como "SALTA-z".

Figura 1: Recolección de muestra del efluente tratado en el punto de lanzamiento en Wukro – Etiopía. FUNASA, 2018.

Figura 2: Análisis de agua de pozo de captación subterránea en Carrefour-Haití. FUNASA, 2018.

Discusíon

Los proyectos brasileños de cooperación están en curso y promueven contrapartidas como el fortalecimiento institucional, en el sentido del perfeccionamiento, verificación y certificación de sus resultados, promoviendo la búsqueda de la excelencia en los procesos internos de la institución. Así mismo, los proyectos también van a compartir las experiencias de éxito con otras comunidades internacionales en desarrollo que necesitan mejorar la salud ambiental, para mejorar la calidad de vida y el bienestar social de las poblaciones.

Referencias

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Poster presentado en 23ª Conferencia Mundial de Promoción de Salud, Rotorua, New Zealand, 2019.

Addressing Lupus Disparities through Effective Social Media Engagement

Thometta Cozart, MS, MPH, CHES, CPH; Leris Bernard, BA, CMP; & Steve Owens, MD, MS, MPH

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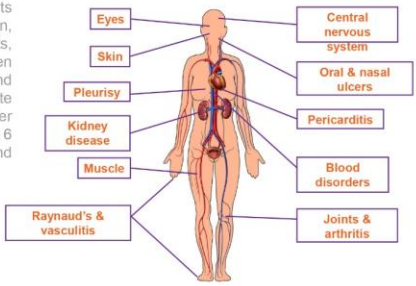
INTRODUCTION

Current research shows that at least 1.5 million Americans have lupus, an autoimmune disease that can damage any part of the body, including skin, joints and organs. Although lupus affects men and children, women of childbearing age are 90% of lupus patients, according to the Lupus Foundation of America. Women of color are 2 to 3 times more likely to have lupus and have worse health outcomes compared to white women. Lupus is a chronic disease that is under discussed. The average diagnosis timeframe is 2 to 6 years. There is a need to increase lupus education and awareness to address lupus health disparities.

SIGNS & SYMPTOMS OF LUPUS



INTERVENTION

The national health education program LEAP: Lupus Education & Awareness Program promotes lupus education messages to patients, health professionals and providers. LEAP implemented a national tradition, digital and social media campaign to increase awareness of lupus through health promotion messages. Through mini-grants, community organizations and health agencies improving the health of African Americans, Hispanics, Chinese and Native Americans communities supported the lupus health promotion media campaign. The campaign objectives were: Integrating lupus messages into National Health Observances; Engaging national health organizations as social media influencers; and Connecting LEAP to existing lupus media communities.

IMPLICATIONS

Health education agencies seeking to increase their online presence as well as promote non-traditional chronic diseases, such as lupus, should consider media health promotion strategies that maximize the utilization of National Health Observances, as well as leveraging partnerships. Social media campaigns should be incorporated into the communication plans of health education programs to increase engagement and awareness of health disparities.

METHODS

LEAP
Lupus Education And Awareness Program

#LupusLEAP SOCIAL MEDIA

@lupusLEAP
@lupusLEAP
@lupusLEAP
LEAP-Lupus-Education-Awareness-Program

RESULTS

LEAP's Year End Social Media Stats

Twitter: Impressions: 3,354,938 Engagement: 3,450
Facebook: Impressions: 9,283 Engagement: 1,055
NEW This Year, LEAP Opened an Instagram Account and Attracted 321 Followers!

Earned Media: LEAP pursued traditional media outlets. The results were a LEAP Feature in AFRO Newspaper that reached **8,000 people through print and 250,000** via their online newspaper. LEAP promoted the online article with Facebook Ads that yielded **4,500 Views** and **176 New Facebook Followers!**

LEAP Interviewed Dr. Sherra White for an article to be published in the National Board Certified Counselors Foundation Newsletter that reached an **audience of 61,069**. The article became the launching point for the #MoreThanPain Campaign that included a Twitter Chat and national press release.

- The #MoreThanPain Twitter Chat was in partnership with the Chronic Coalition and featured LEAP Presenters Dr. Sherra White and Hetlena Johnson. It delivered **1,308,330 impressions on Twitter, 4,744 on Instagram and 479 on Facebook with 43 acts of engagement.**

Addressing the Booming Booze Culture Among ACT Women

Susan Hickson, Foundation for Alcohol Research and Education, Canberra, Australia.

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Combining innovative technology with an awareness raising campaign

About the project

This three year project will evaluate the effectiveness of an electronically delivered health intervention and awareness raising campaign in reducing alcohol consumption among women aged 45 – 64 in the Australian Capital Territory (ACT).

Women participating in a randomized controlled trial will receive either:

- an electronic brief intervention and messaging from a purpose-designed innovative digital platform, in conjunction with exposure to a targeted campaign to raise awareness of the long term harms associated with alcohol consumption, or
- Exposure to the targeted awareness campaign only.

The project, currently in its first year, is funded by a Health Promotion Grant from the ACT Government.

About the ACT

The Australian Capital Territory is situated in southern NSW, with an area of less than 1 percent of Australia's total land mass. The ACT is home to Australia's capital city, Canberra. The ACT has:

- a population of 420,000
- approximately 50,000 females aged 45 – 64
- the highest standard of living in Australia
- the longest life expectancy in Australia
- an ageing population and increased prevalence of chronic disease

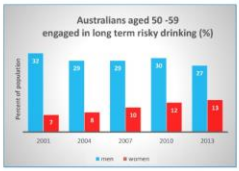
Most adults in the ACT drink alcohol, with nearly 15 per cent doing so at levels considered risky for long term harm[5].

Rationale

In Australia, alcohol causes more than 5,700 deaths and 140,000 hospital admissions annually[1]. Women experience 35 per cent of this burden and are at particular risk for non-communicable diseases such as cancer, with an estimated 6 per cent of breast cancers being attributed to alcohol[2].

Population level alcohol consumption in Australia has been declining in recent years, although it has increased among older women[3], leading to a convergence in rates of drinking at levels for long-term harm for middle aged men and women. There had been no specific health promotion initiative targeting these 'boozy boomers'. In 2018 the local public health authority, ACT Health, identified this group as a target for health promotion activity to reduce harm from alcohol.

Electronically delivered alcohol interventions have been successfully used with individuals with alcohol problems, proving to be cost-effective, readily accessible and providing anonymity[4]. However, there is a lack of evidence about this approach with middle aged women.



Objectives

Online intervention

- Reduce by 10-30% the alcohol consumption of intervention participants by the end of the trial.
- Increase by 25-45 percent motivation to reduce alcohol consumption of intervention participants by the end of the trial.
- For intervention participants unaware at baseline, increase by 80 percent awareness of long-term alcohol harm.

Awareness campaign

- Increase by 10 per cent motivation to reduce alcohol consumption among ACT women aged 45 – 64.
- Increase by 20 per cent awareness of long-term alcohol harms among ACT women aged 45 – 64.

Overall

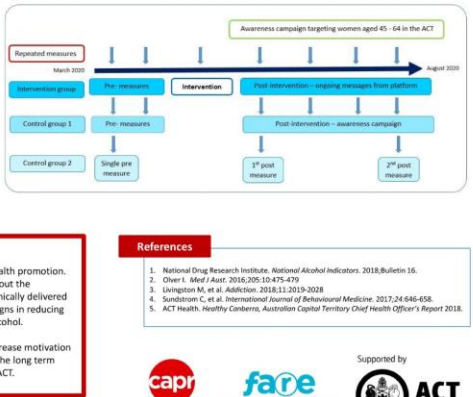
- By the end of the project, determine the effectiveness of the online intervention and awareness campaign to reduce alcohol consumption by women aged 45 – 64 in the ACT.

Study Design

3,000 ACT women aged 45 - 64 age who consume alcohol at least weekly will be recruited through Facebook and randomly assigned to the following groups:

- Intervention (n=1500)
- Control 1 (n=750)
- Control 2 (n=750)

Measures of alcohol consumption, motivation to change and awareness of long term harms will be taken before , during and after the intervention for each group as indicated.



Implications for public health

Randomized controlled trials are not common in health promotion. This project will produce gold standard evidence about the comparative and combined effectiveness of electronically delivered alcohol interventions and awareness raising campaigns in reducing the long term harm to middle-aged women from alcohol.

It also promises to reduce alcohol consumption, increase motivation to reduce consumption and increase awareness of the long term harms from alcohol in this cohort of women in the ACT.

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Gender and Age Difference in Diabetes Self-Management Practices

N Powe[1], N Modeste[2], DA Sealy[3], C Wilson[4], VLC Drayton[5]
Youngstown State University[1] Loma Linda University[2] University of the Southern Caribbean[3]
Oakwood University[4] Booz Allen Hamilton[5]

BACKGROUND

Diabetes was the seventh leading cause of death in the United States.

30.3 million people living with diabetes.

23.1 million people are currently diagnosed with diabetes.

7.2 million people living with the disease are undiagnosed.

$327 billion was spent on direct diabetes medical cost.

$90 billion in reduced productivity among people diagnosed with diabetes in 2017.

Diabetes requires effective self-management practices and monitoring of blood glucose levels to reduce complications.

Researchers have established that challenges exist for diabetics to implement effective self-management practices.

The nature of these challenges depends on race, age, gender and socio-economic status.

Purpose

This study will elucidate the complex relationship between gender, age, the duration of diabetes illness, and adherence to diabetes self-management practice.

Although some relationships between demographic characteristics and adherence to self-management practices have been investigated, the relationship between gender, age and self-monitoring of blood glucose levels and other self-management practices is poorly understood.

RESEARCH QUESTIONS

1. What is the relationship between gender and adherence to diabetes self-management behaviors including: (a) availability of fruit and vegetables at home?; (b) availability of salty snacks and soft drinks at home? (c) frequency of physical activity?; (d) frequency of blood glucose monitoring?; (e) frequency of routine visits to a physician?

2. Are the relationships between gender and diabetes self-management behavior moderated by age?

3. Are the relationships between gender and diabetes self-management behavior moderated by duration of diabetes illness?

4. What is the relationship between diabetics' perceived health status (perceived benefit in the health belief model) and their adherence to diabetes self-management practice (outcome behavior)?

5. What is relationship between diabetics' level of physical, psychological, and emotional disability (perceived barrier) and their adherence to diabetes self-management practice (outcome behavior)?

Methods

This cross-sectional study will use data from the 2009-2012 United States National Health and Nutrition Examination Survey (NHANES) to analyze the relationships between age, gender, duration of diabetes illness, an individual's perception of one's own health, fruit and vegetable consumption, physical activity, and other diabetes self-management practices in the United States.

Moderated linear and logistic regression will be used to analyze these relationships.

RESULTS

Research Questions 1, 2, & 3

No statistically significant effects of age, gender, or duration of illness on fruit availability at home.

No statistically significant effects of age, gender, or duration of illness on dark green vegetable availability at home.

No statistically significant effects of age, gender, or duration of illness on the availability of soft drink at home.

Female diabetics were more likely to visit a physician frequently.

No statistically significant effects of age, gender, or duration of illness on blood glucose measurement.

Research Questions 4, & 5

No relationship between disability status and availability of fruit at home or the availability of dark green vegetables at home.

Those who experienced disability were more likely to have salty snacks available at home.

No statistically significant relationship between disability status and blood glucose monitoring.

Those diabetics who experienced disability were more likely to have more frequent appointments with a physician.

Worse perceived health status was associated with more frequent blood glucose measurement.

Better perceived health status was associated with more frequent consumption of salty snacks.

No relationship between perceived health status and fruit and vegetable consumption at home.

DISCUSSION

Relationship between gender and frequency of visits to a physician in diabetics is supported by previous research and can be accounted for by psychological and physiological differences between genders.

The relationship between disability and increased likelihood of having salty snacks available at home may be attributable to psychological and physical barriers to diabetes self-management.

The relationship between worse perceived health status and more frequent blood glucose monitoring is congruent with the Health Belief Model (HBM).

The relationship between worse perceived health status and salty snack consumption is not congruent with the HBM model.

Conclusion

Age differences can predict diabetes self-management practice.

There is a relationship between diabetics' perceived health status (perceived benefit in the health belief model) and their adherence to diabetes self-management practice.

There is a relationship between diabetics' level of physical, psychological, and emotional disability (perceived barrier) and their adherence to diabetes self-management practice.

Alianza para el litigio estratégico en defensa de los derechos humanos de las mujeres colombianas

Presenta: **Gladys Ariza-Sosa**
gladys.ariza@udea.edu.co

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La situación de **violencia contra las mujeres** en Colombia, constituye un problema de

salud pública y configura una crisis humanitaria

Uso ineficaz de las medidas de **protección** y **atención**

Impunidad

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otras equivalentes, sin una denominación estándar, pero que producen un vínculo con distribución inequitativa de poder

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2018 Programa de investigación
Alianza de trabajo para el litigio estratégico en defensa de los derechos humanos de las mujeres: una experiencia academia – sociedad civil

WAIORA: Promoting Planetary Health and Sustainable Development for All

Alimentación saludable y promoción de salud escolar: estudio de investigación-acción en escuelas básicas de Chile

Autores: Judith Salinas, Fernando Vio, Lydia Lera, Carmen Gloria González, Gabriela Fretes, Edith Montenegro
Afiliación: Universidad de Chile INTA, Santiago, Chile

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Antecedentes

El sobrepeso y obesidad en Chile alcanza un 51.7% de escolares 1ero básico y 74,2% en adultos, constituye uno de los principales problemas de salud pública por su magnitud, multicausalidad y complejidad.

Objetivo

Elaborar, aplicar y evaluar un programa educativo en alimentación saludable para profesores, alumnos de pre-básica, básica y sus familias, que contribuya a enfrentar el problema de la obesidad y promueva la salud escolar.

Método

Investigación-acción educativa con 1.100 estudiantes de 5 a 12 años de edad, sus profesores y padres y apoderados de escuelas municipales de 5 comunas. El diagnóstico cuali-cuantitativo se realizó mediante: encuestas de consumo, conocimientos y hábitos alimentarios en escolares y sus padres; grupos focales con padres y profesores; y evaluación nutricional a los escolares con antropometría. El diseño del modelo educativo se basó en consulta a expertos interdisciplinarios con Método Delphi y Grupo Nominal. Se aplicó en los 7 primeros años del ciclo escolar en grupo experimental, con grupo control de similares características.

Resultados

Modelo educativo diseñado, aplicado y evaluado (figuras 1 y 2), con acción multinivel y enfoque ecológico. Entre otras actividades los profesores y padres se capacitaron en promoción de salud escolar; las comunidades educativas trabajaron en huertos escolares, talleres de cocina, entorno alimentario y políticas institucionales.

En varios niveles se logró mejorar conocimientos y disminuir alimentación poco saludable (cuadros 1 y 2); en otros aumentó el consumo de frutas, verduras y pescado, y habilidades culinarias. Hubo cambios positivos en estado nutricional solo en grupos de mujeres de 7 a 9 años. Se analizaron facilitadores, obstáculos y barreras del entorno familiar, escolar y social, observando escasas diferencias por nivel y establecimiento de educación. Se realizó abogacía con autoridades de gobiernos y actores sociales, para crear políticas públicas sustentables e intersectoriales con empoderamiento ciudadano.

Conclusiones

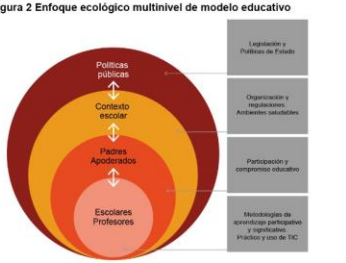
Educación participativa, práctica y multinivel basada en el diagnóstico local y análisis del entorno alimentario logra cambios efectivos y aporta a la formulación de políticas públicas.

Financiamiento

2 Proyectos Fondecyt años 2011-2013 y 2014- 2016.

Figura 1 Modelo educativo en alimentación saludable en escuelas

Figura 2 Enfoque ecológico multinivel de modelo educativo



Cuadro 1 Conocimiento sobre alimentos saludables al inicio y final de la intervención en colegios intervenidos (Liceos 1 y 2) y colegio control (porcentaje que conoce)

	Liceo 1 n = 283		Liceo 2 n = 182		Control n = 352	
	Inicio	Final	Inicio	Final	Inicio	Final
Frutas y Verduras aporte vitaminas y minerales	81,72	89,25	79,03**	91,40**	83,8	86,87
Pescado más saludable que otros	69,53****	82,80****	69,35**	80,11**	65,92*	81, 01*
Manzana en vez de no saludables	85,30**	93,19**	83,33****	95,7****	86,31	89,39
Almuerzo saludable	67,03*	92,11*	75,81***	90,32***	76,19***	86,83***
Lácteos aporte Calcio	50,54	54,12	54,30*	58,6*	48,04	47,21

Test de simetría: *p < 0,01; **p < 0,005; ***p < 0,001; ****p < 0,0001; NS el resto.

Cuadro 2 Consumo alimentos saludables y no saludables al inicio y al final de la intervención en colegios intervenidos (Liceos 1 y 2) y colegio control (porcentaje que consume)

	Liceo 1 n = 283		Liceo 2 n = 182		Control n = 352	
	Inicio	Final	Inicio	Final	Inicio	Final
Papas fritas y sopaipillas	81,36****	67,03****	73,12**	58,60**	75,98	75,98
Frutas	98,57	98,21	96,2	98,92	98,32	97,77
Verduras	93,55	93,19	90,86	90,32	94,41*	91,34*
Completos, hamburguesas, pizzas	76,34**	65,95**	63,98*	55,91*	72,63	69,55
Legumbres	82,37	80,94	81,08	82,16	88,80**	82,63**
Pescado	82,73	82,73	86,41	87,50	88,17	87,61
Snacks salados	74,37***	61,37***	69,73***	52,97***	72,91	73,46
Snacks dulces	78,28**	62,39**	70,43**	56,45**	75,91	74,51
Helados, dulces, pasteles	82,44**	73,48**	74,19**	60,75**	79,61	82,12
Lácteos	98,57	98,57	99,46	98,39	99,72	99,16
Bebidas y jugos con azúcar	91,04*	86,02*	87,63**	75,81**	94,69	91,90

Test de simetría: *p < 0,05; **p < 0,005; ***p < 0,0002; ****p < 0,0001; NS el resto.

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Poster 227 Conferencia Mundial de Promoción de Salud, Rotorua, Nueva Zelanda, Abril 2019

UNIVERSIDAD DE CHILE
Instituto de Nutrición y Tecnología de los Alimentos
Doctor Fernando Monckeberg Barros

WAIORA: Promoting Planetary Health and Sustainable Development for All

An article on HIV and AIDS in mining townships and young people in Botswana: exploring sustainable intervention Programmes

Introduction: All sectors of human interaction are affected by HIV and AIDS internationally, regionally and nationally. The mining sector, which generally employs the largest number of men, has often been the most affected.

Background: This paper seeks to compare HIV prevalence and trends among people aged 6 weeks and above in the 4 mining townships in Botswana, namely: Orapa, Jwaneng, Sowa and Selebi-Phikwe.

Objectives: To: (a) establish the cause of the prevalence; (b) establish the difference and similarity between the four mining townships; (c) provide indicative trends in sexual and preventive behavior among the population aged 10 to 24 years; (d)explore which intervention programmes are sustainable.

Methods: *Data Source:* 2013 Botswana AIDS Impact Survey IV.

Findings: i. Jwaneng an open mining township and Orapa the only closed mining township have the lowest prevalence rate.

ii. Have consistently shown a decline in the HIV prevalence.

iii. Selebi-Phikwe, an open mining township has the highest prevalence (27.5%) lowest literacy rate, highest MCP, cohabitation. v. Has consistently shown an increase in prevalence.

vi. Females are most hard-hit unlike to men of their age group.

vii. Sustainable targeted programmes remains crucial, should be: i. Community level, ii. young–people led, iii. Interactive, v. edutainment , vi, positive or non fear message.

Conclusion and Recommendations: explore, develop and implement sustainable targeted programmes according to the peculiarity of groups and environments.

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An article on a European experience of accessible tourism and social inclusion between Greece and Italy: New Objective: Tourism without Barrier (N.O. BARRIER) project.

European Territorial Cooperation Programme
Greece - Italy
2007-2013
INVESTING IN OUR FUTURE

www.nobarrier-project.eu

1. International Scenario

Accessibility is becoming an important issue:

- **Over one billion people, 15% of the world population, live with some form of disability (WHO, 2011); 80 million people with disabilities in the EU (Eurostat, 2013), 4 million in Italy (Osservatorio Nazionale sulla Salute Regioni Italiane, 2017).**
- **The aging population and the chronic health conditions are increasing.**

2. General Objective

improving the health conditions and the quality of life through routes of social inclusion in the involved territories with actions of accessible and sustainable tourism for people with special needs.

3. Specific Objectives:

- To build and promote interventions of research/action designed to identify and develop situations of national and international success through the analysis of the **best practices** and to **educate** and **involve** cultural tourism **operators** to the theme of accessibility;
- To elaborate and test **methods and tools to "certify"** the accessible places through the creation of a **label** assigning system shared with associations of people with disabilities;
- To prove the economic and social **feasibility**, resulting from breaking down both the tangible and intangible barriers through structural interventions, by improving **information** services for disabled people, producing **instruments** (routes without barriers) and **disseminating** them, in order to promote accessible locations;
- To create a **network** of stable relationships between the involved stakeholders aimed at the adoption of the methods and tools devised, with the signing of **follow-up agreements**;
- To accelerate the process of **"deseasonalisation of tourism"** of social-cultural tourism to optimize resources, to increase competitiveness and to create new opportunities for all.

4. Methodology

includes an identification of macro-areas of disabilities:

A. Psychophysical diversability;
B. Sensory diversability;
C. Cognitive and intellectual diversability.

5. The approach is integrated, universal, multidimensional, taking into account all the communities' resources

6. OUTCOMES

- ✓ **13 accessible routes** in Southern Italy (Apulia), Western Greece and Ionian Islands;
- ✓ **structural interventions** (e.g. gangways for the access to the sea, specific equipment for bathing...);
- ✓ **allocation of labels** through a quality certification system for services and infrastructures: 7 labels relating to the accessibility of the places, 5 to the type of holiday and 8 to tourist accommodation;
- ✓ Analysis of the **best practices** in accessible tourism;
- ✓ international, national and public-private **agreements**;
- ✓ the **N.O. BARRIER portal and free APP** for smartphone and tablet equipped with reading systems for visually impaired and audio guides. The App has integrated the accessible routes with social, health, cultural and leisure information related to infrastructures and transportations.

FINAL REMARKS

A "systemic" approach allows for the promotion of the territory through the supply of accessible tourism, improving the health, well-being, social inclusion, innovation and sustainability for people with special needs.

Best Practice Award 2014 by Interact Programme EU

LEAD PARTNER
PROJECT PARTNERS

Presenting Authors: Prof. Giovanna Da Molin, Ph.D. Maria Federighi
C.I.R.P.A.S.- Interuniversity Research Center "Population, Environment and Health"- University of Bari (IT)

An evolution in health professional education: The need to include ecological determinants of health in health studies education and workforce development

Authors: Lindsey Vold[1], Lauren Wallar[2], Andrew Papadolous[2]
Affiliations: [1]College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan; [2]Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario; [3]Department of Population Medicine, University of Guelph, Guelph, Ontario

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Introduction

Historically, public health policies and interventions have focused on social and behavioural determinants to improve population health. There are pressing public health issues such as climate change, unsustainable natural resource use, and increasing energy demands that require novel approaches that account for how ecosystems affect health and interact with other determinants of health. The root causes of these issues largely reside outside the traditional domain of health that most public health professionals operate in, yet they have profound impacts on health.

The Ecological Determinants of Health (EDoH)

What?

The ecological determinants of health (EDoH) is a paradigm in public health education and practice that aims to prepare students and practitioners to address complex public health issues of ecological origin using inter-sectoral approaches. These competencies were collaboratively developed by the EDGE Core Competencies and Curriculum Sub-Committee, a group of ecological health academics from universities across Canada.

Who?

Understanding how ecological determinants influence the health of general and vulnerable populations can allow public health professionals to help communities adapt to ecological change, thereby mitigating its impact on health.

How?

The seven competencies that can be used to operationalize the EDoH paradigm in public health education and practice, along with recommendations for educational and workplace settings.

To fulfil knowledge, competence, performance and action, we recommend beginning in the classroom with real-world examples. Moving beyond the classroom, students can demonstrate performance of core competencies in controlled settings and experiential learning opportunities.

Next Steps

The integration of EDoH competencies into educational curricula can prepare students to respond directly to the ecologically-determined health needs of their communities and future populations.

These competencies are not an end, in and of themselves, but should be viewed as a starting point for iterative and ongoing development of proficiency as our understanding of the EDoH increases in breadth and complexity.

Incorporating the EDoH in daily practice and evolving this practice as we become better informed is critical in solving many health problems of the future.

	EDoH Core Competencies	Description
1	Explain the ecological determinants of health knowledge domain.	The intersecting knowledge areas related to: global ecological change, societal drivers of ecological change, and impacts of ecological change on population health[1] to inform the basis for designing, implementing, and evaluating multi-level interventions.
2	Link ecological processes and globalization.	These ecological effects of globalization, including the emergence of social pathologies, increasing loss of ecological integrity, and growing ecological inequities in health can be better understood by linking key human forces that drive change on a global level.
3	Describe how global power relations and structures influence ecological health.	An understanding of global power relations and structures: how power imbalances are created and maintained, the quality and distribution of ecological determinants. An emphasis on upstream political and socioeconomic processes
4	Enhance leadership, governance, intervention, advocacy, respectful alliances, and communication.	Flexible and adaptive capacity, leadership, and governance to contribute to managing, leading, and serving the complexities and uncertainties surrounding ecological issues. Advocacy and communication is essential for helping to shape political agendas to address ecological determinants of health.
5	Relate the social determinants and social inequities in health scholarship and practice.	Understanding how EDoH amplify or mitigate the effects of biological, behavioural, social, and physical determinants of health to inform population health planning and interventions.
6	Apply systems thinking.	Understanding the holistic, self-organizing, interconnected, nonlinear, and evolving relationships between various components within and across systems to contribute to a comprehensive understanding of the impact of ecological change[2].
7	Identify values and articulate key ethical issues shaping and influencing priorities and approaches.	These values should include, but are not limited to: intergenerational equity, the right to a healthy environment, environmental justice, adoption of the prevention imperative, application of the precautionary principle, and expansion of anthropocentrism and ecocentrism/biocentrism thinking[1].

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Poster Presented at IUHPE, Rotorua, New Zealand, April 2019. Presented by Dr. Wanda Martin, College of Nursing, University of Saskatchewan, Canada

A Global take on Healthy Eating: Evaluating International Student's Perspectives on Healthy Eating and the Barriers They Face

Juanita Gnanpragasam[1], Naomi T Krogman[2]
[1]University of Alberta, Edmonton, AB [2]University of Alberta, Edmonton, AB

Introduction

"Diet is not a one size fits all"
-Student from Brazil

The focus of this study was to assess the dietary patterns of international students at the University of Alberta as they adapt to life in Canada. Prior research showed that International students face unique barriers to eating healthy such as being new to Canadian food, understanding the concept of seasonal foods, cultural beliefs, and inaccessibility to fresh food options , which may be central to their beliefs and notions of healthy eating[2] . A strategy identified in the Sustainability Plan (2016-2020) for the University of Alberta is "Promoting healthy eating and edible landscapes as an inherent part of the university's sustainable food system." The outcome of this project will support the university to enhance the campus' sustainable food system in a way that allows the cultures of our international students to thrive, creating cultural sustainability, while developing support networks, through food services and programming, to cater to these student's specific challenges to eating healthy.

Methods

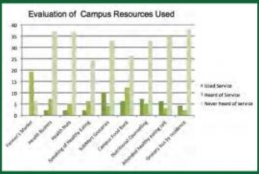
Fig.1: 24 countries are represented in this study including: Malaysia, Brazil, China, United Arab Emirates, Ghana, Nigeria, Bangladesh, England, South Korea, Pakistan, Japan, Mexico, Iran, Ivory Coast, Kuwait, Indonesia, Romania, Australia, Libya , Ukraine, Brunei Darussalam, India , Columbia and Kenya.

This study was opened to any international student who had been on campus for more than six months. Data was collected via focus groups and individual interviews.

Questions consisted of asking students about their definition of healthy eating, any barriers that students faced in eating healthy according to their definition, their perspective on current campus services that foster healthy eating and what services they would like to see on campus to better support their needs.

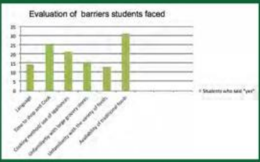
Results

Data showed students are facing barriers to finding culturally relevant and nutritious meals. These barriers fell into four categories: meal planning, grocery shopping, cooking, and purchasing food from vendors and are detailed in a final report found at www.conversecook.com/report.pdf



When asked all 45 students what resources students had heard of or used results show each resource was used by less than half of students interviewed. Many students wished they had heard of resources when they first arrived to campus to make their transition easier.

Definition of resources that aren't self explanatory: Health Busters: Student led grocery bus, Health Nuts: Student led cooking classes, SubMart Groceries: store on campus to buy groceries



31 students participated in individual interviews where they disclosed what barriers they faced. The following barriers were identified by Health Canada as reasons why immigrants do not eat healthy. Students were also asked to give recommendations on how to best alleviate the barriers. The most common answers are listed. Other barriers included answers such as missing home, loneliness and discrimination.

Majority of definitions of healthy eating were similar to what was proposed in Canada's Food guide.

When asked "Do you think eating in ways that students did in their home country is important?"
Majority of students said yes.

"Seedless watermelon is something I don't have at home so when I saw them in Edmonton I thought the watermelon was artificial and sketchy so I didn't buy it."
-Student from Nigeria

Reasons included: cultural beliefs about food, to cope with homesickness and keep culture alive (cultural sustainability), biological reasons (students getting sick from changing their diet too quickly), religious reasons

This study found that a lot of the barriers disappeared when students had some form of social support. Whether this happens through a grocery tour, food mentorship program, or family style dinners once a month , having the ability to connect and learn from other peers helped student more easily adapt the Canadian food landscape to their own ethnic food diets.

Recommendations from Students

-When students first arrive to campus evaluate their knowledge of cooking basics and buying groceries to create programs targeted to help support these students and triage these students to appropriate pre-existing programs.

"I didn't know how to weigh food using scales because back home we were charged by number of items" -Student from Japan

-Cooking classes so students can get familiar with foreign vegetables and fruits in a safe environment and learn how to purchase, ripen, and cook them.

"I think the biggest challenge for me was that the vegetables and fruits do not taste the same as ours." -Student from Romania.

-The creation of resources that give information on what grocery stores sell what ethnic foods (i.e. the fact that T&T caters to Asian cuisine), where these grocery stores are located, and how to bus to them.

"I often had to eat non-halal meat based food because I did not know where I could find halal products." -Student from Bangladesh

-Many cooking utensils that students need to cook ethnic foods, like pressure cookers or rice cookers, are very expensive and so students do not purchase them. As such this is a barrier to students cooking traditional food. Students suggested that the university look into creating an appliance library where students could borrow appliances to off-set the cost.

Conclusion and Next Steps

Food is much more than a nutritious substance. It connects us to culture, community, and identity. Food excites all the senses, can evoke positive memories, and add a sense of belonging. This is the way international students at the University of Alberta engage with food. As such it is imperative that campuses support students in cooking their ethnic meals while also helping them learn to adapt to Alberta's food landscape. Through recreating ethnic meals on campus, we are supporting cultural sustainability and and enhancing students' knowledge of various cultures. In this way food contributes to a thriving campus.

Currently there are a couple initiatives in the planning phase at the University of Alberta to help alleviate barriers found in this study such as: the creation of an online map that will house all the ethnic grocery stores/ restaurants in the city, classes orienting International students to Alberta's food landscape and setting up their kitchens, cooking classes, and grocery buses. In addition this work is now being scaled up to support City of Edmonton residents through the creation of the non-profit Converse and Cook.

Find out more at www.conversecook.com.

If you are currently running programming for international students or are interested in the results from this project please email Juanita Gnanapragasam at Juanitalg@ualberta.ca to request a copy of the finalized report.

Acknowledgements

References

An Intervention Study of Group Mindfulness-based Cognitive Behavioral for Smartphone Addiction among University Students

Authors: Yukun Lan, Jiao-er Ding, Wei Li, Jiang Li, Yifei Zhang, Mingbo Liu, Hua Fu
Affiliations: Fudan University, Shanghai, China

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23rd World Conference on Health Promotion

Introduction

Mindfulness-based intervention has been applied in behavioral addiction studies in recent years. However, few empirical studies using MBI have been conducted for smartphone addiction, which is prevalent among Chinese university students. The aim of this study was to investigate the effectiveness of a group mindfulness-based cognitive-behavioral intervention on smartphone addiction in a sample of Chinese university students.

Methods

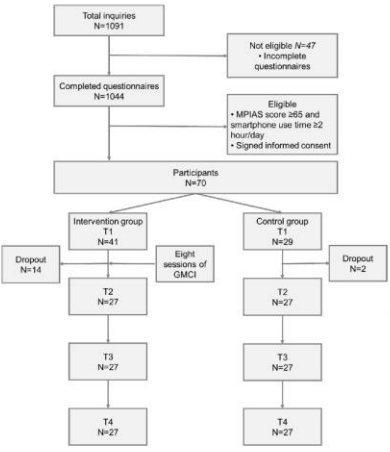
Participants

We applied stratified cluster sampling to select three to six classes from the medical college, the arts college, and the college of science and engineering of a university in Shanghai. Altogether, we distributed 1,091 questionnaires to the students, and 1,044 completed questionnaires (95.7% response) were ultimately returned. The average age of the students was 21.3 ± 1.3 years, and males accounted for 47.6% of the sample.

Procedures

The details of the intervention process are shown in Figure 1.

Figure 1. Participant flow. Note. T1 refers to the baseline measurement (1st week), T2 refers to the post-intervention (8th week), T3 is the first follow-up (14th week), and T4 is the second follow-up (20th week). MPIAS: Mobile Phone Internet Addiction Scale; GMCI: group mindfulness-based cognitive-behavioral intervention



Program description

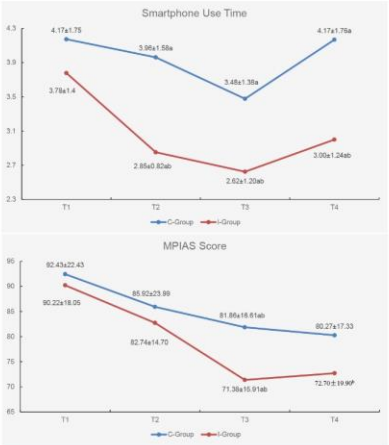
Before the launch of the intervention, both the intervention and the control groups got an educational lecture and flyers about smartphone addiction. The intervention program consisted of eight sessions. The session was once a week with each session lasting approximately 1 hour. In the first three sessions, the interventions were aimed at cognitive reconstruction. They were as follows: the first session consisted of an orientation and individual feedback on smartphone use incentives; the second session focused on identifying high-risk situations; and the third session focused on identifying negative thoughts and cognition reconstruction. We integrated mindfulness meditation into the intervention under the framework of cognitive-behavioral therapy in the last five sessions: the fourth session taught meditation learning and relaxation training; the fifth session taught participants to cope with relapse; the sixth session focused on other activities to replace smartphone use; the seventh session discussed setting life goals and rules; and the eighth session was spent reviewing the program. The participants were asked to do homework, which included reviewing the contents of the last session and/or practicing mindfulness meditation every day.

Results

There were no statistically significant differences between the intervention group and the control group for age and gender. In addition, there were no differences in smartphone use time and MPIAS score between the two groups at T1.

The intervention showed significant effects on both smartphone use time and score of mobile phone internet addiction scale (Figure 2).

Figure 2. The changes in the estimated marginal means for the four time points according to the intervention and control groups. Note. MPIAS: Mobile Phone Internet Addiction Scale; I-group: intervention group; C-group: control group; T1: baseline (1st week); T2: post-intervention (8th week); T3: the first follow-up (14th week); T4: the second follow-up (20th week); the numbers are shown as the mean ± standard deviation. Values with superscript "a" indicate that the means for the I- and C-groups at the same time point are significantly different; "b" indicates that the mean for time point T2, T3, or T4 is significantly smaller than the mean value for T1 in the I- or C-group.



Conclusions

- The pilot study demonstrated the significant effectiveness of the group mindfulness-based cognitive-behavioral intervention on smartphone addiction.
- The advantage of this group mindfulness-based cognitive-behavioral intervention is that it is structuralized and programmed. Accordingly, the GMCI could be easily conducted by an instructor who has received only short-term training.
- A further study with a multicenter, randomized controlled design will be conducted in heterogeneous populations to validate the results.

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Acknowledgements:

The authors would like to thank all of the participants in the study.

Conflict of interest

The authors declare no conflict of interest.

Poster presented at 23rd IUHPE World Conference on Health Promotion, Rotorua, Aotearoa New Zealand, 7 - 11 April 2019

The Transition to Parenting within a Digital Health Context

Lorie Donelle, PhD, RN[1], Jodi Hall, PhD[1,2], Kim Jackson, PhD, RN[1], Ewelina Stoyanovich, BScN, BA, RN[1], Jessica LaChance, MScN, RN[1]
1. Arthur Labatt Family School of Nursing, Western University, London, Ontario, Canada. 2. School of Nursing, Fanshawe College, London, Ontario, Canada

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Background: The use of information and communication technologies are integrated into all aspects of daily life; education, employment, health, social, civic engagement and entertainment. While there is a developing body of literature on the use and effects of digital technology among children, adolescents and young adults, digital technology use in pre-conception, pregnancy and the postpartum period (referred to as the transition to parenting) is understudied. Research pursuing richer understandings of how parents use health information technology is necessary and has the potential to inform recommendations for seeking safe and reliable health information regarding infant and maternal care.

PURPOSE: of this study was to explore the ways digital technology contributes to the transition to parenting; to investigate the role digital technologies play in organizing & structuring pregnancy and early parenting practices.

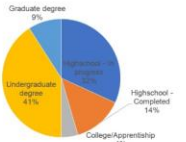
METHODS: Qualitative exploratory study. Data was collected through focus groups and interviews with parents between the ages of 16 and 35 years with at least one child under 2 years.

Inquired about self-reported engagement with digital devices and information technology (i.e. social media apps) during preconception, prenatal and postnatal. Thematic analysis was conducted.

Findings:

Figure 1. Participant Demographics

	N (N=26)	Percentage (%)
GENDER		
Female	26	100
Male	0	0
AGE	Missing Data = 4	
<17	1	4
18-20	7	27
21-29	4	15
30-35	10	38
INCOME	Missing Data = 4	
<20,000	4	15
20,000 – 49,000	3	12
50,000+	10	38
Prefer Not to Answer	5	19



THEMATIC FINDINGS:

1. PREFERRED HARDWARE/SOFTWARE:

- Smartphones = *"easy to use"*.
- "I actually texted my mom when I told her [I was pregnant]".

2. ACCESSING INFORMATION:

- **24/7 access**: "I did google once at 3 in the morning...it was heartburn, but ...I never had it before and I thought I was having a heart attack..."
- "...apps just helped like be aware... what's happening to my body, what's happening inside, like what should I expect... **is this normal**"
- Ease of access vs **trustworthiness of information:** "I think [online information] is helpful for parents, but maybe what's important is teaching new parents how to access ...credible websites."
- "So I thought this doppler I got...if I could hear the [fetus] heartbeat that I would feel better. So, I didn't know how to do it [operate the doppler], so I had to YouTube it....I didn't feel my son move one morning and I was like I'm going to the hospital and my husband's like 'you're on google, you're fine'. But I wasn't fine and then I had him an hour later".

3. DIGITALLY-INFORMED PARENTING:

- Social media supported **breast feeding** "So, it [smartphone use] was what kept me awake and then when I was done [breastfeeding], ...I had a hard time disconnecting and shutting down".
- **Positive** social media impact: positive validation via social media reported as a "confidence boost" and "makes you feel good"
- **Negative** social media impact: "I'm just big and feeling ugly and then you see all these perfect pregnant pictures".
- **Privacy**: "I don't really like the idea of him (baby) having a huge social media presence... I don't want strangers to know details about him.."

4. REIFYING GENDERED ROLES:

- Mother's as **information gatekeepers**: "that's my job",

"You [mother] just let me [father] know what I need to know."

- **Gendered apps** "...a daddy app, so it was like relating it [growth and development of fetus] to like a size of a beer or something like that. It was totally like dad style."

DISCUSSION

- Digital technologies enhanced access to information regarding infant growth and development; mothers' physical and mental symptoms in pregnancy and postpartum. Immediacy of information access appeared to be valued over information integrity. Participants reported little to no change in their partner's (father) digital technology use in their transition to parenting.
- This research has implications for maternal/paternal health education and provides insight into digital health practice for health care providers.
- Future research is warranted to: 1. explore equitable health information access and digital health literacy skills with diverse parent groups, 2. develop a greater understanding of the influence of digital technology on fathers transition to parenthood, 3. understand digital technology use among diverse parent groups (disabled, LGBTQ+2, living in poverty / homeless).

Analysis of On-line News Articles on Women's Health Using Topic Modeling Technique

Kyoung Won Cho and Young Woon Woo

Department of Healthcare Administration, Kosin University, Busan, Korea
Division of Creative Software Engineering, Dong-eui University, Busan, Korea

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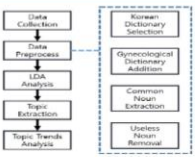
23rd World Conference on Health Promotion

Background/Objective

In this paper, we tried to understand the flow of interest in the field of women's health through analysis of news articles on healthcare. Researches on the analysis of news articles on women's health have been conducted in the past, but were limited to contemporary analysis and only one kind of disease. Therefore, we have collected and analyzed articles that have dealt with women's health related topics in this paper. We would like chronologically to classify and examine how social issues related to women's health and diseases have changed by suddenly changing social environment.

Methods

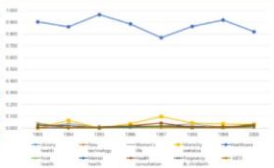


In step 1, the online news articles(1993 ~ 2015) were collected from a selected news website, and the collected news articles were saved as text files in comma separated values file format. In step 2, the saved data were preprocessed so that the analysis results could be accurately derived. In step 3, the preprocessed data were analyzed using the LDA algorithm[18][19]. In step 4, major topics representing the news articles were extracted from LDA analysis results. In step 5, topic trends by year and period were analyzed using the extracted topics.

Results

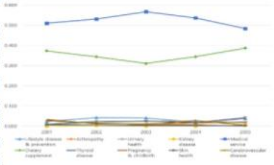
1. Period from 1993-2000

For the period from 1993-2000, 10 representative topics on women's health were identified: "healthcare," "health consultation," "pregnancy and childbirth," "AIDS," "urinary health," "mortality statistics," "foot health," "women's life," "new technology," and "mental health." An examination of the proportions of the topics revealed that most of the articles were focused on the topic of "healthcare." The proportions of articles focused on the other 9 topics were relatively small(Fig. 1).



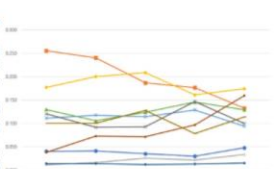
2. Period from 2001-2005

For the period from 2001-2005, 10 representative topics on women's health were identified: "cerebrovascular disease," "arthropathy," "skin health," "medical service," "kidney disease," "dietary supplement," "thyroid disease," "pregnancy and childbirth," "lifestyle disease and prevention," "urinary health." An examination of the proportions of the topics revealed that most of the articles were focused on the topics of "medical service" and "dietary supplement," and some specific topics were characterized as being of high interests (e.g., "healthcare" in the 1990s)(Fig. 2).



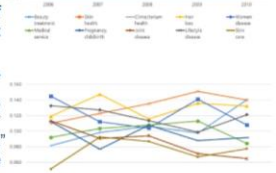
3. Period from 2006-2010

For the period from 2006-2010, 10 representative topics on women's health were identified: "climacterium health," "pregnancy and childbirth," "women disease," "beauty treatment," "medical service," "skin health," "lifestyle disease," "hair loss," "joint disease," "skin care." An examination of the proportions of the topics revealed that the proportion of articles on the topic of "skin health" had been steadily decreasing from 2006-2010. This decrease was also found in several other topics, such as "beauty treatment," "hair loss," and "skin care," as various topics in the field of "skin health" were subdivided. In addition, articles on the topic of "joint disease" continued to increase for 5 years(Fig. 3).



4. Period from 2011-2015

For the period from 2011-2015, 10 representative topics on women's health were identified: "women's cancers," "skin health," "gynecology," "medical service," "lifestyle disease," "dietary supplement," "joint disease," "infectious disease," "skin care," "climacterium." An examination of the proportions of the topics revealed that differences in proportion among the topics was not large after 2011. "Dietary supplement" consistently showed high interest, and the articles related to MERSC were highly reported on because of the MERSC incident that first occurred in Korea in 2015(Fig. 4).



Analytical Study on Japanese Health Education Textbooks for Senior High School Students on Smoking Issues

Suketaka Iwanaga[1], Keiko Kusaka[1], Kazunari Satomura[1], Toshitaka Nakahara[1]
[1]Department of Public Health, Faculty of Medicine, Kyoto University, Kyoto, Japan

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Background

- Smoking cessation treatment is covered by the National Health Insurance Plan in Japan
- Medical staff have to know the patients' knowledge level on smoking hazard
- Health education textbooks can be referred as a basic knowledge of the general population

Methods

- All the three kinds of health education textbooks in use in senior high schools were analyzed for comparison
- Textbooks were issued in 2013 by two publishers
- They are conformed to the curriculum guidelines by the government announced in 2009
- 148 characteristic key words/phrases and 14 images/charts were picked up and cross-checked among the textbooks.

Results

- Each textbook devotes two pages to the chapter
- The key words and phrases were classified into seven categories
- The physical effects category has the highest words/phrases count
- The words "cancer" and "cancer production" are used in all the textbooks but specific cancer names are used in only one of the textbooks
- In the category of social issues, "second hand smoking" is the only word which all the textbooks describes
- In the category of smoking hazard, five words/phrases are the common in the three textbooks
- In the physical effects category, "cancer" and "hyper tension" are the common words
- In the mental effects category, "dependence" is the only common word
- In the start factor category, "curiosity" is the only common word
- In the legal issues category, "Health Promotion Law" and "WHO FCTC" are the common words
- In the legal issues category, there is no common word

Discussion

- Each text book has own characteristic in description with different amount and quality of knowledge
- The students who are almost the legal age of smoking (age 20 in Japan) should have correct and enough knowledge
- The medical staff and counselors should be flexible to the patients with different levels of knowledge on smoking hazards

social issues

	second hand smoking	health effects: loss of labor power	smoking of pregnant women: escalation of medical costs: big ill effect to the whole society	smoking causes ill effects to human body: global health issue	burn caused by cigarette fire: littering
	increase of healthcare expenditure some hundreds to thousands of billions of yen				
TEXTBOOK 1	○		○	○	
TEXTBOOK 2	○		○		
TEXTBOOK 3	○				○

smoking hazard

	nicotine	carbon monoxide: cancer production: tobacco smoke contains various harmful substances	bound strongly with hemoglobin	mainstream smoke	dopamine: tumor promoting activity: sidestream smoke	cyanogen compound: release of pleasant substance: sidestream smoke is more harmful than mainstream smoke: sidestream smoke contains 3 times more tar and nicotine than mainstream	dozens of carcinogens	carcinogen: more than 200 kinds of carcinogens
	tar			sidestream smoke		sidestream smoke contains 5 times more carbon monoxide than mainstream		
TEXTBOOK 1		○	○	○		○		
TEXTBOOK 2		○	○				○	
TEXTBOOK 3		○		○				○

mental effects

	dependence	80–90% of people trying to quit smoking will be frustrated within one year	nicotine dependence	difficult to quit on my own will: habituation of smoking	withdrawal symptoms / frustrating: many smokers have experienced smoking cessation: start with own will and cannot stop by own will	appetite loss: lack of concentration
TEXTBOOK 1	○	○		○		
TEXTBOOK 2	○	○	○		○	
TEXTBOOK 3	○		○			○

physical effects

	cough	strain the heart: heart disease: miscarriage			shortness of breath during exercise	stiff shoulder / heart rate elevation / periodontal disease: headache
		skin aging			life style related disease	breath odor
	preterm delivery	habituation			nicotine addiction	ill effect to athletic performance
	early start smoking causes more effects	husband's smoking causes high lung cancer mortality of wife			oxygen blood flow reduction	declining intellectual ability
	sputum	chronary effects		pain caused in eyes, nose and throat: inhibition of oxygen transport	developing body organs are easily influenced	increases the possibility of sudden infant death syndrome
	acute effects	peripheral vascular constriction	low-birth-weight baby		cell oxygen deficiency	poor athletic performance
	cancer	blood-pressure raised	arterial sclerosis		inhibition of tissue respiration	chronic respiratory illness
	emphysema	pleasantness due to smoking	chronic bronchitis	gastric ulcer	destruction of airway cilia	central nervous system stimulation
					desire to smoke	reduction of cerebral blood flow
TEXTBOOK 1	○	○	○		○	
TEXTBOOK 2	○	○		○		○
TEXTBOOK 3	○		○	○		

	lung cancer	effect on fetus
	bladder cancer	oral cancer
	duodenal ulcer	pharyngeal cancer
	esophagitis	esophagus cancer
	angina pectoris	stomach cancer
	hyper tension	myocardial infarction
	bronchial ectasia	cerebral vascular disease
	awful smell	pregnancy complication
	headache	decrease in body endurance
	wheeze	discomfort feeling
TEXTBOOK 1		
TEXTBOOK 2		
TEXTBOOK 3	○	

measures

	smoking cessation treatment by health insurance	taspocard: countermeasures against smoking: diffusion of correct knowledge: fostering healthy values: learning about smoking from elementary school: ambiguous wording improved to concrete expression: cigarette warning display	vending machine / price increase: Measures for underage: separation of smoking areas: adult sense vending machine: Indication of intention not to smoking cessation supporting: increase of smokers for aiming
		not increasing new smokers is important to decrease smokers: preventing action of minors buying cigarettes on vending machines	Japan is naive about the evils of tobacco: recognition of harms of smoking and making decisions
TEXTBOOK 1	○	○	
TEXTBOOK 2			
TEXTBOOK 3	○		○

legal issues

	WHO FCTC / Health Promotion Law	strengthen: warning indication on tobacco packaging	legal action: Act for Prohibiting Minors from Smoking ad regulation	prevention of minor smoking: street smoking ban: tobacco ad limit: penalty for tobacco sellers to minors	amendment to the minor smoking ban law: smoking cessation and countermeasures against smoking in public facilities
TEXTBOOK 1	○	○	○		
TEXTBOOK 2	○				
TEXTBOOK 3	○	○			○

starting factor

	curiosity	advertising / family influence: friends influence: factors for starting smoking	smoking scenes of TV dramas	low self-affirmation: personal factors: social factors	light heart: person who doesn't care about self: person who has no goals or dreams in the life
TEXTBOOK 1	○	○	○	○	
TEXTBOOK 2	○	○			○
TEXTBOOK 3	○		○		

culture issues

	South American natives used it as medicine
TEXTBOOK 1	
TEXTBOOK 2	
TEXTBOOK 3	○

chart & image

	IMAGE:"smoker's dirty lungs" / CHART:"effect of husband smoking on wife's health"	CHART:"habituation of smoking"	IMAGE:"skin temperature change" / IMAGE:"capillary vessels change" / CHART:"harmful substances of cigarette smoke and its health effects" / IMAGE:"cigarette warning & taspo card"	MRI IMAGE:"cervical arteries change" / CHART:"Smoking of parents and sudden death of infants" / CHART:"various effects on health by smoking"	CHART:"smoking rate of senior high students" / CHART:"lung cancer & total cancer mortality ratio by smoking start age" / IMAGE:"overseas cigarette packaging warning with pictures" / CHART:"diseases related to smoking"
TEXTBOOK 1	○	○	○		
TEXTBOOK 2	○	○		○	
TEXTBOOK 3	○				○

Training Effectiveness in Early Childhood Education – TEECh Study

IUHPE

Are face-to-face trainings effective in fostering the implementation of health promotion programs? A comparative study in early childhood education.

Renda A., Dirkis H., Voukelatos A., Taki S., Bonnefin A., Pokhrel A., Varas K., Li C., Hyde-Page A, Wen LM.
Health Promotion Unit, Population Health, Sydney Local Health District, NSW Health, Australia

Background

- Currently in Australia, childhood obesity is one of the most important public health issues with 25% of 2 – 3 year olds and 20% of 4 – 5 year olds being overweight or obese.
- World Health Organization report identified centre-based childcare services as an integral setting for prevention programs.
- There is limited research targeting Early Childhood Care Educators involved in promoting a healthy and supportive environment for children.
- There is also insufficient evidence looking into the effectiveness of face-to-face training compared to online training in early childhood settings.

Aims

Study 1

Explore — Via interviews to Early Childhood Educators trained through a live webinar

Identity — **Key factors impacting:**
- **Interest** to complete the *Munch & Move* training
- **Experience** during training
- Experience with **implementation**

Inform
- RCT evaluating modes of training
- Additional identified contingency factors

Study 2

Face-to-Face VS Online

Increase motivation, confidence and knowledge of educators

↓

Effectiveness in implementing a health promotion program over time

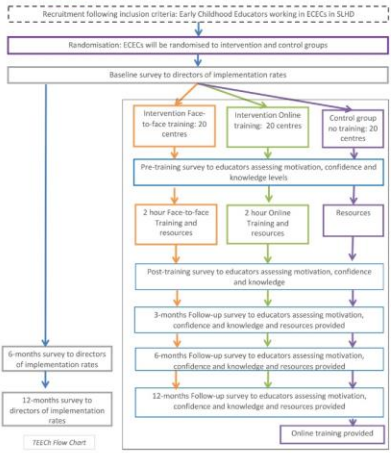
Methods

Study 1

Qualitative individual interviews with:

Early childhood educators from the Inner Sydney area who have:
1. Completed the *Munch & Move* Live Webinar course during 2016-2018 (n=67).
2. Registered but not completed the *Munch & Move* Live Webinar during 2016-2018 (n=16).
3. Not registered nor completed the Live Webinar during 2014-2018 and their centre have not undergone any *Munch & Move* training (n=60).

Study 2



A process evaluation will be conducted post-training with in-depth interviews.

Preliminary Results

Study 1

Recruitment ongoing – Interviewed n=7

Interest

- Educator/Director believes health is a priority for children's wellbeing.
- Educator/Director has demonstrated willingness to implement program.
- Participants reported that they initiated interest in undertaking training.

Experience

- Facilitator's attitude during live webinar contributes to increased motivation.
- Educator finds lack of time as a barrier when motivating colleagues.
- As knowledge increases, motivation increases.

Implementation

- Director perceives own power to implement program.
- Educator perceives that they lack power without director's support.
- Educator feels confident in finding information after training.
- Educator/Director feels responsible for sharing information amongst colleagues.
- Educator/Director feels confident in communicating with parents about healthy eating and physical activity.

Potential benefits of study

Contributes to preventing childhood obesity and encourages ongoing improvements of training provided to Early Childhood Education and Care services.

Contact: Ana Renda - Ana.Renda@health.nsw.gov.au

These results do not represent the *Munch & Move* program and NSW Health.

NSW GOVERNMENT

Articulated interdisciplinary teaching-service experience: which actors are essential for its success?

IUHPE 23rd World Conference on Health Promotion

Ligia Ferreira Gomes[1], Samuel Cecconi [2]

lfgomes@usp.br 3cecconi@gmail.com

1 Faculdade de Ciências Farmacêuticas and Instituto de Física da Universidade de São Paulo; São Paulo, SP, Brasil
2 Unidade Básica de Saúde Vila Piauí SMS CRS Oeste STS LAPI and Associação de Saúde da Família; São Paulo, SP, Brasil

MOTIVATION

- Higher education in Health aims to stimulate knowledge of the world in the continuous search for the best solutions, provide specialized services, and establish a reciprocal relationship with the community.
- The student should be encouraged to "learn to learn, to learn to live together, to learn to be", configuring the education pillars, in a critical and reflexive dialogue with the reality of their environment
- Articulation of Higher Education Institutions with Brazilian Health System (SUS) is an alternative for professional training, provided it contributes to the strengthening and improvement of SUS itself.

OBJECTIVES

The graduation discipline Multiprofessional Practice in Basic Healthcare was conceived by a team of teachers, students and professionals working on Basic Healthcare Services after a program set by the Brazilian Ministry of Health (PET-SAUDE) aimed on improving interprofessional learning and collaborative practice through tutored actions and intervention projects at Brazilian Health System (SUS) scenarios.

METHODS AND STRATEGY

Real world practice scenarios at the SUS Basic Healthcare Units (BHU) are the primary fields for living, immersion and active participation for students from distinct professional courses, in interaction with preceptors, teachers and the community. Entrepreneurship, problem and conflict solving , debates, system analysis, creativity, leadership and sharing, interprofessional learning and cooperation were stimulated.

Multiprofessional Practice in Basic Healthcare creation and approval by University of São Paulo (2014-2015)

University of São Paulo granted Training Fellowship projects:
Multiprofessional Teams as an educational training tool for Basic Health Care (2015-2019)
Interdisciplinary experience in Health Promotion: Primary Health Care in Early Childhood (2018-2019)



Application for internships at the Lapa-Pinheiros Technical Health Supervision from the São Paulo City West Region coordination (STS-LAPI CROeste) (2015-2019, annually renewed)

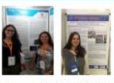
Admission within the scope of the Contracts for Organizing Public Teaching-Health Actions (COAPES) (2015, 2018)

Definition of actions and objects for thematic study (permanent education), planning and pacing of experiential learning and intervention projects.

Active learning about the conceptual bases of work and clinical instruments, development of skills in HealthCare production and management, Permanent Education.



Shared assessment, Institutional evaluation by University and Health Department Secretariat . Local evaluation by users' council of the services and the BHU management



Academic reporting valuing SUS based and teamwork produced knowledge

RESULTS

Experiences on routine actions of the SUS Family Health Program

Health campaigns and vaccination

Health Promotion actions in district


Global and national programs and therapeutic groups (UBS Vila Piauí): Harm reduction and support for halt smoking (2015-2017); Health at School (2016-2018); Integrative complementary practices (2016-2019); Healthy nutrition (2018-2019)







Intersetorial projects and Primary Care Health Clinic : Support for the creation and activities of Baby-parents Group (UBS Vila Piauí, 2015-2017) , activities of the Child Development Follow-up Group (UBS Vila Romana, 2018-2019).


The biggest challenges are to guarantee the groups sustainability and improve material resources and ambience. The main difficulties are for the students to get from their homes to the UBS and for the team to deal with senior professional retirements.

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WAIORA: Promoting Planetary Health and Sustainable Development for All

Assessing the sexual behaviour and HIV knowledge among students in Eswatini: Are 'all in' to end adolescent AIDS?

IUHPE
23rd World Conference on Health Promotion

Authors: Kevin Makadzange[2] Mildred Xaba[1] Rejoice Nkambule[1] Tigest Ketsela Mengestu[2]
Affiliations: *[1]Ministry of Health, Mbabane, Eswatini; [2]World Health Organization*

Background/Objectives:

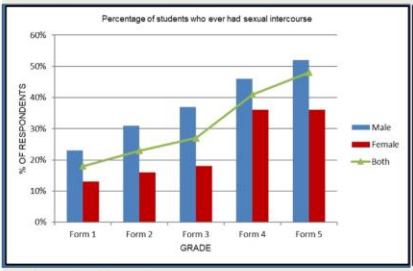
Adolescents and young people are less likely to be vulnerable to HIV when they are offered relevant gender-sensitive prevention information, skills and services in an enabling and protective environment. The study therefore aimed to assess sexual behaviours and HIV knowledge among high school students aged 13 to 17 years.

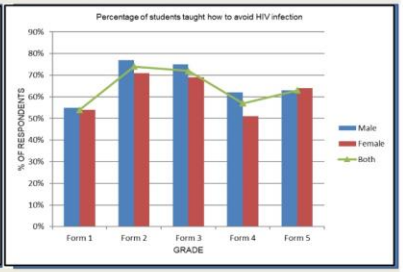
Methods:

A cross sectional descriptive school based national survey was conducted among students in forms 1 to 5. A two-stage cluster sample design was used to produce data representative of all students in Forms 1-5 in Eswatini.

Results:

- **A total of 3, 680 students from 25 schools took part in the survey.**
- **A total of 957 (28%) reported being sexually active with 25% of them starting before the age of 14 years.**
- **The majority reported taking alcohol or other drugs before engaging in sex; 12% had slept with more than 2 people in their life time and one third never used a condom during their last sexual encounter.**
- **About 40% of the students had never received information on the benefits of not having sexual intercourse or how to avoid HIV infection or AIDS in any of their classes.**
- **A total of 1 865 (51%) had never been taught where to get tested for HIV infection and 38% of the students never talked about the disease with their parents or guardians.**
- **In addition 44 % of the students did not know that a pregnant woman with HIV or AIDS can infect her unborn child whereas 26% did not know that a health looking person can be infected with HIV.**





Discussion:

The evidence reveals that young people engage in risk sexual behaviours. Though HIV prevention and control messages are being disseminated through schools some young people are being left out. Efforts to improve this situation including use of qualitative research studies to understand the reasons behind the risk behaviours and some children being missed are urgently needed.

Corresponding author: Kevin Makadzange, World Health Organization, 2nd UN House, P.O.Box 903, Mbabane, Eswatini. Telephone +268 7631 5919, Fax +268 2404 4566. Email: makadzangek@who.int

World Health Organization

WAIORA: Promoting Planetary Health and Sustainable Development for All

Assessing the status of diabetes associations in the Pacific: a starting point for strengthening associations to address diabetes

Authors: Si Thu Win Tin[1,2] , Elisiva Na'ati [1],Solene Bertrand[1]; Paula Vivili[1], Sunia Soakai[1], Viliami Puloka[3]; Erin Passmore[1]
Affiliations: [1]The Pacific Community (SPC), [2]The University of Sydney, [3]Otago University

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Background and Objective

Diabetes imposes an unacceptably high economic cost and is a major health and development challenge, especially in the **Pacific Island countries and territories** (PICTs). Declarations and commitments aimed at addressing diabetes consistently highlight the urgent need for a whole of government and society approach. It is well-recognised that stakeholders such as **diabetes association** play an important role in tackling diabetes, however, limited information is available about their existence and functions.

This study aimed to assess the status of diabetes associations in PICTs, as a starting point for strengthening their efforts to tackle diabetes and to promote health as PICTs move towards achieving the **Sustainable Development Goals** and **Healthy Island Vision.**

Method

This **cross-sectional study** was conducted in 21 PICTs using a structured questionnaire, which gathered information on the **existence of diabetes associations**, **organisational structure**, **funding sources** and **ongoing activities** to address diabetes.

Results

Overall Findings

Overall status of existing diabetes associations/coalitions (12 PICTs)

Results (continued)

Status of existing diabetes associations (12 PICTs)

Description	Number (%)
Organisation	
Diabetes associations with a specific purpose, vision and goal, and is functioning.	7 (58%)
Diabetes associations with a board of directors / committee for governance, and is functioning.	7 (58%)
Funding	
Diabetes associations with a regular source of funding.	6 (50%)
Activities	
Diabetes associations that hold annual events (World Diabetes Day, World Food Day, World Health Day etc.).	9 (75%)
Diabetes associations that organise education and awareness activities on an ongoing basis.	7 (58%)
Diabetes associations that organize ongoing health programs (physical activity program, health food cooking demonstration program, etc.).	4 (33%)
Diabetes associations that produce resources (pamphlets, flyers, posters, etc.).	4 (33%)
Diabetes associations that collaborate with other organisations in their country (Ministries of Health, schools, colleges, non-government organisations, etc.).	9 (75%)

Discussion and Conclusion

Having strong and well-functioning diabetes associations is key in our collaborative approach to address diabetes in the Pacific. This study **fills a knowledge gap** on the status of diabetes associations and forms a baseline from which **associations can be strengthened**.

The findings from this study will draw attention to the need for Pacific leaders **to invest and engage** more in civil societies for better and effective diabetes care and to promote health for all. This will ensure **Pacific people reach their potential and lead healthy lives.**

Inaugural Pacific Diabetes Associations Meeting to strengthen the governance and function of associations, 2017

Association with eating habit, body mass index and health risk factors among the first-year students of university, South Korea

Young-Bok Kim

Department of Rehabilitation & Health Promotion, College of Rehabilitation Science, Daegu University, South Korea

IUHPE 23rd World Conference on Health Promotion

Background and Objectives: Healthy eating habit is known the effective factor to reduce health risks and health problems. On the other hand, unhealthy behaviors have been increased for several years among young people in South Korea. Especially, to improve health status, it needs to provide the customized health services to promote health behaviors. This study performed to analyze BMI and health risk factors related to eating habits among the first-year students of university.

Methods: To examine the association with eating habit and health promotion behaviors, health survey was conducted with 3,918 students who were first-year students in a university by self-reported questionnaire from February 26 to March 10, 2015. In this study, eating habit was defined whether they had been once and more having breakfast in recent two day or not. BMI was classified by Asian criterion. Multiple logistic regression analysis was performed to identify the difference of BMI and health behaviors by eating habit.

Results: 2,921 (74.6%) students were healthy eating practitioner and 37.4% of survey participants was regular exerciser. 11.9% (n=466) of them was current smoker and 11.3% was risky drinker. Low weight group was 20.9%, and 24.3% included in overweight and obesity group. In multiple logistic regression models, it remained significantly the difference of eating habit by gender, subjective health status, BMI, frequency of having fruits and vegetables per one day, drinking behavior, regular exercise and participation of health check-up ($p<0.05$, $p<0.01$). On the other hand, it was not significant the difference of that by smoking behavior, sleeping hours and mental health.

<Table 1> General characteristics

Classification		Total (n=3,918)	
		n	%
Gender	Male	2,076	53.0
	Female	1,842	47.0
Subjective health status	Healthy	2,120	54.1
	Unhealthy	1,798	45.9
BMI (Kg/m^2)	Under 18.5	819	20.9
	18.5-29.9	2,146	54.8
	23.0-24.9	512	13.1
	25 and plus	441	11.2
Eating breakfast	Yes	2,921	74.6
	No	997	25.4
Vegetables & fruits intake per 1 day	None	396	10.1
	1 time and plus	3,522	89.9
Regular exercise	Yes	2,020	51.6
	No	1,898	48.4
Monthly drinking	Non-drinker	1,348	34.4
	Drinker	2,570	65.6
Binge drinking	Non-heavy drinker	3,473	88.6
	Heavy drinker	445	11.4
K-AUDIT	Normal	2,352	60.0
	Drinking problem	1,249	31.9
	Alcohol abuse	183	4.7
	Alcohol dependence	134	3.4
Current smoking	Non-smoker	3,452	88.1
	Smoker	466	11.9
Secondhand smoke exposure time per 1 day	Under 1 hour	3,745	95.6
	1 hour and plus	173	4.4
Sleeping hours per 1 day	Under 7 hours	1,460	37.3
	7 hours and plus	2,458	62.7
Health check-up within 2 years	None	2,640	67.4
	1 time and plus	1,278	32.6
Stress level	Low	2,895	73.9
	High	1,023	26.1
Depression	No experience	3,595	91.8
	Experience	323	8.2
Suicidal thoughts	No experience	3,746	95.6
	Experience	172	4.4

<Table 2> health factors by eating habit

Classification		Eating breakfast (n=2,921)	
		ORs	95% CI
Gender	Female	1.000	-
	Male	0.656	0.550-0.783
Subjective health status	Unhealthy	1.000	-
	Healthy	1.225	1.050-1.429
BMI (Kg/m^2)	Under 18.5	1.000	-
	18.5-29.9	1.221	1.009-1.477
	23.0-24.9	1.077	0.821-1.413
	25 and plus	1.195	0.888-1.609
Vegetables & fruits intake per 1 day	None	1.000	-
	1 time and plus	1.232	1.155-1.313
Regular exercise	No	1.000	-
	Yes	1.252	1.063-1.475
Binge drinking	Non-heavy drinker	1.000	-
	heavy drinker	0.659	0.506-0.859
K-AUDIT	Normal	1.000	-
	Drinking problem	0.821	0.688-0.980
	Alcohol abuse	0.798	0.548-1.163
	Alcohol dependence	0.884	0.561-1.394
Current smoking	Non-smoker	1.000	-
	Smoker	0.776	0.600-1.004
Secondhand smoke exposure time	Under 1 hour	1.000	-
	1 hour and plus	0.839	0.587-1.200
Sleeping hours	Under 7 hours	1.000	-
	7 hours and plus	0.981	0.931-1.033
Health check-up within 2 years	None	1.000	-
	1 time and plus	1.252	1.015-1.405
Stress level	Low	1.000	-
	High	0.935	0.803-1.088
Depression	No experience	1.000	-
	Experience	0.847	0.635-1.129
Suicidal thoughts	No experience	1.000	-
	Experience	1.313	0.890-1.936
Goodness-of-Fit Test		x^2=13.481	

Conclusion: To reduce health risk factors of university students, it should build healthy policies and provide comprehensive health promotion programs on campus. Also it needs to develop various tailed messages and smart healthcare service using health information technology (IT) on campus to help the achievement of their academic goal and health promotion.

Key words: Eating habit, health risk factors, health promotion behavior, university students

Association with subjective health status, health promotion practices and mental health among university students

Young-Bok Kim

Department of Rehabilitation & Health Promotion, College of Rehabilitation Science, Daegu University, South Korea

IUHPE 23rd World Conference on Health Promotion

Background and Objectives: Life style modification program improves their health status of young people and reduces the health risks. On the other hand, in the results of National Health Survey, subjective health status of youth has not been better until recently. Therefore, to help the achievement of academic goal of university students, it needs to analyze the effective factors to prevent health problems among them. This study performed to analyze health promotion practices and mental health related to subjective health status among first-year students of university.

Methods: To examine the association with subjective health status, health promotion practices and mental health, health survey was conducted with 3,918 students (male 2,076 vs. female 1,842) who were first-year students in a university by self-reported questionnaire from February 26 to March 10, 2015. Multiple regression analysis performed to identify the difference of promotion practices and mental health by subjective health status.

Results: 53.9% of the survey participants responded that they were healthy (mean=3.60). The 40% of them was alcohol use disorders, and 466 (11.9%) students were current smoker. The 4.4% was exposed to secondhand smoking for one hour and over per one day. In multiple regression models, it remained significantly the difference of subjective health status by BMI, AUDIT, secondhand smoking, eating breakfast, frequency of having fruit and vegetables per one day, practice of walking, strengthen exercise, vigorous exercise per one week, stress level, and suicide thought ($p<0.05$, $p<0.01$). On the other hand, it was not significant the difference of that by gender, current smoking, practice of moderate exercise, sleeping hours, health check-up, and depression experience.

<Table 1> General characteristics

Classification		Total (n=3,918)	
		n	%
Gender	Male	2,076	53.0
	Female	1,842	47.0
Subjective health status	Healthy	2,120	54.1
	Unhealthy	1,798	45.9
BMI (Kg/m2)	Under 18.5	819	20.9
	18.5-29.9	2,146	54.8
	23.0-24.9	512	13.1
	25 and plus	441	11.2
K-AUDIT	Normal	2,352	60.0
	Drinking problem	1,249	31.9
	Alcohol abuse	183	4.7
	Alcohol dependence	134	3.4
Current smoking	Non-smoker	3,452	88.1
	Smoker	466	11.9
Secondhand smoke exposure time per 1 day	Under 1 hour	3,745	95.6
	1 hour and plus	173	4.4
Eating breakfast	Yes	2,921	74.6
	No	997	25.4
Vegetables & fruits intake per 1 day	None	396	10.1
	1 time and plus	3,522	89.9
Regular walking per 1 week	Yes	1,122	28.6
	No	2,796	71.4
Regular strengthen exercise per 1 week	Yes	1,407	35.9
	No	2,511	64.1
Regular moderate exercise per 1 week	Yes	299	7.6
	No	3,619	92.4
Regular vigorous exercise per 1 week	Yes	756	19.3
	No	3,162	80.7
Sleeping hours per 1 day	Under 7 hours	1,460	37.3
	7 hours and plus	2,458	62.7
Health examination within 2 years	None	2,640	67.4
	1 time and plus	1,278	32.6
Stress level	Low	2,895	73.9
	High	1,023	26.1
Depression	No experience	3,595	91.8
	Experience	323	8.2
Suicidal thoughts	No experience	3,746	95.6
	Experience	172	4.4

<Table 2> Health factors by subjective health status

Classification		Subjective healthy status (n=2,120)	
		ORs	95% CI
Gender	Female	1.000	-
	Male	1.067	0.909-1.253
BMI (Kg/m²)	Under 18.5	1.000	-
	18.5-29.9	1.138	0.955-1.356
	23.0-24.9	1.269	0.992-1.624
	25 and plus	0.693	0.533-0.901
K-AUDIT	Normal	1.000	-
	Drinking problem	1.167	1.003-1.358
	Alcohol abuse	1.007	0.726-1.398
	Alcohol dependence	0.878	0.589-1.309
Current smoking	Non-smoker	1.000	-
	Smoker	0.912	0.723-1.152
Secondhand smoke exposure time per 1 day	Under 1 hour	1.000	-
	1 hour and plus	0.502	0.357-0.706
Eating breakfast	No	1.000	-
	Yes	1.235	1.058-1.442
Vegetables & fruits intake per 1 day	None	1.000	-
	1 time and plus	1.674	1.332-2.104
Regular walking	No	1.000	-
	Yes	1.257	1.069-1.477
Regular strengthen exercise	No	1.000	-
	Yes	1.416	1.206-1.663
Regular moderate exercise	No	1.000	-
	Yes	1.016	0.753-1.370
Regular vigorous exercise	No	1.000	-
	Yes	1.637	1.329-2.016
Sleeping time per 1 day	Under 7 hours	1.000	-
	7 hours and plus	1.123	0.979-1.290
Health examination	None	1.000	-
	1 time and plus within lifetime	1.081	0.937-1.247
Stress level	Low	1.000	-
	High	0.543	0.473-0.623
Depression	No experience	1.000	-
	Experience	0.810	0.620-1.060
Suicidal thoughts	No experience	1.000	-
	Experience	0.549	0.385-0.784
Goodness-of-Fit Test		x^2=8.6651	

Conclusion: To improve health status of university students, it should provide the comprehensive health promotion programs enhanced mental health and healthy policies on campus. Also in future, it should be focused on multi-dimensional and multi-level approaches on campus to reduce health risk behavior and environment and to build the health promoting university.

Key words: subjective health status, health promotion practices, mental health, university students

AWARENESS AND ACCEPTANCE OF HUMAN PAPILLOMAVIRUS (HPV) VACCINE: A STUDY AMONG FEMALE UNDERGRADUATES AND ANTENATAL MOTHERS IN PORT HARCOURT, NIGERIA.

Author(s) GEORGE-OPUDA IBITOROKO.M[1], OJIMAH CHIBIANOTU[2], EDDEH-ADJUGAH OROMA[3], ADEGOKE O.ADEBAYO[1]

INTRODUCTION

Perception of HPV vaccine in Nigeria is related to its acceptability. The perception that there is no immediate need for vaccination, and therefore acceptability of HPV vaccine had been shown to be influenced by a lot of factors.

OBJECTIVE:

To assess the level of awareness and acceptance of HPV vaccine amongst female undergraduate students and Antenatal (ANC) mothers in Port Harcourt.

METHOD:

A descriptive cross-sectional study was conducted among 800 participant; 436 female undergraduates and 364 ANC mothers. The University of Port Harcourt and the Braithwaite Memorial Specialist Hospital (BMSH) in Port Harcourt was used to obtain data. A self- administered questionnaire was used to obtain relevant information from participants.

RESULTS:

Level of HPV awareness was poor, but the level of HPV vaccine acceptability was high.

able 1.1 **ACCEPTABILITY OF HPV VACCINE**

ACCEPTABILITY OF HPV VACCINE					
Variable	**Yes**	**No**	**X^2**	**df**	**P-value**
Group					
Female undergraduates	198 (43.3%)	237 (69.3%)	53.201	1	<0.001
ANC Mothers	259 (56.7%)	105 (30.7%)			
Knowledge about HPV					
Yes	228(49.9%)	17(5.0%)	185.648	1	0.001
No	229(50.1%)	325(95.0%)			
Knowledge HVP vaccine					
Yes	158(34.6%)	20(5.8%)	93.220	1	0.001
No	299(65.4%)	322(94.2%)			

CONCLUSION:

Enlightenment programs on HPV and HPV vaccination among the study population should be encouraged.

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Better Health Programs Associated With Fewer Problems in Schools in Taiwan and Thailand

Kay, Noy S. [1], Fu-Li Chen [2], Sudgasame Jantaraweragul [1], and Niu, Jingjing [3]
[1] Indiana University School of Public Health, Bloomington, IN; [2] Fu-Jen Catholic University, Taiwan; [3] Iowa Healthcare Collaborative, Des Moines, IA

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Background

It is well supported that school health programs can promote health and safety of young people, help establishing lifelong healthy behaviors, reduce the prevalence of risk behaviors, and improve academic performance.

School health programs based on the Whole School, Whole Community, Whole Child (WSCC) or Coordinated School Health Model have been linked to improved academic achievement outcomes among students. Few studies have evaluated the health related policy and practice using the WSCC framework in Taiwan and Thailand.

Purpose

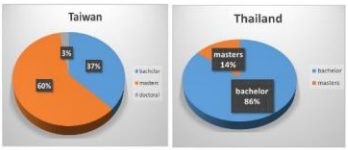
The purpose of the current study is to: 1) provide accurate data on school health policies/practices and risky/protective factors in schools; 2) compare data between Taiwan and Thailand; and 3) identify professional development needs

Methods

Sample

- Procedures: school health education teachers were surveyed on school health programs and school related problems.
- Data of 70 teachers in Taiwan and 44 teachers in Thailand were analyzed

Graph 1: Highest degrees earned by HE teachers



Measurements

School Principal Questionnaire adapted from the CDC School Health Profiles monitors the following aspects:

- School health education requirements and content
- Physical education and physical activity
- Family and community involvement in school health programs
- School environment
- School health policies related to nutrition
- School health coordination

Analysis

All data were analyzed using SPSS package version 24.0. ANOVA tests were applied to detect significant associations between health programs and school problems.

Results

Physical Education and Health Education are required courses in both Taiwan and Thailand.
Teachers of Physical Education and Health Education have at least a bachelor's degree in the sampled schools

Patterns of current programs and teachers' perceptions were presented in frequency by location and educators' demographic factors, such as gender, age, degree, teaching experiences. Significant differences were tested using Independent t-Test or Analysis of Variance.

Table 1: Components of health promoting schools

Component	% developed	
	Taiwan	Thailand
School Policies	90.0	95.9
School Management Practices	81.4	100
School/Community Projects	71.4	95.9
Healthy School Environment	92.9	95.9
School Health Services	90.0	98.0
School Health education	97.1	98.0
Nutrition and Food Safety	90.0	87.8
Physical Exercise, Sports and Recreation	91.4	98.0
Counseling and Social Support	70.0	71.4
Heath Promotion for Staff	78.6	95.9

Significant Associations:

A WSCC score was computed by adding up all available components of health education physical education, health policy, school environment, and health services. A higher WSCC score indicates a better health program. The seriousness of school problems was presented using the mean of problems. A higher problem score indicates a more serious problem. Our linear regression shows that a higher WSCC score is significantly associated with less serious problems in school (Beta=-.299, P=.001).

School health interventions can promote positive health behaviors by:(1) offering students opportunities to practice healthy behaviors; (2) increasing student knowledge and skills through school nutrition programs and services, physical education, and comprehensive health education; (3) enhancing protective factors such as school connectedness or parent engagement; and (4) shaping school health services and environments more broadly.

Table 2: Top problems in schools

Taiwan	Thailand
Student tardiness	Student tardiness
Lack of academic challenge	Student absenteeism
Lack of parent involvement	Poverty of student family
Student come to school unprepared to learn	Student joining gangs
Student absenteeism	Student drug abuse or smoking

University of Salford MANCHESTER

IUHPE 23rd World Conference on Health Promotion

Biographic disruption in families of a child with Short Bowel Syndrome: A sibling perspective

Cooper-Ryan, A.M.[1], Coffey, M[1], Whiteley L.[1], Brooke J.[1], Coletta R.[2], Morabito A.[2], Khalil, B.[3]

1 – University of Salford, UK; 2 - Meyer Children's Hospital, Florence, Italy; 3 - Sidra Medicine, Doha, Qatar

a.m.cooper-ryan@salford.ac.uk

Background

- This unique study explored how being a sibling of a child with Short Bowel Syndrome (SBS) impacts an entire family and the resultant biographic disruption (social experience of living with a chronic illness).
- SBS is a serious and rare condition affecting about 2 per million in the EU, that is not often researched from a social perspective.
- SBS occurs following extensive removal of the small bowel, leading to mal-absorption and intestinal failure with life-changing consequences, and typically long hospital stays.

Method

- The study used a mixed-methods design comprising diary keeping and interviews with parents and siblings over 11yrs. For children between 4-11yrs, electronic tablets, hosting the 'Digitising Children's Data Collection' (DCDC) application were used to record children's answers digitally from four complementary methods.
- Framework analysis was used to analyse the interview data.
- Data from the DCDC application was analysed in multiple ways: thematic analysis was used for voice files, pictures, and drawings, while basic frequency calculations were carried out on the questionnaire data.

Results

- 6 families participated fully, which included 5 siblings, 2 older and 3 younger siblings.
- Siblings had varying degrees of understanding about SBS, and reported that it impacted on them more as they got older and recognised the biographic disruption to a larger extent (e.g. missing out on activities) or caring responsibility (e.g. being aware of medication needed).
- The impact was also changeable depending on how old the child with SBS was, or the need for medical appointments.

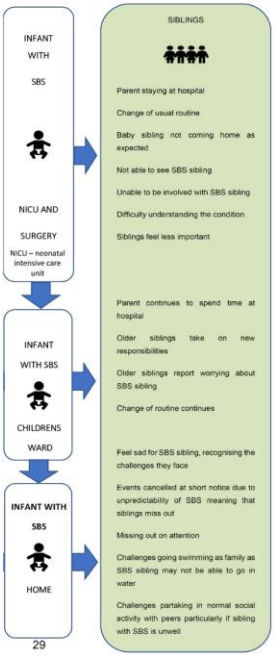
  "*we have to take special medication with us when we go anywhere*" and "*we have to make sure he is ok to do things*";
- Siblings also had a wider awareness, e.g. the impact on their parents, and their wish for things that would help themselves or their sibling. Whilst they all talked favourably about their sibling, even the younger siblings were aware of some of the impact of SBS on the family.

  "*by making him not have that problem with him*"

  "*his bum work*"

  "*There is a massive upheaval. Your life does change and I think it can make you a little bit self centred but not. When my mom was in hospital I remember feeling…I feel like I'm going to cry…I remember feeling like, not as important".*
- For example on a number of occasions one of the siblings talked about wanting to go swimming more ("*like when we go swimming we have to plan it first because he needs a double nappy on him so..*"), play outside or have less responsibility (when they were older) ("*…He's not mine and we don't orientate that way, but I spend every day with him. So the things that affect my mum affect me the same. But its different, because obviously I am older, and I am his sister I get to go…whereas she doesn't get to go …*").

Graphic showing the themes around the experience and impact over time of being a sibling of a child with SBS



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Discussion

- SBS is a complex condition that often produces a range of challenges for those born with the condition, and their families.
- This small study shows that there is a need for greater integrated working and increased dialogue between sectors to recognise that the impact goes far beyond medical challenges and causes social biographic disruption that extends to the family.
- This study highlights the importance of engaging siblings of all ages to understand and respond to their lived experience, which differs from their parent's needs, and those of their sibling with SBS. at different stages of their lives.

Acknowledgments

We acknowledge the generous support of the PSI Endowment Fund – Royal Manchester Children's Hospital and would like to thank the families for sharing their stories with us.

Bocaina Observatory of Sustainable and Healthy Territories – the importance of cooperation between institutions

Author: Juliana Carvalho Rodrigues
Affiliation: National Health Foundation – Funasa, Brazil

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Setting/problem

The Bocaina Mosaic is an environmental protection area that shelters traditional communities indigenous, quilombolas and caiçaras, under socio-environmental vulnerability, due to climatic impacts, real estate speculation and large construction projects.

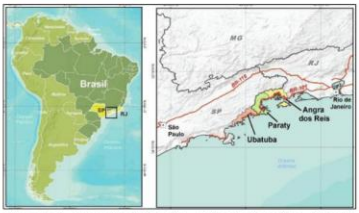

Figure 1 - Bocaina Mosaic – Rio de Janeiro - Brazil

In Brazil, specific public policies for traditional communities, policies for sustainable development or healthy and sustainable territories are recent. One of the challenges for Brazilian public managers is to integrate the execution of public policies, including the resources, to work in a territorial logic.

Intervention

National Health Foundation - Funasa and the Oswaldo Cruz Foundation – Fiocruz, Ministry of Health of Brazil was established a partnership for the Project "Observatory of Sustainable and Healthy Territories of the Mosaic of Bocaina", with the objective of constituting a techno-political space that is territorialized and articulated to other scales that generates critical knowledge and innovative technologies (social technologies), to promote sustainable development and health.

The project proposes cooperation and integration processes and actions to obtain effective results, knowledge production and interchange, and other partners awareness and qualification to promote territorial development. It considers those different traditional communities which are under the same threats, making them vulnerable.

Outcomes

The Observatory of Sustainable and Healthy Territories of the Mosaic of Bocaina creation, that was one of the results, has contributed for other steps and actions in view of the importance of systematization and dissemination of information and knowledge for the management process based on the principles of governance.

This contribution has included research, technology development, networking, horizontal cooperation, thus constituting a networking that can guarantee the promotion and sustainability of the actions and communities involved.

The Observatory of Sustainable and Healthy Territories of the Mosaic of Bocaina contributed to, for example:

1) Structuring of the Social Technologies Incubator;
2) Support to agroecological practices;
3) Ecological sanitation;
4) Support for community-based tourism enterprises;
5) Differentiated education;
6) Social cartography;
7) Culture and water management;
8) Governance and socio-environmental justice - Map of Socio-environmental Conflicts of Bocaina;
9) Evaluation and monitoring - Matrix of Analysis of Effectiveness of Territorialized Strategies.

Other informations about the Observatory of Sustainable and Healthy Territories of the Mosaic of Bocaina: https://www.otss.org.br/

Figure 2 – Some initiatives: ecological sanitation; agroecological practices; differentiated education; Social Technologies Incubator.

Implications

The Observatory of Sustainable and Healthy Territories of the Mosaic of Bocaina constitution is an efficient mechanism to promote development, expanding the social and economic opportunities of communities, such as greater access to health services, education and sanitation, and allows more sustainable initiatives for income generation and for productive sufficiency. This partnership realization also implies the possibility that the successful results and experiences may become strategies and alternatives for public policies to guarantee the rights of traditional communities.

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Poster presented at 23rd Conference of Health Promotion
7 – 11 April 2019, Rotorua, Aotearoa New Zealand

Bringing Health to Your Doorstep - Increasing the Community-Dwelling Older Adults' Health Knowledge and Eliciting Positive Health Behavioural Changes via a Roving Health Team

Authors: L Lai, K T Han, S Siew, E J Tan
Regional Health and Community Outreach Division,
Health Promotion Board, Singapore

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INTRODUCTION

Singapore faces an ageing population and with it, an increased burden of non-communicable diseases (NCDs) such as diabetes, dementia etc. Poor lifestyle choices are contributing factors to NCDs and as of 2010, 3 in 4 older adults in Singapore did not consume enough calcium and 6 in 10 had insufficient physical activity.

Lifestyle interventions have been shown to improve chronic conditions and currently there is a lack of lifestyle interventions for community-dwelling older adults. One innovative approach was to bring practical health messages to the community.

BACKGROUND

The Healthy Lifestyle Centre (HLC) was formed in December 2012 and it comprised of allied health professionals who would rove around the Southwest region of Singapore to bring practical healthy lifestyle workshops to the community-dwelling older adults. The aim was to increase community-dwelling older adults' health knowledge and to encourage them to have adopt healthy lifestyle habits. This pilot consisted of one-on-one consultations and a minimum of six weekly interactive health workshops that covered three main health pillars; nutrition, physical activity and mental well-being. The pilot ran till 31 March 2015 at 20 sites.

METHODOLOGY

Recruitment platforms: Participants were recruited from community clubs, screening events and senior activity centres.

Programme: Each site had a minimum of 6 health-related workshops that covered three main pillars of health; nutrition, physical activity and mental well-being and one-on-one consultations upon request. An hour's workshop with health messages (awareness), practical tips (for behavioural change) and call-to-action were included.

Topics covered: There were a total of 30 topics developed for the CDOA which covered nutrition, physical activity, mental wellbeing, chronic disease management and weight management.

Evaluation: Self-reported survey forms and qualitative feedback were collected.

Healthy Lifestyle Centre
WORKSHOP EVALUATION

Name:	Contact:
Age:	Gender: Female / Male
Race: Chinese/ Malay/ Indian/ Others	
Workshop Name:	Today's:

Please circle the rating that most closely describes your reaction. Your feedback is appreciated.

Descriptions					
Workshop Content	Very Poor		Average		Very Good
1. The objectives of the workshop were met	1	2	3	4	5
2. I have learnt new knowledge/skills useful to me	1	2	3	4	5
3. I can and am willing to apply what I have learnt	1	2	3	4	5
Training/ Instruction					
4. The information provided is useful & relevant	1	2	3	4	5
5. The instructor was well prepared and delivery	1	2	3	4	5

Overall, my knowledge (/ability) before the course was: ___/10

After the course, my knowledge (/ability) was: ___/10

Name 2 areas you enjoyed most:

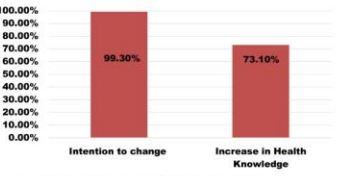
Name 2 learning points you have picked up from the workshop:

Duration of the pilot: The pilot ran till 31 March 2015 at 20 sites. At each site, the health team stayed for at least 7 weeks.

RESULTS

During the pilot, a total of 1,341 individuals participated in the programme. We asked if they had the intention and/or made positive health behavioural changes and measured their increase in health knowledge via a quantative data after the programme. The results can be seen in the table below

Table 1
Overall Response Rate Out of 1,341 Individuals



Qualitative data showed that the common behavioural changes were increased consumption of fruits, vegetables and whole grains, an increase in the duration of physical activity sessions, improvement in mood and greater confidence in reaching health goals.

I love the exercise sessions. Why don't we have an exercise activity at the end of every session?

I've started eating whole grains and it's good! I've also gotten my family to eat more whole grains too

Such meaningful activities; it's better than watching tv at home!

I have a happier and better outlook towards life now

DISCUSSION

Suitability of lifestyle interventions: With the CDOA, their preferred mode of seeking medical advice and/or interventions were during their visits to the medical or allied health professionals in healthcare institutions. One-on-one coaching on lifestyle behaviour in the community setting was new to the CDOA and it was not something most were ready for. Thus, talks and workshops that comprised of bite-size information and practical tips was the preferred mode of lifestyle intervention.

The programme relied on self-reported intention to change existing behaviours, as well as any form of actual health behavioural changes. Although this method of evaluation may not be as robust in measuring impact, it was considered the most appropriate for the target audience as most of them had lower education levels (primary school and under) or were illiterate.

It was also observed that most participants in the programme were women, and of a certain ethnicity. This could be due to the locations where the programme was held, and probably the health-seeking behaviour of women compared to men.

Limitations:

• Due to limited resources, the programme was not able to determine if the intention to change/positive behavioural changes were acted upon or sustained.

•There was also no biometric data available for a robust evaluation of the long term effectiveness of the intervention.

CONCLUSION

The program was successful in increasing the CDOA's health knowledge and had also elicited positive health behavioral changes. Following the pilot, the program was incorporated in the national Senior's Health Curriculum in mid-2016. As of December 2017, 1,245 sessions were conducted nationwide and 22,221 older adults benefited from the curriculum

Calidad de Vida Percibida por Adolescentes Embarazadas.

Autores: Sierra-Macias A[1]., Valadez-Saavedra G[2]., Dávalos-Pérez A[2]., Ramirez-Pereira M[3].
Afiliación: [1]Universidad de Guadalajara, Guadalajara, México; [2]Universidad de Guanajuato, León, México; [3]Universidad de Chile, Santiago, Chile.

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I. Introducción:

El embarazo implica distintos cambios que se consideran parte de un proceso fisiológico, sin embargo dichos cambios pueden alterar la capacidad de las mujeres embarazadas para desarrollar sus funciones habituales, repercutiendo en su calidad de vida.

II. Objetivo:

Describir la calidad de vida percibida por las adolescentes embarazadas de dos ciudades en México y en Chile.

III. Material y Métodos:

- Estudio observacional descriptivo.
- Embarazadas (13 a 19 años) en control prenatal.
- En dos ciudades: León-México y Coquimbo-Chile (año 2013).
- Variable: Calidad de vida relacionada con la salud Medical Outcomes Study 36-Item Short Form (SF-36).
- Variables sociodemográficas y obstétricas.
- Análisis: Frecuencia, porcentaje, media, deviación estándar DE.
- Las participantes firmaron consentimiento informado.

IV. Resultados:

Se incluyeron a 170 adolescentes embarazadas, 100 originarias de León y 70 de la Ciudad de Coquimbo.

Embarazadas de León

Media de edad 17.3 años, principalmente de tercer trimestre de embarazo. Respecto a la calidad de vida, presentaron cifras por encima de la media de la población de referencia en México excepto en la dimensión "Rol físico".

Tabla 1. Calidad de vida relacionada con la salud de las adolescentes embarazadas de León – México (n=100).

DIMENSIÓN	MEDIA (DE)
Función física	68.5 (19.4)
Rol físico	49.5 (42.0)
Dolor corporal	58.6 (21.3)
Salud general	55.3 (17.2)
Vitalidad	51.3 (15.9)
Función social	72.8 (20.2)
Rol emocional	59.0 (40.7)
Salud mental	65.1 (18.9)
Transición de Salud	42.0 (23.5)
Componente de salud física	41.7 (8.8)
Componente de salud mental	45.6 (10.3)

Fuente: Medical Outcomes Study 36-Item Short Form (SF-36).

Embarazadas de Coquimbo

La media fue de 17.7 años, cursaban el segundo y tercer trimestre de embarazo. Respecto a la calidad de vida las puntuaciones de las 8 dimensiones se comportaron de manera superior a la media de referencia en Chile.

Tabla 2. Calidad de vida relacionada con la salud de las adolescentes embarazadas de Coquimbo – Chile (n=70).

DIMENSIÓN	MEDIA (DE)
Función física	82.0 (14.5)
Rol físico	54.6 (32.5)
Dolor corporal	55.5 (23.2)
Salud general	67.9 (15.9)
Vitalidad	55.2 (17.3)
Función social	73.5 (20.0)
Rol emocional	69.5 (37.5)
Salud mental	71.3 (18.4)
Transición de Salud	42.5 (20.5)
Componente de salud física	44.6 (7.7)
Componente de salud mental	47.7 (11.1)

Fuente: Medical Outcomes Study 36-Item Short Form (SF-36).

V. Conclusiones:

Los resultados reportados en este estudio señalan que tanto las adolescentes embarazadas de León como las de Coquimbo perciben una mejor Calidad de Vida Relacionada con la Salud en la mayoría de las dimensiones en comparación con las puntuaciones de la población referencia. Se requieren estudios que exploren subjetivamente las condiciones ligadas a percibir mejor o peor calidad de vida relacionada con la salud, con la finalidad de crear acciones y políticas intersectoriales encaminadas a atender las necesidades y demandas de los y las adolescentes en contextos determinados.

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Declaración de conflicto de intereses:

Los autores declaran no tener conflicto de intereses.

Poster presentado en:

23rd. World Conference on Helth Promotion. del 7-11 de abril 2019, en Rotorua Nueva Zelanda.

Characteristics of children's behavioural reactions to the extreme competitiveness of Japanese society : An investigation based on data related to bullying, long-term absenteeism, schoolyard violence, and suicide

Watanabe A[1], Tanaka R[2,3], Shikano A[4], Noi S[4]

[1]Nippon Sport Science University, Master Degree Program Graduate School, Tokyo, Japan
[2]Nippon Sport Science University, Doctoral Degree Program Graduate School, Tokyo, Japan
[3]Japan Society for The Promotion of Science, Research Fellowship for Young Scientists, Tokyo, Japan
[4]Nippon Sport Science University, Tokyo, Japan

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Background

During the period of high economic growth in Japan, which started around 1960, changes have been observed in the bodies and minds of children, the likes of which had never been witnessed before. Although the children's status cannot be considered an illness, it cannot be called a healthy state either, and this "abnormalities" became increasingly serious. To address these kinds of health issues, we convened the 'Annual Meeting on Physical and Mental Health Among The Children Proceeding' (sponsored by the National Network of Physical and Mental Health in Japanese Children) annually. In addition, we continued the discussion concerning the bodies and minds of children with yogo teachers and grade school teachers, doctors, parents, and children, based on the *Annual Report of Physical and Mental Health among the Children*. This publication addresses health problems related to children's physical and mental conditions. The report is supported by evidence from various sources, domestic trends, published government statistics, and other materials, as well as liaison conferences and network members' own research results. It can be confirmed that the particular health problems observed in Japanese children (e.g., bullying, long-term absenteeism, schoolyard violence, suicide, etc.) are becoming increasingly serious. Meanwhile, one key perspective argues that these symptoms are behavioural features stemming from the extremely competitive nature of Japanese society.

Objectives

Therefore, this study aimed to examine the characteristics of child behaviour in the extremely competitive Japanese society based on evidence published in the latest *Annual Report of Physical and Mental Health among the Children 2018*.

Methods

We observed the characteristics of the physical symptoms of Japanese children based on the evidence published in the Annual Report of Physical and Mental Health among the Children 2018. This report presented data concerning bullying, long-term absenteeism, schoolyard violence, and suicides.

Results

Trends in bullying, long-term absenteeism, schoolyard violence, and suicides by Japanese children showed alarming changes.

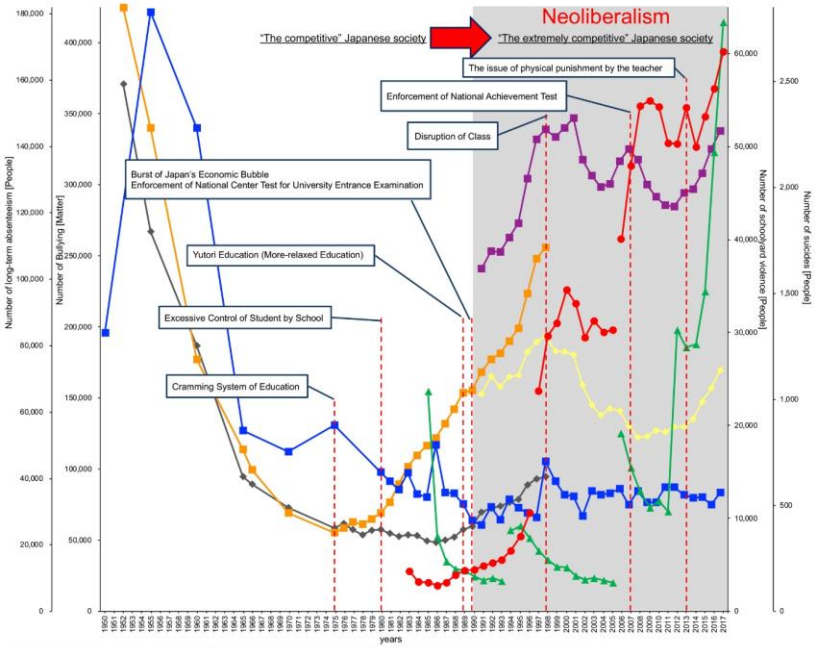

Figure 1 Children's bullying in Japan, long-term absenteeism, schoolyard violence, and trend of suicide.

Bullying (▲), Long-term absenteeism : Primary school "A year more than 50days (◆) /30days (◆)", Long-term absenteeism : Junior high school "A year more than 50 days (■) / 30days (■), Schoolyard violence (●)", Suicide (■).

Long-term absenteeism : A survey on the number of long-term absenteeism over 50 days a year has ended in 1998. A survey on the number of long-term absenteeism over 30 days per year began in 1991.

Bullying : The investigation method was changed in 1994 and 2006. Number of occurrences until 2005, cognition number since 2006. Includes high school communication course from 2013. Private schools have been studied since 2006. Correspondence course is included in high school from 2013.

Discussion

Upon analysing the results described above, we came to the following conclusions: bullying is a phenomenon used to transfer pressure to others, long-term absenteeism occurs as children attempt to escape from this pressure, schoolyard violence reflects attempts to push back against those creating pressure, and suicide occurs when those who feel pressure try to escape themselves.

Contact us:
Watanabe Akira
Nippon Sport Science University, Master Degree Program Graduate School
e-mail : akira.062489@gmail.com

Citizen sensor network as a tool to promote air quality

Françoise JABOT[1], Flora POULIQUEN[1], Manon TURQUAND[1], Arnaud DALONGEVILLE[1], Guilhem DARDIER[1], Jacques LE LETTY[2], Pauline MORDELET[3], Audrey MARTIN[3]

[1] École des hautes études en santé publique, [2]Maison de la consommation et de l'environnement, [3]Ville de Rennes (France)

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Rennes was the first city to join the French WHO Healthy Cities Network, which it currently presides. The city has been working towards a clean and sustainable environment for a number of years and one of its priorities is air quality. Ambassad'Air is an experimental and collaborative scheme to monitor and improve outdoor air quality with help from citizens. The scheme, brought about through a strong political will to protect the environment while empowering communities, draws on a network of local community organizations dealing with environmental issues and digital innovation. It was introduced in two districts in 2016 before being extended to a third, then covering the whole city. It has been adjusted using feedback from citizens and observations made by researchers.

Mobile measure

Political and technical coordinators

RENNES

mce la maison DE LA CONSOMMATION ET DE L'ENVIRONNEMENT

A volunteer measuring air quality

1 **Measuring and recording levels of fine particules (PM 2.5) using a geolocalised sensor**

ambassad' air

2 **Raising awareness with peer-education in order to change behaviours**

Air quality sensor

ÉCOLE DES HAUTES ÉTUDES EN SANTÉ PUBLIQUE

EHESP

Academic partner

DIY sensor workshop

METHOD

Goals: analyse how the volunteers had taken to their roles as citizen sensors and ambassadors, and learn more about the scheme's implementation and the peer education strategy in order to assess its effectivenes in changing people's behaviour

Steps: reconstruction of the scheme's intervention logic through clarification of scheme managers' thoughts and insights, literature review to clarify the concepts and identify similar experiments, two surveys with the citizen ambassadors conducted after one and then two years after the scheme was set up

Themes: motivation to join the scheme, use of the Air Casting sensor and website, involvement in the scheme's activities, perception of the scheme and the volunteer roles, impact on the volunteers and entourage, proposals

RESULTS

Profile: high social status, environmental activists, involved in NGOs, personal concerns, eco-friendly behaviour

Involvement in the activities

- measurements taken either by individuals on their own or as part of collective activities
- pitching ideas for derived products and communication tools (key ring, expression walls, dashboards)
- raising awareness among family, friends, colleagues and the wider community (by showing the sensor and measurements, and putting up posters or flyers about the project)
- talking unprepared to the media about their experience

Perception of their role: personal feeling as pioneers, sense of responsibility towards the scheme as it is in line with their values, weak feeling of legitimacy insofar as their knowledge is limited, questioning the way to convince other people without making them feel guilty, no sense of belonging to the same community (that remains fragile)

Behaviour change: no change in lifestyle habits but incentives to remain eco-responsible; limited influence reported over their entourage

DISCUSSION

Findings are consistent with other studies on volunteers' profiles and motivations as well as key factors identified as being critical to the success of such a strategy (sharing information, positive interactions, social networking) (Commodore et al., 2017, Oltra et al., 2017, Stepenuck at Green, 2017). The status of peer-educator remains too weak. Literature about citizen sensing initiatives doesn't often examine the social context within the community; it generally focuses on issues about environmental monitoring (Carton et Ache, 2017, Hubbell et al, 2018). The scheme's design and implementation are examined from the perspective of volunteer recruitment, training, communication, data use, and community building. The aim is to assess how well equipped the ambassad'airs are to fulfil their roles within the scheme.

Co-design with Young Refugees and Asylum Seekers in Mental Health - Seat at the Table

Author: Helen Scudamore

Affiliation: HealthWest Partnership, Melbourne, Australia

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Seat at the Table

Context

Seat at the Table (SATT) brought young people from refugee and asylum seeker backgrounds together with mental health service providers in Melbourne's western suburbs.

SATT worked to actively engage these stakeholders (both young people and service providers), to design and pilot ideas that address the barriers to help-seeking behaviour in mental health.

Outcomes

SATT highlighted the importance of working with young people, specifically from diverse communities.
Ultimately, showcasing the value of including the target community in decision-making when designing interventions in mental health.

The project:

- Developed an exemplary model of participation for service providers when engaging community.
- Improved participation in mental health services via young people on a governance group.
- Piloted innovative strategies to promote mental health led and facilitated by young people.

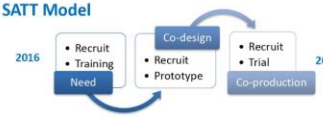
Design

Co-design & Co-production

Co-design incorporates all stakeholders in solving a problem. Co-production incorporates all these stakeholders further, in the trial and implementation of the proposed solution(s). Both attempt to develop an "equal and reciprocal relationship between health services, people using the services and their families" *(1)*.

Co-design is not JUST engagement or consultation. It further builds capabilities and capacities of people to enable the change they want to see.

SATT Model



Lessons

Power

"...We're not going from top down.
We're not going from bottom up.
We're actually getting everyone down onto the floor and then working up together *(2)*."

Co-design and co-production has to deal with ongoing issues of power. Such as perceived authority, experience, privilege and decision-making control.

To manage the power, SATT involved a shifting of responsibility over time. At the beginning of the project the service providers played a vital role (with a high level of contribution). As the project developed young people began taking more control in creating and co-production *(Fig. 1)*.

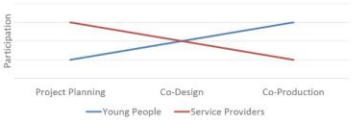


Figure 1.

Recommendations

Learnings from SATT and recommendations for future co-design and/or co-production projects in a community:

- **Uncertainty** - is built into the co-design process. Organisations with strict timelines and output measures may not suit co-design and should consider where it is the right fit.
- **Role clarity** - project staff should expect to negotiate the role of stakeholders across the life of the project.
- **Self-care** - the mental health and well-being of young people who take on facilitator roles needs to be explicitly addressed during the planning stages.
- **Time** - co-design can be a lengthy process. Stakeholders need to be able to come and go, with mechanisms built to support this.
- **Capacity building** - training needs be provided to stakeholders throughout the process to educate them about co-design and communication strategies.

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Acknowledgements

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Download Evaluation Report

+61 (03) 9248 9662
healthwest.org.au
HWOffice@healthwest.org.au

HealthWest Partnership

IUHPE Oral Presentation

Co-design is "best practice" but is it best for you?

Thursday, April 11th, 2019 - 8:30am
Sudima Hotel - Baycrest Room 1

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Poster presented at the 23rd IUHPE World Conference on Health Promotion, New Zealand, 2019

WAIORA: Promoting Planetary Health and Sustainable Development for All

Comment les Tables de quartier à Montréal (Québec, Canada) agissent-elles pour transformer les milieux de vie? Le cas des Jardins des Patriotes dans Saint-Michel

Chabot, C; Martin, N; Bilodeau, A; Potvin, L.
École de santé publique, Université de Montréal (Québec, Canada)

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23rd World Conference on Health Promotion

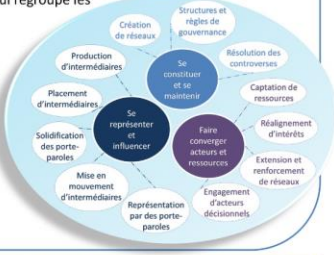
Contexte

- L'action intersectorielle est l'une des stratégies de promotion de la santé pour agir sur les déterminants sociaux
- À Montréal, *l'Initiative montréalaise de soutien au développement social local* finance un réseau de Tables de quartier qui mobilisent les acteurs locaux afin de travailler de manière concertée à l'amélioration des milieux de vie.
- Le quartier Saint-Michel comprend plusieurs déserts alimentaires, dont l'un autour de l'École secondaire Louis-Joseph-Papineau qui accueille une portion importante de jeunes défavorisés.
- **Question de recherche :** Comment les Tables de quartier agissent-elles pour transformer les milieux de vie?

Méthodologie

- Étude de cas rétrospective (2015-2018) retraçant les événements marquants dans le processus d'action.
- Interprétation de ces événements selon un répertoire de *12 résultats transitoires (RT)* par lesquels opère l'action intersectorielle pour entraîner des transformations dans les milieux de vie.
- Répertoire de *12 résultats transitoires (RT)* inspiré de la théorie de l'acteur réseau et qui regroupe les 3 fonctions essentielles des réseaux d'action pour la production du changement :

1. Se constituer et se maintenir 2. Se représenter et influencer 3. Faire converger les acteurs et les ressources.



Chaîne des résultats transitoires : projet des Jardins des Patriotes de la Table en alimentation de Saint-Michel

RT Production et Placement d'intermédiaires — Composition et envoi par une professeure d'un document présentant le projet de jardin pédagogique à divers organismes

RT Création de réseau / Engagement d'acteurs décisionnels — • Engagement d'un organisme communautaire • Engagement de la direction de l'école

RT Représentation par des porte-paroles — Participation de la professeure à une démarche de réflexion collective de la Table de concertation en alimentation

RT Extension et renforcement de réseaux — Choix des Jardins des Patriotes comme nouvelle action de quartier suite à la réflexion collective de la Table

RT Captation de ressources — Obtention d'un financement permettant l'embauche d'un chargé de projet

RT Création de réseaux — Engagement des acteurs en alimentation au sein d'un nouveau comité de travail multisectoriel

RT Production et Placement d'intermédiaires — Dépôt d'un projet multisectoriel de système alimentaire auprès d'un important financeur

RT Captation de ressources / Engagement d'acteurs décisionnels — Obtention d'un financement substantiel : mise en place d'actions pour la création d'un système alimentaire

RÉSULTATS

Création d'un jardin pédagogique qui :

- Sert de lieu d'apprentissage et de plateau de travail pour les jeunes et des personnes vulnérables.
- Distribution des récoltes via un Marché solidaire, un groupe d'achats collectif, les banques alimentaires et les cuisines collectives.

EFFETS DANS LES MILIEUX DE VIE

- Augmentation de la motivation scolaire des jeunes;
- Amélioration de l'offre alimentaire;
- Création d'emplois;
- Éducation à la saine alimentation et à l'agriculture urbaine.

Conclusion

- L'engagement initial d'un acteur détenant les leviers d'action (l'École) a permis la création de nouveaux processus intersectoriels en alimentation et l'élargissement à d'autres réseaux (dont l'employabilité).
- L'obtention d'un financement substantiel a permis au collectif d'acteurs de s'engager et de mettre en action la vision développée collectivement.

Référence : Bilodeau, A., Galarneau, M., Lefebvre, C. and Potvin, L. (2019), Linking process and effects of intersectoral action on local neighbourhoods: systemic modelling based on Actor–Network Theory. Social Health Illn, 41:165–179. doi:10.1111/1467-9566.12813

Cette recherche a été réalisée grâce à une subvention des Instituts de recherche en santé du Canada (IRSC) 2017-2021 OCTROI PJT-153093(ROH115211).

Condom non-use and associated factors from adolescents: Brazilian National School Health Survey

IUHPE 23rd World Conference on Health Promotion

Noll, M[1]; Noll, PRS[2]; Gomes, JM[2]; Abreu, LC[3]; Sorpreso, ICE[2]

[1] Instituto Federal Goiano (matias.noll@ifgoiano.edu.br)
[2] Faculty of Medicine, Universidade de São Paulo
[3] Faculty of Medicine, ABC

Aim

To evaluate sex differences and associated factors to condom non-use from the Brazilian National School Health Survey.

Methods

Cross-sectional study using the National School Health Survey 2015 database

- ✓ A sample of 101,898 Brazilian adolescents enrolled in the 9th;
- ✓ Outcome: condom non-use in adolescents;
- ✓ Poisson regression model with robust variance.

Results:

- ✓ Sexual intercourse in the life: 37.2% boys and 19.7% girls (were inserted in the present);
- ✓ 67.9% of girls and 69.9% of boys pointed out that they used a condom in the in the last intercourse.
- ✓ The following variables are associated with condom non-use: not to seek health service or professional for care related to their own health ($p<0.001$); not receiving counseling on prevention of pregnancy and AIDS or other Sexually Transmitted Infections (STIs) at school ($p<0.001$); increased age for girls ($p<0.001$); increased number of sexual partners for boys ($p<0.001$); substance use (smoke, alcohol and drug use) ($p<0.001$); bad self-reported health ($p<0.001$) and bad body image perception ($p<0.001$).
- ✓ The increasing age first sexual intercourse late was found to be protective factors.

Conclusion

The prevalence of condom non-use is high and educative programs at schools and health services are necessary especially on health risk behaviors (sexual behavior and substance use).

Contraceptive Users in Rwanda Persist with Family Planning Program Despite Unmanageable Side Effects

Hilary Schwandt[1], Angel Boulware[2], Julia Corey[3], Ana Herrera[4], Ethan Hudler[5], Claudette Imbabazi[6], Ilia King[7], Jessica Linus[8], Innocent Manzi[9], Maddie Merrit[1], Lyn Mezier[8], Abigail Miller[1], Hailey Morris[10], Uwase Nadine Musekura[11], Diuedonne Musemakweli[9], Divine Mutuyimana[6], Chimene Nakarumfmana[12], Nirali Patel[13], Adriana Scanlearu[14], Bgannelle Shemeza[1], Madi Stapleton[1], Gi'anna Sterling-Donaldson[15], Chantel Umuton[6], Lyse Uwera[6], Madeleine Zeiler[1], Seth Feinberg[1]

[1]Western Washington University, Bellingham, USA; [2]Spelman College, Atlanta, USA; [3]Wheaton College, Norton, USA; [4]Northwest Vista Community College, San Antonio, USA; [5]Whatcom Community College, Bellingham, USA; [6]INES, Ruhengeri, Rwanda; [7]Xavier University of Louisiana, New Orleans, USA; [8]UMBC, Baltimore, USA; [9]SUNY Oswego, Oswego, USA; [10]Western Oregon University, Monmouth, USA; [11]Eastern Oregon University, La Grande, USA; [12]University of Kentucky, Lexington, USA; [13]Arcadia University, Glenside USA; [14]Rutgers University, New Brunswick, USA; [15]Drexel University, Philadelphia, USA

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Introduction:

Rwanda's use of family planning (FP) more than doubled over a five-year period from 17% in 2005 to 53% in 2010. Despite this, the vast majority of contraceptive users experience side effects in some capacity, potentially leading users to discontinue. In some contexts, over half of users cease use within only one year. Rwanda has low discontinuation rates, at just 28% of users discontinuing at one year of use, versus the 38% global average. Due to Rwanda's impressive level of FP use, this research sought to better understand discontinuation experiences of users in Rwanda.

Methods:

This qualitative study was conducted in 2018 in Rwanda's Musanze and Nyamasheke districts, the districts with the highest and lowest FP use, respectively. Eight focus group discussions were conducted with FP providers. 32 in-depth interviews were conducted with FP users.

Results:

FP providers mentioned switching methods more than discontinuation. The absence of discussing discontinuation as an option was unanticipated.

> ***Due to the side effects she has with the method it will be difficult for nurses to convince her to continue with that method. That's why I said she will leave with another method.***
>
> 54, male, 5 children, CHW, Nyamasheke

Respondents expressed a desire to continue using FP despite side effects. When side effects were too severe, respondents often switched to another method. Discontinuation was not an option even considered.

> ***Even though I had those side effects when I started using family planning, if I had given up using family planning in the first place I would have more children so I continued to use it even though I knew that I was passing through a hard time with the side effects….***
>
> 40, female, 4 children, married, condoms, Nyamasheke

Even those who identified as discontinuers were still using methods such as abstinence, standard day's method, withdrawal, and condoms.

> ***I: So you told me that you stopped using family planning now, what is helping you to not get pregnant?***
> ***R: There is nothing that I do now. I'm just abstinent and I know that being abstinent is difficult but I know that it is my duty and I have to do it.***
>
> 42, female, 3 children, married, injectable, Musanze

Discussion:

FP providers reported only two causes of discontinuation: the desire for pregnancy, and improper method use leading to failure or unmanageable side effects. Users complaining of side effects were met with two options: persevere with the same method, or switch to another method. Rwanda's success may be rooted in women's desire to use family planning regardless of side effects, provider's support of unsatisfied users, and both providers and users refusing to acknowledge discontinuation as an option.

Creation of an Institute for Health Equity and Policy at McMaster University

Fran Scott | Jim Dunn | Lindsay Godard
McMaster University
Hamilton Ontario
https://mihe.mcmaster.ca

The Institute's Purpose

The proposed Institute for Health Equity & Policy would:

- push for better inter-disciplinary understandings of the social, economic, cultural, political and bio-physical forces that lead to inequities
- be leaders in encouraging evidence-based action on health inequities and develop a body of expertise from interventions adopted
- develop capacity in researching Health Equity
- engage and support decision-makers at all levels in efforts to operationalize commitments to health equity

History: Rooted in environmental health research

McMaster Institute for Healthier Environments

The McMaster Institute for Health Equity & Policy has evolved from a research institute focusing on environment and health research

- Founded in the late 1980s, the McMaster Institute for Environments and Health, later the McMaster Institute for Healthier Environments (MIHE) capitalized on increased societal interest in environmental sustainability and local concerns
- MIHE worked to promote interdisciplinary research and collaboration, at McMaster and beyond, on topics like:
    - Health effects of air pollution
    - health and environmental ethics
    - social aspects of disease and illness,
    - environmental health policy

University Context

McMaster University located in Hamilton, Ontario was ranked as Canada's most research intensive university in 2017 and 2018.

Health research and education are particular and historic strengths

- McMaster has a new strategic vision of "health and well-being for all" and recently adopted the Okanagan Charter for Health Promoting Universities
- McMaster was the birthplace of population health research in Canada when Dr. Fraser Mustard, then Dean of the Faculty of Health Sciences received government funding from the new Canadian Institutes for Advanced Research for a population health research program
- Strength in population health research extends across many disciplines (business, economics, sociology, geography, medicine, rehabilitation science, psychiatry)

Local Context

The City of Hamilton, population slightly over 700,000, is a port city located in the "Greater Golden Horseshoe" region of Southern Ontario

- Formerly a hub of heavy industry, Hamilton has transitioned to a service-based economy, notably higher education and health care – but not all have benefitted from new economy
- There is significant poverty and income inequality, concentrated in the inner city urban core neighbourhoods once home to industrial workers
- Stark neighbourhood level health inequities, such as 23-year gap in age of death between one of the lowest and highest income neighbourhoods
- Community assets include a long history of strong organized labour and thriving cohesive immigrant communities

Knowledge Mobilization: A Framework for Action

Addressing health inequities is a core mandate of health promotion practitioners, and local governments are major players in these initiatives.

The 5-Stage model of the policy making process provides a framework for the Institute to engage with local government

Agenda Setting → Policy Formulation → Decision-making → Implementation → Policy Evaluation

- Fafard discusses how the health-sciences literature on policy-making concentrates on the role of research evidence in decision-making; but that different types of evidence are critical at all stages of the process
- The Institute will support research and engagement in each stage of the policy making process

Interdisciplinary Academic Research Relationships

- The Institute will engage across Faculties with departments across disciplines

BRIGHTER WORLD

McMaster University

Cultural sensitiveness and concurrent validity of the revised European Health Literacy Survey (HLS-EU-PT/BR) short version via exploratory factor analysis

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Aim: This research aims at exploring epistemological cultural validation (HLS-EU-PT/BR) of a short European Health Literacy Survey (HLS-EU-Q) in the context of health promotion strategies based in health literacy assessment & development. This is needed to reduce client burden and administration time and improve the transportability characteristics of the HLS-EU-Q. Research is needed to assess the feasibility and validity of a short HLS-EU-Q that is culturally sensitive.

HLS•EU•BR

Methods: Participants are from (n=587) a school-based & hospital setting (reception services of Adult and Children Emergency Relief rooms, SUS Fácil, Quality Control and Patient Safety from the university hospital of Uberaba-BZ (HC/UFTM). The present study sought to develop a shortened version of the HLS-EU-PT/BR® from the European Health Literacy Survey (HLS-EU) using factor analysis.

Results:
Using standard factor analytic techniques, HLS-EU-PT/BR reduction identified 18 items to integrate a short version (i.e.: HLHC05, 06, 07, 09, 10, 11, 12, HLDP21, 22, 23, 24, 31,32, 39, 43, HLHP34, 35, 36), with KMO of .934; Bartlett's Test of Sphericity: $X^2(153) = 5925.713$; $p < 0.001$); Total Variance Explained of 65.5% and Cronbach's Alpha of .932.
A second level analysis explored the 16 HLS-EU short version consistency with the 18 version identified in this research. Commonality items (seven items) were introduced in the analysis (HL 5, 11, HL13, HL21, 23, 39, 43) and all except one (HL 13) presented concurrent validity (Alpha C .853).

HLS•EU•PT

Conclusions:
These preliminary results enhance the concurrent validity of the short HLS-EU-PT/BR version, internal validity and linguistic validity, as land marks of the translation and validation process of the HLS-EU survey (to Portuguese speaking participants). The tension between finding ways to shorten the entire 47 items HLS-EU-PT®-survey (to achieve the goal of overall briefer assessment) is contingent to compromise the reliability of the scores. The exclusion of items needs a broader discussion that is to be done with an international perspective in order to captivate comparability across countries/cultures. Failing to achieve this can jeopardize a global set of goals to promote HL levels of populations across continents and different cultures. Further research will need to include different settings and groups. The validated HLS-EU-PT/BR short version of the HLS-EU survey, with the user's manual can be accessed from www.literacia-saude.info

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Escola Nacional de Saúde Pública

Saboga-nunes L [1], de Araujo Pereira G [2], Martins R [3], Rodrigues E [4], Paixão E [5]
[1] ProLiSa; CISP - National School of Public Health, Universidade Nova de Lisboa; University of Education Freiburg, Germany; Isamb-FML; Portugal; (saboga@prosalus.com; +351 914747066)
[2] Pesquisa e Inovação Tecnológica - GEP-HC-UFTM/Filial Ebserh, Uberaba, Brasil
[3] ProLiSaBr; Federal University of Triangulo Mineiro - UFTM, Uberaba, Brasil
[4] Emanuel Rodrigues Departamento de Epidemiologia - INSA, Porto, Portugal
[5] Administração Regional de Saúde do Alentejo, Portugal

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Delivering equitable maternity care using pay for performance at Primary Health Care level in Brazil

Bruna L. F. de Almeida Barbosa[1,2], Franciele M. Costa Leite[1], Rita de Cassia D. Lima[1], Angela Dawson[2]
[1] Postgraduate Program in Public Health, Federal University of Espirito Santo, Vitoria, Brazil. [2] Faculty of Health, University of Technology Sydney, New South Wales, Australia.

BACKGROUND

The Brazilian Primary Health Care (PHC) model aims to provide universal access and comprehensive health care, coordinate and expand coverage to more complex levels of care (e.g. specialist care and hospital care), and implement intersectoral actions for health promotion and disease prevention.

PMAQ is a Pay-for-performance program that provides financial incentives for health professionals and services for meeting performance measures to improve health outcomes.

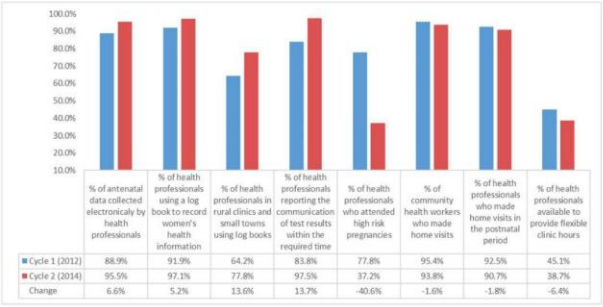
Objective: To examine the quality of services offered in PHC facilities in the PMAQ program to pregnant women and new mothers.

METHODS

- We undertook a survey of health professionals in 842 PHC health services across 71 municipalities in the state of Espírito Santo, Brazil.
- The study was carried out between 2012 and 2014, during the first and second cycle of PMAQ.
- The analysis was undertaken using the Stata 13.0 statistical program.

FINDINGS

- We report the interview responses of 842 health professionals in Cycle 1 and Cycle 2



	% of antenatal data collected electronicaly by health professionals	% of health professionals using a log book to record women's health information	% of health professionals in rural clinics and small towns using log books	% of health professionals reporting the communication of test results within the required time	% of health professionals who attended high risk pregnancies	% of community health workers who made home visits	% of health professionals who made home visits in the postnatal period	% of health professionals available to provide flexible clinic hours
Cycle 1 (2012)	88.9%	91.9%	64.2%	83.8%	77.8%	95.4%	92.5%	45.1%
Cycle 2 (2014)	95.5%	97.1%	77.8%	97.5%	37.2%	93.8%	90.7%	38.7%
Change	6.6%	5.2%	13.6%	13.7%	-40.6%	-1.6%	-1.8%	-6.4%

DISCUSSION

- Over the two cycles of the PMAQ, there was an improvement in the recording of women's health status and health care procedures, as well as improvements in the adherence to Ministry of Health guidelines.
- However, there was a decrease in routine care provided by health professionals due to severe staff shortages. These results shows that P4P can improve health professional performance to enhance maternity care outcomes however, attention must be paid to appropriate human resource planning to ensure equitable care coverage.

Des enfants en bonne santé pour l'avenir de nos îles

Un projet de promotion de la santé en milieu scolaire dans les îles de Wallis et Futuna

Auteurs : Dr Pragya Singh[1], Solène Protat[2], Olivier Dinh[3], Penikosite Logote[4]
[1]Fiji National University
[2]Communauté du Pacifique (CPS)
[3]Direction de l'enseignement catholique de Wallis et Futuna
[4]Agence de santé de Wallis et Futuna

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Contexte et objectifs

La lutte contre l'obésité infantile est une priorité pour les États et Territoires de la région Pacifique. Cependant, les données disponibles concernant la prévalence du surpoids et de l'obésité dans la région sont rares et aucune étude n'a été menée auprès des enfants de moins de 11 ans. De plus, peu d'outils pédagogiques adaptés au contexte des îles du Pacifique sont disponibles pour permettre aux équipes éducatives ou de santé de mettre en place des interventions de promotion de saines habitudes de vie en milieu scolaire.

Ce projet avait plusieurs objectifs :

- Évaluer le niveau de connaissances, l'attitude et les pratiques en matière d'alimentation, d'activité physique et d'utilisation des écrans des enfants de CE1-CE2 des écoles de Wallis et Futuna et de leurs parents ;
- Évaluer la prévalence du surpoids et de l'obésité des enfants ;
- Élaborer, mettre en œuvre puis évaluer un ensemble d'interventions visant à promouvoir l'alimentation équilibrée et la pratique de l'activité physique.

Méthode

Le projet s'est déroulé en 3 phases :

Phase d'évaluation initiale (avril 2018)

Phase d'intervention (mai à octobre 2018)

Phase d'évaluation finale (novembre 2018)

L'ensemble des enfants scolarisés en classe de CE1 et CE2 ont été inclus dans l'étude, soit un échantillon de 411 élèves.
Des méthodes qualitatives (groupes de discussion) et quantitatives (questionnaires sur les connaissances, attitudes, pratiques + mesures anthropométriques) ont été utilisées pour collecter les données auprès des enfants et de leurs parents lors des phases d'évaluation initiale et finale.

Les enfants ont bénéficié de 15 interventions sur des thèmes variés en rapport avec la nutrition (1 séance tous les 15 jours) et de 30 minutes d'activité physique quotidienne pendant le temps scolaire.
Des séances pédagogiques ont été développées spécialement pour le projet, de même que des supports de communication (posters, bandes dessinées, jeux) adaptés au contexte des îles du Pacifique.
Des interventions destinées aux parents ont également été mises en place afin de les impliquer dans le projet.

Résultats

L'analyse des résultats est en cours, mais de premiers éléments positifs ont été rapportés par les enseignants et les parents :

- Le projet a incité les enfants à rejoindre des clubs sportifs (hors temps scolaire) ;
- L'assiduité à l'école s'est améliorée depuis le lancement du projet, car les enfants ne veulent pas manquer les interventions ;
- Des jardins potagers pédagogiques ont été installés dans certaines écoles.

Cependant, des points restent à améliorer :

- L'implication des parents a diminué au fur et à mesure des 6 mois d'intervention,
- Les enseignants n'ont pas toujours réalisé les séances d'activité physique quotidiennes requises.

Discussion et conclusion

Le projet a permis de mettre en place une collaboration inédite entre le secteur de la santé, le département des sports et les enseignants de Wallis et Futuna. De nombreuses activités annexes ont vu le jour spontanément au fil des interventions (journée récréative sur le thème de l'alimentation, marche pour tous ou tournois de sport).
Le projet ayant reçu un accueil favorable de la part des enseignants et des élèves, il a été décidé de l'intégrer au programme scolaire pour les années à venir.
Le projet a également été mené aux Fidji pour permettre d'effectuer des comparaisons entre les deux îles.

DESCRIPTION OF PHYSICAL ACTIVITY AND SCREEN TIME EVOLUTION DURING ADOLESCENCE USING GROUP-BASED TRAJECTORY MODELING

Teodora Riglea[1,2], Marie-Pierre Sylvestre[1,2], Jennifer O'Loughlin[1,2]

[1]Centre de recherche du Centre Hospitalier de l'Université de Montréal, [2]École de Santé Publique de l'Université de Montréal

Introduction

- Physical activity (PA) and screen time (ST), a marker of sedentary behaviour, are unique attributes that may have independent effects on health.
- Their co-existence and evolution during adolescence is not well-documented.

Objectives

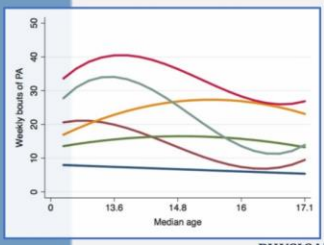
- To identify sex-specific trajectories of weekly bouts of PA and of ST.
- To describe the relationship between PA trajectory and ST trajectory memberships.

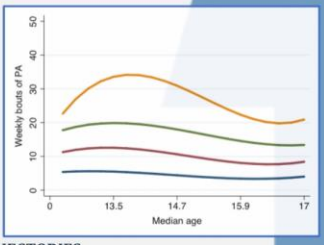
Methods

- Data were drawn from the Nicotine Dependence in Teens (NDIT) study.
- 1294 adolescents were recruited in 1999-2000 from all grade 7 classes in 10 high schools in Montreal, Canada. Follow-up data were collected every 3 months until participant left high school after grade 11.
- Self-report questionnaires were completed at every study visit. Participants reported the number of PA they engage in weekly and the number of hours spent in front of a TV or computer screen.
- Group-based trajectory modeling was used to describe sex-specific trajectories of PA and ST.

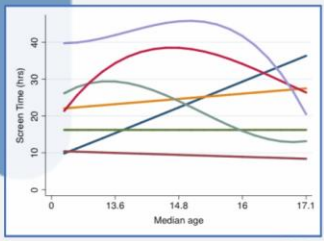
Results & Conclusion

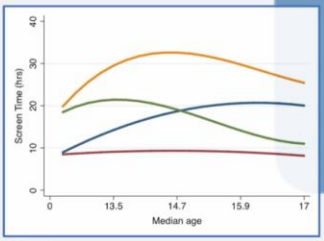
- 645 girls and 577 boys had at least 3 data points over the follow-up period.
- The number and shape of both PA and ST trajectories differed by sex.
- PA and screen time were not correlated at any of the 20 cycles of data collection.
- Cross-tabulation of memberships in trajectory groups suggested no statistically significant association.
- Results support previous findings that PA and ST evolve independently during adolescence.
- PA and ST should be targeted separately by public health interventions.





PHYSICAL ACTIVITY TRAJECTORIES





SCREEN TIME TRAJECTORIES

CRCHUM Centre de recherche Centre hospitalier de l'Université de Montréal

Institut de recherche en santé publique IRSPUM Université de Montréal

Université de Montréal | Direction des affaires internationales

ESPUM L'École de santé publique de l'Université de Montréal

Designing an Internet Tlevision to Promote Health in Indonesia: a Case of InaHealth TV (Indonesia Health Television)

Authors: Dewi F [1,2] , Sitaresmi M [2,3] , Kusumaningrum F [1,2] , Adhi W [2]

Affiliations: [1]Department of Health Behaviour, Environment and Social Medicine, Faculty of Medicine, Public Health And Nursing, Universitas Gadjah Mada, Sleman, Yogyakarta, Indonesia; [2]INAHEALTH TV, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Sleman, Yogyakarta, Indonesia; [3]Department of Pediatrics, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Sleman, Yogyakarta, Indonesia.

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Collaboration is needed on: creating , broadcasting videos

INTRODUCTION/CONTEXTUAL CONDITION

- Social media become more popular information source however can cause public health problems (1)
- Faculty of Medicine, Public Health and Nursing (FMPHN) initiated
- the Inahealth TV, a health TV channel

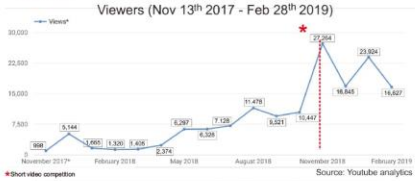
We reports the experience of planning and piloting InaHealth TV

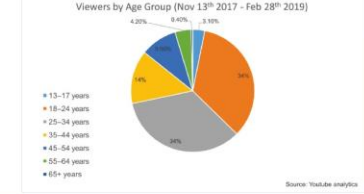
PLANNING

- The Dean of FMPHN assigned a teamwork consist of 10 people (health promotion lecturers and technical officers)
- The InaHealth TV is developed use the four phases of project management (2) and the principle of non-profit community service
- Target audience segmentation according to age:
  - < 35: short video duration (<10 minutes), broadcasted through YT
  - 35+: long video duration (≥10 minutes), broadcasted through satellite TV, in a channel with a third party company (*Sarana Media Vision* or SMV Co.)
- To develop appropriate TV channel, the team arrange some activities: desk review, observation to local TV station and experts panel discussion
- FMPHN provide relatively small fund (USD 25,000) for the piloting InaHealth TV

PILOTING INAHEALTH TV

- The project manager arranged some programs, identified some "hot issues" and coordinated the creative teams to produce episodes fit for each "hot issues"
- In 13th November 2017, we arranged a kick off inauguration of InaHealth TV in front of invited stakeholders
- Eight months later: YT statistics showed watched time of about 66,000 minutes, 27,000 viewers and 560 subscribers
- The viewer slowly increased until November 2018 a sharp jump happened when a short film festival was held.
- We fail to access indicators of monitoring and evaluation from the SMV Co.





FIRST AID is a program shows the first action to do when having emergency health problem before seeking further medical assistance

SEHATPEDIA is a program that clarify "hot issue" in a short, easy to understand video animation format

LESSON LEARNT AND OPPORTUNITIES

- It is possible to develop a health TV channel with a relatively small resources
- A more successful channel through social media are involving the audience to develop the content and predict "hot issue"
- It is important to explore the utilization of other social media
- Collaboration is needed on: creating , broadcasting videos

ACKNOWLEDGEMENT

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Poster presented at The IUHPE 23 World Conference 2019

Further information: fatwasari@ugm.ac.id, inahealthtv@gmail.com

UNIVERSITAS GADJAH MADA
FACULTY OF MEDICINE, PUBLIC HEALTH, AND NURSING

INAHEALTH TV

Determinants of pregnancy among Native Hawaiian and Other Pacific Islander adolescents: a systematic review

Katherine E. Peck, MPH(c) University of Hawaiʻi at Mānoa, Office of Public Health Studies

IUHPE
23rd World Conference on Health Promotion

Background

- Since the 1990s, both Hawaiʻi[1] and the United States[2] have seen a consistent decline in the teenage birth rate (ages 15-19 years)
- While the crude adolescent birth rate for Hawaiʻi decreased to 20.6 births per 1,000 population in 2015, the NHOPI birth rate remained nearly five times higher at 105.0 births per 1,000 population[1]
- There are also notable variations in teenage pregnancy within Hawaiʻi at the county level
  - Maui County: 120 births per 1,000 population among teenage NHOPI[1]
  - Hawaiʻi County: 145 births per 1,000 population among teenage NHOPI[1]

Purpose

- This systematic literature review sought to examine which factors contribute to higher rates of adolescent pregnancy among NHOPI, as well as potential options for intervention

Why Examine This Issue?

- Hawaiʻi has the second highest rate of unintended pregnancy in the United States at 61 unintended pregnancies per 1,000 women of reproductive age (15-44 years)[3]
- Native Hawaiians have the highest rate of unintended pregnancy among all racial/ethnic groups in Hawaiʻi[4]
- Adolescents in Hawaiʻi have among the lowest rates of condom use in the United States[5]
- Addressing health disparities and reducing rates of teenage pregnancy are public health goals at the state and federal levels given the health and socioeconomic impacts[6, 7]
- This review builds on extant literature examining pregnancy among Native Hawaiians, adolescent sexual health behaviors in Hawaiʻi, and socioecological factors related to teenage pregnancy identified in other contexts (highlighted in Figure 1 below)[8, 9, 10, 11, 12]

Figure 1: Factors related to adolescent pregnancy in the context of the socioecological model

Policy/Enabling Environment: State and Federal Policies, Geography and Environment

Community: Cultural Attitudes/Beliefs

Institutional: Availability of Sex Education + General Education, Access to Sexual and Reproductive Health Care

Interpersonal: Family Structure, Peer Networks

Individual: Health-Risk and Health-Protective Behaviors (including condom and alcohol use, age of sexual debut) SES, Education Status

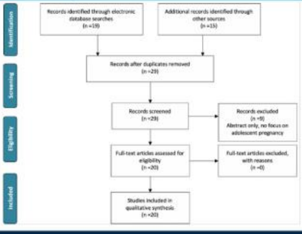
Methods

- **Eligibility:** Studies were eligible for inclusion if they met the following criteria: (1) published in an English-language peer-reviewed journal between January 2000 and October 2018; (2) discussed a factor related to adolescent pregnancy (as identified in the literature); (3) included findings relevant to NHOPI youth
- **Search Strategy**: Electronic searches were performed in PubMed/MEDLINE and Google Scholar in October and November 2018
  - **Search terms for adolescent pregnancy** included: unintended pregnancy, pregnancy, birth, childbirth, abortion, family planning, contraception, sexual health AND adolescent, youth, teen, minor
  - **Search terms for population** included: Hawaiian, Native Hawaiian, Other Pacific Islander, Pacific Islander, Asian Pacific Islander (API). Note: The U.S. Census definition of Native Hawaiian and Other Pacific Islander was utilized, which includes Polynesian, Micronesian, and Melanesian groups but excludes the indigenous peoples of Australia and New Zealand[13]

Results

- Results summarized in Figure 2 using PRISMA Flow Diagram (below)[14]
- A total of 20 articles met the inclusion criteria
- No studies focused exclusively on NHOPI adolescent pregnancy, assessed teenage pregnancy as the primary outcome, or directly measured risk or protective effects
- Most studies included teenagers of other racial/ethnic groups, or additional issues such as substance abuse and STI prevention
- The following factors emerged: individual health risk behaviors; role of family, peers, community, and culture; lack of contraceptive awareness and access; lack of access to comprehensive sexuality education; social determinants of health; need for culturally-adaptive interventions
- Detailed study descriptions available on handout and by email

Figure 2: PRISMA Diagram



Findings

Individual health risk behaviors (5 articles)[15, 16, 17, 18, 19]

- NHOPI adolescents had the highest prevalence of lifetime sexual intercourse, early sexual initiation, substance abuse before sexual intercourse, sexual abuse, and dating violence relative to other racial/ethnic groups in Hawaiʻi[17, 18, 19]
- All included studies analyzed Youth Risk Behavioral Survey or comparable dataset

Role of family, peers, community, and culture (5 articles)[20, 21, 22, 23, 24]

- Unplanned pregnancy relatively accepted/common within the Hawaiian community[20, 21, 22]
- Unintended pregnancy not a resonant term; family support and the need to take responsibility for one's actions often invoked to encourage women to keep pregnancies[22]
- Key influencers around STIs and pregnancy decision-making differed across age groups;[24] peers can have a negative influence, parents can be positive force but intergenerational communications challenges are common[23]

Lack of contraceptive awareness and access (3 articles)[2, 25, 26]

- Lower levels of awareness, usage, and availability of family planning and emergency contraceptives for adolescents, though knowledge was found to increase with age[2, 25]
- Studies of EC availability in pharmacies across Hawaiʻi have identified lack of options on neighbor islands as a potential contributor to unintended pregnancy among teenagers[26]

Lack of access to comprehensive sexuality education (2 articles)[27, 28]

- As of 2015, comprehensive sexuality education (CSE) must be offered in Hawaiʻi Public Schools; opt-in system must include information on abstinence and contraception[27]
- Challenges to quality CSE include lack of monitoring system for sexual education data, absence of funding to supplement relevant professional development, and ensuring that teachers are adequately trained and comfortable teaching CSE[28]

Social determinants of health (1 article)[29]

- Multigenerational trauma; discrimination; poverty; and inequities in education, environment, health care, housing, and social capital are all contributing factors to adolescent health; however, no specific discussion of pregnancy determinants

Need for culturally-adaptive interventions (4 articles)[5, 30, 31, 32]

- Four studies identified the absence of culturally-resonant sexual health and multi-factor interventions targeting NHOPI adolescents; none led to lasting behavior change or health improvements

Summary

- Adolescent NHOPI are at a higher risk of substance abuse, unsafe sexual practices, and sexual violence relative to peers of other races/ethnicities in Hawaiʻi
- Limited access to reproductive health services and quality sex education can contribute to unplanned pregnancies
- Unintended pregnancy is not a resonant term within the Hawaiian community and families are often willing to support pregnant teenagers
- There are a limited number of related interventions for NHOPI, but to date none have shown significant changes in health behaviors/attitudes, or been scaled/replicated
- Culturally-tailored, community-based programs engaging peers and family appear as a first step to addressing this health disparity

Limitations and Discussion

- Very few articles explicitly examined the determinants or risk factors contributing to adolescent pregnancy among NHOPI, and none relayed a causal effect
- Variability in study designs and methods complicated direct comparisons of articles
- There remains a notable gap in the literature, and additional research is needed to discern the effects of geography, socioeconomic status, and community attitudes on teenage pregnancy among NHOPI
- Further disaggregation of data (by race and age) is critical to fully defining this issue, especially among younger adolescents

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WAIORA: Promoting Planetary Health and Sustainable Development for All

Poster presented at Poster Circle 6c: Approaches to Sexual Health, Energy Events Centre, April 10, 2019

For more information: peckk@hawaii.edu

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DEVELOPMENT AND VALIDATION OF THE *TOOL ON THE PRODUCTION OF EFFECTS BY LOCAL INTERSECTORAL ACTION* FOR MANAGERS AND PRACTITIONERS

Bilodeau A, St-Louis MP, Boyer G, Meunier A, Martin N, Chabot C, Lefebvre C, Potvin L.
École de santé Publique, Université de Montréal (Québec, Canada)

CONTEXT

From 2011 to 2016, a research based on the Actor-Network theory produced a modelling of production of the effects of local intersectorial action:

- ❑ A limited number of transitional outcomes punctuates the progression of intersectoral action to its effects in living environments.
- ❑ A list of 12 transitional outcomes has been identified (bit.ly/afficheRT).
- ❑ The transitional outcomes represent the critical events in the progression of action toward the desired goals. They are linked in many singular ways according to the contexts.
- ❑ Systemic modeling links chains of transitional outcomes to effects of intersectoral action.

OBJECTIVES

- ➢ High interest of actors of intersectoral action for these research results.
- ➢ Need for a tool to produce timely information about the effects of intersectoral action.
- ➢ Production of an interactive and user-friendly online tool of the modeling that could be used by intersectoral actors in order to increase understanding of their actions.

METHODS USED TO CREATE THE TOOL

1st step

Identify the needs and establish the characteristics of the Tool :

- ➢4 workshops (2016-12 to 2017-03) resulting in an online 3-module tool :
- ➢1) To appropriate the foundations of the Tool;
- ➢2) Identify the critical events of a project and translate them into a chain of transitional outcomes until its effects in living environments;
- ➢3) Model the chain of transitional outcomes and learn from it.

2nd step

Produce the central piece of the Tool – a workshop animation guide to identify critical events of a project and the chain of transitional outcomes leading to effects.

➢3 workshops (2018-06 to 2018-09).

The guide includes instructions and cautions to lead the workshop.

3rd step

Edit the Tool online and promote it.

❑Tool hosted on: www.communagir.org/

❑Various networks and social development support organizations introduce the Tool to their target audiences.

RESULTS

AN ONLINE 3-MODULE TOOL

1) **PREZI presentation** of the research that founds the Tool: objective, team, partners, theoretical anchoring, method, results (1).

2) **Animation Guide** to identify critical events of a project and their translation into a chain of transitional outcomes.

3) **Power Point presentation** on modelling of the chain of transitional outcomes, and a **guide** to learn from it.

3 TYPES OF USE

❑Retrospective : portrait, balance sheets, reporting to funders;

❑Forward-looking : planning of the action;

❑Formative : collective reflection, concerted work training, explanation of the concertation process.

Financed by the Services aux collectivités du Gouvernement du Québec

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DEVELOPMENT OF A HEALTH EDUCATION INSTRUCTIONAL PROGRAM USING THE CONCEPT OF EDUCATION FOR SUSTAINABLE DEVELOPMENT TO ENHANCE SYSTEMS THINKING AND LEARNING ACHEIVEMENT OF TENTH GRADE STUDENTS

Pongnatee Sattayathewa
Chulalongkorn University, Bangkok, Thailand

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23rd World Conference on Health Promotion

Research Goals

The purpose of this research was to study the systems thinking and learning achievement of tenth grade students who were taught Health Education by using an instructional program based on the concept of education for sustainable development.

Background

Education for sustainable development is a learning concept that enhance systems thinking of the learners. Many techniques and methods are used to provide systems thinking skill in many dimensions including social skills, emotional quality, life skills, and decision-making skills. The Education for sustainable development strategy consisted of seven components which are 1) Integration, 2) Connection Beyond Self to Society, 3) Thinking skill, 4) Cooperation, 5) Diversity of Perspective 6) Technology and 7) Temporal Perspective. These components help learners gain the systems thinking ability, to be attentive and considerate to others, to be responsible for their own decisions and to cope with situations effectively. The previous studies also reveal that social and emotional learning can promote the development of learners' thinking skills.

Participants

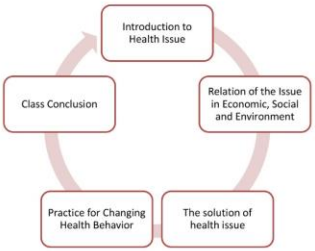
The subjects consisted of sixty students in the tenth grade of Samsenwittayalai School and divided equally into two groups: an experimental group and a control group.

Methods

The experimental instrument consisted of lesson plans using the concept of education for sustainable development. The duration of the experiment was eight periods over a span of eight weeks. The data collecting instrument included systems thinking test and learning achievements test. The data were analyzed by arithmetic mean , standard deviation (S.D.) and t-test.

Health Education Instructional Program Based on ESD Concept

The lesson plan consists of five steps based on education for sustainable development strategy



Introduction to Health Issue: Raise the awareness of the impact health issue to students.
Relation of the Issue in Economic, Social and Environment: Relate the health issue to the three dimension of sustainable development to find what are the effects them.
The solution of Health Issue: Students propose the best solution that they think or the way that they can change their health behaviors.
Practice for Changing Health Behavior: Students show how to change health behavior.
Class Conclusion: Sum up what they have learnt in the class

Outcomes

- A Health Education instructional program using the concept of education for sustainable development is able to enhance systems thinking and learning achievement of tenth grade students.
- The students in the experimental group had a higher level of systems thinking and learning achievement after using a Health Education instructional program using the concept of education for sustainable development than before at the level of significance of .05
- The students in the experimental group had a higher level of systems thinking and learning achievement than students in the control group at the level of significance of .05.

The Comparison of mean score After Applying The Program

Variables	Ex. Group (n = 30)		Con. Group (n = 30)		t	p
		SD		SD		
Systems Thinking Score	3.63	2.15	1.2	1.06	5.54	.000*
Knowledge Score	15.76	1.4	14.86	1.63	2.28	.026*
Attitude Score	76.23	4.65	59.33	4	15.08	.000*
Practice Score	66.36	4.02	58.53	4.9	6.76	.000*

Conclusion

The development of health education instructional program using the concept of education for sustainable development which consisted of five steps; 1) Introduction to health issue 2) Relation of the issue in economic, social and environment 3) The solution of health issue 4) Practice for Changing Health Behavior and 5) Class conclusion can enhance systems thinking and increase learning achievement of tenth grade students in Thailand

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Development of Be Cancer Alert (BCA) Mass Media Campaign based on National Cancer Awareness Bench Marking Study (ABC)

Tin Tin Su, Désirée Schliemann, Saunthari Somasundaram, Nor Saleha Binti Ibrahim Tamin , Maznah Dahlui, Siew Yim Loh, Michael Donnelly

1 South East Asia Community Observatory (SEACO), Monash University Malaysia; 2 University of Malaya; 3 Queen's University Belfast; 4 National Cancer Society Malaysia; 5 Ministry of Health Malaysia

Background/Objectives

To develop culturally sensitive mass media cancer awareness raising campaign based on national cancer awareness bench marking study (ABC)

Methods

The survey was carried out from March 2014 until November 2014 using a CATI (Computer-Assisted Telephone Interview). A random digit dialling (RDD) method was performed to select the random sample of people age 40 and above.

Validated Attitude and Belief about Cancer (ABC) questionnaire was used

Results

Altogether 1895 participants across Malaysia responded the survey.

The number of symptoms recalled was on average, less than 1. When prompted, 5.5 symptoms were recognised as among the 11 cancer warning signs and symptoms.

BELIEFS ABOUT CANCER OUTCOMES	Overall percentage	Female	Male
Agreed with *"These days, many people with cancer can expect to continue with normal activities and responsibilities"*	83.9 (81.4-86.4)	86.7 (83.8-89.5)	81.1 (77.1-85.1)
Agreed with *"Cancer can often be cured"*	71.4 (68.7-74.1)	73.3 (69.5-77.2)	69.5 (65.6-73.4)
Did not agree with *"A diagnosis of cancer is a death sentence"*	66.3 (63.2-69.4)	66.7 (62.3-71.1)	65.9 (61.6-70.3)
Did not agree with *"Most cancer treatment is worse than the cancer itself"*	35.0 (31.9-38.2)	33.4 (29.0-37.8)	36.7 (32.2-41.1)

According to multivariate data analyses, **Malay ethnicity has more negative belief and attitude** on cancer compared to other ethnicities (Chinese and Indian).

Having a university degree were inversely associated with cancer denial (APR 0.64 95%CI 0.41-1.00).

More than 70% of participants believed that cancer screening is only necessary for those who have symptoms. There was a strong association with negative belief and cancer screening behaviour among Malaysian.

BELIEFS ABOUT CANCER OUTCOMES	PERCENTAGE % (95%CI)		
	Overall percentage	Female	Male
Agreed with *"I do not want to know if I have cancer"* (Cancer denial)	18.8 (16.2-21.4)	18.5 (14.6-22.3)	19.1 (15.6-22.5)
Going to the doctor as quickly as possible after noticing a symptom of cancer could increase the chances of surviving (Benefits of early presentation)	90.7 (88.8-92.6)	90.4 (87.8-93.1)	90.9 (88.2-93.7)

Discussion

Based on the finding of the study, we designed and implemented a culturally sensitive "Be Cancer Alert (BCA)" mass media cancer awareness raising campaign in 2018 April (Colorectal Cancer) and October Breast Cancer) that will improve negative belief, and achieve behaviour change among the Malaysian population and lead to positive health outcomes (e.g. improvement in uptake of screening, prompt health seeking behaviours and early diagnosis).

Keywords: Cancer awareness, Mass media, Early detection, Attitude and belief about Cancer, Malaysia

Contact: TinTin.Su@monash.edu

Development of nutrition knowledge-based learning model by Information Technology for blood sugar control among diabetic patients

Charuwan Manmee1, Sathit Niramitmahapanya2, Ong-art Sickamann3, Hataya Srithong4
1Department of Research and Technology Assessment, Rajavithi Hospital,Bangkok, THAILAND
2Department of Medicine, Rajavithi Hospital, Bangkok, THAILAND
3Department of Family Medicine, Rajavithi Hospital, Bangkok, THAILAND
4Department of Nutrition, Rajavithi Hospital,Bangkok, THAILAND

Background

Diabetes can be prevented by lifestyle modification. Smart technology is an alternative way to deliver educational and motivational advice about lifestyle modification.

Objectives

To develop nutrition knowledge-based learning model (classify food game) for blood sugar control among diabetic patients in Rajavithi hospital.

Methods

The quasi-experimental study with two phases was conducted. The first, the development of nutrition knowledge-based learning model by Information Technology was generated by situation analysis of diabetes care and multidisciplinary brainstorming. The second, outcomes of the model were evaluated by pretest and posttest of fasting blood sugar (FBS), knowledge to classify food types and satisfaction. The subjects comprised 80 diabetic patients and equally assigned into an experiment and a comparison group. The experiment was given classify foods game via smart devices. Three food types were classified as unlimited intake, limited intake and forbidden foods. Their knowledge scores before and after counseling by nurses and nutritionists were recorded. The comparison group received pre-knowledge paper assessment, were consulted by nurses and nutritionists, and post-knowledge paper assessment was done. The satisfaction about the model was assessed. At the second week of follow-up, the nutritionists called to both groups for lifestyle modification, and FBS was measured at follow-up. This study was reviewed and approved by the ethics committee, Rajavithi hospital.

Results

The characteristics of both groups were similar. The experiment group had significantly better knowledge about food classification than before the study, and better than the comparison group (p=0.035). An average level of FBS in the experiment group was significantly lower than before the trial, and significantly lower than those of the comparison group (p=0.041). The satisfaction of the experiment group was significantly higher than those of comparison group (p<0.001). The experiment group was most satisfied about the food game model in terms of interesting style, better knowledge, modern model, and easy to use.

Figure 1 A: Classify Foods Games by Android system, B: Score summary, C: Three food types were classified as unlimited intake, limited intake and forbidden foods, choose each food picture to each category

Table 1. Comparison factors between before and after experiment

Factors	Control group	Experiment group	P-value
FBS (mg/dL)			
Before	149.70 ± 41.65	150.10 ± 37.09	0.964
After	151.92 ± 37.21	137.00 ± 25.94	0.041*
Knowledge to classify foods			
Before	77.00 ± 10.67	75.74 ± 12.09	0.625
After	83.00 ± 9.66	87.03 ± 6.91	0.035*
Satisfaction about devices	3.79 ± 0.76	4.65 ± 0.66	<0.001*

Discussion

The classify food game model is an effective learning tool which significantly improved FBS in diabetic patients. Using technology increases the potential for diabetic caring and is similar to literature. Further investigation should apply this model for longer term to manage proper dietary behavior and control blood sugar levels.

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Disclosures

The authors have nothing to disclose. This study was supported by a research grant from Rajavithi Hospital.

Acknowledgements

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Difference in Advance Glycation End-Products (AGEs) value of female college students with or without exercise habits

SANAE NAKAJIMA Kyoritsu Women's Junior College, Tokyo, JAPAN

IUHPE 23rd World Conference on Health Promotion

【Introduction】

Advance Glycation End-Products (AGE) are harmful substances formed through an excess of protein and sugar in human body(Figure1). Excessive accumulation of these substances has been reported to accelerate the aging process and contribute to multiple diseases such as arteriosclerosis and diabetes. It has also been reported that AGE accumulation is related to food intake.

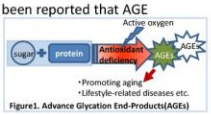


Figure1. Advance Glycation End-Products(AGEs)

【Objectives】

The purpose of this study designed to determine the relationship between food intake and AGEs value by researching the food intake of female university students and then measuring their AGEs values. Furthermore, we investigated female university students are examining whether the momentum difference is related to the AGEs values.

【Materials & Methods】

- The AGE values presented here are measured with a TruAge scanner, and the measurement is taken from the front part of the left forearm (Fig.2). This nonintrusive method measures in vivo AGE accumulation by exposing accumulated AGE to light mild ultraviolet exposure. The specific fluorescence of AGE is used to measure the amount of AGE accumulation under the skin.

Figure 2. TruAge scanner

- The body physical characteristics, body fat percentage, body weight were measured using Body analyzer TBF-410.
- This study of dietary habits includes a food intake survey created on the basis of the Food Frequency Questionnaire (FFQg).

【Results & Discussion】

1) Physical characteristics of students: athletes and non-athletes

Table1. Characteristics of Subjects

	Students: Athletes	Students: Non-athletes	
Age (years)	19.6±1.1	18.7±0.7	*
Height (cm)	158.8±6.3	158.5±4.8	
Weight (kg)	54.7±8.0	52.2±6.7	*
BMI	21.7±2.7	20.7±2.2	*
Body fat (%)	24.3±4.2	27.8±5.3	*
Muscle mass (kg)	39.4±3.4	35.3±2.8	*

The AGE levels of the athletes were significantly higher (127.7±15.3 IU) than those of the non-athletes (157.0±21.4 AU) (Table 2 & Figure 3).

2) Levels of AGEs

Table 2. Levels of AGEs among students: athletes and non-athletes

	Students: Athletes[a]		Students: Non athletes[b]			
	M	SD	M	SD	t	p
AGEs	157.0	21.4	127.7	15.3	9.71*	0.00

*:n=77, ᵇ:n=76, M=average, *:p<.05 (Two-sided test)

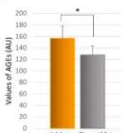


Figure 3. Comparison of AGEs values between students: athletes and non-athletes

3) Dietary intake situation

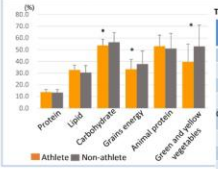
Table 3. The ratio of Nutrient intake

	Students: Athletes	Students: Non-athletes	
Energy	1972.2±481.3	1741±481.5	
Protein	67.6±19.5	58.5±23.1	*
Carbohydrate	255.2±62.3	232.6±58.4	*
Lipid	72.3±22.1	60.3±24.9	*
Calcium	552.0±189.0	508.8±201.6	
Iron	7.5±2.4	6.3±2.7	*
Vitamin B1	1.1±0.3	0.8±0.4	*
Vitamin B2	1.2±0.4	1.0±0.4	*
Vitamin C	72.8±36.6	70.2±41.9	

The values of protein, carbohydrate, lipid, iron, and vitamin B1 & B2 intake were significantly higher in athletes than in non-athletes (Table 3).

Table 4. The ratio of nutrient intake

(%)	Students: Athletes	Students: Non-athletes	
Protein	13.7±2.2	13.3±2.7	
Lipid	32.6±4.3	30.4±6.1	
Carbohydrate	53.6±5.2	56.3±8.3	*
Grains energy	33.3±8.5	37.7±11.1	*
Animal protein	52.9±9.5	51.0±13.1	
Green and yellow vegetables	39.0±15.8	49.6±21.7	*



The values of intake of carbohydrates, cereals energy, and green vegetables were significantly lower in athletes than in non-athletes (Table 4).

Table 5. Amount of intake of each group of foods

	Students: Athlete	Students: Non-athlete	
Rice(g)	246.6±109.8	166.7±103.2	
Baked	38.4±26.6	27.8±23.1	
Noodles	69.0±58.6	60.3±56.4	
Potatoes	26.9±26.1	24.8±31.0	
Green and yellow vegetables	67.4±39.8	74.3±55.4	
Fruits	82.3±85.3	67.9±71.0	
Confectionery	107.6±77.2	79.2±62.9	*
Favorite beverage	123.7±123.4	63.3±117.0	
Sugar	4.6±4.0	3.7±3.3	

The intake of confectionery was significantly higher in athletes than in non-athletes (Table 5).

4) Results of questionnaire survey on dietary habits and health

The FFQg comprises four categories related to dietary habits and health: [items related to exercise and health], [items related to food attitudes], [items related to eating behaviors], and [items related to eating consciousness].

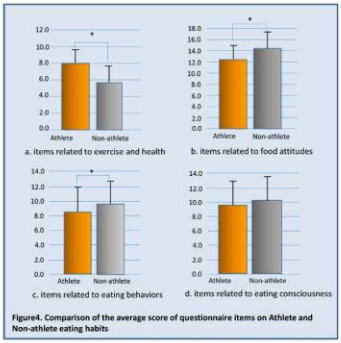


Figure4. Comparison of the average score of questionnaire items on Athlete and Non-athlete eating habits

The score of the item about【health and exercise】of athletes was significantly higher than that of non-athletes. However, the item about [food attitudes] and [eating behaviors] showed a reverse result (Figure 4).

【Conclusions】

We observed that the non-athletes had good dietary habits and the intake of AGEs was low, while the athletes showed the opposite result. This may suggest that AGE values can be suppressed if dietary habits are improved. However, it cannot be denied that damage caused by excessive exercise on a daily basis is also a factor influencing the AGE value. To not promote saccharification, it is thought that a balanced diet that is suitable for exercise quantity leads to suppression of AGE values.

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THE UNIVERSITY OF AUCKLAND NEW ZEALAND

MEDICAL AND HEALTH SCIENCES

IUHPE 23rd World Conference on Health Promotion

DIFFERENCE OF IMPACT BETWEEN AID INTERVENTIONS VS COMMUNITY BASED INTERVENTIONS

Beatrice Meadowcroft
University of Auckland - School of Population Health

BACKGROUND:

At what point does AID become something that is not useful to a community? From a health promotion perspective, we can identify a need for a sustainable method of aid delivery, including the beneficial role of community development. The Ottawa Charter tells us that a key task of health promoters is to enable community processes, and to support people and communities to develop personal skills.

METHODS:

A literature review has been conducted to compare the benefits and disadvantages of each method of Aid through:

- Existing aid plans/interventions
- WHO
- Minitry of Health NZ
- UN Library

AID

- Provides temporary relief
- Short term
- Limited Growth
- Emphasies dependence
- Potential power imbalance

+

COMMUNITY DEVELOPMENT

- Develop personal skills
- enable communities
- Empowerment
- Sustainability focused
- Promotes independence

→

- A constructive and sustainable method for empowering communities is to develop personal skills.

- External aid is still required for resources that cannot be accessed.

- A health promotor's role is to enable the development of skills, so that the community can establish where and how the aid is needed most rather than implementing ideas from an external point of view.

- A combination is more efficient and effective in satisfying community needs.

'We would very much like to depend on ourselves... ... to lead our lives and be self supporting'
- Mr Gurmu, Ehthiopian Native

FUTURE DIRECTIONS:

- Paris Declaration on Aid Effeciveness endorsed by over 100 donors and developing countries to monitor success, failure and effectiveness upon 56 commitments.
- New Zealand upholds it's responsibility to assist in the development Pacific communities to become independent.

Contact:
Beatrice Meadowcroft
bmea902@aucklanduni.ac.nz

Acknowledgements:
I would like to thank the School of Population Health at the University of Auckland and Dr. Debbie Hager for the opportunities in learning and developing my knowledge in health promotion.
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GREENH City
GoveRnance for Equity
EnviroNment & Health in the City

Autors: Marion **Porcherie** (1), Anne **Roué Le Gall** (1), Frédérique **Quidu** (1), Zoé **Héritage** (3), Clément **Bader** (3), Emmanuelle **Faure** (4),Stéphane **Rican** (4), Jean **Simos** (5), Nicola **Cantoreggi** (5), Zoé **Vaillant** (4), Marie-Florence **Thomas** (2)

(1) EHESP, Arènes UMR 5061
(2) EHESP/IRSET UMR 1085
(3) WHO French HEalthy Cities network
(4) Université Paris - Nanterre - Ladyss UMR 7533
(5) Institute of Global Health - University of Geneva

The health-in-all-policies approach to promote healthy green spaces in urban setting and equity

A study of the French Healthy Cities profiles

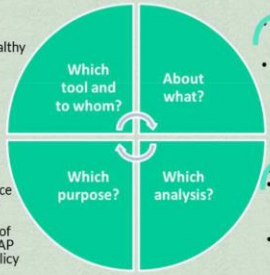
Introduction

Green spaces in the city appear to be one of the major protective factors in everyday living conditions for population health. But this protection can be unfairly distributed, depending on people uses and on public policy capacities for integrating health consideration.
The Health-in-all-policies (HiAP) approach is a strategy enabling this goal.

This communication presents the first results of the interventional participatory research project entitled GREENH-City (GoveRnance for Equity, ENvironment and Health in the City -Subvention N°2017-003-INCA) based on **a multiple case study** among the members of the WHO French Healthy Cities network.

How to identify the patterns of municipalities regarding HiAP in order to reduce health inequities through green spaces policies and municipal interventions?

Method



- An on-line survey among the health services of 80 Healthy Cities

- Gather knowledge from the healthy cities on green space policies and health inequities
- Assess the degree of maturity in the HiAP approach in the policy making
- Establish "profiles" based on HiAP analysis

- Collaborations between health service and environment services
- Health inequities considerations

- Qualitative analysis
- Statistical multivariate analysis with clustering analysis based on cities profiles
- Qualitative theory-based analysis to identify types of HiAP profiles

Results

Based on 58 eligible answer, clustering analysis shows :

- 8 clusters defined 3 HiAP profiles (HiAP+/-/++)

HiAP -	19 cities
HiAP +	16 cities
HiAP ++	13 cities

Coupled with socio-economic characteristics and data on spatial disparities for each cities, **6 cities among the 3 profiles** were chosen for the rest of the study.

Conclusion

Urban green spaces can support healthy interventions and healthy political choices. But the definition of **healthy green spaces** deals with **complexity** and includes :
- people uses,
- green spaces nature
- ecosystem services.

This research combines **mixed methods with a systemic approach** and offers opportunities for linking policies with implementation, political will with the use of population.

It enables **knowledge transfer** and support political decision.

Référence:

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Domestic violence against women: representations and practices of the community health worker

Adriana Miranda Ferreira Leite Jacinto
Marco Akerman

Post-graduate program in public health at the University of São Paulo, Brazil

IUHPE
23rd World Conference on Health Promotion

Introduction

Acts of violence against women are present in the most varied contexts, regardless of race, class or color. They can manifest themselves as verbal aggressions, by name-calling, rude speech, and humiliation. Or physical assaults, by tapping, pinching, jerking, punching, and burning. Also, by forced sex, from fear, physical coercion and beatings (Schraiber et al., 2005). Often frequent and routine, acts of violence often go unnoticed, being considered as fatality, which increases and aggravates the banalization of violence. These acts of violence against women are perpetrated by intimate partner, spouse, or ex-partner in 80% of cases, most of which occur domestically (Schraiber et al., 2005). Through the feminist struggle and the study of gender relations, the oppression and domination suffered by women within patriarchy became public, and the approach to conflict and violence between men and women was debated (Debert and Gregori, 2008). As an effective member of the Family Health Strategy (FHS), the community health worker (CHW) assumes the role of mediator between the community and the team professionals. Because of the relationship with the reality and the health practices of the neighborhood where he lives and works, CHW is in a strategic position to contribute to the identification of cases of domestic violence against women.

Objective

To know and problematize the representations of the CHW on domestic violence against women.

Methodology

Qualitative study, since it is important to know the universe of the meanings, representations, beliefs, perceptions and opinions of the community health workers. Data were collected through five focus groups, with the CHW of the five health units of the family of the municipality of Jundiaí - São Paulo / Brazil. In total there were 26 CHW participants. The group interviews were recorded and transcribed. For the analysis of this material was used the Content Thematic Analysis (CTA) proposed by Bardin. The data were grouped by topic, and the investigator examined the sense nuclei thoroughly to ensure that all manifestations were included and compared. The research aimed to describe these thematic groupings and later sought to relate them (Pope and Mays, 2009). These thematic groupings allowed the construction of two categories and seven subcategories of analysis, as shown in the table below:

Table 1: Distribution of analysis categories.

General Categories	Intermediate Categories	Specific Categories
1 Representations of community health workers on violence against women	1.1 Conceptions of community health workers about women in situations of violence	1.1.1 Factors contributing to triggering or reinforcing situations of violence against women 1.1.2 The view of community workers on women's justifications for staying in situations of violence 1.1.3 Ways women face violence 1.1.4 Legislation
2 Attention to violence in health services and care network	2.1 Representations of community workers on health services	2.1.1 Practices of community health workers to women in situations of violence

Source: The researcher (2018)

Results and Discussion

This step will present the main results obtained in the categories and subcategories described previously.

Among the representations of the CHW, it was observed the responsibility of the woman to break with the cycle of violence, as well as the understanding of the relationship of the couple as a private one, highlighting the famous statement: "In a husband and wife dispute, no one spoon".

"Inside his house, he's in charge, the time he closes the doors, you go home for five hours, the owner of the home, the alpha, the male and the guy will do it right, the woman does what she wants, it's not up to me to get involved in home life. If she catches, if she does what she does and does not tell me, I can not intervene. Unless the person asks for help, the intervention or orientation becomes difficult" (Speech of a CHW).

The community workers point to the culture of violence and gender representations as factors contributing to trigger or reinforce situations of violence.

"There is no teaching of the man, there is a teaching of the woman to protect herself. To the man not to beat he does not have to do what He does not leave the house at night, do not wear short skirt, do not speak, do not provoke, husband do not know what there" (Speech of a CHW).

According to the CHW, the main female justifications for staying in a situation of violence are linked to the fear of reprisal; financial and emotional dependence, and low self-esteem.

Among the alternatives experienced by women to confront violence, CHW pointed out their participation in the psychology group of the FHSC (Family Health Support Center); the immersion in the labor market and the induction of pregnancy.

"Sometimes the woman herself gets pregnant to have a security for 9 months, which will not catch as much of the companion" (Speech of a CHW).

The community workers report the low credibility of women in the Maria da Penha Law and the Protective Measure, as well as the fragility of Public Security services; the lack of preparation of professionals and the deficiency of the Judiciary in guaranteeing the effectiveness of the Law.

In the discourse of community workers, it is observed the lack of consideration of the demand for violence as pertinent to health services. This aspect reflects in the underreporting of cases as well as in the recurrent confusion between police reporting and compulsory notification.

Regarding the CHW practices of women in situations of violence, they understand the orientation process as singular, although they recognize the listening, dialogue and discussion of cases with management as common aspects. They emphasize the importance of the link with the user and the professional approach to adherence to treatment. Regarding the orientation of the police complaint, there is no consensus among community workers.

Conclusion

It was observed that the difficulty of the CHW and other professionals of the team with in relation to violence approaches is linked the gap in undergraduate curricula, lack of training and cases supervision. Therefore, adherence to a protocol of violence is fundamental to guide the actions of professionals. After all, women need to be valued, supported and encouraged to break the cycle of violence. In this sense, the gender relations debate needs to be included also in schools and health services. In conclusion, it is important to emphasize that the CHW are in a situation of vulnerability. Many of them have experienced or experienced trajectories of violence. In this way, this professional class needs not only training, but care.

Figure 1: Community Health Workers and researcher (2016)

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Effect of a Designed Health Education Program on Puberty Health Knowledge among Female Blinded Adolescent Students

Roza bahary[1], **Farkhondeh Amin Shokravi**[2*]
1.Ms of Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran; Email: Rozabahary@modares.ac.ir
2.PhD, Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, No. 7, Jalal Al Ahmad Street, Tehran 14115-116, Iran. Tel: +09821 82884506; Fax: 009821 82884555;
E-mail: aminsh_f@modares.ac.ir

Background/Objectives: Reproductive health is one of the most fundamental aspects of life and receives little attention in public policy discussions because of its cultural and political sensitivities. The aim of this study was to evaluate the effect of a designed health education program on knowledge about puberty health among female blinded adolescent students during periods of 2011–2015.

Methods: This was a quasi-experimental study, which was conducted on 100 blind girls aged 9–19 years. Data collection tool was a researcher made questionnaire. Samples were recruited with convenience sampling method from the Narjes educational center of blind girls in Tehran. *The educational needs assessments* survey was used to learn about important issues and problems faced by female-blinded students in order to *design* effective *educational programs*. The effectiveness of designed program was assessed by comparing the students' knowledge between the baseline and one-month follow-up.

Results: The results showed that puberty knowledge of blind students was increased in all five educational domains after intervention compared to the baseline. Knowledge about onset of puberty changes showed the highest increase and the knowledge about personal hygiene had the least change after intervention. The majority of students did not have any information resource regarding puberty health and about one quarter of them reported their mother as the main resource of puberty information**.**

Discussion: Performing educational programs during puberty has a crucial role in young girls' knowledge increase. Performing a continuous health educational program tailored to the needs of blind students by using the suitable strategies is recommended.

Keywords: Puberty, Health education; Blindness; Adolescent; Women's health.

Effect of eating speed and sedentary life on obesity in residents of Gangwon Provine, Korea

Heui Sug Jo,[1] Su Mi Jung[1]
[1]Kang Won National University, Chuncheon, South Korea

IUHPE
23rd World Conference on Health Promotion

Research background / Objective

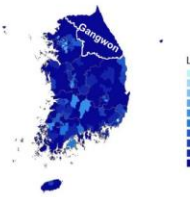
According to the Korean Community Health Survey, the median obesity rate has increased every year. Many studies have been conducted on physical activity and obesity, but reports from Korea that have considered sitting time and eating habits are rare.

This study aimed to investigate the relationship between obesity and eating speed and sedentary life to gather basic research data for preventing of obesity among residents of Korea.

Methods

We used data from Gangwon Province in Korea, which has the highest rate of obesity among the 2017 Community Health Survey (Figure 1). A total 7,311 men and 8,522 women were included in the study. Descriptive statistics and a chi-square test were used to investigate the association of obesity with lifestyle and eating habits. Multiple logistic regression analysis was performed to simultaneously analyze their associations with other factors. Data were analyzed using IBM SPSS Ver. 24.0 (IBM Corp., Armonk, NY, USA) and SAS Ver. 9.4 (SAS Institute, Cary, NC, USA).

Figure 1. Gangwon Province's obesity rate(self-reported) in South Korea (2017).



Source: Key findings of 2017 Community Health Survey by the KCDC(obesity part of health behavior) https://chs.cdc.go.kr/chs/index.do .

Results

Univariate analysis of variables related to obesity.

Chi-square analysis to identify single variables related to obesity showed that obesity were higher in men than in mealtimes, while obesity rates were higher in meals in 20 minutes or less. Obesity rates were higher in women who were on weekdays and weekends, while those who spent more than 2 hours on weekdays and weekends had less than 20 minutes of meals (Table 1).

Table 1. Univariate analysis of variables related to obesity

		Male			Female		
		obesity	normal	X^2	obesity	normal	X^2
Total		2559 (35.9%)	4448 (63.5%)		2263 (29.9%)	5303 (70.1%)	
Sitting leisure time (weekdays)	≥ 2 hours	1216 (35.9%)	2171 (64.1%)	1.082	1184 (32.6%)	2446 (67.4%)	24.250 ***
	< 2 hours	1343 (37.1%)	2277 (62.9%)		1079 (27.4%)	2855 (72.6%)	
Sitting leisure time (weekend)	≥ 2 hours	1314 (36.4%)	2297 (63.6%)	0.056	1211 (31.7%)	2604 (68.3%)	12.356 ***
	< 2 hours	1245 (36.7%)	2151 (63.3%)		1051 (28.0%)	2697 (72.0%)	
Regular eating pattern	No	570 (37.8%)	939 (62.2%)	1.302	571 (31.7%)	1233 (68.3%)	3.412
	Yes	1989 (36.2%)	3509 (63.8%)		1692 (29.4%)	4069 (70.6%)	
Meal time	≥ 20 minutes	2090 (37.4%)	3493 (62.6%)	9.801 **	1720 (31.1%)	3813 (68.9%)	13.586 ***
	< 20 minutes	469 (33.0%)	954 (67.0%)		543 (26.7%)	1490 (73.3%)	

* p-vale<0.05, ** p-vale<0.01, *** p-vale<0.001

Multiple logistic regression analysis of relationship between obesity and sitting time and meal time

Analysis showed eating speed was a significant factor among male respondents (table 2). High obesity rates were observed among male participants who finished a meal within 20 minutes compared with those who took at least 21 minutes to finish a meal (OR=1.21, p<0.01). For women, time spent sitting on weekdays, regular eating pattern, and meal time were statistically significant. Female participants who spent at least 2 hours sitting on weekdays (OR=1.23, p<0.05), those who had regular eatin g patterns (OR=1.16, p<0.05), and those who took 20 minutes or less to fini sh a meal (OR=1.18, p<0.01) had higher obesity rates than those who spe nt less than 2 hours sitting on weekdays, did not eat regularly, or took at le ast 21 minutes to finish a meal.

Table 2. Multiple logistic analysis of variables related to obesity

Variables(ref)		Obesity (ref=normal)			
		Male		Female	
		OR	(95% CI)	OR	(95% CI)
Age(20s)	30s	1.44**	(1.12, 1.86)	1.26	(0.90, 1.76)
	40s	1.06	(0.82, 1.37)	1.57**	(1.12, 2.18)
	50s	0.78	(0.60, 1.02)	1.37	(0.98, 1.93)
	60s	0.72*	(0.55, 0.94)	1.60**	(1.13, 2.27)
	70s +	0.44***	(0.33, 0.59)	1.03	(0.71, 1.48)
Education level (none)	Elementary	1.10	(0.82, 1.46)	1.13	(0.96, 1.34)
	Middle	1.42*	(1.07, 1.90)	0.93	(0.76, 1.14)
	High	1.25	(0.95, 1.66)	0.71**	(0.58, 0.87)
	Above University	1.31	(0.98, 1.76)	0.57***	(0.44, 0.73)
Marital status (married)	Not married	0.67***	(0.56, 0.80)	0.93	(0.69, 1.24)
	Others	0.77**	(0.64, 0.93)	0.96	(0.84, 1.09)
Moderate physical activity(yes)	No	0.91	(0.81, 1.02)	1.06	(0.92, 1.22)
Walking(yes)	No	1.11	(0.99, 1.23)	1.02	(0.91, 1.14)
Regular exercise (yes)	No	0.91	(0.82, 1.02)	1.07	(0.96, 1.20)
Sitting leisure time in weekdays (< 2 hours)	≥ 2 hours	1.03	(0.88, 1.22)	**1.23***	**(1.03, 1.46)**
Sitting leisure time in weekend (< 2 hours)	≥ 2 hours	1.05	(0.90, 1.24)	1.03	(0.87, 1.23)
Regular eating pattern (yes)	No	1.01	(0.89, 1.14)	**1.16***	**(1.03, 1.30)**
Meal time (≥ 20 minutes)	< 20 minutes	**1.20****	**(1.06, 1.36)**	**1.19****	**(1.06,1.33)**

ref: reference category/ OR: Odds Ratio/ CI: Confidence Interval
* p-vale<0.05, ** p-vale<0.01, *** p-vale<0.001

Conclusions

- In this study, we analyzed the association of obesity with sedentary life and eating speed. For both men and women, meal time of 20 minutes or less was found to a major factor affecting obesity. Irregular eating habits and sedentary lifestyle with at least 2 hours spent sitting on weekdays were identified as major factors affecting obesity among women.
- To increase the effect of community-based obesity prevention and management programs based on the results of this study, behavioral intervention strategies that can help people to modify eating habits and sitting time must be included. It has recently been claimed that sedentary behaviors and low physical activity must be considered two separate concepts.

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Disclosures

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Effect of health promotion intervention on salt intake (estimated from spot urine samples) among urban adults in Chandigarh, India: A Cluster Randomised Controlled Trial

Jasvir Kaur[1], Manmeet Kaur[1], Venkatesan Chakrapani[1], Jacqui Webster[2], Claire Johnson[2], Joseph Alvin Santos[2], *Rajesh Kumar[1,2]
[1] School of Public Health, Post-graduate Institute of Medical Education and Research, Chandigarh, India
[2] The George Institute for Global Health, University of New South Wales, Sydney, Australia

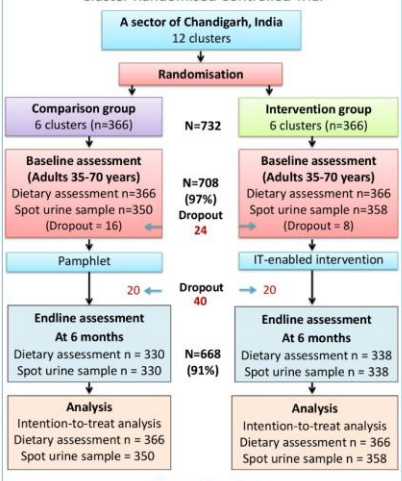
BACKGROUND

- High salt intake is a major risk factor for hypertension – a leading cause of CVD.
- Although 24-h urinary sodium excretion is the gold standard for estimating salt intake, it has high participant burden. Available evidence suggests that spot urine samples could provide valid estimates of population salt intake.
- This study evaluated the effect of Information technology-enabled (IT) 'SMART Eating' health promotion intervention on salt intake among urban adults (35-70 years).

METHODS

Study design

Cluster Randomised Controlled Trial



Sample size

15% prevalence of adequate salt intake, Power=80%, p=0.05, Design effect=2, Attrition=10%, for 20% improvement in the intervention group compared to the comparison group.

Intervention description

- **IT component:** SMS, email, Social Networking app (whatsApp) – Weekly; 'SMART Eating' website.
- **Interpersonal component:** 'SMART Eating' kit containing a dining table mat, a kitchen calendar & a measuring spoon.
- **Intervention period**: Six months

Data collection

- **Dietary data:** Food Frequency Questionnaire(FFQ)
- **Biochemical data:** Single spot urine sample

Outcomes

- Changes in dietary salt intake
- Changes in urinary salt excretion

Data analysis

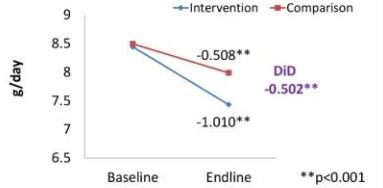
- **Intention-to-treat:** Last Observation Carried Forward (LOCF) method
- **Dietary salt intake (g/day) estimation:** Indian Food composition tables from *'Nutritive value of Indian foods'.*
- **Urine samples:** Fully-Auto analyser
  - **Mean salt excretion (g/day) estimation:** Kawasaki formula
- **Inferential statistics:** chi-square, independent samples *t*-test and paired *t*-test.
- **Net change:** Difference-in-Differences (DiD) using Multi-level mixed effects linear regression models – Adjusted for cluster design.

RESULTS

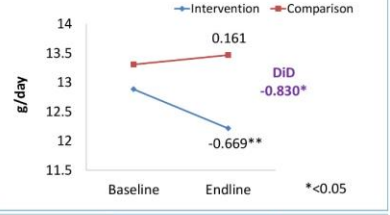
Baseline characteristics

Characteristics	Comparison	Intervention	p
Mean age, years	52.9 (0.5)	52.6 (0.5)	0.7
Women, n (%)	269 (74)	288 (79)	0.1
Married, n (%)	329 (90)	325 (89)	0.5
Hindu, n (%)	278 (76)	281 (77)	0.4
Graduates/post-graduates, n (%)	193 (53)	182 (50)	0.8
Homemakers, n (%)	226 (62)	239 (65)	0.5
Dietary salt intake, g/day	8.5 (0.1)	8.4 (0.2)	0.8
Urinary salt excretion, g/day	13.3 (0.2)	12.9 (0.2)	0.1

Change in dietary salt intake



Change in urinary salt excretion



DISCUSSION

- Salt consumption among urban adults of Chandigarh in India was more than double the current WHO recommendation of 5 g/day.
- SMART Eating intervention was found to be effective in reducing mean salt intake significantly over a six month period when measured by spot urine sample as well as by food frequency questionnaire.

*contact email: dr.rajeshkumar@gmail.com

Effect of Long Working Hours on Mental Health Status Among Employees in Shanghai: The Role of Having Leisure Hobbies

Authors: [1] Zan Li, [2] Ning Wu,[3] Chao Wang,[4] Yingnan Jia,[5] Junling Gao,[6] Hua Fu,[7] Junming Dai
Affiliations: [1,2,3,4,5,6,7]Fudan University, Shanghai, China; [3]The Beijing Prevention and Treatment Hospital of Occupational Disease for Chemical Industry, Beijing, China

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Background:

To date, long working hours are common in many regions worldwide, especially in the East Asian countries. A report from the International Labor Organization (ILO) indicated that the proportion of workers with weekly working hours ≥49 or 50 h in 2004–2005 was 49.5% in South Korea, 23.6% in New Zealand, 20.4% in Australia, 18.1% in the United States, and 14.7% in France, and noted that 22.0% of total workers globally were working more than 48 hours per week. Long working hours have been an increasingly serious health threat among the occupational population. Evidence indicates that long working hours can be harmful to this group's physical and psychological health. One earlier study using data from the China Health and Nutrition Survey (CHNS) from 1991 to 2009 found that the average weekly working hours of Chinese employees were around 47 h, with approximately 62% of respondents working more than the national standard of 40 h per week. However, research on the associations between long working hours and mental health status has remained very limited in China, and no research has demonstrated whether having hobbies could play a beneficial role in this relationship. Hence, the present study aimed to firstly explore the distribution of working hours among Chinese employees and examine how long working hours affect their mental health status using representative data from a large cross-sectional survey conducted in Shanghai, and secondly investigate the impact of having hobbies on this relationship.

Methods:

This survey was conducted using cross-sectional methodology between July and August 2018. Shanghai is one of the boom cities in eastern China, and employees live a fast-paced life with a great of hustle and bustle. Excessive dedication to work could make them vulnerable to mental health problems due to a work–life imbalance and lack of recovery after busy routines. To make up as representative a sample as possible, we used a multistage random sampling scheme containing a variety of work types in Shanghai, including white-collar workers, blue-collar workers, service personnel, and self-employed industrialists. We designed a questionnaire to collect demographic and work characteristics data and used the PHQ-9 scale and WHO-5 scale to assess depression and mental well-being, respectively. All of the participants completed the questionnaires independently with informed consent.

Results:

Table 1. Prevalence of depression and PMWB by characteristics of participants

Variables	Depression n (%)	PMWB n (%)	p
Gender			0.485; 0.048
Male	248 (19.2%)	316 (24.1%)	
Female	298 (19.1%)	423 (26.9%)	
Age			0.307; 0.392
15–24	161 (19.5%)	220 (26.4%)	
25–34	245 (19.1%)	333 (25.6%)	
35–44	91 (20.5%)	115 (25.6%)	
≥45	58 (15.6%)	81 (21.8%)	
Education level			0.765; 0.153
Junior high school	138 (19.0%)	199 (27.4%)	
Senior high school	159 (19.3%)	194 (23.3%)	
College	107 (17.4%)	152 (24.2%)	
Bachelor or above	139 (19.5%)	197 (27.3%)	
Household registration			0.215; 0.003
Local	105 (17.8%)	122 (20.6%)	
Migrant	449 (19.3%)	627 (26.6%)	
Marital status			<0.001; 0.378
Unmarried	253 (20.5%)	329 (26.3%)	
Married	276 (17.4%)	395 (24.7%)	
Divorced and others	19 (44.2%)	14 (31.8%)	
Monthly income (¥)			0.402; 0.466
<3,000	101 (21.5%)	132 (27.9%)	
3,000–6,000	305 (18.4%)	408 (24.4%)	
6,001–10,000	103 (17.6%)	154 (25.9%)	
≥10,000	36 (18.8%)	48 (25.0%)	
Sleeping status			<0.001; <0.001
Good	218 (15.3%)	263 (18.4%)	
Bad	328 (22.2%)	477 (31.9%)	

Figure 1. Prevalence of depression and poor mental well-being (PMWB) for job demand and job control

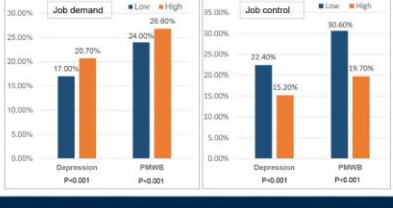
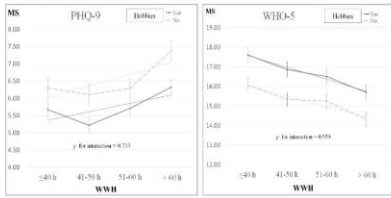


Table 2. The odds ratios and 95% confidence intervals of the relationships of weekly working hours (WWH) with depression and PMWB

	Factors	ORs of Depression	ORs of PMWB
Model I	WWH		
	≤40	Reference	Reference
	41–50	0.87 (0.68–1.15)	1.09 (0.88–1.39)
	51–60	1.01 (0.79–1.29)	1.14 (0.91–1.42)
	>60	**1.62** (1.26–2.09)**	**1.81* (1.44–2.29)**
	Having hobbies		
	No	Reference	Reference
	Yes	**0.72** (0.59–0.86)**	**0.58** (0.49–0.68)**
Model II	WWH		
	≤40	Reference	Reference
	41–50	0.91 (0.67–1.25)	1.14 (0.86–1.51)
	51–60	0.93 (0.69–1.25)	0.95 (0.76–1.28)
	>60	**1.40* (1.03–1.90)**	**1.66** (1.26–2.18)**
	Having hobbies		
	No	Reference	Reference
	Yes	**0.78* (0.62–0.97)**	**0.62** (0.51–0.75)**
	Job demand		
	High	Reference	Reference
	Low	**0.74* (0.59–0.92)**	**0.81* (0.67–0.98)**
	Job control		
	High	Reference	Reference
	Low	**1.05 (0.82–1.34)**	**1.30* (1.04–1.62)**
	Social support		
	High	Reference	Reference
	Low	**2.93** (2.27–3.77)**	**2.04** (1.64–2.54)**

Model II: Adjusted logistic model including full factors.
* Statistically significant at p < 0.05.
** Statistically significant at p < 0.0001.

Figure 2. Mean score trends of PHQ-9 and WHO-5 in four WWH groups by having hobbies or not



Conclusions:

Long working hours (over 60 h/week) were uniformly associated with a decline in mental health status compared to standard working hours when using two types of outcome measurements. Having hobbies played a buffering role in this relationship for working-age people. These findings have important implications for workplace policy and prevention of mental illness among workers. Strengthening regulation of long working hours and improving time management skills among working-age people in workplaces, while encouraging employees to cultivate certain kinds of hobbies or leisure activities in their spare time, may be conducive to their mental health status. Workplace health promotion programs or interventions should also pay close attention to these factors to achieve the goal of total worker health.

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Effectiveness of community-based lifestyle intervention to control prehypertension and/or prediabetes in Thailand: a RCTs

Pengpid S and Peltzer K (E-Mail supa.pen@Mahidol.ac.th)

The aim: assess the two-year effect of a community-based RTCs lifestyle intervention

Participants: N=443, with pre-DM and/or pre-HT

Intervention: a 6 of 1-2 hour sessions over 6 months.

Measurements were at baseline, 12 months (89%) and at 24 months (84.7%).




The aim: assess the two-year effect of a community-based RTCs lifestyle intervention **Participants**: N=443, with prediabetes and/or prehypertension **Intervention**: received a six one-two hour group sessions over 6 months. **Measurements** were at baseline, 12 months (89%) and at 24 months (84.7%).

Results:

- Statistically = NS for FBS, DBP at 12 and 24 months,
- Significant intervention effects = decrease in HDL and increase in LDL cholesterol at 24 months.
- Non-sig improvements were found (FBS, SBP, DBP, Cholesterol).
- Non-sig of group differences in psycho-behavioural variables.

Variable	Intervention group	Control group
	n (%)	n (%)
Type 2 diabetes[1]		
Baseline	0	0
24 months follow-up	5 (2.8)	9 (4.6)
Hypertension[1]		
Baseline	0	0
24 months follow-up	5 (3.0)	5 (2.6)

Conclusion: The lifestyle intervention did not provide additional benefits compared to the control group at 24 months follow-up.

Trial registration number: TCTR20170721001

Effectiveness of a Lifestyle intervention on self-efficacy, health behaviours and metabolic status in Korean population

Soo Kyoung Kim*, Eunhee Nah**, Hyekyeong Kim*,***
*Department of Health Convergence, Graduate School of Ewha Womans University,
**Korea Association of Health Promotion, Health Promotion Research Institute,
***Department of Health Convergence, Ewha Womans University, Seoul, Korea

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BACKGROUND & OBJECTIVE

- Metabolic syndrome (MetS) refers to the presence of a combination of cardiovascular risk factors.
- Managing MetS before its development into cardiovascular diseases is a major public health issue and MetS can be easily improved by practice of health behaviours.
- The aim of this study is to identify **the effectiveness of lifestyle change program on health outcomes related to MetS, as well as on self-efficacy and practice of health behaviours.**

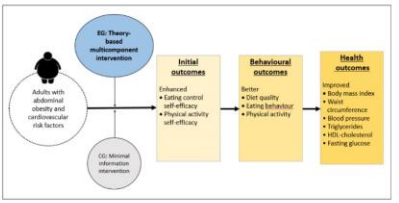
METHODS

- A randomized controlled trial was conducted in 2013, among Korean adults.
- A total of 583 people with abdominal obesity were assigned to either experimental group (EG) or comparison group (CG).
- Participants in EG received multi-component lifestyle intervention, consisted of multiple behavioural intervention activities which combined individual health counselling with education and self-monitoring.
- Participants in CG were received with minimal information on health statuses.
- Health examinations were conducted at baseline, midline, and at the end of the program in branch facilities of Korea Association of Health Promotion.

Table 1. 'Healthy Life Plan' program components and strategies

2012 US Preventive Service Task Force recommendations	Program components In health counseling, self-management booklet and health diary
	Social Cognitive Theory, Transtheoretical Model and Self-regulation Theory based behavioral strategies -Enhancing outcome expectation (Pros of change): Knowledge on the benefits of healthy eating, physically active lifestyle & managing obesity -Building self-efficacy: Cumulative mastery experience, modeling, continuous encouragement
• Behavioral management activities	-Building skills: Behavioral skills for balanced diet, lowering daily calorie intake, increasing physical activity, moderate drinking, stress management, etc. -Consciousness raising: Information on healthy weight loss -Self-reevaluation: Reassessment of unhealthy eating habits & sedentary lifestyle -Self liberation: Signing a pledge card for lifestyle change -Setting a weight loss goal: Weight loss of 5% -Information tailored to the stages of change (preparation, action & maintenance)
• Improving diet or nutrition & increasing physical activity	-Counseling on healthy eating and physical activity by clinical nutritionists -Computerized dietary assessment & prescription -Customized physical activity guidelines
• Addressing barriers to change	-Anticipating risky situations and planning coping strategies -Tips for getting support form family, friends, health professionals etc.
• Self-monitoring	-Regular self-monitoring: Keeping a health diary on food consumed and amount of physical activity, smoking, alcohol drinking and water
• Strategizing how to maintain lifestyle changes	-Providing material reward to reinforce healthy lifestyle -Providing social support

Figure 1. Logic model of the lifestyle change program



RESULTS

Table 2. Mean and proportion difference in health conditions between baseline and at the end of the program

Variables	Experimental group (n=291) Baseline	At the end of program	Difference (95% CI)	p-value*	Comparison group (n=292) Baseline	At the end of program	Difference (95% CI)	p-value*
General characteristics								
Age, years	53.7 ± 10.1				53.9 ± 10.2			
Male	118 (40.6%)				106 (36.3%)			
Self-efficacy and health behaviours								
PA self-efficacy	4.6 ± 2.1	4.9 ± 2.1	0.3 (0.1; 0.5)	**0.0051**	4.7 ± 2.1	4.8 ± 2.0	0.1 (-0.1; 0.4)	0.2676
Eating control self-efficacy	8.0 ± 1.7	6.4 ± 1.6	0.3 (0.2; 0.5)	**<0.0001**	6.1 ± 1.5	6.2 ± 1.4	0.2 (-0.01; 0.3)	**0.0349**
Diet quality	34.3 ± 5.9	35.0 ± 5.2	0.6 (0.1; 1.2)	**0.0307**	34.6 ± 6.1	34.7 ± 5.8	0.1 (-0.5; 0.7)	0.8042
Commuting PA	0 [0-120]	0 [0-150]	-19.8 (-71.4; 31.9)	0.4519	0 [0-120]	0 [0-240]	25.0 (-26.0; 76.0)	0.3355
Leisure-time PA	300 [0-840]	320 [0-900]	85.8 (-99.5; 270.0)	0.1649	240 [0-900]	200 [0-840]	-6.5 (-128.6; 116.5)	0.9187
Household PA	720 [0-1680]	480 [0-1680]	-82.5 (-299.1; 134.1)	0.4540	650 [0-1680]	420[0-1680]	-70.7 (-304.8; 163.3)	0.5525
Occupational PA	0 [0-4200]	0 [0-4200]	-68.3 (-365.9; 369.8)	0.7879	100 [0-4410]	0[0-2880]	-638.9 (-958.9; -318.9)	**0.0046**
Health conditions								
MetS prevalence	179 (61.5%)	141 (48.5%)	38 (13.1%)	**<0.0001**	175 (59.9%)	150 (51.4%)	25 (8.6%)	**0.0074**
BMI, kg/m^2	28.0 ± 2.8	27.6 ± 2.9	-0.4 (-0.5; -0.3)	**<0.0001**	28.2 ± 3.1	27.9 ± 3.1	-0.3 (-0.4; -0.2)	**<0.0001**
Waist size, cm	92.5 ± 5.8	90.9 ± 6.6	-1.6 (-2.0; -1.1)	**<0.0001**	93.2 ± 6.1	91.2 ± 6.8	-1.0 (-1.5; -0.6)	**<0.0001**
SBP, mmHg	125.1 ± 13.4	123.0 ± 13.2	-2.0 (-4.3; -0.8)	**0.0013**	125.4 ± 13.5	124.1 ± 14.0	-1.4 (-2.9; 0.2)	0.0819
DBP, mmHg	79.1 ± 10.0	77.9 ± 9.5	-1.3 (-2.1; -0.4)	**0.0041**	79.0 ± 9.5	78.4 ± 9.2	-0.6 (-1.6; 0.4)	0.2252
Triglycerides, mg/dL	157.0 ± 102.7	153.7 ± 97.3	-3.3 (-11.9; 5.4)	0.4587	145.4 ± 73.3	145.5 ± 72.6	0.1 (-6.9; 7.2)	0.9679
HDL, mg/dL	47.6 ± 10.2	48.8 ± 10.6	1.2 (0.3; 2.0)	**0.0079**	48.3 ± 13.0	48.7 ± 9.7	0.4 (-0.9; 1.7)	0.5253
Fasting glucose, mg/dL	101.4 ± 16.2	100.3 ± 15.0	-1.1 (-2.4; 0.2)	0.0917	100.1 ± 16.7	100.9 ± 19.5	0.8 (-0.8; 2.4)	0.3282

Abbreviation: PA, Physical activity; MetS, Metabolic syndrome; BMI, Body mass index; SBP, Systolic blood pressure; DBP, Diastolic blood pressure; HDL, High-density lipoprotein.
Values are presented as mean ± standard deviation or number (%).
Missing values are were replaced with the most recent observed values.
* p-value obtained by paired t-test and McNemar's test.
p-value with bold-faced are statistically significant.
A participant was diagnosed as having MetS when he or she met at least 3 out of the 5 diagnosis criteria.

DISCUSSION

- Effects of the intervention differed from two groups, in each variable such as self - efficacy, physical activities and eating habits, and health outcomes.
- For both groups, improvements were seen in many of the variables, but the magnitude and significance were stronger in EG.
- Further study is needed to develop more intensive and effective lifestyle change program managing metabolic syndrome.

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✓ **Contact email: youngk9203@gmail.com**

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KOREA ASSOCIATION OF HEALTH PROMOTION

Effectiveness of Oral Health Action Plan for Elementary School Children in Chiayi County, Taiwan

Author(s): [1] Lu Yi-Yuan, [2] Hsiao-Ling Huang, [3] Jin-Cyuan Deng, [1] Chun-Hui Lee, [3] Hong-Ding Huang

Affiliations:

[1]Da-Shiang Elementary School, Chiayi County, Taiwan(R. O. C);
[2]Department of Oral Hygiene, Kaohsiung Medical University Kaohsiung, Taiwan(R. O. C);
[3]Chiayi County Government, Taiwan(R. O. C)

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Background:

Oral health is the foundation of physical health, and the World Health Organization has clearly stated that oral health is integral to overall health. For the past several years, health examinations of schoolchildren in Chiayi County, Taiwan have generally revealed the highest rate of oral disease (68.84%) in the nation and a tooth decay rate of 41.18% that is higher than the national average for schoolchildren (40.41%). To reduce the proportion of schoolchildren with tooth decay and improve schoolchildren's overall oral health, the "Oral Health Action Plan" has been actively promoted in recent years.

Objectives:

The objective of this study was to examine the effectiveness of the Oral Health Action Plan intervention measures for upper-grade elementary school students.

Context of Intervention :

The oral health education interventions included health education courses as well as promotion of proper brushing methods, use of toothpaste with fluoride, use of dental floss, and reduced intake of foods with sugar.






Methods:

A one-group pretest–posttest quasi-experimental design was employed to study 2062 upper-grade elementary school students in Chiayi County. The study was conducted from October, 2017 to April, 2018, and an oral health promoting school program was implemented for one semester. Pretest and posttest data collection were performed using an "oral health" questionnaire compiled by the Ministry of Education of the Republic of China. Data on variables relevant to the oral health education of upper-grade elementary school students in the county were collected using a census. Finally, a paired t test was used to determine differences between the pretest and posttest results.

Results:

1. Intervention measures were as follows. The students were encouraged to brush their teeth with fluoride toothpaste after lunch, to brush their teeth before bed, and to use dental floss at least once a day.
2. Additionally, the students were discouraged from consuming snacks or drinks with sugar between meals. Regarding the success rates, the posttest oral health scores were all significantly higher than those of the pretest ($P < 0.001$). (Table1)
3. Among the results, those for the use of toothpaste with fluoride increased the most (increase of 27.13%). Although the use of dental floss increased (increase of 24.06%), the success rate did not reach 50% (49.93%). Additionally, brushing before bed exhibited the smallest increase (increase of 6.09%); however, more than 90% (91.28%) of the students had already developed the habit of brushing their teeth before bed.(Table2)

Table1 Paired samples test

	Average	standard deviation	Standard error average	95% trust interval of the number of differences		T	df	P
				Lower limit	Upper limit			
Student with fluoride toothpaste after lunch	(27.1310)	58.4848	1.2908	(29.6624)	(24.5997)	-21.019	2052	.000
Student cleaning teeth before going to bed	(6.0887)	37.9410	0.8374	(7.7308)	(4.4465)	-7.273	2052	.000
Use floss at least once a day	(24.0623)	57.1094	1.2622	(26.5370)	(21.5871)	-19.064	2052	.000
No snacks between school meals	(22.1140)	57.5491	1.2701	(24.6048)	(19.6231)	-17.411	2052	.000
Do not drink sugary drinks between meals at school	(18.4698)	50.0664	1.2374	(20.8875)	(16.0541)	-14.919	2052	.000

Table2 Paired sample statistics

Project	Average	N	standard deviation
Student with fluoride toothpaste after lunch(Pretest)	51.6805	2053	49.98393
Student with fluoride toothpaste after lunch(Post test)	78.8115	2053	40.87434
Student cleaning teeth before going to bed(Pretest)	85.1924	2053	35.52618
Student cleaning teeth before going to bed(Post test)	91.2811	2053	28.21813
Use floss at least once a day(Pretest)	25.8646	2053	43.79973
Use floss at least once a day(Post test)	49.9269	2053	50.01213
No snacks between school meals(Pretest)	40.1851	2053	49.03916
No snacks between school meals(Post test)	62.2991	2053	48.47553
Do not drink sugary drinks between meals at school(Pretest)	50.5602	2053	50.00904
Do not drink sugary drinks between meals at school(Post test)	69.0209	2053	46.25198

Conclusions

1. Oral health workshops for teachers and parents were implemented in county elementary schools with high rates of tooth decay among the upper-grade students, and post-lunch brushing activities were included in the children's school evaluations.
2. All of the schools in the county were able to implement the oral health intervention measures.
3. However, the intervention measures of "dental floss use by upper-grade students" and "banning drinks with sugar on campus" were only announced and were not implemented in students' daily lives.
3. Based on the study results, the schools should implement case management guidance mechanisms, return to use of standardized teaching methods, and establish oral health education measures.
4. Under positive influence from peers and through the alteration of primary caregivers' views regarding healthcare, schoolchildren can learn to self-manage their health.
5. Together, these measures can resolve the problem of oral diseases among schoolchildren.

Keywords:

health promotion, oral health, elementary school children

Poster presented at Circle 1b: Addressing child health
Apr 8, 2019 10:45 AM - 12:15 PM
Energy Events Centre - Wai Ora Spa Grand Hall

Effectiveness of Printed Educational Materials on Paediatric Asthma for Caregivers with Asthmatic Children

Mei-Chuan Chang[1], Yueh-Chih Chen[2], Jui-Hung Yu[3]

[1] Associate Professor, Department of Nursing, Tzu Chi University of Science and Technology; [2] PhD, RN, Professor, Graduate School of Nursing, Hungkuang University; [3] MS, Lecturer, Department of Public Health, Tzu Chi University

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Background/Objectives

Printed health education materials are vital teaching tools for the training of asthmatic children and their caregivers; however, the effectiveness of these materials depends on the ability of the intended audience to read and understand the information. In this study, we developed novel education materials on the topic of paediatric asthma. We adopted the criteria of the Suitability Assessment of Material (SAM) in the development of the materials and verified their effectiveness among actual asthmatic children and their caregivers.

Methods

Research design

A quasi-experimental design included pretesting and post-testing.

E	O1	X1	O2
C	O1	X2	O2

O1 pretest
O2 posttest
X1 new materials
X2 existing materials
E experimental group
C control group
—— nonrandomization

Figure1 research design

Participants

Seventy-six caregivers with asthmatic children were assigned to 4 groups .

Table 1 the number of participants among study groups

group	experimental group used the new materials	control group used the existing materials
adequate literacy	23	20
limited literacy	17	16

Outcome indicators

The participants' comprehension of the subject matter and their satisfaction with the materials (as derived using questionnaires)

Data analysis

Two-way ANCOVA (Analysis of Covariance) was applied to evaluate understand the effectiveness of the educational materials.

Treatments: new materials vs existing materials

Figure2 new materials : brochure

Results

Regardless of the literacy level, participants in the experimental group (EG) outperformed those in the control group (CG) in terms of comprehension, as follows: EG limited-literacy (30.06±5.07), EG adequate-literacy (34.52± 2.39), CG limited- literacy (15.25±4.52), and CG adequate-literacy (24.55± 4.25). The interaction between the two variables (material and literacy) revealed that the advantages of the proposed educational materials were sufficient to raise all EG participants (even those with limited literacy) above all CG participants (even those with good literacy skills). In the EG, the comprehension gap among those with different literacy skills also decreased. Participants in the EG assigned higher satisfaction scores than did those in the CG, regardless of their literacy level.

Table 2 Analysis of participants' comprehension scores among the 4 groups via two-way ANCOVA

source	SS	df	MS	F	P
Total score§					
covariate(pretest score)	88.06	1	88.06		
material (A)	2946.72	1	2946.72	190.45	0.00***
literacy level (B)	745.96	1	745.96	48.21	0.00***
A×B	111.294	1	111.294	7.19	0.01*
error	1098.57	71	15.47		

* p<.05;**p<.01;*** p<.001; § the total score of comprehension of asthma care

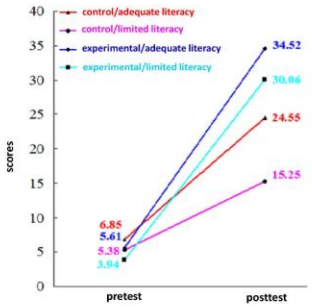

Figure4 the differences in comprehension scores among the 4 groups

Figure3 existing materials: leaflets

Discussion

Our results in this study verify that printed educational materials based on SAM criteria can be highly beneficial in terms of comprehension and satisfaction.

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Effectiveness of the Educational Programs with Spouse's Participation to Prevent Excessive Weight Gain

Azita kiani aciabar[1], **Farkhondeh Amin Shokravi**[2*]
1.PhD candidate of Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran; Email: kianacia@modares.ac.ir
2.PhD, Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, No. 7, Jalal Al Ahmad Street, Tehran 14115-116, Iran. Tel: +09821 82884506; Fax: 009821 82884555;
E-mail: aminsh_f@modares.ac.ir

Background/Objectives: Men can influence health care utilization during pregnancy but less attention paid to the development and implementation of strategies for pregnancy health care. This study aimed to evaluate the effectiveness of the educational programs with spouse's participation to prevent excessive weight gain**.**

Methods: In this Randomized Controlled Trial, 128 nulliparous women attended to Najmieh hospital in Tehran-Iran were randomly allocated into two groups of intervention and one control group. Group A: women received the intervention with their Spouses' participation, Group B: women received the same intervention solely. Group C: women received only routine prenatal care. Data collected by completing questionnaires including: demographic characteristics, 24-hour dietary recall, semi-quantitative food frequency questionnaire (FFQs), Nutrition and Exercise Knowledge questionnaires and some other questionnaires related to constructs (stage of change. Self-efficacy, dehiscence balance) of the Trans theoretical model (TTM).

Results: No significant differences found in the demographics variables, of the subjects. Also, Mean total scores of knowledge of nutrition, knowledge of exercise, nutrition status and the constructs of TTM were not different at baseline in three groups. Repeated Measure analysis showed significant differences between groups (A&B with C) in the mean total scores of the stages of change, self-efficacy, and decision balance of the constructs of the TTM, knowledge of nutrition, prenatal exercise and nutrition status after intervention. But the two intervention groups A and B, except for consumption of vegetables were not significantly different after the intervention too. The mean of the total gestational weight gain in the groups A and B was significantly lower than in the control group (13.50 ± 3.85, 13.55 ± 3.20 and 15.53 ± 4.20 kg, respectively, $p > 0.05$).

Discussion: Although the presence of spouses can play an important role in improving the health status of the pregnant women, but the lack of significant differences between two intervention groups demonstrate the effectiveness of the combined educational communication methods and may compensate the absence of the participations' spouses.

Keywords: Exercise, Nutritional status, Weight gain, knowledge, Spouses' participation, Transtheoretical model (TTM).

Effectiveness of Worksite Smoking Cessation Programs: Systematic Review

Author(s): Rodriguez Rocha Norma Patricia, Kim Hyekyeong
Affiliation: Department of Health Convergence, Ewha Womans University, Seoul, South Korea.
Contact: Norma Rodriguez (raducan19@gmail.com)

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1. BACKGROUND

Smoking is one of the main burdens for public health and this is also a major problem at the worksites due to the association of smoking with diverse health-related problems, which translate into absenteeism, low productivity, and higher medical service costs for the employers. Additionally, exposure to secondhand smoking at the workplace can become a carcinogen factor that increases the employee's risk to develop pulmonary cancer and cardiovascular disease, therefore it is necessary to reduce the exposure to secondhand smoking by implementing preventive measures at the workplace. Thus, it is paramount to identify the strategies that account for larger effectiveness in smoking cessation among employees to develop successful worksite interventions.

2. PURPOSE

To identify studies implementing workplace smoking cessation programs, including at least one intervention and control group, targeted to employees, and identify the strategies used, evaluate its effect size, and describe the most successful strategies.

3. METHODS

•This systematic review was conducted according to the "PRISMA-P checklist 2015".

•An online database search was conducted between November-December 2017 using ERIC, Google Scholar, Pubmed, and RISS.

•A combination of keywords in English and Korean was used to identify relevant studies:

Smoke-free, smoking cessation, program, intervention, tobacco, nonsmoking, non-smoking, workplace, worksite, employees, workers, RCT, controlled trial, randomized controlled trial, effectiveness, 금연, 프로그램, 중재, 담배, 담배연기없는, 사업장, 근로자, 직장인, 직장, 효과성, 근무 환경, 금연 상담, 무작위대조시험, 평가. MESH terms: Tobacco Use Cessation, Smoking Cessation, Workplace

•**Eligible studies** were those using RCT or quasi-experimental designs, conducted at the worksite, including at least one control and one intervention group, reporting results as quit rates, smoking frequency, smoking intensity, smoking behavior stage change, and studies published in peer-review journals in the last 10 years.

•**Exclusion criteria** were studies reporting results qualitatively, studies conducted among pregnant women or patients with a particular disease, and systematic reviews or meta-analyses.

•**Data extraction** was conducted using a coding form in Excel developed for this purpose.

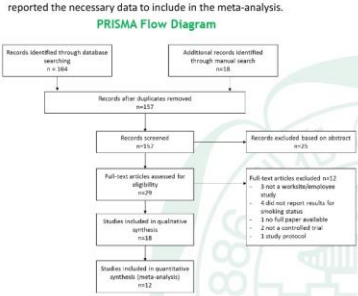
•**Quality of evidence** was evaluated based on Cochrane's GRADE guideline.

•**Meta-analysis** was conducted using odds ratio for differences between groups (CI=95%). Heterogeneity was analyzed using I^2 statistic. All analyses were conducted using Comprehensive Meta Analysis (CMA) version 2.0

4. RESULTS

A total of 18 studies were selected for the qualitative analysis, from which 12 reported the necessary data to include in the meta-analysis.

PRISMA Flow Diagram



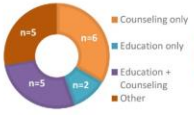
Characteristics of studies

Characteristics of participants:

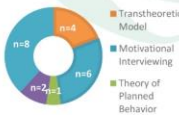
- Total of participants: 37,675.
- Mean age: 23.14 ~ 48.55.
- Most studies target white collar and blue collar workers. (n=11)

Characteristics of interventions:

TYPE OF INTERVENTION



BEHAVIOR THEORY USED



Meta-analysis results

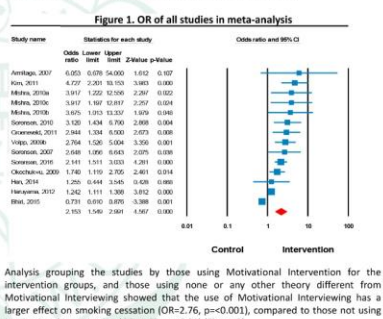
•All studies, included in the analysis showed a positive effect for smoking cessation in favor of the intervention groups.

•Out of these studies, eleven showed a significant positive effect (p<.05).

•Overall, workplace interventions for smoking cessation show a statistically significant difference favoring the intervention group (OR=2.15, CI 95%, p=<0.001) (Figure 1).

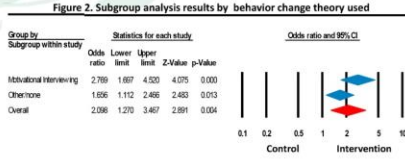
•According to the heterogeneity test conducted, there is a large between-study heterogeneity (I^2=85.19%, p<.001), indicating that approximately 85% of the variance is due to real differences among studies, rather than by random error.

Figure 1. OR of all studies in meta-analysis



- Analysis grouping the studies by those using Motivational Intervention for the intervention groups, and those using none or any other theory different from Motivational Interviewing showed that the use of Motivational Interviewing has a larger effect on smoking cessation (OR=2.76, p=<0.001), compared to those not using Motivational Interviewing (OR=1.65, p=<0.01) (Figure 2).

Figure 2. Subgroup analysis results by behavior change theory used



CONCLUSIONS

In general, the use of intervention programs targeting employees appear to be effective in the smoking cessation rates. Particularly, evidence suggests that using Counseling and Motivational Interviewing for the delivery of the cessation programs might result in better effects on the quit rates. Nonetheless, it is evident that there is a large heterogeneity of interventions among worksite programs, and therefore conducting more in-depth meta-analysis is not possible.

EFFECTS OF AN INFORMATION – MOTIVATION – BEHAVIORAL SKILLS PROGRAM FOR ABSTAINING FROM SEXUAL INTERCOURSE AMONG TENTH GRADE STUDENTS

NUTTAYA SUWALUCK,[1] SUPREYA TANSAKUL[2]

Mahidol University, Bangkok, Thailand

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Research Goals

To study the changes of sexual intercourse behaviors of the tenth grade students after participating in the program, in regard to:

1) Knowledge about abstaining from sexual intercourse among school students.

2) Motivation abstaining from sexual intercourse among school students.

2.1) Attitudes toward abstinence sexual intercourse among school students.

2.2) Social motivation for abstinence sexual intercourse among school students.

3) Decision – making and problem solving skills for abstinence sexual intercourse among school students.

4) Perceived self – efficacy to prevent sexual intercourse among school students.

5) Abstinence sexual intercourse behaviors among school students.

Introduction/Background

Sexual intercourse among adolescent creates many problems, for instance, sexual relationship without protection, getting sexual transmitted diseases, undesirable pregnancy, etc. The behavioral surveillance survey of the Epidemiology Bureau, Ministry of Public Health, 2010 – 2014 showed that Mathayomsuksa 2, Mathayomsuksa 5 and Second year – Certificate in Vocational Education students had higher sexual intercourse behavior.

Undesirable sexual relationship behavior affects on the problems about pregnancy and child bearing before the appropriate age, which are found in every areas in Thailand. The data about abortion in Thailand in 2014 showed that many adolescents behaviors are the important problems, for example, unprotected sexual intercourse has increased, condom use and the use of reliable birth control method have decreased, and almost half of the patients with abortion did not use birth control method or used temporary birth control methods for instance, emergency birth control skills, that leads to unprepared pregnancy which then leads to abortion.

Data Analyses

1) The general data were analyzed by using descriptive statistics in regard to frequency, percent, mean, and standard deviation.

2) The comparative analysis of means scores within groups and between groups by using Paired t – test and Independent t – test.

Participants

The study populations were Mathayomsuksa 4 students enrolling in the first semester of academic year 2017 in the secondary schools under the administration of the Educational Region 3, Nonthaburi province.

The samples were Mathayomsuksa 4 students enrolling in the first semester of academic year 2017 of 2 secondary schools under the administration of the Educational Region 3, Nonthaburi province; two selected schools were divided into the experimental school and the comparison school.

The study sample comprised 63 students of grade 10 students, 31 of them were assigned into an experimental group and 32 were in a comparison group.

Methods

This study was a quasi – experimental research design. The samples were divided into 2 groups, experimental and comparison groups. The experimental group participated in the program of information – motivation – behavioral skills abstaining from sexual intercourse among tenth grade students. While the comparison group learned normal teaching system of the school, the research was lasted for 10 weeks.

Intervention Program

The program of information –motivation – behavioral skills abstaining from sexual intercourse among tenth grade students, this instrument was composed of 8 learning activities; 50 minutes each (1 session).

Results

Table 1 Comparison of mean scores of Knowledge, Attitudes, Social motivation, Decision – making and problem solving skills, Perceived self – efficacy, and Abstinence sexual intercourse behaviors within the experimental and the comparison groups, before and after the experimentation

Variables	Before		After		t	p – value
	n	S.D.	n	S.D.		
1. Knowledge about abstaining from sexual intercourse among school students						
Experimental G.	12.26	3.214	15.97	2.025	5.607	<0.001
Comparison G.	12.56	3.222	12.31	3.335	0.000	0.225
2. Motivation abstaining from sexual intercourse among school students						
Experimental G.	61.48	7.288	80.39	7.134	11.2007	<0.001
Comparison G.	60.66	9.006	61.09	10.259	1.1007	0.022
2.1 Attitudes toward abstinence sexual intercourse among school students						
Experimental G.	30.35	4.958	39.23	3.758	7.986	<0.001
Comparison G.	29.66	5.475	31.28	5.062	1.1007	0.106
2.2 Social motivation for abstinence sexual intercourse among school students						
Experimental G.	31.13	3.298	40.97	4.774	9.3107	<0.001
Comparison G.	30.88	4.265	30.44	5.872	1.1107	0.106
3. Decision – making and problem solving skills for abstinence sexual intercourse among school students						
Experimental G.	6.23	2.699	8.65	1.305	4.9707	<0.001
Comparison G.	6.03	2.545	5.88	1.775	0.403	0.679
4. Perceived self – efficacy for abstinence sexual intercourse among school students						
Experimental G.	46.87	8.328	58.42	6.297	7.3207	<0.001
Comparison G.	44.69	7.008	47.38	7.206	6.2807	<0.001
5. Abstinence sexual intercourse behaviors among school students						
Experimental G.	44.87	15.730	85.48	0.500	6.7807	<0.001
Comparison G.	47.59	11.930	49.19	12.777	0.3407	0.731

t = Wilcoxon signed-rank test

Table 2 Comparison of mean scores of Knowledge, Attitudes, Social motivation, Decision – making and problem solving skills, Perceived self – efficacy, and Abstinence sexual intercourse behaviors between the experimental and the comparison groups, before and after the experimentation

Variables	Experimental Group (n=31)		Comparison Group (n=32)		t	p – value
	n	S.D.	n	S.D.		
1. Knowledge about abstaining from sexual intercourse among school students						
Before	12.26	3.214	12.56	3.222	0.1257	0.769
After	15.97	2.025	12.31	3.335	5.237	<0.001
2. Motivation abstaining from sexual intercourse among school students						
Before	61.48	7.288	60.66	9.006	0.2707	0.492
After	80.39	7.134	61.09	10.259	9.2077	<0.001
2.1 Attitudes toward abstinence sexual intercourse among school students						
Before	31.39	4.958	30.66	5.475	0.5507	0.581
After	39.23	3.758	31.28	5.062	6.6607	<0.001
2.2 Social motivation for abstinence sexual intercourse among school students						
Before	31.13	3.298	30.88	4.265	0.0507	0.921
After	40.97	4.774	30.44	5.872	8.4707	<0.001
3. Decision – making and problem solving skills for abstinence sexual intercourse among school students						
Before	6.23	2.699	6.06	2.295	0.376	0.707
After	8.65	1.305	5.88	1.775	7.0407	<0.001
4. Perceived self – efficacy for abstinence sexual intercourse among school students						
Before	46.87	8.328	46.00	7.008	0.4907	0.277
After	58.42	6.297	47.76	7.206	5.894	<0.001
5. Abstinence sexual intercourse behaviors among school students						
Before	44.87	15.730	47.59	11.930	0.7307	0.467
After	85.48	0.500	49.19	12.777	6.2607	<0.001

t = Mann Whitney U test

Results of the study revealed that after the experiment, the experimental group had significantly better knowledge about abstaining from sexual intercourse among school students, attitudes toward abstinence, social motivation, decision – making and problem solving skills for abstinence, perceived self – efficacy, and better abstinence behaviors than the comparison group ($p<0.05$).

Conclusion

The finding also showed that the program was effective in enhancing knowledge, attitudinal change, social motivation, decision – making and problem solving skill, perceived self-efficacy and abstinence.

This program is therefore recommend for use in schools and related organizations as learning activities and to be added to the health education school curriculum to promote acceptable sexual behaviors among students.

Effects of Governance System on Oral Healthcare Network

Heloisa Godoi [1], Ana Lúcia S. Ferreira de Mello [1]
[1] Federal University of Santa Catarina, Florianópolis, Brazil

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Background

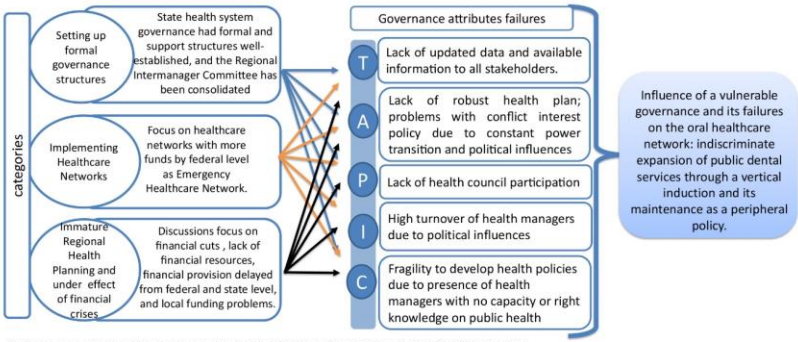
The regionalized health care network's structuring is in consolidating process in Brazil. It's presented as a broad solution to organize the public health system, in two perspectives, the management dimension and the health practitioners' process. The healthcare network purpose is to offer a continuum and a comprehensive health care to the population, overcoming models less resolute. Nonetheless, the healthcare network needs to be grounded in a governance system which supposed to be participative, unique and systemic, known in decision making spaces that allows negotiation, agreements and building consensus among stakeholders.

Objectives

The aim was to understand the governance undertaken to develop the regionalized health care network in the Santa Catarina State, Southern Brazil, and its influence on decision-making and structuring oral health care.

Results

State health system governance had formal and support structures well-established, and the Regional Intermanager Committee has been consolidated. The theoretical model developed identified failures of the governance attributes and exposed the limitations in the legitimacy of the Santa Catarina's health care system. The governance system has been continuously affected by the ongoing changes in power from one political party to another, leading to short-term preferences and decision that negatively impacts the process of structuring oral health care services.



Governance attributes: T : Transparency; A: Accountability; P: Participation; I: Integrity; C: Policy Capacity

Discussion

These problems in the governance system highlighted the overall lack of importance given to oral health care. The neglect led to the indiscriminate expansion of the services through a vertical induction and without taking into account the needs of the population, as well as the urgency of health policies to deal with increasing oral health diseases, recognizing them as a health public priority. Currently, there is a need for policies to inform the public, as well as the inclusion in the system of professionals and managers that can advocate for the importance of oral health as a major priority in the healthcare network. This research aims to contribute to the advance of governance practices through a theoretical framework that underpins the best practice and can be used to organize and structure the oral health care in the Unified Health System.

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E-mail: heloisagodoi@gmail.com

Promoting Your Health
Health Promotion Administration, Ministry of Health and Welfare

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Effects of Question Prompt List (QPL) intervention on improving patient question asking: reducing health literacy disparities

Mi-Hsiu Wei[1], Ying-Wei Wang[2,4] , Mei-Chuan Chang[3], Jyh-Gang Hsieh[4]

1.Department of Communication Studies, Tzu Chi University, Hualien, Taiwan.
2.Director-General, Health Promotion Administration, Ministry of Health and Welfare, Taipei, Taiwan.
3.Department of Nursing, Tzu Chi University of Science and Technology, Hualien, Taiwan.
4.Heart Lotus Hospice, Family Medicine, Hualien Tzu Chi Hospital, Taiwan.

Background & Objective

- Patients with low health literacy often ask fewer questions during clinical consultations than those with sufficient health literacy. Provision of a Question Prompt List (QPL) before a consultation might help patients overcome communication barriers.
- The purposes of this research were to evaluate a QPL intervention designed to improve patients' question asking during consultation in general practice and to determine whether patients' health literacy levels moderate the effects of QPL intervention on patient's question asking.

Methods

- A leaflet with checklists of common questions surrounding health problems in general practice was created.

a. The front page

b. Chose the kind of appointment

c. To talk about a new health problem

d. To talk about an existed health problem

e. To get medical test

f. To get vaccine

Fig 1 The Question Prompt List (QPL)

- Patients were subjected to cluster random assignment to the experimental (n=349) or control group (n=332).

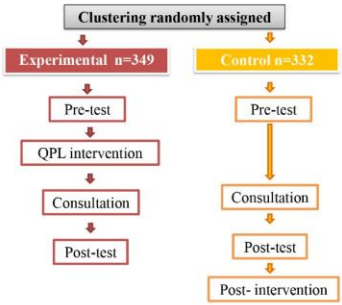
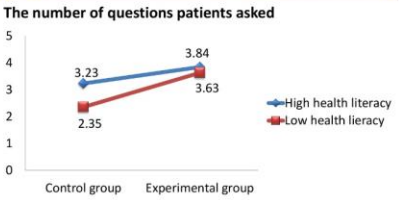


Fig 2 The research design

Results

- After controlling for gender, age, and health status, factorial ANOVA analysis revealed a significant interaction between condition (control/ intervention) and health literacy level (lower/ higher) (F=4.15, p=.042).
- Simple main-effect tests revealed that the number of questions that patients asked were consistently higher for those in the experimental group than in the control group across the whole sample.



Conclusion

- Patients with lower health literacy appeared to benefit more from the QPL intervention than those with higher health literacy.
- QPLs could be considered by healthcare organizations as communication aids to enhance patient behavior regarding question asking.

➢ *Acknowledgements: This work was funded by the Health Promotion Administration, Ministry of Health and Welfare (MOHW106HPA-M-114-134402).*

Embarazo en Adolescentes y Situación Escolar

Autores: Sierra-Macias A[1]., González-Pérez G[2]., Alfaro-Alfaro N[2]., Dávalos-Pérez A[2].
Afiliación: [1]Universidad de Guadalajara, Guadalajara, México; [2]Universidad de Guanajuato, León, México.

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I. Introducción:

El embarazo en la adolescencia ha sido asociado con las desigualdades e inequidades así como a la carencia de políticas públicas que aseguren el acceso a una educación sexual integral. En personas adolescentes se acentúa aún más el acceso desigual a recursos materiales y simbólicos necesarios para la apropiación y ejercicio de los derechos sexuales y reproductivos, afectando negativamente sus perspectivas futuras como el desarrollo escolar y la construcción de la ciudadanía en general.

II. Objetivo:

Describir la situación escolar y las características sociodemográficas de las adolescentes que acuden a control prenatal en unidades de primer nivel de la Secretaria de Salud en León Guanajuato durante el año 2017.

III. Material y Métodos:

- Estudio descriptivo transversal.
- Mujeres embarazadas de 13 a 19 años en control prenatal.
- Unidades de primer nivel de atención de la Secretaria de Salud en León Guanajuato México (año 2017).
- Se aplicaron encuestas semiestructuradas basadas en (ENJUVE 2010).
- Las participantes firmaron consentimiento informado.

IV. Resultados:

Se incluyeron a 529 participantes, la media de edad fue de 17.13 años, las participantes de menor edad fueron 2 mujeres de 13 años. El 60% de la mujeres que han trabajado, lo han hecho por falta de dinero.

Tabla 1. Características sociodemográficas de las adolescentes embarazadas de León durante el año 2017 (n=529).

VARIABLE	FRECUENCIA (%)
Edad	
- 13 a 16 años	167 (31.57%)
- 17 a19 años	362 (68.43%)
Número de embarazo	
- Primero	439 (82.99%)
- Segundo	80 (15.12%)
- Tercero	10 (1.89%)
Deseo de tener más hijos	
- Si	444 (83.93%)
Edo civil	
- Unión libre	342 (64.64%)
- Casada	10 (5.47%)
- Soltera	158 (29.85%)
Consumo de drogas	
- Si	136 (25.71%)
Ha trabajado (empleo)	
- Si	443 (83.74%)

Respecto al nivel educativo el 57% tenía estudios de secundaria, 15% de Primaria y 25% de preparatoria, Únicamente el 5.86% estudiaban actualmente, el 30% dejó de estudiar a los 15 años, entre los principales motivos de no estudiar se reportó la falta de interés o aburrimiento (32.7%), falta de dinero (16%) y por el embarazo (14.5%); de la participantes que no estudiaban el 89% respondió que le gustaría volver a estudiar, para mejorar su nivel de vida y el de su bebé.

Figura 1. Adolescentes embarazadas de León que estudiaban actualmente (n=529).

Figura 2. Deseo de seguir estudiando de las adolescentes embarazadas de León que habían dejado de estudiar (n=498).

V. Conclusiones:

Si bien se ha manifestado que el embarazo durante la adolescencia propicia la deserción escolar y acentúa la pobreza, no siempre se considera que varias mujeres ya habían desertado de la escuela antes del embarazo y provenían de hogares de bajos recursos, tal como se vio reflejado en nuestros resultados.
Se requieren estudios que replanten el fenómeno del embarazo en la adolescencia desde diversos enfoques, articulando las dimensiones individuales y colectivas que reflejen las posibles situaciones encubiertas respecto a la salud sexual y reproductiva de los y las adolescentes en diversos contextos.

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Declaración de conflicto de intereses:
Los autores declaran no tener conflicto de intereses.

Poster presentado en:
23rd. World Conference on Helth Promotion. del 7-11 de abril 2019, en Rotorua Nueva Zelanda.

Empoderamiento en mujeres de pueblos originarios para incrementar acciones de autocuidado de salud

Dra. Ma. del Rocío Figueroa Varela, 1 Dra. María Elena Rivera Heredia 2
1 Universidad Autónoma de Nayarit, México
2 Universidad Michoacana de San Nicolás de Hidalgo, México

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Introducción

El cáncer de mama (CAMA) es un problema de Salud Pública en México. Es la principal causa de mortalidad por cáncer en las mujeres (las de 40 a 64 años tienen mayor riesgo; se encuentra en 15 de cada 100 mil). La mayoría de los casos son diagnosticados en etapas avanzadas. Los esfuerzos del gobierno mexicano se han centrado en campañas de detección precoz a través de mastografías e incentivar la autoexploración. En los pueblos indígenas de Nayarit, los índices de desarrollo humano (IDH) son menores. La infraestructura médica es de primer nivel de atención. No se cuenta con la infraestructura necesaria para hacer diagnósticos oportunos. La NORMA Oficial Mexicana NOM-041-SSA2-2011 especifica como necesario las acciones de comunicación educativa a la población para el conocimiento de los riesgos y la promoción de estilos de vida sanos

Objetivo

Diseñar estrategias de comunicación en salud que propicien la conducta de autoexploración mamaria en mujeres de pueblos originarios Wixárica, Náayeri y Odam, adaptados a su lengua y cultura.

Método

22 talleres participativos en las diferentes zonas serranas del estado de Nayarit con 635 mujeres de las etnias Wixarika, Náayeri y Odam.

3 cuadrípticos traducidos y

3 videocápsulas (un testimonial de CAMA)

Resultados

Ellas se vuelven un referente en salud en su comunidad, logrando romper barreras, como la vergüenza para tocar su cuerpo,

Aceptación de los hombres para que sus esposas se hagan la autoexploración

Orgullo y satisfacción con su rol de promotoras de salud

Solicitan ampliar sus conocimientos para dar más temas de salud.

Las mujeres pudieron entender la técnica e importancia de la autoexploración mamaria.

Discusión

El trabajo se hizo desde una perspectiva de género, interculturalidad, derechos humanos y autonomía, con enfoque de gobernanza e igualdad en salud colectiva.

Es necesario la interacción entre actores para fomentar la toma de decisiones, pero con un respeto a su cosmovisión en donde la mujer tiene la responsabilidad de la reproducción biológica y cultural, más no de tener un rol de actividad pública, aunado a las condiciones precarias con las que se vive en las zonas indígenas se conjugan los determinantes en salud, que inciden para que se ahonde su vulnerabilidad.

Al validarse sus saberes como una alternativa a la hegemonía de la biomedicina androcéntrica e invasiva sobre el control del cuerpo femenino y su salud reproductiva, propicia en sus espacios estrategias subjetivas, de comunicación afectiva y efectiva entre pares (ver ejemplo de material en https://youtu.be/s1yPAZunsul)

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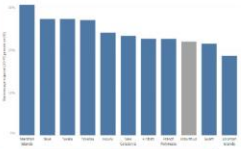
Empowering the Pacific eyecare workforce to engage their communities in the prevention and management of diabetes and diabetic retinopathy through the use of indigenous health promotion models.

Authors: Dr Malakai Ofanoa [1] ; Associate Professor Vili Nosa [1] ; Komal Ram[2] ; Prarthana Dalmia [2]; Grace Johnstone [2]
[1] The Pacific Health Section, School of Population Health, The University of Auckland
[2] The Fred Hollows Foundation NZ

PROBLEM

9 of the top **10** countries in the world with the highest prevalence of diabetes are in the Pacific.



The greater availability of cheap, unhealthy foods and a change to more sedentary lifestyles are significant contributors to the rising rates of diabetes in the Pacific.

Every person with diabetes is at a risk of developing diabetic retinopathy. It is a complication that affects the eye, which when not diagnosed and treated in time, can lead to irreversible blindness.

INTERVENTION

APPROACH: The Fred Hollows Foundation NZ organized a *Diabetic Retinopathy Health Promotion Workshop* in conjunction with the Pacific Health Section at The University of Auckland. Participants included eye nurses, medical assistants, public health staff and ophthalmologists from 7 Pacific island countries.

The purpose of this workshop was to:

- Review existing challenges in health promotion.
- Use indigenous models to inform future approaches and build local capacity.
- Train the trainer to transfer their knowledge to primary care level.
- Empower the Pacific health workforce to lead health promotion in their communities.

METHODOLOGY: The Pasifika research methodology of *Talanga* was used to initiate discussions and conduct workshop activities. *Talanga* is an "empowering, interactive, collaborative, participatory, encouraging and purposeful interactive dialogue", traditionally used by Tongans to collectively exchange ideas, address issues and make strategic decisions.

OUTCOME

WORKSHOP OUTPUT: The need to adopt a tailored approach to develop health promotion resources for Pacific communities was identified at the workshop. As result, a flipchart prototype on *Diabetes and Diabetes Eye Disease* was developed after collating the learnings from the workshop.

Pretesting feedback incorporated in the final flipchart

PRETESTING: The flipchart prototype was pretested in Fiji and Samoa.

- There were 2 focus groups of 5-8 participants including community health workers and primary level nurses in one and diabetes patients, diabetic retinopathy patients and community members in the other.
- The Talanga approach was used to conduct these pretesting sessions.
- The results were recorded in a standard template.

RESULT: The pretesting results have guided the development of the final flipchart. This flipchart will facilitate the training of community health workers in the region, who will in turn be empowered to use this resource and lead health promotion in their communities. This will be followed by an evaluation to assess whether the training has achieved the intended outcomes.

INTENDED OUTCOMES: It is expected that the workshop outputs will improve health equity by activating Pacific communities to lead the prevention and management of diabetes and diabetic retinopathy.

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THE QUEEN ELIZABETH DIAMOND JUBILEE TRUST
THE UNIVERSITY OF AUCKLAND NEW ZEALAND
MEDICAL AND HEALTH SCIENCES SCHOOL OF POPULATION HEALTH

WAIORA: Promoting Planetary Health and Sustainable Development for All

Engaging patients and providers of healthcare to co-create an ehealth educational platform in translating best-practice outcomes for post-discharge hip fracture care: a mixed methods study

THE UNIVERSITY of ADELAIDE

Lalit Yadav[1], Tiffany Gill[1], Mellick Chehade[1], Renuka Visvanathan[1]

1- School of Medicine, Faculty of Health & Medical Sciences, The University of Adelaide

-Older age; healthcare system challenge, social cost, physiological changes

-Fragility fractures; standing height (low trauma), ageing(>60), osteoporosis

-Hip fractures; 6.3 million by 2050, surrogate of osteoporosis & how health system deals with older people

Uncertain about recovery?

"At the hospital you feel strong but when you go home it could be different. You have to be careful"

"The hip fracture has made me grow old, like turning a new page in a book"

Objectives

-To determine the level of eliteracy; hip fracture patients

-To establish educational content; perspective of patients and their carers; clinicians and residential care providers

-To determine important factors that need to be considered at the time of designing an ehealth educational platform for the patients with hip fractures by using an open source learning management system (LMS)

"Need to communicate in a simple & effective way"

- NICE guideline

"Patient information should be available in a range of media & in appropriate languages"

Australia New Zealand Hip fracture guideline

"eHealth utilise ICT built within computers, mobiles, sensors and web-based applications to support effective delivery of health services and information"

- Jin et al (2018)

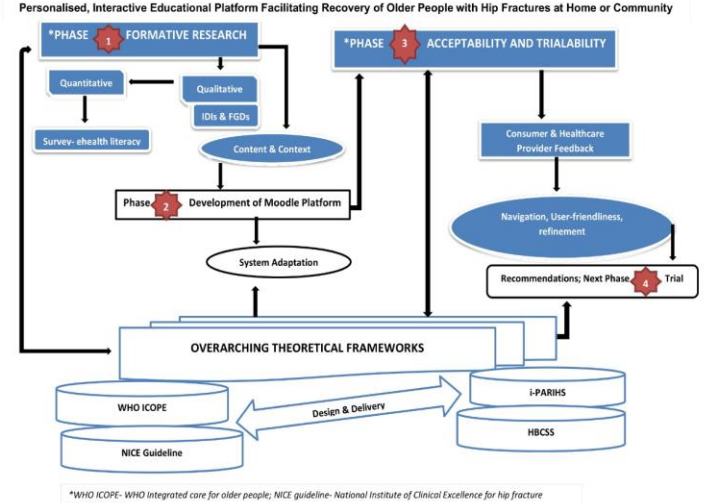
-Pragmatic mixed methods design; guiding theoretical framework of implementation, engage patients, their carers & Health care practitioners (HCPs)

-Setting; Two tertiary care centres, Adelaide, South Australia

-Inclusion; Patients-age 65 & above hip fracture admitted, consecutive recruitment, 6 months, HCPs- multiple disciplines

Ethics: HREC Central Adelaide Local Health Network and the University of Adelaide

The proposed research aims to improve quality of life and independence among older people with hip fractures by maintaining continuity of optimum care through provision of patient-centric, evidence-based quality health information"



*WHO ICOPE- WHO Integrated care for older people; NICE guideline- National Institute of Clinical Excellence for hip fracture management;
i-PARIHS- Integrated promoting action on research implementation in health services; HBCSS- Health behaviour change support systems

Equity in Health and Intersectoriality in Northeast Brazil: Actor-Network Theory unveiling cognitive, strategic and logistic translations in the process of local change

[1] Maria do Socorro Machado Freire, [2] Ronice Franco de Sá, [3] Idê Gomes Gurgel, [4] Simone Tetu Moyses
[1]NUSP/UFPE, Recife, Brazil; [2]PPGSC/UFPE, Recife, Brazil; [3]FIOCRUZ/PE, Recife, Brazil; [4]PUC/PR, Curitiba, Brazil

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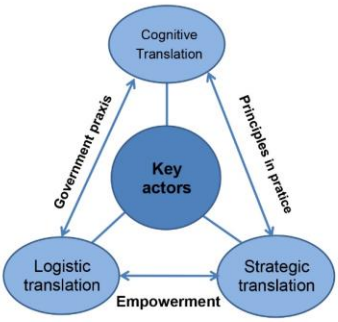
Background/Objectives

Studies in the field of public health consider intersectoriality as a strategy to promote equity in addressing social determinants of health. The municipality of Sairé, a member of the Healthy Pernambuco Municipalities Network (RPMS), is outstanding due to its adoption of an intersectorial policy called "Healthier Sairé". The aim of the present study is to understand how this policy has promoted local equity.



Source: Adapted from Potvin, (2015).

Methods

A case study was conducted using a timeline to record critical events, documental analysis, interviews and participant observation. Actor-network theory was used as a theoretical reference, which thereby established how adopting the municipal policy had been central in promoting local empowerment and equity.

Results

The results demonstrate that initially it was necessary to obtain a cognitive translation, conducted through the direct influence of the RPMS, which facilitated a second strategic translation, with the construction of a policy anchored to the municipal program, and which is currently being translated logistically into concrete actions directed towards equity.

Discussion

The role of strategic leadership, valorizing training and that which had previously been built were key categories in this process for promoting local equity.

Keywords

Health Promotion. Healthy Cities. Intersectoral Action. Equity. Actor Theory Network.

Núcleo de Saúde Pública e Desenvolvimento Social – NUSP/UFPE
www.ufpe.br/nusp *socorromfreire@gmail.com*

436. Evaluación de la calidad de vida de los cuidadores de adultos y ancianos

Autor(s): Mariangela Bitar'; Ibrana Carvalho'
Afiliaciones: 'Department of Physical Therapy, Speech Therapy and Occupational Therapy of Faculty of Medicine of University of São Paulo, Brazil Contato: mlbitar@usp.br

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INTRODUCCIÓN

- Proceso de transición demográfica poblacional causado por las caídas de la tasa de mortalidad y de la tasa de fecundidad
- Aumento del número de ancianos
- Alta prevalencia de enfermedades crónicas no transmisibles (ECNT) en la población anciana
- Incapacidades, disminución de la calidad de vida y baja autonomía
- Necesidad de ayuda en el cuidado
- Cuidador informal / familiar sin orientaciones
- Acumulación de tareas, presión familiar y falta de apoyo
- Síndrome de *Burnout*

OBJETIVOS

- Evaluar el índice de calidad de vida (CV) de cuidadores no remunerados de adultos y ancianos con dependencia funcional
- Analizar el impacto temporal sobre el índice de CV de los cuidadores
- Relacionar el índice de CV de los cuidadores con el grado de dependencia de las personas que reciben los cuidados

MATERIALES Y MÉTODOS

✓La investigación sometida y aprobada por los Comités de Ética en Investigación de la FMUSP (nº 2.001.790) y del HU-USP (nº 2.037.920);

✓El estudio fue realizado en la Enfermería de Clínica Médica;

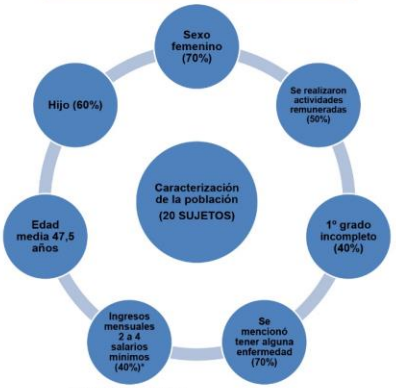
Se incluyeron en el estudio cuidadores familiares no remunerados, de ambos sexos, de personas internadas en la Enfermería de Clínica Médica, que presentaban algún grado de dependencia funcional, con edad igual o superior a 18 años y que acordaron participar del estudio

Se excluyeron del estudio cuidadores que recibían remuneración para prestar los cuidados, que tenían edad igual o inferior a 17 años de edad y aquellos que no estuvieron de acuerdo en participar del estudio

RECOLECCIÓN DE DATOS

- SF36
- Escala de Zarit
- Índice de Barthel

RESULTADOS Y DISCUSIÓN



* Salario mínimo: USD$ 260,00

✓El índice de CV de los cuidadores presentó valores altos, aunque el 75% de los cuidadores presentaron sobrecarga de grado moderado a severo por la Escala de Zarit, que puede ser explicado por el hecho de que gran parte de los cuidadores ser hijo y del sexo femenino;

✓Se sabe que el cuidar tiende por un largo plazo e irreversible, pudiendo así generar gran sufrimiento físico y psíquico al cuidador;

✓Se encontró una relación del impacto temporal sólo con el componente "Limitación por aspectos emocionales" (p-valor = 0,040) del SF-36 y correlación del grado de dependencia de persona que recibe los cuidados sólo con el componente "Salud mental" del SF- 36 (p-valor = 0,043).

CONCLUSIÓN

✓A pesar de presentar valores altos de CV, existe sufrimiento físico y psíquico relacionado al acto de cuidar. Sin embargo, éste acaba siendo enmascarado por el sentimiento de retribución del cuidado y por el afecto ligado a la relación familiar.

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Evaluating the effect of educational intervention on health literacy through social networks to promote quality of life for students

Mahnaz Khaleghy[1], **Farkhondeh Amin Shokravi**[2*]
1.Ms. of Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran; Email: Mahnazkhaleghyr@yahoo.com
2.PhD, Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, No. 7, Jalal Al Ahmad Street, Tehran 14115-116, Iran. Tel: +09821 82884506; Fax: 009821 82884555;
E-mail: aminsh_f@modares.ac.ir

Background/Objectives: Studies have shown the health literacy effects on the general state of health and its related factors and health outcomes, physical and mental health as well as health-related quality of life. This study aimed to investigate the effect of training based on health literacy through social networking strategies to promote health-related quality of life among students of Islamic Azad University, Shahr Rey Branch, Iran.

Methods: This randomized controlled trail was conducted on120 students with poor or average quality of life score. Subjects were randomly assigned into experimental and control groups (60 subjects each). The health literacy and quality of life data were collected at baseline, immediately and three months after intervention. Educational intervention was conducted in cyberspace and using social networks. Data was analyzed using SPSS software version16.

Results: The results showed that there was no significant difference between two groups in terms of health literacy and quality of life at baseline ($p=0.979$ and 0.269, respectively). The mean score of health literacy and quality of life in experimental group, compared with control group, significantly increased immediately and three months after the intervention ($p <0.001$).

Discussion: The educational intervention by applying health literacy strategies through cyberspace and social networks can be effective in improving the quality of life of students.

Keywords: Health literacy; Quality of life; Social networks; Student.

Evaluation of Weight Loss Program for Chronic Disease Prevention

Yasutaka Hasegawa[1], Hidekatsu Takada[2], Yuki Fukuyama[1], Takanobu Osaki[1], Hideyuki Ban[1], Toru Nakagawa[3], Shouji Negishi[4], and Norihito Kunichika[4]
[1]Hitachi, Ltd. Research & Development Group, [2]Hitachi, Ltd. Financial Information Systems, [3]Hitachi Health Care Center, [4]Hitachi Health Insurance Society

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Background / Objective

Increasing medical costs caused by aging populations and rising numbers of chronic disease patients are a critical issue in developed countries. To address this, we developed a weight loss program that effectively helps to prevent chronic diseases. The aim of this study is to evaluate the effects of the program.

Summary of the program

(1)**Face to face consultation** with a nurse
Participants set target weight as 5% loss and concrete behavioral objectives using "*100 kcal cards*". These cards show the quantity of food equivalent to 100 kcal or the exercise time required to burn 100 kcal.
(2)**Recording weight and behavior** (executed cards) every day on an internet-based system for 6 months
The system helps participants visualize the relationship between their weight and behavior.
(3)**Periodic support** and advice by e-mail from a nurse every 10 days
Nurses can confirm the weight and behavior of the participants, check their daily tasks on a to-do list, and send e-mails using message templates that are pre-generated based on the participants' condition.

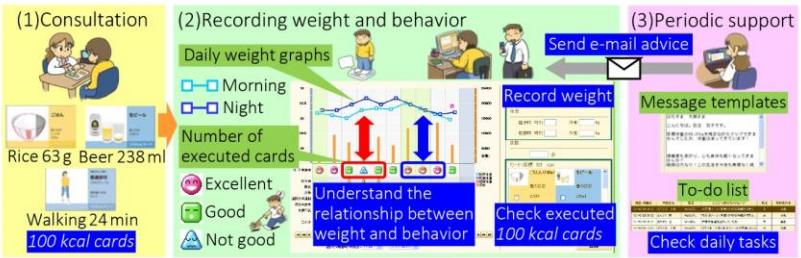

Fig.1 Internet-based support system for the program

Evaluation of the program

Using the system, the 568 participants on the program lost **4.6kg** on average and **51.6%** of them achieved their target weight. The system also reduced the time required for nurses to create e-mails **from 25 minutes to 5 minutes** per participant. The preventive effect on chronic diseases was also evaluated for the 253 participants who we could track for 7 years after the intervention in 2008.

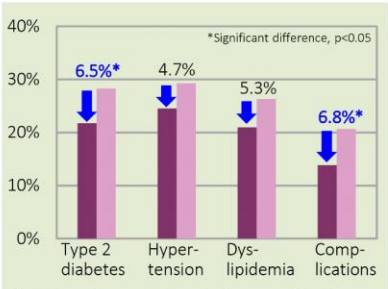

Fig.2 Prevalence of chronic diseases after 7 years

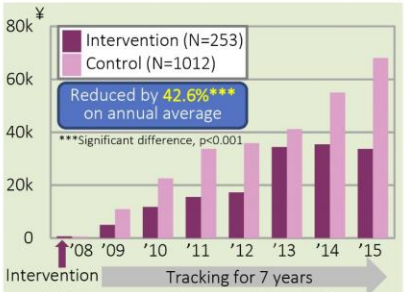

Fig.3 Average medical cost of chronic diseases

Conclusion

Compared with the control group, the intervention group was found to have a 5-7% lower prevalence of chronic diseases and a 42.6% lower medical cost. The system also led to a five-fold improvement in the work efficiency of the nurses. We showed that the developed program and system can lead to effective and efficient chronic disease prevention.

Existential health

Presenting Author:
Catrine Kostenius 1
Co-Author:
Cecilia Melder 2
Affiliations:
1.Luleå University of Technology, Sweden 2.Uppsala University, Sweden

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Existential health

A valuable dimension when promoting health throughout the life-course in Sweden

Background

According to the World Values Survey Sweden is one of the most secular countries in the world. However, there is a high demand for forums to discuss existential questions and spiritual believes. Sweden provides an opportunity for research on existential health promotion in a secular context, providing knowledge and practice for other contexts internationally undergoing a secularization process. In international studies, the existential dimension of health is increasingly recognized as an important addition to physical, mental, and social health. The World Health Organization (WHO) and several other organizations and authorities emphasize the existential dimension of self-rated health. Additionally, research has established a connection between existential health and increased quality of life. There is a need for methods to study how the existential health dimension effect human beings and therefore methodological development was the objective.

(Photo: Catrine Kostenius)

Methods

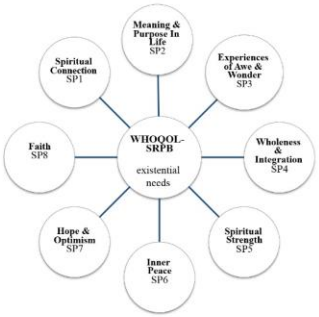
The WHOQOL-SRPB instrument developed by the WHO in 2002 which focus on health related quality of life including aspects related to spirituality, religiousness and personal beliefs was validated to the secular context of Sweden. The validated version was used measuring the function of the existential dimension in four Swedish contexts – 1) to enhance patient's self-care capabilities in self-help groups 2) interventions for suicide prevention 3) treatment for persons on long time sick leave and, 4) promoting health in a global age friendly city (Melder, in press; WHO, 2007).

Results

The results were promising when promoting health throughout the life course in these four Swedish contexts. The instrument focus on personal health and quality of life through eight aspects of existential health; spiritual connection, meaning and purpose in life, experience of awe and wonder, wholeness and integration, spiritual strength, inner peace, hope and optimism, as well as faith. The questions relate to existential *approach* rather than the *content* of existential beliefs, which make it applicable to a secular context.

Discussion

Based on the findings we suggest using this instrument through the life-course in Sweden and other secular contexts adding the dimension of existential health as a way to explore the combined processes of essential thoughts, actions and feelings as humans relate to different life situations in relation to themselves, their context and personal beliefs.



(WHO, 2002; Melder 2011; Melder & Kostenius 2016)

Expérience pilote des activités physiques adaptées portées par le Réseau « Maita'i sport-santé »

Dr Bruno Cojan[1], Christian Weislocker[2], Clément Boinot[1], Dr Laurence Bonnac-Théron[3], Anthony Pheu[3]

[1] Direction de la santé de Polynésie française.
[2] Réseau Maita'i Sport-Santé.
[3] Direction de la jeunesse et des sports de la Polynésie française

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CONTEXTE/PROBLÉMATIQUE

Les maladies de surcharge sont le premier fléau de santé publique en Polynésie française :

- 70% d'adultes sont en surpoids dont 40% au stade de l'obésité.
- 26 % présentent une hypertension artérielle, 18% un diabète.
- % enfants scolarisés âgés de 13 à 17 ans sont en surpoids dont 19.8% obèses.
- 35.8% des enfants de 7-9 ans en 2014 sont en surpoids, dont 16.2% obèses.

L'enjeu est de développer une action innovante concourant à la maîtrise des dépenses de santé (79.4 milliards XPF en 2015 soit 14.4 % du PIB). 1 habitant sur 7 est en longue maladie.

Une **expérience pilote** a visé la pratique d'activités physiques adaptées (APA) par des patients présentant une ou plusieurs pathologies: surcharge pondérale, diabète de type 2, hypertension artérielle, cancer, broncho-pneumopathie chronique obstructive ou perte d'autonomie. Ces APA sont portées par le réseau Maita'i sport-santé.
Les APA proposées sont : la remise en forme, le Qi Qong, la natation, la marche nordique , l'aviron, le basket, le karaté et le multi-activités.

Le parcours de soins du patient, une prise en charge pluridisciplinaire

1. RDV avec le médecin traitant: bilan médical (critères d'inclusion)
2. Inscription
3. Bilan médico-sportif initial
4. Pratique d'une APA: 2 à 3h /sem, éducation thérapeutique du patient par diététique et bilans intermédiaires
5. Bilan final: médico-sportif et médical
6. Réajustement du traitement: médecin traitant

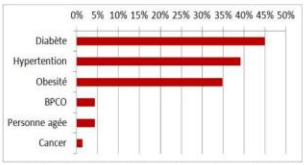

Figure N°1 : Critères d'inclusion à l'expérience pilote et répartition des patients en fonction de leur pathologie (% du nombre total de patients pris en charge).

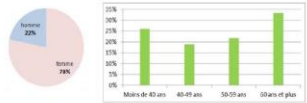

Figure N°2 : Caractérisation socio-démographique des patients pris en charge au sein du parcours de soin du réseau Maita'i sport-santé au cours de l'expérience pilote. A : sex-ratio ; B : âge .

Sur la période écoulée de novembre 2017 à juin 2018, sur 155 patients inscrits initialement (78% sont des femmes, 22% des hommes ; moyenne d'âge de 48 ans ; 46% sont sans emploi, 26% occupent des postes d'employés ou d'ouvriers, 26% sont à la retraite), 76 ont réalisé l'intégralité du programme (51 % d'abandon).

Impacts du programme d'APA sur les paramètres anthropométriques des patients

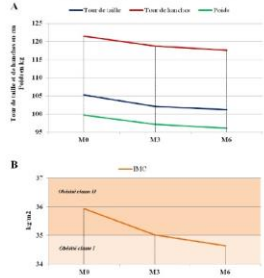

Figure N°3 : Impact d'une pratique régulière d'activités physiques adaptées (mesuré à M0, M3 et M6) sur les paramètres anthropométriques des patients. A : évolution du tour de taille (en cm), de hanches (en cm) et du poids (en kg) ; B : évolution de la valeur d'IMC (en kg/m²), obésité de classe I (30 ≤ IMC ≤ 34.9), obésité de classe II (35 ≤ IMC ≤ 39.9).

Impacts du programme d'APA sur la condition physique des patients

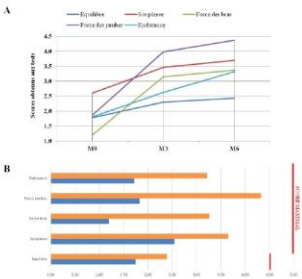

Figure N°4 : Évolution de la condition physique des patients. A : Valeurs moyennes des scores obtenues au cours des tests physiques à M0, M3 et M6 ; B : Comparaison de la moyenne des scores obtenus aux tests physique entre M0 (barre bleu) et M6 (barre orange), le trait rouge à droite représentant le score maximal qu'il est possible d'obtenir pour chacun des tests.

- **L'analyse de l'évolution des paramètres anthropométriques montre une perte généralisée de l'ordre de 5% sur l'ensemble des variables.**
- **Concernant l'IMC, la diminution atteint 3.5% à 6 mois de pratique.**
- **Les bilans des tests médico-sportifs montrent une nette amélioration de la condition physique des patients pendant le 1° trimestre, plus modérée sur le second trimestre**

CONCLUSION : Ces résultats, jugés très positifs, montrent la faisabilité et l'efficacité des activités physiques adaptées portées par le réseau Maita'i sport-santé en Polynésie française.

TIME'S UP, TOBACCO
END THE DIRTY TACTICS OF THE TOBACCO INDUSTR

Paper No. 701

Exposing tobacco industry tactics in implementation of 85 Graphic Health Warnings through media advocacy

Background and challenges to implementation: Pictorial health warnings on packaging of tobacco products is legally mandated as per India's national tobacco control legislation Cigarettes & Other Tobacco Products Act 2003. Pictorial health warnings were notified on 15th October, 2014 & effective from 1st April, 2015 - pictorial warning to cover 85% area on both sides of tobacco packs. However the notification was kept in abeyance in March 2015, due to tobacco industry pressure.

Intervention or response: Right to Information Act (RTI) is a part of fundamental rights under Article 19(1) of the Constitution of India. This empowers citizens to question the Government, inspect their files. The RTI was used as a tool to get info on representations from the Tobacco Industry for delaying the implementation and exposing the industry interference

Results and lessons learnt: The information received under RTI, revealed that several hundreds of written representations have been sent by tobacco industry as well as so-called independent and/or industry bodies opposing on various grounds in the implementation of the larger health warnings on tobacco product packs. This was exposed in the media and the stories created pressure and become a national debate. After a two-year battle, India implemented 85 percent graphic health warnings on tobacco products package from 1st April, 2016.

Conclusions and key recommendations: This has helped civil society to effectively strategize and mount a stringent campaign on tobacco control across the country, garner political support from select leaders, sensitize the media and seek general public support for compliance & implementation of pictorial warnings.

Akiruno city, Tokyo, JAPAN

has a population of 80,779 people and 35,511 households (as of March 1, 2019)

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Factors of community sports participation: an interim analysis of a community sports promotion plan in Akiruno city in Tokyo

Key words: community sports participation, subjective physical activity, active policy

Ken'ichi Egawa, PhD

Professor, Exercise Ecology Studio

Department of Human Nutrition, Faculty of Human Nutrition

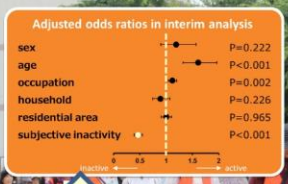
Department of Health Nutrition, Graduate School of Human Life Science

Tokyo Kasei Gakuin University, JAPAN

Sports promotion plan aimed that 70% or more adults will engage in sports by 2020.

Question: Usually, do you feel a lack of exercise?

Subjective physical activity is a key to promote sports participation.



The result suggested that feeling inactive decreased the rate of sports participation in the studied city. To enhance subjective activity through active policy or campaign may be important as to promote objectively measured physical activity.

Factors supporting Aboriginal health and wellbeing staff retention rates: A strengths-based journey

Deroy S[1] and Schutze, H[1]
[1] University of Wollongong, NSW, Australia

UNIVERSITY OF WOLLONGONG AUSTRALIA

Background

Aboriginal health and wellbeing staff are central to culturally appropriate health care, but may have high rates of burnout. In contrast, Waminda South Coast Women's Health and Welfare Aboriginal Corporation (Waminda) has a high (94%) staff retention rate.

Aim

To identify factors supporting the retention rate of health and wellbeing staff employed at Waminda.

Methods

Semi-structured interviews. Themes were identified using Braun and Clarke's framework for thematic analysis.

Results

Six themes were identified:

"…community control is…about responding to community need…I did a lot of community consultation so what I noticed is [I] go out to community and consult with the women and bring it back in to the service and… management would take that on board and, where possible, try and manoeuvre programs or create programs from that." HWW06

"…there's a recognition that we need to work collaboratively with other community services and…there's a lot of encouragement to work on those relationships." HWW05

"I actually love working at Waminda because if there is a problem all staff have the flexibility of getting in contact with our CEO. She's very approachable and she's very solution focused and I feel that, that's needed in an organisation like this because…we need that high level of expertise to deal with complex issues." HWW03

Figure 1: Schematic diagram showing bidirectionality of relationships at Waminda compared to unidirectional relationships which may be present in other organisations.

…if other services are looking to improve their retention rates I think they need to probably just identify their workers …I mean, especially Aboriginal organisations, they need to look at that person, you know, working, living in community as well…we come with just as much as the community issues as a client." *HWW04*

"Waminda is always supporting us to improve our qualifications and our training and our upskill[ing]. …it wasn't easy, you know, doing those advanced diplomas and the Certificate 4, running a household and all that sort of stuff. Like the support that Waminda gave me, giving me study time during work hours….yeah the support's there for us to go in directions that we probably thought that we couldn't." HWW04

"…we work really hard and deliberately on our culture here, so it's not something that we just hope that we're going to get right… We try and ensure that people are supportive, not tearing people down,…and I think that's really, really important because people come from other organisations or situations where that's just the norm… So I think that's why here works because you don't expect to be treated disrespectfully, you expect to be treated with respect and be included." HWW02

Conclusion

Implementing strategies to reduce staff burnout and turnover is paramount to a healthy workforce and continuity of patient care. Showcasing exemplar organisations like Waminda can assist other health services to implement similar effective strategies.

Acknowledgement

The authors wish to thank Waminda South Coast Women's Health and Welfare Aboriginal Corporation and all staff who particpated.

Contact

Sara Deroy scd230@uowmail.edu.au
Dr Heike Schütze hschutze@uow.edu.au, **T** +61 2 4221 4582

23rd IUHPE World Conference on Health Promotion,
7 - 11 April 2019, Rotorua, Aotearoa New Zealand

Family Planning Providers and Women Agree, Spousal Communication is Key to Contraceptive Use in Rwanda

Hilary Schwandt[1], Angel Boulware[2], Julia Corey[3], Ana Herrera[4], Ethan Hudler[5], Claudette Imbabazi[6], Ilia King[7], Jessica Linus[8], Innocent Manzi[9], Maddie Merrit[1], Lyn Mezier[2], Abigail Miller[3], Haley Morris[10], Uwase Nadine Musekura[11], Diuedonne Musemakweli[6], Divine Mutuyimana[6], Chimene Mukanyirimana[12], Nirali Patel[13], Adriana Scantlenuru[14], Bigarnette Shemezis[8], Madi Stapleton[1], Gi'anna Sterling-Donaldson[15], Chantel Umuton[8], Lyse Uwera[6], Madeleine Zeiler[2], Seth Feinberg[4]

[1]Western Washington University, Bellingham, USA; [2]Spelman College, Atlanta, USA; [3]Wheaton College, Norton, USA; [4]Northwest Vista Community College, San Antonio, USA; [5]Whatcom Community College, Bellingham, USA; [6]AEE, Rulingeri, Rwanda; [7]Xavier University of Louisiana, New Orleans, USA; [8]UMBC, Baltimore, USA; [9]UNF Oswego, Oswego, USA; [10]Western Oregon University, Monmouth, USA; [11]Eastern Oregon University, La Grande, USA; [12]University of Kentucky, Lexington, USA; [13]Arcadia University, Glenside USA; [14]Rutgers University, New Brunswick, USA; [15]Drexel University, Philadelphia, USA

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Introduction

- Spousal communication is a strong predictor of family planning (FP) use
- FP use increased dramatically in Rwanda from 17% to 52% in 5 years
- This study aims to explore the role spousal communication plays in FP use in Rwanda

Methods

- Qualitative study conducted in 2018 in Musanze and Nyamasheke Districts of Rwanda
- 8 focus group discussions with FP nurses and community health workers (CHWs)
- 32 in-depth interviews with female current modern contraceptive users

Results

- Providers noted that women initiate FP conversations
- Women noted that male partners sometimes initiated the conversations

I: When you first discussed that idea of family planning to your husband, how did he feel?

R: I was so surprised because it was him who first told me about family planning…

38, married, 2 children, condom user

- FP use was noted as causing marital dissolution less often than it was noted as saving marriages

I use family planning because I don't want fights in my family.

38, married, 3 children, pill user

- Male partners were noted as supportive beyond just communication

One thing that motivates me is that my husband continues to encourage me to use family planning.

29, married, 2 children, implant user

Discussion

- Providers and women concur – most men are supportive of FP use
- Men engage in discussions, motivate use, and support sustained use
- This differs from the findings from other nations, which find men less supportive of FP use
- Differences might be due to the strong leadership in Rwanda that actively supports FP use as well as locally elected male CHWs who engage in discussions about FP use at the household level

FOOD ADVERTISEMENT AND CHILD OBESITY: A COMPLEX PROBLEM FOR HEALTH PROMOTION

Juliana da Rosa Wendt[1]; Camila Ribeiro dos Santos[2];
Edna Linhares Garcia[2]; Hildegard Hedwig Pohl[2]

[1]Federal University of Santa Maria, Brazil; [2]University of Santa Cruz do Sul, Brazil

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BACKGROUND AND OBJECTIVES

- Pandemic health problem;
- Multifactorial etiology;
- Reflects the life style changes in the past decades, principally in children's eating habits and levels of sedentarism.

- Children are known to be more vulnerable to advertisement;
- The influence of advertisement on food choices have been subject of frequent discussions.

? What is the relationship between food advertisement and child obesity?

METHODS

Integrative literature review

Studies published in the last five years

In English, Spanish or Portuguese

Indexed in *PubMed* or *Scielo* databases

Search terms: "child obesity" "food advertisement to children"

1,200 studies found

Exclusion of studies that did not comteplate the objetives

45 studies were included in this rewiew

RESULTS

- ❑ Food is the most frequent type of product advertised in television;
- ❑ Many food ads are directed to children's audience, advertising mainly foods containing high calories, high levels of sugar, sodium and fat, and low levels of proteins and fibers, especially fast foods and candy;
- ❑ Most ads use bright colors, slogans, songs, cartoon characters, games and/or gifts to enchant children;
- ❑ More than half food ads directed to children present false health claims.
- ❑ Although there is no hard evidence that food advertisement directly harms children's health, undoubtfully it negatively influences eating habits and is considered among the factors that can lead to child obesity.
- ❑ The World Health Organization recommends the reduction of children's exposure to food advertising since 2010;
- ❑ An international policy of food advertising self-regulation was implemented recently;
- ❑ Studies showed that the regulation of food advertising to children has not been sufficient to protect this vulnerable public.

DISCUSSION AND CONCLUSIONS

- Childhood obesity is associated with children's over-exposure to unhealthy food advertising directed at them. Health promoting measures to children must include policies to regulate food advertising, particularly those aimed at this vulnerable public.

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Conflits of Interest Declaration

The authors declare they have not received any payment from a third party for this work and do not have any conflicts of interest to declare.

Growing Healthy Greater Christchurch
Waka Toa Ora

The Need

- Healthy Christchurch is a recognised and valued network of over 200 signatories.
- It has been in place for more than 15 years but has focused largely around Christchurch city.
- As the DHB has become a strong partner in the Greater Christchurch Partnership, the obvious progression was for Healthy Christchurch to expand in a collaborative way across the regions.
- The Greater Christchurch Partnership also recognised the value of the network and identified it as the group that could help it deliver against the Health and Community objectives of the Urban Development Strategy.

The Aim

- To extend the network into the regions, to better support a greater part of Canterbury.

The Plan

- To work in partnership to address the community needs around regional housing, health and social wellbeing, and enhanced environments.
- Fostering action that support outcomes for the partnership.
- To report effectively to the Greater Christchurch partnership on a workplan to identify how to continue to grow and strengthen the region.

Implementation

- Over the past year, Healthy Greater Christchurch have worked closely with regional partners to expand the network into Selwyn and Waimakariri.
- In February 2018, a hui was held for over 70 people from more than 40 organisations, to establish the 'greater' network and promote conversations and relationship building across the regions.

Healthy Greater Christchurch Hui 2018

This was the first the first hui to cover the expanded geographic boundaries. Participants learnt about the role of Healthy Greater Christchurch in implementing the 'healthy communities' goal of the Urban Development Strategy. Participants also had a chance to connect with each other around their own aspirations for health and wellbeing, with opportunities to collaborate around a range of social determinants. Hui participants reported that overall, the hui was informative and engaging.



Healthy Streets - Lucy Saunders 2018

Rather than the traditional approach of tackling physical inactivity by putting the responsibility on the individual and encouraging them to be more active, Healthy Streets focuses on incidental exercise, where people are supported by their environment. This was the message Lucy Saunders shared with the governors, planners, community groups and policy makers of the city. Following her visit, supported by Healthy Greater Christchurch, there are already changes being signalled through planning and policy agencies.



Waka Toa Ora (Healthy Greater Christchurch) Charter

The signatories to this charter agree to work together to promote, protect and improve the health and well-being of people and whenua.

We believe that by working together, we will achieve more than we could separately.

See the rest of the refreshed Charter here

Results

- Healthy Greater Christchurch reported to the Greater Christchurch Partnership on its newly developed work plan. The Work plan identifies how to continue to grow and strengthen connections in the region while fostering action that supports outcomes for the partnership.
- Grew collaboration with members from across Greater Christchurch participating.
- Strengthened local linkages and built on existing regional health and well-being networks and outcomes.
- Refreshed the Charter, with an engagement process that revealed the strength of the network over time.

Sustaining and Embedding

- The network enables effective collaboration and ensures that all people working in health and wellbeing across the region are supported to collaborate through strong information networks, face-to-face discussions, and planning around issues important to the community.
- In the next five years, Healthy Greater Christchurch would like to see outcomes with partners grow across the region. The aim is to do this by adding value to existing networks and the great work already under way (rather than duplication).
- A recent example of collaborating with partners was enabling Lucy Saunders, a visiting public health transport specialist, to share her knowledge over a range of forums with governors of the city, transport planners, and 150 individuals and organisations the region.

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Health Ambassadors in the Workplace: Change Led by Middle Management

Keren Greenberg, MPH[1]; Elisheva Leiter, PhD[1]; Milka Donchin, MD,MPH[1,2]; Liora Nave, BA; Donna R. Zwas, MD, MPH[1]
[1]Linda Joy Pollin Cardiovascular Wellness Center for Women, Hadassah Medical Center; [2]Braun School of Public Health

Background/Objectives

- The workplace is an ideal location for health promotion (HP), as workers spend long hours in the workplace, and the workplace provides long term access to pre-clinical populations.
- Middle managers are potential strategic agents of organizational change, as they have the legitimacy to lead processes both top down and bottom up.

Objective

- To evaluate a HP training intervention for middle managers.

Methods

- The "Health Ambassadors in the Work Place" program trains mid-management women to plan, implement and evaluate health promotion programs in the workplace.
- Questionnaires were filled out pre and post program, assessing self-efficacy (SE) and personal health behaviours. Semi-structured interviews were carried out post workshop

Workshop:

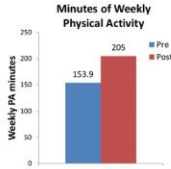
- Key component: Management commitment
- Skills acquired:
  - Personal change and empowerment
  - Designing and implementing programs
  - Health knowledge
- 15 sessions + 4 maintenance meetings
- 1 year professional guidance

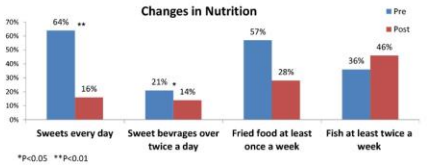
Results

- Thirteen government offices sent 22 mid-managers to take part in the program.
- Post program:
  - Participants improved personal health behaviours and SE
  - 70% of workplaces made multiple health-promoting changes

Conclusion

Training mid-managers in HP, focusing on personal health change, skill development and SE can catalyse HP processes in the workplace.





Workplace HP Activities Implemented by Health Ambassadors

Nutrition	Physical Activity	Organizational Change	Raising Awareness
Cooking workshops	Exercise classes	Steering committees	Risk factor Screening
Nutrition lectures	Competitive groups	Training branch health ambassadors	Heath lectures, teasers, and Newsletters
Healthy refreshments	Pedometer competitions	Recruit Management	First aid courses
Cafeteria menu changes	Employee sports day	Integrate health into routine activities	Ergonomic changes
8/13 workplaces ~7400 exposed	8/13 workplaces ~8600 exposed	5/13 workplaces ~6000 exposed	10/13 workplaces ~12,400 exposed

The Linda Joy Pollin Cardiovascular Wellness Center for Women

Hadassah University Hospital

IUHPE
23rd World Conference on Health Promotion

Health and lifestyle choices of students studying at an urban university in the UK

Dr Maxine Holt & Professor Susan Powell
Manchester Metropolitan University, UK

Background

- 2.3 million students enrolled at universities in the UK
- 75% of enduring mental health problems manifest by the age of 24 years
- Student suicide rates rising in England and 10% of students use counselling services
- Little known about the health and lifestyle choices of 18-24 year olds

Aims

This research aimed to:

- Explore the health and lifestyle choices of students attending an urban university in the UK
- Identify health issues within that student population.
- Design appropriate interventions.

Methods

Online, 60 question questionnaire, mainly closed questions, about health care utilisation, eating and dietary ,alcohol, smoking, sexual health, mental health, drug and substance use. This was administered at a time when no other student surveys were taking place. The inclusion criteria were students must study on campus, be full time or part time on any programme of study

Results: 3683 respondents (10% of student population)

only 56% prepare own food and 11% eat the recommended 5 or more portions of fruit and vegetables per day

23% (n=792) males and 50% (n=1,700) females wanted to get drunk
42% could not remember the night before

30% used illegal or legal recreational substances

78% sexually active with 30% tested for sexually transmitted diseases

28% had an emotional or mental health issue
Groups most at risk were white and mixed race females, studying arts, humanities and health programmes

The most commonly sought support was from from Students Union and Personal Tutors and the top reason for not seeking support was embarrassment.

Discussion

Going into higher education is an important time of transition for young people. The research gave valuable insight into

Self-reported lifestyle choice and health behaviours not previously known. Data were used to inform a new wellbeing strategy for students. The research was also used to inform the design and implementation of interventions such as cookery classes delivered on campus and meditation sessions.

The study was limited as it was a single snap shot in time but we are working with our colleagues at the University of Applied Sciences, Hamburg to design and implement a surveillance system for student health.

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Contact: m.holt@mmu.ac.uk **or** s.Powell@mmu.ac.uk

Health and social system challenges to tackle social determinants of NCDs in Nepal: A systemic analysis

Sharma SR[1,2], Matheson A[3], Lambrick D[4], Faulkner J[5], Lounsbury DW[6], Vaidya A[7], Page R[2]
1 DIYASU, 2 Massey University, 3 Victoria University of Wellington, 4 University of Southampton, 5 University of Winchester, 6 Albert Einstein College of Medicine, 7 Kathmandu University

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Background:

- Health system is a key social determinants of complex health issues like non-communicable diseases (NCDs) (1)
- Health system in developing countries face systemic governance and structural challenges to address NCDs and related social determinants of health (SDH) (2,3)
- Systems thinking approach sits well with understanding the wicked problems (4-6)

Objective:

- Examine health and social system challenges in addressing the NCD issues in Nepal from systems perspective.

Method:

- The study was informed by the adapted social determinants of health framework (Figure 1) (1)
- Study design was multi-methodology [case-study (6) and causal loop diagram (7)], participatory and action-oriented guided by systemic intervention methodology (Figure 2) (8)
- Data was collected through key informant interviews (n=63) and focus group discussions (n= 12) from two case study areas and policy level
- 3 sense making sessions conducted to interpret findings
- *Dedoose (9)* was used to manage the qualitative data and *Vensim* (10) was used to build CLD

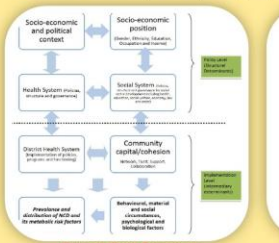

Figure 1: Study Framework

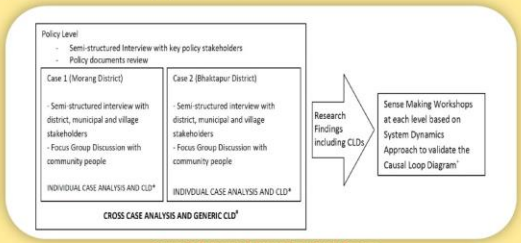

Figure 2: Systemic Intervention Study Design

Results:

- Three key interacting thematic areas emerged from the study (Table 1) and their dynamic interactions illustrated in Causal Loop Diagram

Table 1: Key thematic areas relating to health system determinants of NCDs

S.	Themes	Key observations	Key Quotes
1	NCD prevention policy structure ineffective and under-resourced	Curative orientation of the health system Leadership and structural gap for NCD prevention Low priority/resources allocated for health promotion Multi-sectoral coordination not emphasized System unable to address major behavioural risks through policy measures Political instability and limited political commitment	*"Curative Service Division is leading this fight against NCD but more from curative perspective and less from health promotion." (ID: 15; Policy level; Health)* *"Finance Ministry do not provide enough resources despite huge amount is generated from tobacco tax." (ID; 14; Policy level; Health)*
2	Functioning and management of district health system ineffective in addressing NCDs and their risks	District Health System ineffective and inefficient in leading multi-sectoral actions Poor management at district level offices Limited NCDs prevention actions planned CHWs and FCHVs limited training The local primary health care system not effective	*"Often development budget are expended and finished in the last few month of the fiscal year and this has no any impact or output. Lack of accountability and transparency is hurting." (ID: 20; Policy level)* *"We are working with few NGOs but not with DHO and others, there is no trend of working jointly." (ID; 48; Morang District; Non-health)*
3	Health system role in impacting overall equity and access to services	Difficulties for poor and vulnerable to easily access the services Issues of quality of care and services from the facilities focusing on underserved areas	*"Still today, despite favourable policies, people do not have access to free medicines; community people do not know what type of free medicine available. Our system is elite, it favours elite people." (ID: 20; Policy level)*

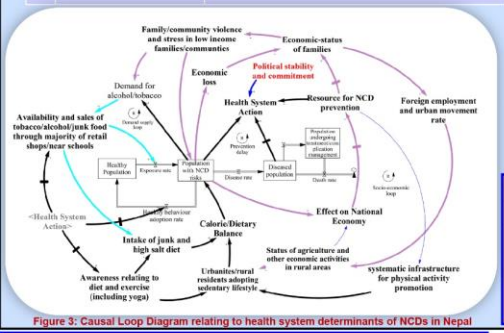

Figure 3: Causal Loop Diagram relating to health system determinants of NCDs in Nepal

Causal Loop Model:

Three key sub-systems driving behavioural risks of NCDs

- Sub-system one (black arrows) indicates towards the delays in preventative and multi-sectoral actions from the health system reflecting the curative orientation
- Sub-system two (aqua arrows) presents the demand-supply sub-system indicating universal availability of tobacco, alcohol and junk food (hence, policy failure)
- Sub-system three (violet arrows) demonstrated the socio-economic context driving the problem and system inability to address equity and access issue

Conclusion: In Nepal

- Health and social system is acting as a rigid/ inflexible structure
- Strengthening and reorientation of the primary health care system of Nepal towards addressing complex problems needed

Recommendation:

- Envisage a national agency for health promotion focusing on pushing NCDs agenda and multisector coordination mechanism

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MASSEY UNIVERSITY TE KUNENGA KI PŪREHUROA UNIVERSITY OF NEW ZEALAND
VICTORIA

WAIORA: Promoting Planetary Health and Sustainable Development for All

HEALTH PROMOTION COMPETENCIES IN CITIZEN AND VOLUNTARY: A PILOT EVALUATION FOR SCOUT ASSOCIATIONS

Alessandra Sotgiu1, Graziella Salis 3 , Alessio Decina 2, Paolo Contu1, Claudia Sardu 1,
1 Università di Cagliari, 2 CADAS, 3 Ats Sardegna – ASSL di Nuoro

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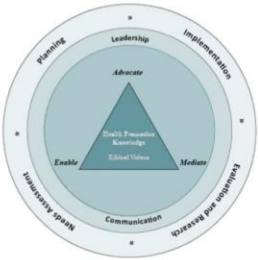
Background/Objectives

Between 2009 and 2013, IUHPE defined competencies and established an accreditation system of Health Promotion Practitioners.

Public Health requires partnership with patients, sports and scouts associations.
An assessment of scout associations was therefore implemented, also considering their impact on young and adults, their capacity in Community Empowerment, and the importance for community action of good citizens cooperating to build health promoting setting.
The competencies assessed are those of the IUHPE Health Promotion Practitioners.



Methods

The mapping is divided into 3 phases:

1) identification of the common documents for each association;
2) blind evaluation by two assessors, one expert in HP;
3) final comparison and drafting of results.

The target are the Italian scout associations present on the national territory:
AGESCI, CNGEI, ASSORAIDER, SCOUT D'EUROPA.

Besides the documents of the associations we used: "Scouting for boys", "The manual of the wolf" and the "The Jungle Books".

Results

Researchers found 58 competences.
No association includes all IUHPE competences.

The distribution sees Agesci with 48 competences, Assoraider 32, Cngei 16 and FSE 2.

It is noted that Agesci has most of the competences in all domains; Cngei has few, in Advocacy, Planning, Implementation, Evaluation, has no competencies. Assoraider lack competencies only in Advocacy while in all the others it has at least one competence, while Fse has not been evaluated for lack of documents.

Dominio	Items totali	Items Agesci	Items Cngei	Items Assoraider	Items FSE
Enable Change	5	5	1	3	0
Advocate For Health	5	4	0	0	0
Mediate Through Partnership	4	4	3	2	0
Communication	4	3	2	3	0
Leadership	6	6	3	4	0
Assessment	7	3	2	3	0
Planning	5	5	0	4	0
Implementation	5	5	0	3	0
Evaluation And Research	5	3	0	1	0
Totale		48	16	32	

Discussion

The lacking competencies are mainly linked to the application of extremely specific methods and techniques, such as statistical methods, which do not appear strictly linked to the activities carried out by the single associations.
It is not important for associations to have all the competencies, but it is important that they have those that can enable them to achieve specific goals while adhering to the principles of health promotion.
The scout associations adhere to the health promotion working methodology principles, and include fairness, respect and participation in the associative principles.
The competencies are used with respect to the associative purposes, in order to reach their aim "build the good Citizen".

Keywords
Health Promotion competence, Scouting Movement, Community Empowerment, Public Health

Health promotion for cervical cancer in India: Why is it a challenge and what can be done? A multi-contextual approach

Dsouza JP[1], Van den Broucke S[1], Dhoore W,[1] Pattanshetty S[2]
[1]Université Catholique de Louvain, Belgium , [2]Manipal Academy of Higher Education, Manipal, India

IUHPE 23rd World Conference on Health Promotion
UCLouvain

Introduction

- With an age standardized incidence rate of 14.7/100,000 person years, cervical cancer is the second most common cancer among Indian women[1]
- Only 22.3% of Indian women have ever undergone examination of cervix[2]
- Various factors promote uptake of cervical screening[3]
- The Government of India has developed operational guidelines for cervical cancer screening under the National Program for Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS)[4]
- The States of India are tasked with the implementation of the NPCDCS screening guidelines but encounter specific challenges.

Aims

- To asses the state of implementation of primary prevention and screening of cervical cancer in India.
- To explore specific challenges to cervical cancer screening.
- To assess women's knowledge and opinions on cervical cancer and screening.

Methods

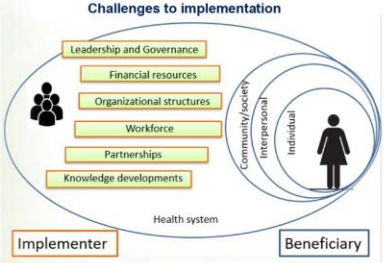
- The study took place in three different States (Himachal, Meghalaya and Karnataka). Two to three districts in each state were selected to participate in the study.
- State and district program managers and implementers were interviewed to asses the state of implementation of strategies for prevention and screening of cervical cancer.
- Women aged 30-59yrs were randomly selected from the participating districts and interviewed to assess their knowledge and opinion on cervical cancer and screening.
- Data from program managers and implementers on existing strategies were triangulated and content analyzed. Encountered challenges to cervical cancer prevention and screening were classified using the dimensions of the Public Health Capacity Framework[5]
- Knowledge and utilization of screening services provided by beneficiaries was used to assess the effects of the programs.

Results

Cervical cancer screening: Current status

HIMACHAL	MEGHALAYA	KARNATAKA
Pilot test (training)	Training, procurement	Training
• Geographic accessibility • Service availability	• Geographic accessibility • Service availability	• Service availability

Challenges to implementation



Discussion

- The National Program for cervical cancer is in its initial phase of implementation in all three the participating States
- Health system related challenges to implementation as experienced by implementers at state and district level include problems with resources, organizational structures in the form of accessible and affordable services, trained workforce, and involvement of associated stakeholders.
- Individual challenges to implementation of the program include low health literacy among the population.
- The overall poor uptake of cervical screening by beneficiaries suggest that strategies to improve the utilization of available screening services must be developed.
- In addition to targeted strategies for families and communities to enhance participation in cervical cancer screening, there is a need for context specific implementation plans that take beneficiary characteristics and specific determinants of screening participation into account.
- Integrated strategies involving NGOs and other stakeholders and making use of available facilities could improve screening coverage.

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Health promotion for children and teenagers living in shelters and correctional institutions in Taiwan

Hsin-Nung Kao[1,2] Tsan-Hon Liou[1,2] Kuang Shuo Chen[2] Yiing Mei Liou[3] Jung-Su Chang[2] Ying-Wei Wang[4] Li-Ju Lin[4] Chen-Su Lin[4] Chiung-Dan Chang[4] Yen-Jung Chang[4] Li-Hui Yu[4]

1.Shuang Ho Hospital, Taipei Medical University
2.Taipei Medical University, Taiwan
3.National Yang Ming University School of Nursing
4.Health Promotion Administration, Ministry of Health and Welfare, Taiwan, R.O.C.

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BACKGROUND

White Paper of Health Inequality indicates that all citizens have the same right in improving the knowledge in health literacy. Children and teenagers living in shelters and correctional institutions are those who receive less care and education from the elder.

AIM

To investigated the current health literacy of children and teenagers living in shelters/correctional institutions, followed by an intervention to improve their knowledge of health.

Health promotion program

METHOD AND STATISTICAL ANALYSIS

A total of 275 students were collected from the northern, middle, and eastern parts of Taiwan. Another 141 staffs from shelters/correctional institutions were also recruited to understand their health knowledge and behaviors.

◆ Participant

☐ Location

☐ Baseline characteristics of the study population

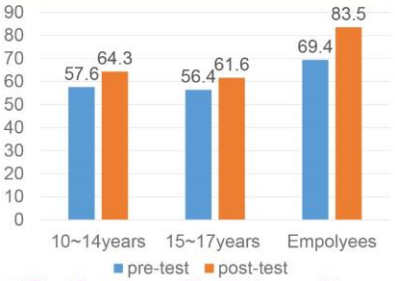
Characteristics	n=275	%
Gender		
Male	139	50.5
Female	136	49.5
Age(years old)		
10~14	205	74.5
15~17	70	25.5
Live in the institution		
<6MS	33	12.0
>6MS	242	88.0
BMI (kg/ m²)		
Underweight	28	10.2
Normal	182	66.2
Overweight	41	14.9
Obesity	24	8.7

RESULTS

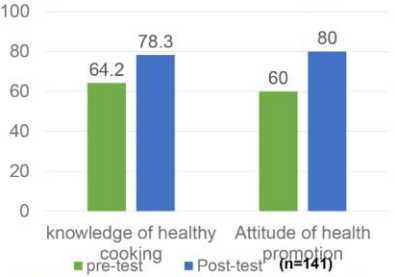
Results showed that 8.8% of 10 to 14-year-old subjects were underweight and 24.6% were overweight or obese while 13% of 15 to 17- year-old subjects were underweight and 40% were overweight or obese. Their health attitude scores also increased from 3 to 4 points after the intervention.

Table1. Description of the body mass index.

N=275	10~14ys	15~17ys
Underweight(n,%)	18(8.8)	9(13.0)
Normal(n,%)	134(65.4)	33(47.0)
Overweight(n,%)	25(10.2)	15(21.2)
Obesity(n,%)	28(13.9)	13(18.8)



☐ Fig.1 Correct rate of health Literacy(%)



☐ Fig.2 Caregiver health promotion knowledge and attitude positive rate(%)

CONCLUSION

In conclusion, the health educational intervention is positive and effective for those children and teenagers living in shelters and correctional institutions as well as the staff working there.

◆ Acknowledgement

This work is supported by Health Promotion Administration, Ministry of Health and Welfare, Taiwan (R.O.C.). Source of funding is from the tobacco control and health care funds.

Health support for new mothers facing isolated baby raising in the super ageing Japanese society

Junko Otani,[1] Takuzo Osugi,[2]
[1]Osaka University, [2]Kyoto Sangyo University

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Setting/problem

Japan, being the first country to enter 'super-ageing' population, has the most ageing population in the world. This demographic change results in serious concerns about the motherhood of the young generation who have no chance of having seen actual baby birth and care but facing sudden lifestyle and environment challenge of isolated baby raising.

The leading cause of death among pregnant women and new mothers from 2015 through 2016 in Japan was suicide, making up about 30 percent of the total, according to a survey by the National Centre for Child Health and Development and other research institutes (Sep. 2018). The women apparently killed themselves because of postnatal depression, according to the first survey showing a nationwide incidence of suicide among by women in pregnancy or shortly after childbirth (Mori, 2018). The reasons for the suicides are considered to be varied but pregnancy and delivery are big events for a family and people involved tend to have worries.

The health ministry of Japan launched a new program in the fiscal year of 2017 to provide financial support to municipal governments offering health check-ups and counselling by clinical psychologist two weeks or one month after childbirth in a bid to prevent postnatal depression or child abuse. Therefore many new facilities and programmes have started.

Intervention

Participant observation. The authors have recently experienced their own baby birth; received new health check-ups and have been participating in various community health programmes by public health nurse, child minders, midwives of municipal government health department as well as NPOs of midwives and others.

Home visit by public health nurse and midwife before 4 month health check-up by municipal health centre, Height and weight measurement of baby. Edinburgh Postnatal Depression Scale (EPDS) for mother.

Baby massage class for new parents by municipal sports centre in collaboration with Mizuno co.

"Baby has come!" class (4 times) for new mothers to make friends with other mothers with same age baby and learn how to get to know their own baby organized by municipal health centre

Baby-food cooking class for new mothers by City Health Centre

NPO's making art calendar class with baby hands and foots class for new mothers

Square with baby toys to gather, chat, offering a place for mothers with a baby to go out at a local community centre: nurse, midwife, nutritionists, or pediatricians are available to consult

Baby swimming class by Sports gym

NPO's Yoga class for new mothers by Midwife Yoga-instructor while nurse takes care of baby with educational toy

Outcomes

When a new mother left hospital, therefore daily attention from midwives and nurses, and started the new life with a baby on their own is a time of challenge. Various new programmes attempt to provide at this timing new mothers a chance to meet other new mothers, share their concerns, experience and information for support. Various programmes targeting different groups of mothers. The programmes and activities vary by municipal government. Mothers may select which city to live due to the availability of community support programme.

Implications

The mental health issues such as postnatal depression are a challenge for the provision of medical care for pregnant women and new mothers. A support system using community networks for new lonely mothers is needed especially at the super ageing society of Japan.

Most support programme targets new mothers but this implies the social norm of Japan's gender role is that mother is the one to take care of a baby. This has two types of risks: firstly this may reinforce the norm that mother is to take the responsibility to take care of a baby, often alone, while a father is busy working, and secondly this may leave a single father isolated and alone.

Healthy and Sustainable Territories of Brazilian Semi-Arid Region – Brejo da Fortaleza and Fornos communities experiences, Piauí – Brazil

Author: Juliana Carvalho Rodrigues
Affiliation: National Health Foundation – Funasa, Brazil

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23rd World Conference on Health Promotion

Setting/problem

Brejo de Fortaleza and Fornos are communities of semi-arid region of Piauí - Brazil, have subsistence family agriculture as activity, low Human Development Index, difficulties in land and water access (rainy season dependence), what make them vulnerable.

The Project "Healthy and Sustainable Territories of the Region of the Semi-Arid of Brazil", a partnership between National Health Foundation - Funasa and Oswaldo Cruz Foundation - Fiocruz, Ministry of Health – Brazil, allowed actions realization in these communities.

Intervention

Actions objectives: support Healthy and Sustainable Territories in the Semi-Arid development and the concept application, based on the identification, articulation and evaluation of the territorialized social agendas, allowing the development of methods, technologies, parameters and indicators of characterization and analysis other experiences.

The strategy used is the cooperation and integration processes to realize actions to obtain effective results, for knowledge production and interchange, and for sensitization and empowerment of other partners for initiatives that promote territorial development. In these communities was proposed the nets creation and participatory governance for articulation, mobilization and empowerment, with two objectives:

1) Elaboration of Local Intervention Plans for Healthy and Sustainable Territories in the Semi-Arid;
2) Popular and intersectoral mobilization to participate in the monitoring and evaluation of Healthy and Sustainable Territories in the Semi-Arid.

Outcomes

Participatory workshops were carried out to elaborate Local Intervention Plans, local social actors were identified and articulated to form the net, and a digital platform was provided for the interaction of the actors of the net.

One course in Popular Surveillance in Health and Water Management was carried out in order to facilitate the connections and interrelationships between water, health, sanitation and agroecology, which drove the first steps of the Popular Surveillance in Environmental Health, by articulating levels of responsibility and sources of information.

Some actions will also be implemented such as decoding the Sustainable Development Goals to establish a matrix of re-signified indicators that make sense to the semi-arid living conditions. Popular surveillance will be organized to collect, analyze and disseminate real-time information, a local forum too. Agenda 2030 and the instruments/mechanisms for local processes monitoring and evaluation will be socialized.

Figure 1 - Intersectoral mobilization and participatory governance

Figure 2 – Water collection and analysis by National Health Foundation - Funasa

Figure 3 – Maps elaboration: participatory methodology of graphical representation of the territory, using communities knowledges to describe the territory reality

Implications

This experience allows social inclusion that contributes for Funasa's premises achievement - sanitation access and health promotion. And, this partnership, that is referenced in institutional missions and in Brazil's commitments (Sustainable Development Goals and Agenda 2030), can bring results over time in the daily lives of communities.

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Poster presented at 23rd Conference of Health Promotion
7 – 11 April 2019, Rotorua, Aotearoa New Zealand

Healthy Together Children's Health Program

An innovation to support healthy weights for Canadian children and families

Joan L Bottorff[1], Catherine Nesmith[2], Anne Huisken[1]
[1]Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia, Kelowna BC.
[2]The Bridge Youth and Family Services, Kelowna BC

Background

- In Canada, unhealthy weights disproportionately affect vulnerable children and families.
- National level efforts are needed to strengthen community capacity and promote healthy weights for children and families.
- The Public Health Agency of Canada identified community-based interventions as an important strategy to meet this goal, and launched a multi-phased, national funding program to support novel population health initiatives in 2010.
- The **Healthy Weights for Children** project received three phases of funding to develop and implement a community-based approach to achieve healthy weights among Canadian children and families.

Interventions

Healthy Weights For Children Project

Goal: To develop, evaluate, adapt and scale-up a community-based approach to achieve healthy weights among children and families, and support policy/practice changes that create environments supportive of healthier choices.
The project includes two initiatives: 1) The Healthy Together program 2) Healthier 4 You convenience store initiative.

Healthy Together

Designed to strengthen organizational capacity to promote healthy eating and physical activity among vulnerable families (0 to 18 years)

- 30 sessions supported by a toolkit of resources and delivered by trained facilitators.
- Each session has 3 components that engage participants in learning, cooking and eating, and physical activity.
- The Healthy Together program model supports flexible delivery to enable scale-up and integration into existing community programs.
- Implementation sites received funding to support integrating up to 30 Healthy Together sessions into their core services.

Healthier 4 You

Designed to support healthier food and beverage choices in convenience stores in local communities

- Healthier food/beverage choices, identified by a dietitian, are marked to encourage healthier choices.
- Three convenience stores in western Canada have volunteered to participate in an 8 week pilot of the Healthier 4 You initiative.
- Sales data and customer surveys will be used to evaluate the initiative.

Outcomes

A) Incorporating Healthy Together into core service programs

- 29 diverse organizations have delivered 30 Healthy Together sessions reaching over 950 families across Canada.

To date, 14 implementation sites have been reached for 6-month follow-up. The majority of organizations reported integrating Healthy Together into at least one core service program, although plans to continue offering Healthy Together vary as shown below.

Continue to offer Healthy Together (9 sites)	Plan to offer Healthy Together in next 12 months (1 site)	Cannot continue to offer Healthy Together (4 sites)
6 sites have integrated Healthy Together as a core service program at their location 3 sites are continuing to offer Healthy Together with remaining project funding.	Site was in process of applying for a grant. Considering partnering with another implementation site in community.	Constrained by limited financial resources due to stagnant funding or cuts to funding for existing programs. No foreseeable sources for additional funding.

Over 100 facilitators were trained in face-to-face workshops to deliver Healthy Together. However, the increased need for facilitators to support continued scale-up as well as staff turnover prompted the development of online training modules.

B) Guiding policies and practices in community programs

Healthy Together inspired the implementation of new practices and policies in a number of participating organizations, including:

- Serving healthy food/beverages at all organizational programs or events, and
- Incorporating cooking/physical activities into other programs.

Throughout the scale-up phase, a National Advisory Committee has provided guidance to the Healthy Weights for Children project team by:

- Supporting efforts to expand the reach of Healthy Together by leveraging existing networks and serving as program champions.
- Providing advice on refinements and additions to the Healthy Together program.
- Advising on the development of a checklist to guide policy and practice changes at the organizational and community level.
- Assisting with the development of plans to support long-term sustainability and integration of Healthy Together into other community programs and services across Canada

Conclusion

The Healthy Weights for Children project has enabled implementation of new community-based strategies that have strong potential for sustainability and extend capacity within communities to support healthy weights for children and families.

Financial contribution from Public Health Agency of Canada / Agence de la santé publique du Canada
The views expressed herein do not necessarily represent the views of Public Health Agency of Canada

THE BRIDGE Youth & family services

THE UNIVERSITY OF BRITISH COLUMBIA

http://healthy-together.ca
joan.bottorff@ubc.ca

Healthy Towns Happy People Process Evaluation

Presenter: Dr Jane Taylor
Senior Lecturer, Public Health Discipline Leader
School of Health and Sport Sciences
University of the Sunshine Coast, Queensland, Australia

IUHPE
23rd World Conference on Health Promotion

HEALTHY TOWNS Happy People

Introduction

About Healthy Towns

Healthy Towns is a community-based health promotion program that recognises the work of regional and rural community groups to improve the health and happiness of their communities through annual awards where recipients receive recognition and/or financial reward to build on their good work. Healthy Towns was initiated by Central Queensland, Wide Bay, and Sunshine Coast Primary Health Network (PHN) CEO, Patti Hudson, in 2015, and has been developed and piloted by a working group comprising local community, government and university representatives. Healthy Towns awards are available in three categories: Connections between people, Connections with place, and Connections with greenspace.

CONNECTIONS BETWEEN PEOPLE AWARD

CONNECTIONS WITH PLACE AWARD

CONNECTIONS WITH GREENSPACE AWARD

Methods

Evaluation process and frameworks

A process evaluation of the Healthy Towns program was undertaken in 2018 using a program logic approach (Figure 1). Process evaluation aims to understand how a program worked, what happened in 'real life' and how people reacted to it.[1] Specifically, did it reach its intended target group, were program participants satisfied, were associated materials of good quality, and did it 'roll out' as planned.[2] The process evaluation focused on three key components of the program: (1) the Healthy Town's Working Group, (2) program participants, and (3) the program communication and marketing. An evaluation framework was developed, which identified a range of indicators related to: program exposure, program participation, delivery (program fidelity), satisfaction, quality and contextual factors. Data collection methods included a desktop analysis of project documents and resources, and an online satisfaction survey of working group members and program participants. Ethics approval was granted from the University of the Sunshine Coast Human Ethics Committee (A181121).

Figure 1: Healthy Towns Program Logic Model

Acknowledgements
Healthy Towns is a collaboration between Central Queensland, Wide Bay and Sunshine Coast PHN, University of the Sunshine Coast, Sunshine Coast Council, Noosa Shire Council, Caloundra Community Centre, Griffith University and Gympie Regional Council. The evaluators acknowledge the following for their contribution: Healthy Towns award applicants; Central Queensland, Wide Bay, and Sunshine Coast PHN Healthy Towns project officers; and the Healthy Towns Working Group.

Disclosures - The contents of this process evaluation report are an accurate reflection of the evaluation as facilitated by the evaluation team in partnership with the Healthy Towns Working Group, however, do not necessarily represent the views of Working Group member organisations.

Key findings

Over 2016/17, 82 applications were received from community groups across the award categories. Collectively applications supported many of the priority population groups, applicants have been satisfied with various aspects of Healthy Towns events, and provided useful feedback for improving application and communication processes. The working group included seven regional organisations representing tertiary education, health, local government, and community sectors, and 15 public health students from University of the Sunshine Coast (USC). Working group activity focused primarily on conceptualisation (i.e. program values, principles, and branding), and development and resourcing of the Healthy Towns pilot phase.

Healthy Towns working group

- Working Group members were satisfied with group operations and felt that the level of commitment required was reasonable, and their involvement added value to their professional roles.
- There were some changes in the working group's membership, however, consistent engagement at meetings was maintained by PHN, local government and USC representatives. There were several changes in the PHN Healthy Towns Project Officer, and reduction in the capacity of the role over the pilot phase.
- Working group members felt the holistic nature of the program, award categories, targeting smaller towns that might otherwise be forgotten, the award ceremony, the focus on celebrating and recognising the work of local community groups, and the branding should be continued. The need for more resourcing to enable more communities to be rewarded and recognised, and adequate time for the project officer to secure additional resources were identified.

Figure 2: Working group satisfaction survey – levels of agreement

Program participants

- 82 award applications were received in the pilot phase (55 in 2016 and 27 in 2017) representing all targeted local government areas.
- The primary reason applicants reported applying for an award was for recognition, followed by the opportunity to promote their organization, use funds to expand programs and purchase equipment, attract new members, and for financial reasons.
- In 2016 and 2017 Award Ceremony applicants were satisfied with all aspects - venue, accessibility, catering, length of the ceremony, and alignment with program principles.

Communication and marketing

- Award applicants indicated email and social media most successful in promoting the program.
- Most Award applicants agreed that the Healthy Towns website was easy to navigate, provided sufficient information about the application process, and was visually appealing and professional.

Conclusion

Process evaluation findings indicate Healthy Towns successfully engaged several community groups, and success factors included investment in planning, strength of the working group collaboration, and ongoing resource commitment of participating organisations. However, sustainability of Healthy Towns and future expansion is dependent on enhanced resourcing and further evidence of contribution to health and wellbeing at the community level.

References
1. Bauman A, Nutbeam D. Evaluation in a nutshell: A practical guide to the evaluation of health promotion programs. 2nd ed. North Ryde: McGraw Hill Education; 2014.
2. Hawe P, Degeling D, Hall J. Evaluating Health Promotion: A health workers guide. Sydney: Maclennan and Petty; 2005.

Curtin University

HIV & MOBILITY IN AUSTRALIA

A COALITION & ROAD MAP FOR ACTION

CORIE GRAY, GEMMA CRAWFORD, ROANNA LOBO
COLLABORATION FOR EVALUATION, RESEARCH & IMPACT IN PUBLIC HEALTH, CURTIN UNIVERSITY

ISSUE

Like other high-income countries, Australia has experienced increasing HIV notifications among people born overseas & people travelling to & from countries of high prevalence. This is different to historic trends. Achieving Australia's target of no new infections by 2022 will need more nuanced understanding of these mobile & migrant populations.

RESPONSE

The **HIV & Mobility in Australia: Road Map for Action (2014)** was the first attempt to capture what was known about HIV & mobility in Australia. The Road Map identified 5 action areas with 71 locally, nationally & internationally focused strategies to guide related activity outlined in *Australia's National HIV Strategy*.

A national **Community of Practice for Action on HIV & Mobility (CoPAHM)** was established and now has over 80 members from government, non-government, research & community to keep HIV & mobility on the agenda.

HIV & MOBILITY: WHAT ARE WE TALKING ABOUT?

Adapted from Crawford, G (2014). Australian travellers, relationships & risk: exploring the nexus.

WHERE TO

Action is now gaining momentum. **CoPAHM** continues to advocate for a focus on HIV & Mobility in Australia's HIV response. **Priority Actions** (2018) published by CoPAHM outlines 6 actions to further guide policy & operationalise the Australian response to HIV in migrant and mobile populations:

- **Local solutions:** State-specific responses to HIV
- **Health literacy:** Increased access to available combination prevention.
- **Test:** Reduced testing barriers. New testing technologies widely available.
- **Treatment & prevention:** Policy mechanism to provide access to treatment & PrEP for temporary visa holders who are Medicare ineligible.
- **Inform:** Harmonised surveillance data, including sexual behaviour, testing rates, notifications, treatment initiation & PrEP.
- **Evaluate:** Core indicators assessing program effectiveness.

MORE INFO? Email copahm@curtin.edu.au or visit https://siren.org.au

PUBLIC HEALTH
ADVOCACY INSTITUTE OF WESTERN AUSTRALIA

Curtin University

Dr Melissa Stoneham
Scott Mackenzie

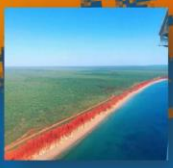
EHTP

ENVIRONMENTAL HEALTH TRACHOMA PROJECT

41 AT RISK Western Australia COMMUNITIES

Australia is the only developed country that has endemic trachoma. Almost all cases of trachoma are detected in remote Aboriginal communities.

The EHTC aims to reduce the incidence of trachoma and skin infections in 'trachoma at risk' Aboriginal communities in remote WA by December 2020.



This project only looks at the F and E strategies within the WHO SAFE trachoma strategy, which represent Environmental change and Facial cleanliness. We train and work with the WA Aboriginal Environmental Health workforce who live in remote communities, to collect information and identify what they and their communities need to reduce trachoma and other hygiene related illnesses. Together, we are developing community environmental health action plans that identify a diverse range of community led initiatives and strategies. We also plan 8 demonstration projects in remote communities each year. Some examples of the demonstration projects include in-house bathroom maintenance to upgrade health hardware, community laundries and providing free soap to community members.

Government of Western Australia
WA Country Health Service

How denormalized was the cigarette smoking behaviour? A prevalence study among adult smokers in North East Malaysia

Authors: M Hanief Ahmad[1], Azriani ARahman[1], Kamarul I Musa[1], Faridah M ZIn[1], N Aryana Hassan[2], Maizurah Omar[3], Ruhaya Hasan[4], Rehanah M Zain[5], M Ismail Ibrahim[1].

Affiliations: [1]School of Medical Sciences, Universiti Sains Malaysia, [2]Tobacco Control Unit, MOH Malaysia, [3]National Poison Centre, Pulau Pinang, Malaysia, [4]School of Dental Science, Universiti Sains Malaysia. [5]School of Health Sciences, Universiti Sains Malaysia.

IUHPE 23rd World Conference on Health Promotion

Paper number: 265

1 Background

Denormalization has been a key strategy adopted by WHO in achieving the tobacco endgame. Positive Smoker Identity, which was derived from PRIME Theory of West, was a newly developed construct that measured the degree of denormalization of cigarette smoking culture.

The goals of this study were to determine:

1. The prevalence of Positive Smoker Identity among smokers in government agencies in Kota Bharu, Malaysia.
2. The factors associated with Positive Smoker Identity.

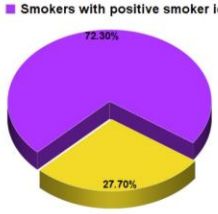
2 Methodology

A cross-sectional study was performed using data gathered from 253 smokers working in all government agencies in Kota Bharu.

The respondents filled up a set of proforma and questionnaires including the PSmoQi, which measured Positive Smoker Identity construct.

Factors associated with Positive Smoker Identity were analysed using multiple logistic regression.

3 Results



Factors associated with Positive Smoker Identity

Variables		Crude OR[a] (95% CI)	Adjusted OR[b] (95% CI)	Wald Stat[b] (df)	p-value[b]
Age		1.055 (1.021,1.089)	1.042 (1.004,1.081)	4.81(1)	0.028
Smoker Self Concept Score		1.198 (1.109,1.293)	1.216 (1.112,1.329)	18.31(1)	<0.001
Heaviness index		1.003 (1.001,1.004)	1.002 (1.001,1.004)	6.53(1)	0.011
Education attainment (Certificate or higher)	No	1.000	1.000		
	Yes	0.414 (0.229,0.746)	0.458 (0.233,0.900)	5.13(1)	0.024

4 Conclusions

- The prevalence of Positive Smoker Identity among smokers in government agencies in Kota Bharu, Malaysia was high (72.3%), which reflected low denormalization of smoking behaviour.
- The employment of measures to dwindle Positive Smoker Identity were imperative and pressing in order to denormalize smoking culture, thus shrinking the prevalence of tobacco smoking.

Further reading

JOURNAL

- Ahmad, H. M., Ibrahim, I. M., Ab Rahman, A., Musa, I. K., Mohd Zin, F., Mohd Zain, R., Hasan, R., Hassan, N., Ahmad, I. & Idris, S. N. (2019). Development and Validation of Positive Smoker Identity Questionnaire (PSmoQi): A New Instrument for Smoking Cessation Correlates. International Journal of Environmental Research and Public Health, 16(3). doi: 10.3390/ijerph16030351

Thanks to

The author would like to acknowledge Dr Mohd Ismail Ibrahim and other fantastic lecturers in the Department of Community Medicine for their continuing support and expertise.

Ethical consideration

Research and Ethical Committee of the Universiti Sains Malaysia (JEPeM) accorded ethical approval for this research (USM/JEPeM/17010063)

Contact information

- Email: haniefahmad@gmail.com
- Twitter: @haniefahmadajil

UNIVERSITI SAINS MALAYSIA

How do Chinese physicians think about electronic cigarettes and its application in smoking cessation?

Authors: [1]Yitian Feng, [1]Pinpin Zheng, [2]Wang Fan, and [3]Abu Abdullah
Affiliations: [1]Fudan University, Shanghai, China,[2]East China Normal University, Shanghai, China ,[3]Duke Kunshan University, Jiangsu, China

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Introduction

With electronic cigarettes (e-cigarettes) gaining popularity recently, it is important to find out what is currently being discussed about e-cigarettes between Chinese physicians and patients. We sought to assess the beliefs, attitudes and practices of e-cigarettes among Chinese physicians, then explore the factors related to their recommendation of e-cigarettes.

Methods

We developed e-cigarettes questionnaire items based on previous research with similar topics. Nationwide physicians were invited to fill out the questionnaire using the platform provided by DXY (www.dxy.cn) during April 26th to May 24th, 2018. In total, 1023 physicians completed the survey, including 692 males and 331 females, with the average age of 36.0 (±7.53) years old. Descriptive analyses were used to characterize participants, and multivariate logistic regression models were applied to evaluate the relationship between physicians' characteristics and the frequency they recommending e-cigarettes.

Results

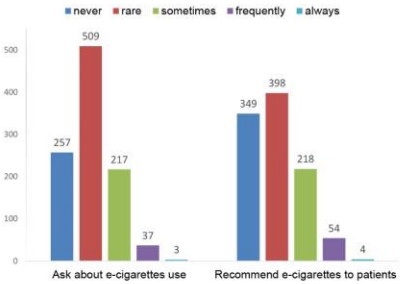
1.The knowledge, attitudes, and confidence of Chinese physicians toward e-cigarettes

Only 46.3% respondents agreed that e-cigarettes had adverse health effects, and 69.6% thought e-cigarettes were safer than conventional tobacco cigarettes. Particularly, 68.6% physicians believed that e-cigarettes can decrease the number of cigarettes smoked, with 66.8% supporting that e-cigarettes can be regarded as a type of smoking cessation treatment. (**Table 1**) Overall, 74.9% of physicians had asked their patients about e-cigarettes use, and 65.9% had recommended e-cigarettes to smokers. (**Figure 1**)

Table 1 Knowledge, attitudes and confidence to deliver e-cigarettes counseling among 1023 Chinese physicians

Statements	N(%)
Knowledge("strongly agree" or "agree")	
E-cigarettes are not safer to use than conventional tobacco cigarettes.	311(30.4)
E-cigarettes could be a "gateway" to other tobacco use.	421(41.2)
E-cigarettes could cause duel use of e-cigarettes and traditional tobacco.	619(60.5)
E-cigarettes have adverse health effects.	474(46.3)
Exposure to secondhand e-cigarettes vapor is harmful.	507(49.6)
E-cigarettes are highly addictive.	467(45.6)
Attitudes toward communicating with patients about e-cigarettes ("strongly agree" or "agree")	
It is important to discuss e-cigarettes with the patients.	627(61.3)
Attitudes toward using e-cigarettes to quit ("strongly agree" or "agree")	
E-cigarettes can decrease the number of cigarettes smoked.	702(68.6)
E-cigarettes can lower the risk of tobacco-related disease.	731(71.5)
E-cigarettes can be regarded as a type of smoking cessation treatment.	643(66.8)
It is better to recommend e-cigarettes to smokers who failed to quit with conventional smoking cessation treatment.	737(72.0)
Confidence ("strongly agree" or "agree")	
I am confident about my ability to answer patients' questions about e-cigarettes.	733(71.7)

Figure 1 The frequency of Chinese physicians asking their patients about e-cigarettes use and recommending to them



2. Multilevel analysis of the frequency of recommending e-cigarettes as a smoking cessation tool

Multivariable logistic regression suggested that respondents who were ever cigarette smokers(OR = 1.68; 95% CI: 1.14-2.46), ever e-cigarettes users (OR = 2.67; 95% CI: 1.54-4.60), more supportive toward e-cigarettes using in quitting(OR = 1.74; 95% CI: 1.33-2.27) and confident about their ability to answer patients' questions about e-cigarettes (OR = 2.44; 95% CI: 1.64-3.64) were more likely to recommend e-cigarettes to patients. Furthermore, physicians who were more agreeable on e-cigarettes' adverse effects (OR = 0.50, 95% CI: 0.37-0.67) were less likely to recommend e-cigarettes frequently as a smoking cessation tool.

Table 2 Odds of high frequency of Chinese physicians recommending their patients about e-cigarettes use

Variable	OR(95%*CI*)
Smoking status*	
Never smoker (referent)	1.00
Ever smoker	1.68 (1.14,2.46)
Have ever use e-cigarettes*	
No(referent)	1.00
Yes	2.67 (1.54,4.60)
Knowledge of e-cigarettes*	0.50 (0.37,0.67)
Attitudes toward using e-cigarettes to quit*	1.74 (1.33,2.27)
Confident about my ability to answer patients' questions about e-cigarettes*	
No(referent)	1.00
Yes	2.44 (1.64,3.64)

Note: *CI* - Confidence interval; OR - Odds ratio.*P < 0.01

Conclusions

E-cigarettes were frequently discussed in the daily clinic activities, and more than half of the physicians had recommended them to smokers. Chinese physicians appeared to ignore the adverse health effects of e-cigarettes, and considered e-cigarettes as a smoking cessation treatment. Physicians need to learn more about the safety and efficacy of e-cigarettes to ensure that patients receive evidence-based recommendation about e-cigarettes using in tobacco cessation.

Support

This study was supported by the National Natural Science Foundation of China (No. 71573047).

复旦大学 健康传播研究所
Health Communication Institute, Fudan University

WIRED Sex

How men who have sex with men use social networking apps to engage in chemsex: A scoping review

Numer, M., Doria, N., Spencer, B., Holmes, D., Patten, S., LeBlanc MA., & Joy, P.

Background

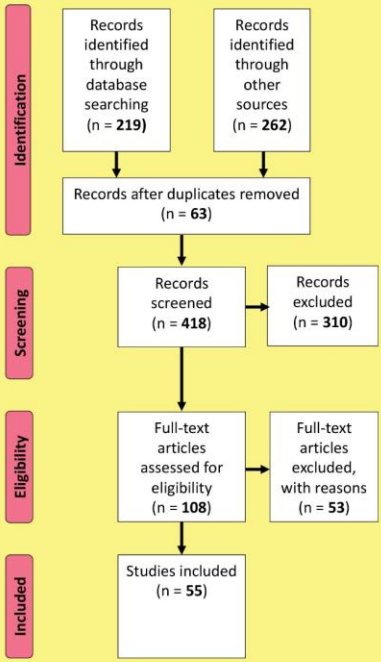
Despite unprecedented pharmaceutical advancements in HIV treatment and prevention, rates of transmission remain consistent among men who have sex with men (MSM). Sex in the technological age is changing in an extraordinary fashion, and virtual space has come to dominate the way MSM meet for sexual encounters. In addition to this new venue and means of communication for connecting bodies, sex is often fuelled by various "chemical" influences such as steroids or recreational drug use. The landscape for prevention and risk management of HIV and other sexually transmitted and blood borne infections (STBBI) has never been so complex. We reviewed the current literature to outline the complexity of the interplay between MSM, various forms of chemicals, and social networking apps.

Methods

We reviewed published abstracts and full articles identified from MEDLINE, Embase, PsycINFO, Scopus, and Sociological Abstracts (January 2008 to August 2018). We included any existing studies that investigated all three of the following: men who have sex with men, various forms of drugs, and social networking apps.

A total of **219** studies were identified from the electronic searches. These studies were screened in Covidence by two reviewers, with discrepancies resolved by a third reviewer. Reviewers independently screened each article at the title/abstract level and full text level; **24** studies were included. Additionally, **167** studies were identified from reference lists and were examined for relevant articles and reviewed with the same process; **15** studies were included. To identify grey literature, relevant stakeholders across Canada were emailed, and electronic searches took place using the database search strategy; **95** studies were identified and **16** grey literature sources were included. Information from all included sources (n=**55**) were charted by one reviewer and checked by a second reviewer.

Final Prisma



Conclusion

This review aimed to illustrate the interplay between MSM, chemicals, and social networking apps. It concluded that online technologies, specifically social networking apps, are creating a culture of chemicals or "chemculture" among MSM. Further, this relationship creates the need for work in HIV and STBBI prevention to reconceptualise community-based efforts within these domains.

DALHOUSIE UNIVERSITY

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

How to Improve Family Planning Messages by Image Mapping: Is There Any Difference Based on Age?

Author (s) : [1]Sarah Handayani, [2]Rita Damayanti, [3]Iwan Ariawan, [4]Fitra Yelda, [5]Douglas Storey
Affiliation : [1]Faculty Of Science Public Health Universitas Muhammadiyah Prof. DR. HAMKA, [2]Centre For Research Universitas Indonesia, [3]Centre For Research Universitas Indonesia, [4]Centre For Research Universitas Indonesia, [5]Department Of Health, Behavior & Society, Johns Hopkins Bloomberg School Of Public Health

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Background/Objectives

Image mapping is one method that can be done in evaluating the level of community preference for a product compared to other similar products. This method is a direct assessment of Family Planning (FP) clients using multi-dimensional scale techniques or correspondent analysis. This study examines the attributes and FP potential client preferences of mix-contraception based on aged and how to improve messages by image mapping.

Methods

This analysis used Improving Contraceptive Method Mix (ICMM) Project in Indonesia which conducted in 2015 by the Center forHealth Research at the Universitas Indonesia. This cross-sectional study was conducted in three districts in the East Java Province three districts in West Nusa Tenggara. The total sample size was 12.945 married women of reproductive age (15-49 years). Multivariat analysis is done using multidimensional scaling (MDS). Ethical clearance for this study was obtained from the Ethics Committee, Faculty of The Public Health Universitas of Indonesia.

Results

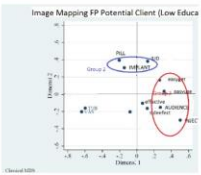
The results of this study indicate that based on age differences, young age segments prefer short-term attributes, namely "easy to use" and "easy to get." Whereas in the middle and old age the preferred attributes have led to the attributes 'effective' and 'long-lasting.'For the young, middle and old age respondents, the first group shows the distance between the audience and contraception and the essential attributes according to their perception. In group one, it was known that the contraceptives they were most interested in were injections with attributes 'easy to use' and 'easy to get.' Group two are pills, IUDs, and implants that go into a group that shows high similarity.

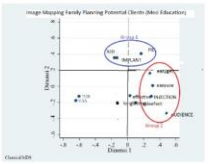
Discussion

This study found no difference between the preference for various contraceptives and attributes based on age. The recommendation for making advocacy media for LAPM contraception improvement is to use characteristics that are easy to use and easily obtained as messages in media. However, because preferences can change over time, it is recommended that FP program managers evaluate audience perceptions regularly. Image mapping is one technique that can be used to improve information, communication and education tools for FP.

Keywords:

Image mapping, FP messages, Health Communication, Health Promotion.





CENTER FOR HEALTH RESEARCH UNIVERSITAS INDONESIA

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ICMM Improving Contraceptive Method Mix in Indonesia

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Identifying factors that predict the experience of social inclusion: A four-country study

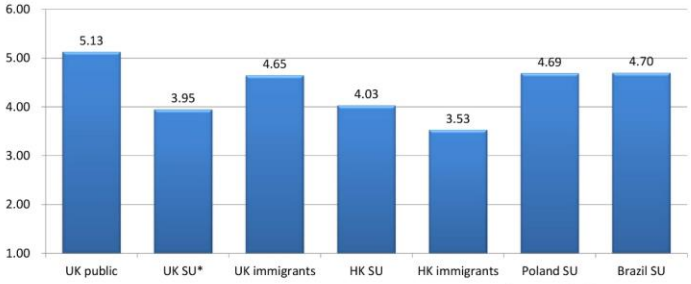
Kara Chan, *Hong Kong Baptist University*; Peter Huxley, *Bangor University*; Marcus YL Chiu, *City University of Hong Kong*; Lukasz Balwicki, *Medical University of Gdansk*; Jussara Carvalho dos Santos, *University of São Paulo (EEUSP) Brazil*

Social inclusion experience

Social inclusion is a key outcome measure of mental health programs and interventions. The Social and Communities Profile (SCOPE) developed in the UK (Huxley et al., 2012) was administered to a sample of 935 individuals, including immigrants, mental health services users, and the public in Brazil, Hong Kong, Poland, and the UK.

Social inclusion did not differ by demographic variables. Respondents who were not mental health services users, who did not have a disability, who had economic means, and frequently having friends to visit their homes experienced a higher level of social inclusion than the other respondents.

Overall social inclusion by society by sub-sample



*SU=mental health services users

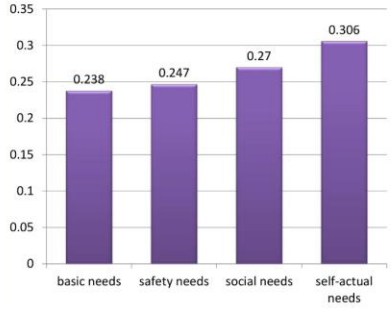
Predicting social inclusion

The Maslow's theory of hierarchical needs provide inspiration for our regression analysis. We categories questions in the SCOPE instrument into five groups, representing basic, safety, social, and self-actualization needs.

The four-country sample demonstrated that basic needs, including employment and accommodation, were crucial in the influence of social inclusion.

Results provide guidance for design of social policies and intervention to encourage social inclusion.

R square of social inclusion predicted by different types of needs in the stepwise regression models



Impact of Child Mortality on Fertility Preferences in Six Sub-Saharan African Nations

Authors: Erin McQuin[1], Hilary Schwandt[1]
Affiliations: [1]Western Washington University

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Introduction

High fertility has been linked with suppressed economic development, shortages in natural resources, and increased risk of mortality—especially infant and child mortality. A current social-behavioral theory suggests a woman's fertility choices are informed by living in a society with high rates of child morality. Since, to a certain extent fertility is a choice, when faced with child mortality declines, how do women respond?

Methods

This quantitative study utilized demographic health survey data from Burundi 2010, Malawi 2015, Rwanda 2015, Tanzania 2015, Uganda 2011, and Zambia 2013. Bivariate and multivariate analyses were conducted on each model to test each association.

Model One: Desire for More Children

The first model in this study, compared a woman's desire for more children and her experiences with child mortality.

Model Two: Ideal Family Size

The second model in this study, compared a woman's ideal family size and her experiences with child mortality

Results

The multivariate analysis of the first model a yielded a significant association between experience of a child's death and desire for more children only for women in Malawi and Rwanda (Table 1). The multivariate analysis of the second model yielded a significant association between the experience of a child's death and ideal family size also only for women in Malawi and Rwanda (Table 2).

Table 1. Model One: Multivariate Logistic Regression Between Experience of Child Death and Desire for More Children for Burundi, Malawi, Rwanda, Tanzania, Uganda, and Zambia

	Country					
	Burundi 2010	Malawi 2015	Rwanda 2015	Tanzania 2015	Uganda 2011	Zambia 2013
Sample Size	7,517	16,140	11,486	10,062	6,405	8,840
Child Death						
Yes	-0.14	-0.22††	-0.33††	-0.14	-0.09	-0.10

†Model significant at p < 0.05 ††Model significant at p < 0.01
Controls: age, wealth, education, number of children, media exposure, employment, geography, marital status.

Table 2. Model Two: Multivariate Logistic Regression Between Experience of Child Death and Ideal Family Size for Burundi, Malawi, Rwanda, Tanzania, Uganda, and Zambia

	Country					
	Burundi 2010	Malawi 2015	Rwanda 2015	Tanzania 2015	Uganda 2011	Zambia 2013
Sample Size	1,613	4,553	2,878	2,228	1,227	2,397
Child Death						
Yes	-0.33	0.65††	0.76†	0.36	-0.43	0.18

†Model significant at p < 0.05 ††Model significant at p < 0.01
Controls: wealth, education, number of children, media exposure, employment, geography, marital status.

Conclusions

- In the Model One multivariate regression, only Malawi and Rwanda demonstrated a relationship that women who experienced a child die, did not want another birth. Both of these countries had the lowest mortality rates within the countries sampled. This suggests that as countries transition to a lower child mortality rate, women broaden their definition of a child's value to the household.
- The second model showed that women who experienced a child die, did desire larger family sizes in Malawi and Rwanda only.
- Both Malawi and Rwanda had the lowest fertility rates within the countries sampled. Also, women from Malawi and Rwanda desired smaller family sizes than women from the other sample countries. This suggests that women who live in countries with lower rates of child mortality, tend to desire smaller family sizes than those who live in countries with higher rates of child mortality.

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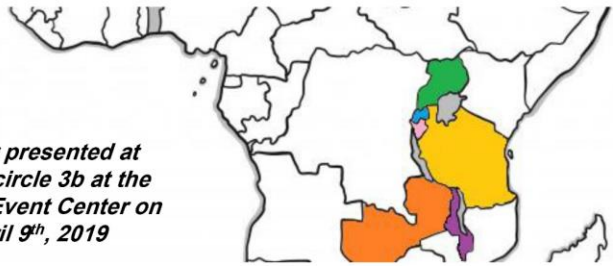

Poster presented at poster circle 3b at the Energy Event Center on April 9th, 2019

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23rd World Conference on Health Promotion

Impact of the sex education with husbands' participation on sexual function of the couples during third trimester of pregnancy

Masumeh Heidariy[1], **Farkhondeh Amin Shokravi**[2*]
1.PhD candidate of Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran; Email: M.heidary@modares.ac.ir
2.PhD, Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, No. 7, Jalal Al Ahmad Street, Tehran 14115-116, Iran. Tel: +09821 82884506; Fax: 009821 82884555;
E-mail: aminsh_f@modares.ac.ir

Background/Objectives: Sexual life is very important during pregnancy, however different condition of the life such as physiological and anatomical changes during pregnancy could affect the sexual life of couples and lack of sex education interventions for couples, caused rigidity of couples .The aim of this study was to evaluating the impact of the sex education with husbands' participation on sexual function of the couples during third trimester of pregnancy.

Methods: This quasi experimental study conducted on 123 couples, allocated to two intervention (A: couples, B: pregnant women) and one control (C) groups. Group (A) couples received sex education, Group (B) women received sex education without their spouses, and Group (C) women received routine prenatal care without sex education (control). The intervention groups received sexual counseling based on PLISSIT model by a trained midwife tow session lasted 90 minutes end of first trimester. Also, telegram was applied to send the contents about the sexual activities in pregnancy to couples and the written educational booklet was handed out to the intervention groups. Sexual functions and sexual satisfaction of couples were assessed by FSFI, IIEF, WMSSQ and ISS questionnaires, before sex education, four weeks after the intervention, end of second trimester and end of third trimester. The data were analyzed by independent t-test, chi-square, ANOVA, Tukey's test and ANOVA for repeated measures in SPSS v16.

Results: No significant differences found in demographics variables of the subjects. Mean total scores of FSFI, IIEF, WMSSQ and ISS were not different at baseline in three groups. Repeated Measure analysis showed significant differences between groups (A&B with C) in the mean total scores of during third trimester. The mean total scores of FSFI, IIEF, WMSSQ and ISS of two intervention groups of A and B were not significant.

Discussion: Sex education for prenatal care would be effective even if the participation of their spouses was not satisfactory. Then sex education of pregnant women alone could result on the benefit of less time and resources allocation and saving the national capitals.

Keywords: Sex education; Couple; Pregnancy; Sexual function; sexual satisfaction; plissit model.

Implementation of Kangaroo Mother Care (KMC) Program in Depok District General Hospital, West Java, Indonesia

Authors: Evi Martha[1*], Hadi Pratomo[2], Tiara Amelia[3], Caroline EW[4], Indah Jamiatun H[5], Zakiah[6]
Affiliation: [1,2,3,4,5] Universitas Indonesia, Depok, Indonesia; [6] Municipal Health Office, Depok, Indonesia

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Background :

Low Birth Weight Infants (LBWIs) is a serious problem as it affects both life-expectancy and quality of life of 30-50% of newborns. KMC is an effective care for LBWIs because KMC can improve their health outcomes, and at the end it could reduce the neonatal mortality rate. In fact, the KMC is more efficient than the use of incubators. In Depok District General Hospital currently the care for LBWIs depend mostly on the use of incubators which are limited and costly. Increasing cases of LBWIs in the hospital requires more effective newborn care

Methods:

This study used both quantitative and qualitative approaches. The quantitative research used a pre-post-test design to measure the difference of KMC knowledge among 32 health personnel. A 2 day KMC training by professional team was performed. A self-administered questionnaire consisting of 20 items concerning KMC knowledge was performed. The qualitative research employed A Rapid Assessment Procedure using in-depth interview (10 management and health staf) and 2 Focus Group Discussion methods (of health workers in Depok District Hospital). This part was aimed to understand the implementation of KMC after training and its obstacles in implementation.

Results:

KMC training by Faculty of Public Health, Universitas Indonesia and The Indonesian Society for Perinatology (Perinasia) was given to 32 health staff from the hospital, Depok Municipal Health Office (MHO) and Basic Obstetric Neonatal Emergency (PONED) Health Centers have succeeded to increase knowledge as much as 38.58%. However, this number is still small compared to the number of health workers related to KMC services in hospital, MHO and health centers that should have standardized knowledge and skills about KMC. Although the hospitals already have KMC Standard Operating Procedure (SOP) but knowledge and skill of policy-makers and health workers vary. Moreover, KMC facilities owned by the hospital is still limited. Thus, the implementation of standardized KMC still needs a long time.

Nevertheless, KMC training that has been done was able to trigger the development of policies, facilities, knowledge and skills of KMC in hospital and MHO along with 2 Poned Health Centers. This can be seen from the making of KMC SOPs at the hospital after the training was done, the nurses who have attended the training start applying education and practice of KMC to LBWs patient in accordance with the standard, budgeting allocation fund to complete the KMC facilities, develop nurses skills in KMC, plan of utilization of space for NICU services complete with necessary facilities in new hospital buildings. This shows the hospital's commitment to the implementation of KMC.

Discussion:

Most health workers who directly related to the care of LBW babies already know the concept and principles of KMC. They believe this method is cost-efficient, easy and safe to treat LBW babies. Benefits of KMC for infants and families include preventing hypothermia, facilitates breastfeeding to accelerate weight gain, provide comfort for the baby, build closeness between the baby and family, and more economical. KMC benefits not only the baby and family, but also health workers as they feel KMC could ease their work because the family helps in taking care of the baby at home, and relieving the hospital burden because there was no need to use an incubator and time efficient.

On the other hand, the successful implementation of KMC in hospital should be in line with LBWs referral from hospital to Health Center or LBW's homes as well as vice versa. However, apparently the referral associated with LBW is still a challenge in itself. Although, concept of health service regionalization has been discussed, the regulation itself does not yet exist. Meanwhile, the mayor of Depok city government still sees the priority of access and existence of hospital services.

Conclusion:

The KMC training has succeed to increase knowledge 38.58% among 32 health staff from hospital, MHO and Health Centers. However, the number of trained personnel still needs to be increased.In addition, the KMC knowledge among health workers who work with LBW, and the hospital management should be improved. Moreover, after KMC training, the implementation of KMC was changed to better practice.There was SOPof KMC but the practice needs to be consistent with the SOP among health workers in order to increase the quality as well. Unfortunately, the KMC practice is still facing limited facilities, budget and resources. Therefore, there is still a need for advocacy to the management of hospital and MHO to maintain process of KMC implementation, which is standardized and has good quality so that has significant impact on increasing quality of life among LBW.

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KMC Training Attendant

Corresponding Author: evie.martha@ui.ac.id

Improving Cognitive Function in Elderly People by Mental Abacus Training—a Single Arm Pilot Study

Li-Kai Huang[1], Chaur-Jong Hu[1], Yao-Mao Chang[2]
1Department of Neurology, Shuang Ho Hospital, Taipei Medical University
2Health Policy and Care Research Center, College of Public Health, Taipei Medical University

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Purpose:

Mental abacus (MA) training is a potential tool for enhancing cognition function. However, there is no related research in the elderly people.

Participants and methods:

This prospective, single arm, pilot study was conducted to evaluate the effectiveness of MA training on cognitive function in the elderly. Cognitive function was assessed at the baseline and 3 months when training completed by use of Taiwanese Version of the Montreal Cognitive Assessment (MoCA) and Color Trails Test 1 and 2 (CTT1and 2). Participants with MoCA<26 were subgrouped as in high risk group, while MoCA≥26 as low risk group. All statistical analyses were conducted by student-t and chi-square test with SAS Version 9.4, considering two-sided probabilities.

Results:

Total 80 participants completed MA training. Their mean age was 65.7±7.0 years. MoCA total score was 24.6±3.7 and CTT1 time, 71.3±46.5 seconds, CTT2 time, 132.2±85.4 seconds at baseline. After MA training, MoCA total score was 26.4±3.2, CTT1 time, 68.0±51.3 seconds and CTT2 time115±72.7seconds. In the high risk group, after MA training, the MoCA scores, CTT1 time and CTT2 time were 25.0±4.0, 72.2±55.2 seconds and 123.6±53.0 seconds. Those showed improvement on MoCA ($p<0.0001$) and CTT2 ($p<0.0001$) by comparison with the baseline in overall participants and high risk group. In the low risk group, after MA training, the MoCA scores, CTT1 time and CTT2 time were 28.0±1.7, 58.8±39.0 seconds and 89.8±22.1 seconds, which improved only on CCT2 ($p<0.0001$) by comparison with baseline. High risk group showed greater improvement on MoCA total score than low risk group (3.0±3.4 V.S., 0.3±2.0, p=0.0140). The improvement of CTT1 and CTT2 were not different between groups.

Table 1 Demographic and clinical characteristics of the study groups

	All participants (N=80)	High risk group (N=48)	Low risk group (N=32)	p-value
Age (years)	65.7±7.00	66.7±7.8	64.1±5.2	0.0706
Gender (male)	14(17.5%)	8(16.67%)	6(18.8%)	0.8101
Education (years)	12.7±3.2	11.9±3.4	13.9±2.4	0.0027*
MoCA	24.6±3.7	22.0±4.3	27.8±1.6	<0.0001*
CTT1 (second)	71.3±46.5	78.2±56.4	60.1±23.2	0.0619
CTT2 (second)	132.2±85.4	136.3±56.0	104.3±33.1	0.0086*

Table 2. Cognition assessments in the baseline and post training in high risk and low risk groups.

		Baseline	Post-training	p-value	Difference	p-value
MoCA	All (N=80)	24.6±3.7	26.4±3.2	<0.0001*		
	High risk group (N=48)	22.0±4.3	25.0±4.0	<0.0001*	3.0±3.4	0.0140*
	Low risk group (N=32)	27.8±1.6	28.0±1.7	0.4258	0.3±2.00	
CTT1 (seconds)	All (N=74)	71.3±46.5	68.0±51.3	0.4473		
	High risk group (N=44#)	78.2±56.4	72.2±55.2	0.3105	-3.6±23.1	0.7702
	Low risk group (N=30#)	60.1±23.2	58.8±39.0	0.9388	-0.6±42.4	
CTT2 (seconds)	All (N=75)	132.2±85.4	115±72.7	<0.0001*		
	High risk group (N=44##)	136.3±56.0	123.6±53.0	<0.0001*	-69.0±34.4	0.9002
	Low risk group (N=31##)	104.3±33.1	89.8±22.1	<0.0001*	-45.7±46.3	

MoCA= Taiwanese Version of the Montreal Cognitive Assessment, CTT1= Color Trails Test 1, CTT2= Color Trails Test 2, High risk group indicates MoCA<26. Low risk group indicates MoCA≥26. Adjustment for age and education level, * p-value<0.05, # indicates that 4 participants in high risk group and 2 in low risk group refused the tests. ## indicates that 4 participants in high risk group and 1 in low risk group refused the tests.

Conclusion:

MA training enhances cognitive function in the elderly, especially in the group with low baseline MoCA scores. Controls without MA training for confirming its effects are warrant in the future.

Acknowledgments

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Disclosure

We declare that there are no financial or other personal conflicts of interest associated with this paper. This human study was approved by the Institutional Review Board of Taipei Medical University and was therefore performed in accordance with ethical standards in the 1964 Declaration of Helsinki and its later amendments.

Influence of school meals on the consumption of ultra-processed food by Brazilian adolescents

IUHPE 23rd World Conference on Health Promotion

Noll, PRS[1,2]; Noll, M[2]; Abreu, LC[3]; Baracat[1], EC; Silveira, EA[4]; Sorpreso, ICE[1]

[1] Instituto Federal Goiano (priscilla.noll@usp.br)
[2] Faculty of Medicine, Universidade de São Paulo
[3] Faculty of Medicine, ABC
[4] Faculty of medicine, Universidade Federal de Goiás

Aim

To evaluate the influence of school meals on the consumption of ultra-processed foods, candies, and soft drinks by Brazilian adolescents.

Methods

Cross-sectional study using the National School Health Survey 2015 database.

- ✓ A sample of 101,898 Brazilian adolescents enrolled in the 9th;
- ✓ Outcome: the consumption of ultra-processed salty foods, candies, and soft drinks;
- ✓ Multivariate analysis with a robust variance was performed.

Table 1 - Multivariable analyses of factors associated with the consumption of industrialized/ultra-processed salty foods, sweets or candies, and soft drinks.

	Ultra-processed salty foods [a]		Sweets [a]		Soft drinks [a]	
Variable	**PRa (95% CI)**	**p**	**PRa (95% CI)**	**p**	**PRa (95% CI)**	**p**
Municipality		**<0.001**		0.144		**<0.001**
Not capital	1		1		1	
Capital	1.09 (1.06–1.11)		1.02 (0.99–1.04)		1.03 (1.02–1.04)	
School		**<0.001**		0.140		
Public	1		1			
Private	1.29 (1.23–1.35)		0.97 (0.93–1.01)			
Sex		**<0.001**		**<0.001**		**<0.001**
Male	1		1		1.02 (1.01–1.03)	
Female	1.12 (1.10–1.15)		1.35 (1.33–1.38)		1	
Age (years)		**<0.001**		**<0.001**		**<0.001**
11–13	1		1		1	
14	0.98 (0.95–1.01)		1.01 (0.98–1.03)		1.01 (0.99–1.03)	
15	0.98 (0.94–1.01)		0.98 (0.95–1.02)		1.04 (1.03–1.06)	
16–19	0.89 (0.85–0.93)		0.92 (0.88–0.96)		1.05 (1.03–1.07)	
Availability of food at school						
PNAE		**0.014**		0.463		0.874
Yes	1		1		1	
No	1.06 (1.01–1.11)		1.02 (0.97–1.06)		1.00 (0.98–1.02)	
School cafeteria		**<0.001**		**<0.001**		**0.011**
No	1		1		1	
Yes	1.05 (1.02–1.08)		1.09 (1.07-1.11)		1.02 (1.01–1.03)	

Conclusion

Students who attend schools covered by the PNAE have a lower likelihood of consuming ultra-processed foods, whereas those who study in schools with cafeterias have a higher risk of consuming such foods.

INNOVATIONS IN TEACHING HEALTH PROMOTION IN THE PRIMARY HEALTH CARE CONTEXT: A SUCCESSFUL EXPERIENCE WITH ACTIVE LEARNING AT THE MEDICAL SCHOOL

Juliana da Rosa Wendt[1]; Darcieli Lima Ramos[1]

[1] Clinical Medicine Department, Federal University of Santa Maria – Santa Maria, Brazil

IUHPE 23rd World Conference on Health Promotion

Rotorua, 2019

SETTING / PROBLEM

- Over the past decade, reform efforts in health care education curriculum have emphasized the importance of active learning to improve student engagement and critical thinking skills.
- Although active learning is widely recommended for medical education, faculty are sometimes hesitant to transform teaching practice.
- In our medical school, the traditional teaching style was still very predominant over active learning experiences.

INTERVENTION

OUTCOMES

STUDENTS

- ❑ High levels of satisfaction and engagement with this discipline;
- ❑ Empowered as learners and as future physicians;
- ❑ Prone to incorporate Health Promotion in their professional practice.

TEACHERS

- ❑ Very fulfilling experience for the teachers;
- ❑ High levels of satisfaction and engagement with this discipline;
- ❑ Stimulated continuing professional education in Health Promotion.

OVERALL

- ❑ Promoted critical learning in Health Promotion;
- ❑ Developed health promotion actions in the community setting;
- ❑ Improved the University-community relationship.

IMPLICATIONS

- The experience of active learning in Health Promotion in the Primary Health Care 1 discipline was successful, helped empowering first year medical students as protagonists of their learning process, and is easily replicable in other medical schools.

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Conflits of Interest Declaration

The authors declare they have not received any payment from a third party for this work and do not have any conflicts of interest to declare.

Innovative approaches for behaviour management ——precision prevention for progression from mild cognitive impairment to Alzheimer's Disease

Authors: : Qianyi Xiao[1], Jianxiong Xi[1], Ding Ding[2], QianhuaZhao[2], Hua Fu[1], Zhen Hong[2]
Affiliations: [1]School of Public Health, Fudan University, China. [2]Huashan Hospital, Fudan University, China.

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Background/Objectives

Mild cognitive impairment (MCI) is an intermediate state between normal aging and dementia and it is a stage in which intervention could be effective in reducing the conversion rate to dementia[1]. In the present work, we aimed to evaluate the effect of precision prevention on progression from MCI to AD using the innovative approaches based on genetic risk information and modifiable behaviour. As cholesterol represent easily modifiable behaviour targets, we examined cholesterol-genetic interactive effect on MCI-AD progression.

Methods

At the baseline of the Shanghai Aging Study (2010-2011), we established a sub-cohort with 655 MCI participants aged 50 and over reside in Jinganssi community in downtown Shanghai. The present study sample comprised 316 participants who were prospectively followed up for 4.5-years (Fig. 1). The cholesterol effects on MCI-AD progression were assessed not only among total MCI participants, but also in stratified genetic-risk subgroups using cox regression model.

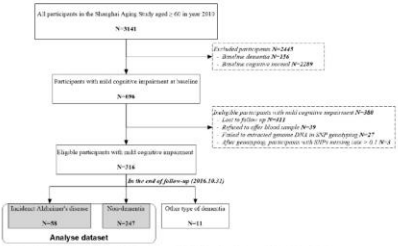

Fig. 1 Flow chart of the MCI cohort study in the Shanghai Aging Study

Results

- Genotype effects on MCI-AD progression.

Table 1 showed the baseline characteristics of MCI participants included in analysis. Among the 35 selected AD-associated single nuclear polymorphism (SNP) identified in genome wide associated study (GWAS), *ABCA7 rs4147929* and *PVRL2 rs6859* were significantly associated with MCI-AD progression (AG/AA vs. GG, HR=1.89, p=0.026, and AG/AA vs. GG, HR=2.34, p=0.019, respectively) (Table 2).

Table 1 Baseline characteristics of included MCI participant

Characteristics	MCI Participants included in analysis (n=305)		
	Incident AD (n=58)	Non-dementia (n=247)	P Value
Age, (y)	78.5 ± 4.99	71.27 ± 8.02	< 0.001
Female, n (%)	33 (56.9)	137 (55.5)	0.481
APOE ε4 positive, n (%)	15 (28.8)	45 (19.1)	0.088
MMSE scores	25.31 ± 3.29	27.47 ± 2.07	< 0.001
Education years, (y)	8.72 ± 5.10	10.89 ± 4.22	0.004
CES-D score	11.60 ± 10.59	9.64 ± 8.63	0.193
BMI, kg/m²	23.58 ± 3.42	24.64 ± 4.0	0.043
Diabetes mellitus, n (%)	10 (17.2)	43 (17.5)	0.569
Hypertension, n (%)	34 (58.6)	134 (54.3)	0.325
Stroke, n (%)	15 (25.9)	32 (13.0)	0.015
CHDs, n (%)	9 (15.5)	32 (13.0)	0.375
Smoking, n (%)	6 (10.3)	28 (11.4)	0.518
Drinking, n (%)	3 (5.2)	26 (10.5)	0.158
TC, mmol/L	5.12 ± 1.30	5.26 ± 1.00	0.474
HDL-C, mmol/L	1.33 ± 0.40	1.34 ± 0.34	0.950
LDL-C, mmol/L	3.09 ± 1.00	3.29 ± 0.91	0.183

Table 2 Significant SNPs for risk of MCI-AD progression

Variants	Total	Case	Hazard Ratio (95%CI)	P Value[a]	Gene Pathway
ABCA7 rs4147929				0.026	Lipid metabolism and immune response
GG	155	26	1		
AG/AA [a]	149	32	1.89 (1.08-3.32)		
PRVL2 rs6859				0.019	Cholesterol and lipid metabolism
GG	131	13	1		
AG/AA [a]	166	44	2.34 (1.15-4.74)		

[a] Multivariate Cox regression model adjusting for age, gender, APOE and education years.
[b] Risk genotypes.

- Serum cholesterol effects on MCI-AD progression in total sample.

No significant association was found between TC, HDL-C, LDL-C concentration and MCI-AD progression in total samples (Fig. 2).

- Serum cholesterol effects on MCI-AD progression in stratified genetic risk subgroups.

Combining the two significant SNPs (*ABCA7 rs4147929* and *PVRL2 rs6859*) and *APOE ε4*, we stratified the MCI participants into low (carrying 0-1 risk genotype) and high (carrying 2-3 risk genotypes) AD genetic-risk groups. In low AD genetic-risk group, no significant association was found between TC, HDL-C, LDL-C concentration (either in continues or category data) and MCI-AD progression (Fig. 2, Fig. 3 A for LDL-C).

However, in high AD genetic-risk group, each-1 mmol/L higher level of LDL-C was associated with 40% decreased risk of MCI-AD progression (HR=0.58, 95%CI: 0.38-0.88, *p*=0.010) (Fig. 2). MCI participants with medium LDL-C (2.6-3.4 mmol/L) and high LDL-C (> 3.4 mmol/L) have significant decreased cumulative risk of AD compared with those with low LDL-C (< 2.6 mmol/L) which was recommend LDL-C lowering value for high cardiovascular risk[3] (*p for trend*=0.006) (Fig. 3B).

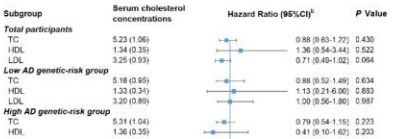

Fig. 2 The association between cholesterol and MCI-AD progression in total participants and stratified AD genetic-risk subgroups. *APOE ε4*, *AG/AA* in *ABCA7* rs4147929, and *AG/AA* in *PVRL2* rs6859 were defined as three risk genotypes. Serum cholesterol concentrations were showed in continuous scales and presented as mean (SD). The cox regression model was adjusted for age, gender, education years and vascular risk factors (BMI, CHDs, DM, hypertension, stroke, smoking, drinking). In total participants, the model was further adjusted for *APOE*.

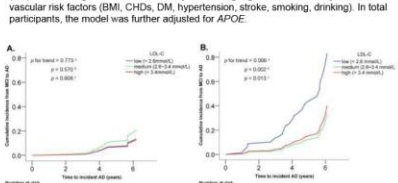

Fig.3 Cumulative conversion rate from MCI to AD between different LDL-C category levels in stratified genetic-risk groups. A. low AD genetic-risk group. **B.** high AD genetic-risk group. These graphs are based on age-, gender-, and education-adjusted Cox. [a] *p* value for trend of three LDL-C category levels; [b] *LDL-C* medium level Vs. low level. [c] *LDL-C* high level Vs. low level.

Conclusion

- Our results suggested that maintaining the medium to high LDL-C level may be beneficial for MCI individuals with high AD genetic-risk to prevent AD onset.
- As LDL-C is also an important risk factor of cardiovascular disease, clarifying the role of LDL-C in the context of AD genetic risk could advance current knowledge on the elderly health.
- It is important and innovative to apply the genetic information into behaviour management to better promote the elderly health.

Acknowledgement:

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GLOBAL HEALTH LITERACY ACADEMY

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The study was commissioned by Merck & Co., Inc

Integration of cancer literacy in cancer control planning

- a document analysis of 45 national cancer control plans from Europe and beyond

Kristine Sørensen, PhD

Global Health Literacy Academy, Denmark | www.globalhealthliteracyacademy.org | contact@globalhealthliteracyacademy.org

1. Introduction

- **The aim of this study was to conduct a systematic assessment of National Cancer Control Plans (NCCPs) in Europe and beyond regarding health literacy and cancer literacy.**
- According to the World Health Organization a **national cancer control programme (NCCP)** is a public health programme designed to reduce the number of cancer cases and deaths and improve quality of life of cancer patients. This is done by implementing systematic, equitable and evidence-based strategies for prevention, early detection, diagnosis, treatment and palliation using available resources. The NCCP helps reduce the cancer burden and improve services for cancer patients and their families.
- **Health literacy** refers to how people access, understand, appraise and apply information to form judgement and make decisions regarding healthcare, disease prevention and health promotion to maintain and improve quality of life during the life course. Health literacy helps people to make informed and aware decisions, which are important aspects in an increasingly complex health care system.
- **Cancer literacy** is an important aspect of cancer control and continuum of care. Yet, it is unclear to what extent cancer literacy is reflected in cancer strategies such as the NCCPs.

2. Methods

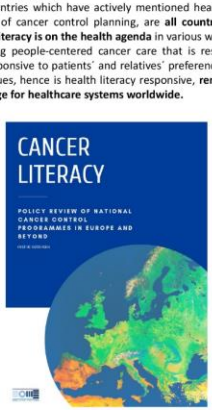
- The study design built on **document analysis** which is a systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material.
- The aim was to identify 25+ NCCPs to be included in the study, primarily from the European Union Member States.
- NCCPs were **retrieved in the period of August to November 2018** from online portals such as the International Cancer Control Partnership and Google as well as through key informants specialised in public health and health literacy.

3. Results

- The **data collection yielded 45 NCCPs** of which 31 originated from the European Union Member States. The remaining NCCPs represented countries from across the world, primarily English and Spanish speaking countries.
- **The document analysis revealed that seven out of 45 NCCPs specifically included the term health literacy including Austria, Belgium, Germany, Portugal, New Zealand and Maryland, the U.S.**
- **Only one NCCP entailed the term 'cancer literacy'**, namely the plan from Maryland, the U.S. which had a section focusing on 'oral cancer literacy', specifically.

4. Concluding remarks

- Although, it is widely recognized from the practice implications that improving the health literacy of the population can be an effective strategy to promote a more (cost)-effective use of the healthcare services and thus contribute to population health, **the present document analysis of NCCPs reveals that 'health literacy' in general and 'cancer literacy' in particular, have not yet been commonly accepted and implemented mainstream as part of NCCPs in Europe and beyond.**
- The countries which have actively mentioned health literacy as part of cancer control planning, are **all countries where health literacy is on the health agenda** in various ways.
- Providing people-centered cancer care that is respectful of and responsive to patients' and relatives' preferences, needs, and values, hence is health literacy responsive, **remain a key challenge for healthcare systems worldwide.**



5. Future avenues

Future avenues for improving the integration of 'health literacy' and 'cancer literacy' as priority areas for NCCPs in Europe and beyond could include to:

- **monitor** the trends regarding the manifestation of health literacy and cancer literacy in NCCPs across the world,
- **increase the awareness of health literacy and cancer literacy and its relevance among decision-makers and policy-makers** at nationally and international to improve strategic planning concerning cancer,
- **increase the responsiveness to health literacy and cancer literacy among health professionals** dealing with cancer management,
- **increase the responsiveness to health literacy and cancer literacy within organizations** related to cancer management,
- **increase the responsiveness to health literacy and cancer literacy within the cancer patient community** to make patients aware of the importance for quality of care.

Integrating screening and care for gestational diabetes and prevention of type 2 diabetes with the prevention of mother-to-child transmission of HIV at primary health care level: Perspectives of key informants versus frontline health workers in South Africa

Jean Claude Mutabazi[1,2], Lorrein Muhwava6, Helen Trottier[1,3], Christina Zarowsky[1,2,4], Shane Norris[4,5], Katherine Murphy[6], Naomi Levitt[6]

[1] École de Santé Publique, Université de Montréal; [2] Institut de Recherche en Santé Publique de l'Université de Montréal; [3] Centre Hospitalier Universitaire Sainte-Justine; 4 School of Public Health, University of the Western Cape; 5 School of Clinical Medicine, University of the Witwatersrand; 6 Faculty of Health Sciences, University of Cape Town .

Contact email: mutajeanc@yahoo.fr

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Background

- Prevention of mother-to-child transmission (PMTCT) of HIV has been shown to reduce transmission at more than 95% and has been successfully integrated and influenced other maternal and child health services at primary health care (PHC) in South Africa (1,2).
- Some pregnant women enrolled under PMTCT are also diagnosed with gestational diabetes (GDM).
- GDM is glucose intolerance recognised for the first-time during pregnancy. GDM increases risk for type 2 diabetes (T2D) for women and their babies, a disease that can be prevented or delayed by lifestyle intervention in postpartum (3).
- GDM is managed at tertiary level in South Africa and the main challenge is that women with GDM must navigate the fragmented health systems for their care and there is no follow-up for these women and their babies in many countries of the developing world (4).
- This situation with other working programmes supports the calls for integrating these services or the same population like PMTCT.

Objective

- To explore the perspectives of health care leaders/researchers considered as key informants (KI) versus frontline health workers (FHW) or health services providers in South Africa on how to integrate the screening and care of GDM and prevention of T2D for women and their exposed babies with the PMTCT cascade at PHC level.

Methods

- Qualitative research design
  - Semi-structured interviews conducted
  - 10 KIs + 9 FHWs
- 19 semi-structured interviews
  - Were in person and were audiotaped and transcribed.
  - Two investigators independently coded transcripts
  - Atlas.ti software used to assist in data analysis/management.

Results

- ✓ All the KI and FHW agreed on the potential of integrating the screening and care of GDM and prevention of T2D for women and their exposed babies into the PMTCT at PHC level.
- ✓ KI stated that the process of such an innovative approach like integration would be slow and mostly limited to the clinics with well-established antenatal and postnatal care.
- ✓ KI pointed out poor quality of care (fidelity to guidelines), shortage and poor training of staff while the FHW emphasized work overload, high staff turnover and infrastructure issues as major challenges to this needed integration.
- ✓ Working with community health workers helps to bring back women and their babies for postpartum follow-up, screening and lifestyle intervention for more health equity at PHC level.

Conclusion

- ➢ There are multiple barriers to integrating the screening and care of GDM and prevention of T2D into PMTCT in South Africa, especially to postpartum follow-up care.
- ➢ Our results will help stakeholders to correct operational challenges towards more integrated and equitable services.

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WAIORA: Promoting Planetary Health and Sustainable Development for All

Interactive Analytics of Food System Metrics for Health Promotion

Matilda O. Johnson, Bryanna Campos, Chomel Johnson, Thometta Cozart, Raphael D. Isokpehi

Bethune-Cookman University, Daytona Beach, Florida, United States

Correspondence: johnsonma@cookman.edu

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Background

- **Community-Based Food System is a complex system with metrics in the categories of 7 principles, 12 topics and 25 strategies (2012 American Planning Association Report on Community-based Food System).**
- **There is diverse and continuously expanding data assets on food system metrics.**

7 Food System Principles:
Health Promoting, Sustainable, Resilient, Diverse, Fair, Economically Balanced and Transparent

12 Food System Topics:
Rural Agriculture, Urban Agriculture, Processing, Distribution, Local Sourcing, Retail, Marketing and Advertising, Access & Availability, Federal Assistance, Community Assistance, Food Education and Waste

25 Food System Strategies:
Support (9), Reduce (2), Promote (1), Preserve (1), Improve (10), Facilitate (1), and Engage (1).

Improve Food Access Strategies:
- Community Gardens
- **Farmers Markets**
- Supermarkets or other large grocery stores

Support
foods
regional
sold
access
system
healthy
gardens
local
community
infrastructure
Improve
food
variety
production
farms
offered
fast
agriculture
eg
new
stores
small
opportunities
urban
grocery
agricultural
distribution
restaurants
Reduce

Objectives

- **Design and Implement computational resources that support the interaction between food system stakeholders and the complex information for health promotion.**

Methods

- **We are constructing datasets and interactive visualizations to support the performance of complex cognitive activities including planning, decision-making and knowledge discovery for health promotion.**
- **Examples of Complex Information for Health Promotion are (1) Food Access Research Atlas, and (2) Directory of Farmers Markets.**
- **With a focus on food access, 16 variables relevant to food access from the United States Department of Agriculture's Food Access Research Atlas were used to construct a 16-digit binary number for 72,864 census tracts in the United States.**
- **The dataset on food access pattern in census tracts was blended with dataset on farmers markets.**

Variables in Food Access Research Atlas for constructing binary number for census tracts.

Field [1]	LongName	Position in Binary Number
Urban	Urban tract	1
GroupQuartersFlag	Group quarters, tract with high share	2
LILATracts_1And10	Low income and low access tract measured at 1 mile for urban areas and 10 miles for rural areas	3
LILATracts_halfAnd10	Low income and low access tract measured at 1/2 mile for urban areas and 10 miles for rural areas	4
LILATracts_1And20	Low income and low access tract measured at 1 mile for urban areas and 20 miles for rural areas	5
LILATracts_Vehicle	Low income and low access tract using vehicle access or low income and low access tract measured at 20 miles	6
HUNVFlag	Vehicle access, tract with low vehicle access	7
LowIncomeTracts	Low income tract	8
LA1and10	Low access tract at 1 mile for urban areas and 10 miles for rural areas	9
LAhalfand10	Low access tract at 1/2 mile for urban areas and 10 miles for rural areas	10
LA1and20	Low access tract at 1 mile for urban areas and 20 miles for rural areas	11
LATracts_half	Low access tract at 1/2 mile	12
LATracts1	Low access tract at 1 mile	13
LATracts10	Low access tract at 10 miles	14
LATracts20	Low access tract at 20 miles	15
LATractsVehicle_20	Low access tract using vehicle access and at 20 miles, in rural areas	16

[1] The 16-digit binary number (FoodAccessPattern) encodes the values for all the 16 Food Access Research Atlas (FARA) "flag" variables. Thus, a pattern of "1000000000000000" indicates an urban census tract that is not in a food desert, not having high share of group quarters, not having the LILA or LA variables; not a low income tract and having high vehicle access.

Overview of Methods for Interactive Analytics of Food System Metrics for Health Promotion

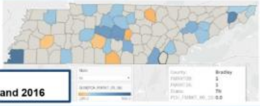
Subgroups of Census Tracts by Food Access Pattern

FoodAccessPattern	USA	TN	TN FM
0000000000000000	8698	280	10
0000000011000100	1509	20	1
0000000011100111	178	0	0
0000000100000000	3013	180	7
0000001000000001	1170	42	5
0000001011000101	181	5	0
0000001011100111	7	0	0
0000011100000001	1549	71	14
0011000111000100	816	25	2
0011011111000101	320	6	0
0011110111100111	139	0	0
0011111111100111	60	0	0
0100000000000000	33	2	1
0100000011000100	7	0	0
0100000011100111	3	0	0
0100000100000000	25	0	0
0111000111000100	4	0	0
0111110111100111	1	0	0
1000000000000000	2888	4	0
1000000001010000	9611	73	4
1000000011111000	13268	299	23
1000000011111001	1	0	0
1000000100000000	5674	16	1
1000001000000001	2	0	0
1000001001010001	1221	6	1
1000001011111001	3028	63	8
1000011100000001	22	0	0
1001000101010000	6895	106	11
1001011101010001	4313	85	10
1011100111111000	3367	85	5
1011110111111001	2	0	0
1011111111111001	4439	149	18
1100000000000000	24	1	0
1100000001010000	88	1	1
1100000011111000	122	1	0
1100000100000000	32	1	1
1101000101010000	91	1	0
1101011101010001	12	0	0
1111100111111000	94	5	0
1111111111111001	13	0	0
	72864	1497	121

Results

- **The census tract dataset and interactive visualizations were applied to discover knowledge on the relationships between access to farmers markets and the locale (urban versus rural).**
- **A case study of 121 census tracts (81 urban, 40 rural) from a jurisdiction is available as an interactive analytics resource (http://bit.ly/afoodsys).**
- **Users of the resource can explore data filters (for example, food access pattern and urban status) to answer specific questions about the data.**

Selected Census Tracts in Tennessee, USA: Food Desert Status and Urban Status
Food Access Pattern
County
Census Tract
Farmers Market
0000000000000000
0011000111000100
1000000001010000
1011100111111000
1100000001010000
1100000100000000
Food Desert
No
Yes
Urban
No
Yes



Changes in count of Farmers Market 2009 and 2016

Farmers markets in census tracts

WAIORA: Promoting Planetary Health and Sustainable Development for All

Intimacy and sex after a heart attack

Australian health professionals' current attitudes and practice

Authors: Ms Kara Lilly[1], Dr Jane Taylor[1], Ms Rachelle Foreman[2], Dr Claire Moran[3]
Affiliations: University of the Sunshine Coast[1], National Heart Foundation of Australia[2], True Relationships and Reproductive Health[3].

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Background

Heart attack survivors experience physical, psychological and social challenges that can impact their quality of life, including sexual activity[1-7]. A 2014 National Heart Foundation Australia survey found 55% of heart attack survivors had not spoken to a health professional about sexual activity after their heart attack or been provided with related information[8].

In practice, research indicates that health professionals do not routinely provide information or initiate discussion with cardiac patients about sexual activity[9-14]. Barriers to providing advice include lack of knowledge in counselling patients about sexual activity and time constraints[13,14].

This study investigated the current attitudes and practices of Australian health professionals toward providing advice on sexual activity and intimacy to patients who have had a heart attack.

Methods

An online, self administered survey was distributed to Australian health professionals via a range of professional association and networks (eg. Australian Cardiovascular Health and Rehabilitation Association). The survey comprised quantitative questions related to health professionals' current attitudes and practices in discussing sexual activity and intimacy with clients post heart attack, and qualitative questions related to professional development and resource needs. Descriptive statistics were used to analyse quantitative data and qualitative data was analysed thematically (not reported here).

Results

Survey respondents (N=252) included nurses (56%), cardiac rehabilitation specialists (9%), physiotherapists (7%), cardiologists (5%) and general practitioners (5%). The majority were female (86%). Fifty seven percent (57%) worked in city/metropolitan, 36.5% regional and 4.4% remote areas.

Key Finding #1

Whilst a majority of health professionals agree that discussing sexual activity and intimacy with cardiac patients is important, few initiate the discussion and even less discuss it regularly (Table 1).

Table 1: Respondents' attitudes and practices toward providing advice on sexual activity and intimacy to patients who have had a heart attack.

Health Professionals' Attitudes and Practices	Sexual activity	Intimacy
Strongly agree or agree that it is **important to discuss**	87% *(n=218)*	84% (n=223)
Discuss regularly or all of the time	25% *(n=62)*	22% *(n=56)*
Strongly agree or agree that **health professional initiates** discussion	47% *(n=119)*	43% *(n=107)*

Key Finding #2

A majority of health professionals felt comfortable discussing sexual activity or intimacy with different genders, however reported being less comfortable with people of different cultures and backgrounds (Figure 1).

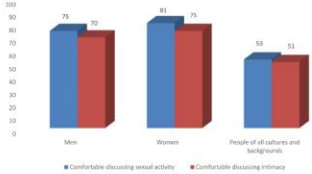

Figure 1: Proportion (%) of health professionals that strongly agreed or agreed they were comfortable discussing sexual activity and intimacy with different genders and people of different cultures and backgrounds (N=252).

Key Finding #3

Just over half of health professionals reported being confident with advice they need to give about sexual activity, though fewer about intimacy. Less than half reported having time to talk with patients, far fewer agreed they have a protocol to follow or adequate resources to support the discussion (Table 2).

Table 2: Respondents' perceptions of challenges associated with providing advice on sexual activity and intimacy to patients who have had a heart attack.

Health Professionals' Attitudes and Practices	Sexual activity	Intimacy
Strongly agree or agree they are **confident with advice**	62% *(n=157)*	48% *(n=120)*
Strongly agree or agree they have **time to talk** with patients	39% *(n=98)*	38% *(n=95)*
Strongly agree or agree they have a **protocol to follow**	19% *(n=48)*	15% *(n=38)*
Strongly agree or agree there are adequate **consumer resources to support** discussion	23% *(n=59)*	17% *(n=44)*

Conclusion

Australian health professionals currently report that it is important to discuss sexual activity and intimacy with patients who have had a heart attack, however only a fifth report doing this in practice. Health professionals report being more comfortable discussing sexual activity and intimacy with females and less comfortable with patients from different cultures and backgrounds. Challenges to discussing sexual activity and intimacy include limited time to talk with patients, lack of protocols to follow and inadequate support resources.

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USC
true relationships & reproductive health
Heart Foundation

WAIORA: Promoting Planetary Health and Sustainable Development for All

Intimate Partner Violence: A scoping review of online interventions

Ebony Rempel[1], Lorie Donelle[2], Jodi Hall[3], Susan Rodger[4]
Affiliations: [1]Faculty of Health and Rehabilitation Science, Western University, London, Canada; [2]Arthur Labatt Family School of Nursing, Western University, London, Canada; [3]School of Nursing, Faculty of Health Science, Human Services and Nursing, Fanshawe College, London, Canada; [4] Faculty of Education, Western University, London, Canada

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Background: Violence against women (VAW) is a global social issue contributing to the inequities with respect to the social determinants of health and affecting many women. Intimate partner violence (IPV) includes controlling behaviours directed by an intimate partner and is one of the most common forms of VAW. The onus on self-care in the face of violence remains almost singularly with the victims. Access to information in support of women's health and safety is fundamental. **Purpose:** Given the ubiquity of online access to information, the purpose of this scoping review was to provide an overview of online interventions available to women within the context of IPV.

Methods: A scoping review of published and grey literature was conducted to gain an understanding of the scope of literature regarding online interventions for women experiencing IPV. The **research question** guiding this scoping review was: what are the online interventions available to women who have experienced IPV? Peer reviewed research literature published between 2000-2016, inclusive, was reviewed.

The analysis was framed using the *Reclaiming Self* framework (Wuest & Merritt-Gray, 2001). Leaving an abusive relationship is understood as a 4 phase process and that IPV has potentially life-long consequences for women even after leaving the abusive relationship.

Online Interventions	Counteracting Abuse	Breaking Free	Not Going Back	Moving On
iCan plan 4 safety. (2015). Retrieved from www.icanplan4safety.ca		✓		
Koziol-McLain, J., Vandal, A. C., Nada-Raja, S., Wilson, D., Glass, N. E., Eden, K.B., . . . Case, J. (2015). A web-based intervention for abused women: the New Zealand isafe randomized controlled trial protocol. BMC Public Health., 151, 56 https://www.isafe.aut.ac.nz/	✓	✓		
Constantino, R. E., Braxter, B., Ren, D., Burroughs, J. D., Doswell, W. M., Wu, L.,. . . Greene, W. B. (2015). Comparing online with face-to-face HELPP intervention in women experiencing intimate partner violence. Issues in Mental Health Nursing, 2840		✓	✓	
Young-Hauser, A. M., Eden, K. B., Wilson, D., & Koziol-Mclain, J. (2014). Intimate partner violence: modifying an internet-based safety decision aid to a New Zealand context. Journal of Technology in Human Services, 324,297–311.	✓	✓		
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Bloom, T. L., Glass, N. E., Case, J., Wright, C., Nolte, K., & Parsons, L. (2014). Feasibility of an online safety planning intervention for rural and urban pregnant abused women. Nursing Research, 634, 243–51.	✓	✓		
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Results: Of 106 documents, **11 interventions** fit the inclusion/exclusion criteria. Interventions focused on more than one of the four stages and 7 interventions supported women in **leaving** the abusive relationship.

Six interventions supported women to create **personal defense strategies** while remaining in the abusive relationship.

Four interventions were in support of women in the **immediate aftermath of leaving** an abusive relationship.

None of the interventions appeared to focus on supporting women during the phase of **"moving on in their lives".**

Discussion: Of the published literature, most online interventions focused on supporting women through the act of leaving an abusive relationship with less emphasis on the experiences that occur after a woman has left the relationship.

All interventions focused on women's individual accountability to negotiate the abusive relationship without consideration of the broader societal context that contributes to the perpetuation of violence against women.

Findings from this research highlight information gaps for women who require extended support after leaving an abusive relationship.

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Involvement of Communities and other Stakeholders in Health Programmes

Author(s): Bhavna B Mukhopadhyay,[1] Alok Mukhopadhyay,[2] Dr. Nancepreet Kaur[3]
Affiliations: Voluntary Health Association of India

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Background

A health of any nation is sum total of its citizens, communities and settlements in which they live in. The Alma Ata declaration advocated a concept of Primary Health Care, which promoted maximum community and individual self-reliance and participation in the planning, organization, operation and control of their health care. It forms an integral part both of the country's health system and overall social and economic development of the community. Unfortunately this holistic and futuristic concept has not been translated into significant change in the implementation process in most parts of the world, in spite of the realization that involvement of communities, NGOs, CBOs and other important stakeholders have many crucial advantages.

In the last five decades, most of the countries of the region has followed a path of social transformation, which mainly relies on five major institutions, namely, the Parliament, the Assembly, the Cabinet, the Bureaucracy and the Party functionaries. The health system lacks transparency in accountability and governance at all the levels.

There has been broad consensus within the region that the challenges of health & development cannot be met without active participation of the communities & other important stakeholders. This is very much reflected in the Government of India's National Health Mission, which lays considerable emphasis on the role of Village Health & Sanitation Committees, Accredited Social Health Activists as well as implementing the concept of community based accountability and monitoring. In the past, there has been disappointing participation of the communities in the public health programs including disease elimination. On the other hand, whenever systematic efforts are made to involve the communities, there has been substantial improvement in the health outcomes.

Methods

Against this backdrop, Voluntary Health Association of India (VHAI) did a comprehensive secondary research on evidence-based successful examples on community involvement, which has vastly improved the effectiveness of health programs in the region. These evidence-based case studies are in diverse settings with complex and unique challenges but uniformly lead to better outcomes due to engagement of the communities and important stakeholders in planning, implementation, governance and accountability of the health programs.

Few case studies from the region are:

Sri Lanka

Sri Lanka is only the nation after Maldives that has logged success over malaria

Achievements are truly remarkable. In mid-20th century it was among the most malaria affected countries but now it is malaria free

- One million cases in 1970
- 264,549 malaria cases in 1999
- Zero cases in 2012
- Elimination of malaria in 2016

How they have achieved it
- Effective inclusive governance at all the levels
- Responsive health policies
- Strong public health system
- Intensive disease surveillance
- Strong stakeholder partnerships
- Active community involvement with focus on unreached population

Malaria Free Sri Lanka

Whole of Government & Whole of Society Approach

Community Health Clinics in Bangladesh

It was observed that only a minority of the people of Bangladesh uses public health facilities for their health care needs. The reasons for low utilization rate include supply and demand-side barriers such as travel expenses, waiting time accessibility and availability of health services

Community health clinics
Government of Bangladesh had set up these clinics as an additional tier to the existing PHC delivery system

These clinics act as interface between formal public health system and the communities

Community ownership & participation is an important pillar for functioning of CHCs

Outcome
- Increase utilization of health services
- Improvement in health seeking behavior
- Better local accountability thereby ensuring sustainability of the program

The "Khoj" (meaning search) is an initiative of Voluntary Health Association of India (VHAI). It seeks to bring about a holistic change in the lives of its beneficiaries by uplifting the socio-economic and health status of vulnerable communities in hard to reach areas of rural India

It build on the inherent capacities of the community and create an enabling environment by incorporating the interrelated components of participation, networking and action

Four thrust areas of the program
- Health
- Community Development
- Community Organization
- Environment

Key Factors that has helped to bring holistic change in the lives of the local communities
- Strategic planning along with the local communities
- Building on the community strengths
- Multi-dimensional approach-Addressing social determinants of health
- Creative partnering with the local communities and stakeholders

Khoj- Sustainable Community Based Health and Development Programmes in Rural India

When communities become active Health services become responsive

Results

These case studies are successful examples where proactive efforts have been made to involve the community, NGOs, CBOs, other important stakeholders in the health programs. Based on the case studies across the region, we have derived a theortical framework from these best practices. This framework will be helpful for health professionals, planners, practitioners and other stakeholders to plan their future health programs which will ensure inclusiveness at the all levels, effective accountability and sustainability of the efforts.

From Practice to Theory

- **Based on Scientific Facts**: Precise analysis and thorough understanding of problems being faced by the community
- **Understanding the community's perception of the problem**: Community's perception is critical in determining people's response and acceptance of any health program
- **Assessment of communities needs and resources**: The community assessment helps to uncover needs & resources as well as underlying culture & social structure that would help to understand how address the community needs & utilize its resources
- **Community Based Planning**: The planning of any health program should be done from the onset with the local community. This will ensure a plan that address their needs and long-term sustainability of the program
- **Programme Evaluation and Review**: The critical path method & PERT should be followed to figure out the major constraints in successful implementation of the program
- **Building linkage between the community and the health system**: Community participation & involvement in the programs will help to build strong linkage between them & the health system. Formation of public health cadre in the government will strengthen this linkage
- **Process of Horizontal Integration**: The horizontal integration between various government departments, important stakeholders & community ensures effectiveness, accountability and sustainability of the program
- **Operation of the health systems**: The success of any program depends upon: Well functioning health services adequate budget & utilization of the same on time and in best possible way good governance Well functioning health information system
- **Concurrent review of the programme**: The evaluation strategy of the program should be precisely based on asset mapping of the community & carefully designed comprising of qualitative and quantitative aspects. Monitoring process should be participatory in nature involving the local communities
- **Evidence Based Outcome**: The outcome of the program should be based on strong evidence-qualitative & quantitative aspects. Using reliable evidence to make public welfare decisions not only improves the effectiveness of the program but also delivers better outcomes for the community
- **Social Determinants of Health**: Health care goals cannot achieved without addressing social determinants of health. While addressing social determinants of health, a gentle & achievable gradient change approach should be followed

Discussion

All the countries in the South East Asia Region have embraced the concept of total involvement of people in its ongoing development efforts. However, to translate this theoretical framework of community participation and inclusive governance into practice, we need to combine scientific planning with reflections, hopes and desires of the community. In order to ensure long-term sustainability of the existing programs, health systems as well as health functionaries should adopt a community linked roadmap. While strengthening community engagement in public health programs, we need to keep in mind that the communities in India and other South-East Asia countries are heterogeneous in terms of race, ethnicity, income, culture and social structure. Therefore, we need to identify a community platform, which captures the interest of all the sections of the community including the deprived sections. At the end of the day, the battle to overcome complex problems like TB, vector borne diseases etc. will not only depend on scientific knowledge, infrastructure and human resources but the degree of passion and inclusivity with which health systems take up this task.

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Acknowledgement

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Poster presented at IUHPE 23rd World Conference on Health Promotion at Rotorua, New Zealand, 7-11th April 2019

WAIORA: Promoting Planetary Health and Sustainable Development for All

Involvement of women in household level decisions in the perinatal period: Findings from a rural community in Sri Lanka

Authors: Najith Duminda Galmangoda Guruge,[1] Manuja Perera,[2] Samath Dharmarathna,[3] Wasantha Gunathunga[4]

Affiliations: [1]Department of Health Promotion, Faculty of Applied Sciences, Rajarata University of Sri Lanka, Mihintale; [2]Department of Community Medicine, Faculty of Medicine, University of Kelaniya, [3]Department of Community Medicine, Faculty of Medicine , University of Peradeniya, [4]Department of Community Medicine, Faculty of Medicine, University of Colombo, Sri Lanka.

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Background/Objectives

- Safe motherhood initiative advocates on 'Equity for women' as its foundation strategy.
- Household level decision making is an indicator of household level equity.
- The prenatal period is considered as a crucial stage for the pregnant woman and her new-born and decisions made in this period can determine the wellbeing of the woman and new-born.

Aims:

To describe the involvement of women in household level decision making in the perinatal period in a rural community in Sri Lanka

Methods

Settings and Design:

A cross-sectional study design was used among 403 women recruited by a multi-stage sampling method from field antenatal clinic services in Polonnaurwa District.

Methods and Material:

Data was collected by a household survey, using a pretested interviewer administered questionnaire.

Statistical analysis used:

Percentages and 95% Confidence Intervals were used to present the findings.

Results

- More than 80% of women were involved in making the selected decisions related to pregnancy.
- However, involvement in making other household level decisions were comparatively lower. In pregnancy related decisions, all three decisions that determine the health seeking behaviour were taken by the woman and the partner collectively in the majority of households (When to seek medical care: n=152,49.4%; Where to seek medical care: n=190,61.7%; Place to deliver: n=130,42.2%).
- In other household level decisions, the commonest scenario was to take the decision collectively with the partner, except for spending on food.
- It was commonly decided by the partner alone (42.2%,n=130).

Discussion and Conclusions

- ❑ The women's involvement in making household decisions in the perinatal period was high.
- ❑ Sri Lankan rural communities probably display a higher level of gender equity in taking decisions in the perinatal period compared to its neighbour countries.

Involving citizens in community-based prevention research - A prerequisite for securing sustainability or a romantic idea about egalitarianism in knowledge-based development?

Vittrup A
Ph.d. Student, Steno Diabetes Center Copenhagen, Health Promotion Research, asser.vittrup.nielsen@regionh.dk

INTRODUCTION

The presence of diabetes is increased and its known that 2/3 of the cases occurs in the big cities. Therefore Steno Diabetes Center Copenhagen signed a partnership with Cities Changing Diabetes (CCD) and studies where made with quantitative surveys where the findings where that some areas was more vulnerable than others. Tingbjerg is one of the three most vulnerable areas in Copenhagen.

The study was carried out within the framework of the international CCD program and comprised one of several components in efforts to mobilise local community resources, social cohesion and action.

Few will dispute the importance of involving citizens in planning, organising and implementing actions addressing personal health and well-being. Citizen involvement fosters ownership and motivation to act voluntarily and decisively, and this strengthens impact and promotes sustainability. The present study goes one step further and addresses pro's and con's of involving citizens as researchers of their own local community. This is consistent with the principles of Participatory Action Research, which aims to maximize participation of citizens and other stakeholders in all stages of the research process.

The study describes processes of recruiting and working with young residents of a socially vulnerable neighbourhood in Copenhagen in research processes evaluating complex community-based interventions on health and social development.

OBJECTIVE

To develop and test a participatory evaluation approach based on engagement of youth citizens as "community researchers" and to stimulate dialogue and interaction among citizens across age groups and cultural backgrounds, and thus empower citizens to engage in the social development of their local community

METHODS/DESIGN

Tingbjerg is a residential area with app. 7000 citizens. It's an area with a high level of ethnic and social diversity and a high occurrence of different culture, language and traditions. This study takes its starting point in a specific health promoting activity, initiated by the SDCC as well as the social housing initiatives of Tingbjerg. The activity entails youth citizens from the local area of Tingbjerg getting involved and participating in the development and design of an interview guide and, subsequently, performing interviews with the residents of Tingbjerg.

9 girls and 2 boys aged 15-24 years, apparently multi-ethnic local citizens, were researchers of their own local community on a voluntarily basis. 7 of them were included in the analyses.

The study was qualitative and based on a semi-structured focus group discussion with the participants of the "community research" initiative.

RESULTS

Through the process, the young people experienced that they obtained a new identity as competent and active participants in the community and it is highlighted that the young people through this project has started potentials to change their conditions

An image emerges showing that young people are experiencing their inclusion and contribution to the activity positively, and we find that they have developed skills and action competencies through their participation.

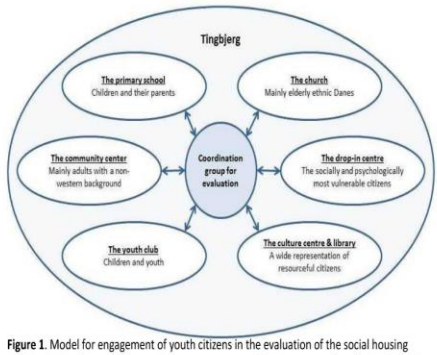

Figure 1. Model for engagement of youth citizens in the evaluation of the social housing initiative in Tingbjerg. The inner circle represent a coordination group of proffesionals action researchers. The surronding circles represent selected community- based settings for approaching different populationgroups through trained "community researchers".

CONCLUSIONS

It is my conclusion that, with young people, we are seeing an impact on both the inner and outer individual empowerment as well as horizontal empowerment. Furthermore, I conclude that, by young people's participation, we are seeing examples of both more positive and more negative views on the local area of Tingbjerg. Also, from an empowerment perspective, this altered view can be not only conducive to the creating of opportunities, but equally carry with it an impact of dilemmas to local Tingbjerg.

REGION H

Steno Diabetes Center Copenhagen

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JOY AS A TOOL FOR TRAINING LINKS, SELF-CARE AND SOCIAL INTERACTION - XING FU'S EXPERIENCE IN BASIC HEALTH UNIT(BHU) VILA PIAUÍ

Author: Samuel Moraes Cecconi. 3cecconi@gmail.com

Introduction

Although the literature on integrative practices such as Tai Chi grow exponentially every year, most describe the use in chronic conditions such as prevention of falls, rheumatology (knees), Parkinson's disease, fibromyalgia, psychological conditions, cardiovascular conditions , peripheral neuropathy and chronic pain. (HARMER, 2014). However, there are authors who debate 3 main points in this respect: there is a lot of research in the area but without great applications (Harmer, 2014); research rarely covers a comparison with financial focus (WANG, 2004); and use weak or poorly representative indicators of efficiency and effectiveness. (CARLSON, 2017)

Goals

To characterize a group that, despite having bases of Tai Chi, received insertion of variations, including rhythms and music, for a greater approximation and identification with the local public, aiming to establish empathy, bond and socialization.

Discussion

The essence of Integrative Practices is to support well-being and good health in all phases of life, but they focus too much on the cure of diseases, giving little importance or ignoring the potential of health promotion and prevention of diseases of these techniques, making comparison with existing drug and surgical therapies inadequate, as it is in the demonstration of efficacy studies.

Methodology

Bibliographical review with experience report on a group of Body Practices called Xing Fuep

Setting/problem

Although a human being is associated with a social being, there is a tendency for isolation whenever something in your life changes in a way that reduces functionality or decreases social status. Thereafter, there is an even greater and increasing decrease in their health, disposition and resocialization capacity. Depressive states, permanent disabilities and addictions further aggravate this situation thereafter.

Implications

In more than 7 years of history of Xing Fu, we see the benefits of growing the sense of belonging and joy in the group's weekly participation. What was built without a specific initial planning for it, was efficient to produce the users' adhesion to the group. It was observed a union based on friendship and coexistence, promoting, more and more, meetings of participants in varied situations with passion, joy and willingness to be in the group, taking advantage of exercise, improving the quality of life, social interaction, emotional and social support. In the organization of actions, this intentionality is revealed by the production of a specific and exclusive logo, planned in a cooperative way. The functioning of a Health Clinic has been established: it favors Joy and Health promotion, the prevention of injuries and even the reduction of damages associated with problems of various types, when there are questions of temperament, social condition, disorders mental and psychic. Although subjective and immaterial, JOY associated with physical activity in the Xing Fu Group proved to be an excellent facilitator of the socialization, health and friendship promoter. Since its inception, chained events have transfigured Xing Fu into an activity that serves as an address for a living entity: the Physical Activity Group of UBS.

Conclusion

The implantation of a group depends on several factors, such as the partnership with the local administration, the level of attractiveness, the intensity of the movements, among others. However, the bases of Tai Chi allow a practical safety, the existing bibliographic base is relatively effective, but more focused on prevention and health promotion are lacking for more accurate results analysis and cost reduction. In order to extract the best of these practices, we must consider focusing on the promotion of well-being and joy for the adepts and practitioners. As with Tai Chi, Xing Fu allows us to observe and study longitude.

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Kaiti Mall-A School friendly Environment

Kaiti School And Ka Pai Kaiti Trust Gisborne

"Taking Back Our Community"

Kaiti

Kaiti Suburb 2018:

Tairawhiti has a population of 37,200 with approximately 10,056 situated in the suburb of Kaiti. Although there are similar health issues across all age groups of Kaiti residents, there are specific health issues for residents in the under 24 age group and specific health issues for residences in the over 55 age group.

There is agreement that smoking, drugs, alcohol, problem gambling are the biggest health issues for Kaiti and that these issues have a negative effect on the physical and emotional health of individuals and of families, across the board. There is also agreement that obesity and poor diet are significant issues for Kaiti residents.

The main causes of poor health issues are tied to poor education, high unemployment and low income. These factors, characterise many of our Kaiti whānau which means that the affordability debate becomes complex.

I ♥ Kaiti

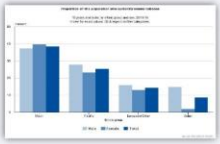
Intervention

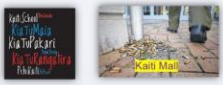
Making Kaiti Mall Smokefree:
Kaiti Primary School is situated directly across the road and faces directly towards the Kaiti Mall. The senior students invited local Mayor and part owner of the Mall to hear their concerns about the smoking behavior and unkept appearance of the Mall. The students told the mayor how untidy the mall looked and that there is so many cigarette butts littering the malls footpath and roads, would he support them to make the mall a tidier place and smokefree.

The students approached a member of the local smokefree coalition group (Taki Tahi Toa Mano) and Ka Pai Kaiti Trust to help provide help and support. Approximately 10 months later, on March 4th 2018, and in recognition of Children's Day, Smokefree Kaiti Mall was launched.

The removal of the Kaiti T.A.B Sports Bar (Pokie gambling site)
Problem gambling is a major concern for most whanau living in Kaiti. Ka Pa Kaiti is a charitable trust situated in the Kaiti mall and Relies soley on volunteer support. A member of the health promotion team is a trustee for Ka Pai Kaiti Trust and was advised by the medical officer of health that the Kaiti T.A.B/Sports bars liquor license was up for renewal. The trustees wrote their submissions objecting to the renewal on the grounds that the problem gambling was the main revenue for the owners and not the sale of alcohol. 2017 the local District Licensing Committee ruled in favour of both Ka Pai Kaiti Trust and local alcohol inspector to **NOT** renew the Kaiti T.A.B/Sports bar liquor license.

"Kids should be seen and not heard" REALLY?





Activating Community

Strong Community Collaboration

Ka Pai Kaiti

GISBORNE

KAITI SCHOOL

Hauora

TAKI TAHI TOA MANO

Gambling and Smoking Harm

Gambling:

Gisborne gamblers have lost almost $23 million in less than three years and a local problem gambling service says with the districts gambling policy up for review, more co-operation is needed to reduce gambling-related harm and bring more benefits back to communities.

Department of Internal Affairs statistics show that between April 2013 and September 2015 , a total of $22.9 million was collected from poker machines in the Gisborne district

Smoking Harm:

Nationally Maori feature high in the smoking harm ratios. The suburb of Kaiti has a high concentration of Maori, the concerns of the Kaiti School students are well founded.
(refer to graph)

Outcomes

Overwhelming community response in support of a smokefree mall and the removal of the Kaiti Mall T.A.B Sports Bar. Keeping the mall smoke free is a ongoing task and the use of different signage ideas that have come from this community. Closing down the Kaiti T.A.B/Sports Bar has had a significant and positive impact on this community.

Implications

- As a community group such as Ka Pai Kaiti Trust, the importance of developing strong relationships and working alongside people/groups e.g Medical officer of health, Police, Local district councilors and the wider community and whanau living in the suburb of Kaiti.
- Raising awareness of the low socio-economic (vulnerable) communities vs high socio-economic communities.
- "Kids should be seen and not heard" a familiar adult saying when we were growing up. Today it is important we encourage our tamariki to have the courage to "speak out", here is a example where they have. There voice needs to be acknowledged and it was, by their community/whanau. Acknowledging there korero will give them the confidence to "speak up" when ever anything concerns them.

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Kaitiaki Ahurea

Effective Health Promotion in Māori Communities

Introduction

Te Rau Ora (originally Te Rau Matatini) is New Zealand's indigenous Māori organisation providing a range of local and national programmes to improve Māori Health.

Abstract

Kaitiaki Ahurea is a foundation health promotion programme for non-Māori and Māori health workforces to work more effectively in Māori communities.

Aim

To develop knowledge and understanding of Māori health promotion for Māori communities.

Evaluation

Qualitative and Quantitative data collection. Analysis of documents. Narrative provided by participants. Pre and Post wānanga online surveys.

Programme Pedagogy

Wānanga held at 2 marae; Utilisation of Te Ao Māori which enables participants to connect with local Māori communities.

Wānanga

Wānanga: is inclusive, uses collective knowledge, encouraging thinking, reflection and reciprocity.

Results

- use of te reo Māori at work:
  - Dunedin: 60%
  - Invercargill: 94%
- knowledge of historic Māori leaders
- knowledge of local hapū and iwi
- knowledge of what makes a difference in Māori Communities, and the difference in Māori health promotion approaches

Qualitative Statements

The overall training reinforced the importance of relationships and that there is never a one size fits all approach.

The programme activities were strengths based and reinforced positive strong Māori role models.

My organisation has to offer better cultural training for its staff.

Conclusions

Kaitiaki Ahurea provides both non-Māori and Māori a foundation knowledge to enable better health promotion delivery in Māori communities.

Acknowledgments

To participants, Tāua and Pōua, ringawera, South Island Alliance Programme Office, South Island Public Health, Te Herengā Hauora, whānau, hapū and iwi that embraced our kaupapa - Ngā mihi mahana kia koutou!

TE RAU ORA
Strengthening Māori Health and Well-Being

WAIORA: Promoting Planetary Health and Sustainable Development for All

Knowledge, Attitude and Practices toward Road Traffic Regulations and Road Safety among Medical Students of University of the Philippines-College of Medicine (UPCM)

Authors: Scarlett Mia S. Tabuñar, MD, MHA,[1] Eleanor C. Castillo, DrPH[2]
Affiliations: [1]Department of Emergency Medicine, University of the Philippines-Philippine General Hospital, UP-College of Medicine, Philippines; [2] Department of Health Promotion & Education, College of Public Health, University of the Philippines Manila, Philippines

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Keywords:
Knowledge, attitude, practices, traffic regulation, road safety, road traffic crash, novice drivers

Background/Objectives:

Road traffic injury is a growing public health concern of governments and health professionals worldwide. Keys factors contributing to its increasing number are knowledge, attitude and practices (KAP) of novice drivers leading to road traffic crashes (RTC). Objectives of this study were to determine the demographics, knowledge and attitude toward traffic regulations of UPCM students and their association to driving practices.

Methods:

This cross-sectional study was conducted from September to October 2016 among 1st-4th year UPCM students. Total enumeration was employed to capture the drivers among the respondents. Tool questionnaire was developed based on identified national laws on traffic and adopted from related literature. It was pretested on medical interns of Philippine General Hospital (PGH). T-test and chi-square were used to determine associations between variables of interest.

Results:

Among the 156 drivers included in the final analysis, 57.05% were men. Mean age was 22.31 ± 1.94, and 54.49% were involved in RTC (Table 1). Overall safe driving KAP were low; knowledge and attitude did not correlate with practice (p> 0.005). Being older was the only demographic characteristic significantly associated (p= 0.0028) with safe knowledge. The high acceptable knowledge and attitude results on the different road safety indicators were not seen on desired practices regarding speeding (39.73%), distracted driving (34.93%), risky driving maneuvers (31.72%)and regular vehicular maintenance (18.54%). Only attitude on speeding (p < 0.001) and use of seat belt (p =0.007) showed significant associations to unacceptable practices

Table 1. Sociodemographic Profile of Drivers

Data	*Mean*	*n= 156*	
1. Age (years)	22.31 + 1.94 (min= 18; max= 30)		
		Number	%
2. Sex	Male	89	57.05
	Female	67	42.95
3. Category of Pre-Med School	Public	148	94.87
	Private	8	5.13
4. City of Residence	National Capital Region (NCR)	136	87.74
	Non-NCR	19	12.26
5. Socialized Tuition Fee Bracket	A	101	64.74
	B	34	21.79
	C	19	12.18
	D, E1 and E2	2	1.28
6. Possession of Driver's License	Yes	144	92.31
	No	12	7.69
7. Driving for how many years?	<1	24	15.48
	1	18	11.61
	2	29	18.71
	3	24	15.48
	>4	60	38.71
8. How many days do you drive in a week?	< 1 day	75	49.34
	1-2 days/week	54	35.53
	3-4 days/week	9	5.92
	5-7 days/week	14	9.21
9. Involvement in RTC	Yes		
	As driver	28	32.94
	As Passenger	27	31.76
	Both	30	35.29
	Total	85	54.49
	No	70	45.51

Discussion:

The findings of the current study reveal that the driving UPCM medical students, who still belong to the young driver's population, have low overall safe driving knowledge, attitude and practices. Although medical students are considered to be of higher educational background the outcome can be due to them being intently focused on the stringent demands of medical schoolwork, rendering less attention on other concerns such as traffic rules and regulations. Being slightly older, (23.35 > 22.10 years old) shows a significant correlation with having safe knowledge, while all other demographic variables have no any association with safe knowledge, attitude or practice on traffic regulation and road safety

The high acceptable knowledge and attitude results on the different road safety indicators that are not seen on practices can be hypothesized to be due to the notorious traffic situation in the city of Metro Manila and the road pressures these medical students are exposed to on a daily basis when driving. Coping reactions to these dreadful traffic situation may include engaging in risky driving maneuvers (eg. going against traffic flow, beating red light, making sharp risky turns or overtaking on blind sharp curbs), over speeding and using mobile phones or other gadgets whilst driving just so to navigate the traffic woes and keep up with their tight schedule.

Conclusion:

- Overall safe driving knowledge, attitude and practices of the driving medical students of UPCM are low and age is the only demographic variable associated with safe knowledge.
- Although there is a high percentage of drivers with acceptable knowledge on speeding, use of seatbelt, drunk driving, risky driving maneuver and regular vehicular maintenance as well as acceptable attitude regarding use of seatbelt, distracted driving, risky driving maneuvers and regular vehicular maintenance, the same results were not noted on the desired acceptable practices particularly on speeding, distracted driving, risky driving maneuvers and regular vehicular maintenance.
- The most notable finding of this study is that attitude regarding speeding and use of seat belt are significantly associated to unsafe practices on the road.

Recommendations:

To address the majority of the unacceptable and unsafe practices of novice drivers, it is therefore recommended that strict and consistent enforcement of traffic rules and regulations should be prioritized as attitude is the only variable that is significantly related to unsafe practices.

Acknowledgments:

To Mr. Orlando Alba, for all the help in the statistical analysis and the Department of Health Promotion and Education- UP College of Public Health for the support in accomplishing this study

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La lutte efficace contre les épidémies de fièvre hémorragique lassa dans la Commune de Tchaourou au Bénin nécessite l'action sur les déterminants sociaux de la santé

David Houeto*, Covalic Bokossa, Luc Béhanzin, Thierry Adoukonou, Maurice Agonnoude
School of Public Health, University of Parakou, Benin Republic

Introduction/Objectifs

La fièvre de Lassa est une fièvre hémorragique foudroyante (causée par un arena virus nommé virus de Lassa), décrite pour la première fois en 1969 dans la ville de Lassa au Nigéria. L'objectif de l'étude était de démontrer qu'en agissant sur les déterminants sociaux de la santé nous pouvons lutter efficacement contre les épidémies récurrentes de Fièvre Hémorragique Lassa (FHL) dans la Commune de Tchaourou au Bénin.

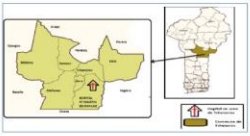

Figure 1 : Commune de Tchaourou

Méthodes

Il s'agissait d'une étude transversale, descriptive visant trois cibles : les cas de FHL, les agents de santé et la communauté de Tchaourou. Nous avons effectué un recrutement exhaustif à la fois pour les dossiers de cas de FHL et le personnel de santé. En communauté, au niveau de chaque village/quartier, nous avons fait la technique du parcours aléatoire pour sélectionner les sujets à enquêter.

Résultats

Au cours des années 2016, 2017 et 2018, la Commune de Tchaourou a enregistré 12 cas confirmés de FHL dont 5 cas étaient décédés, ce qui donne une létalité de 41,6%.

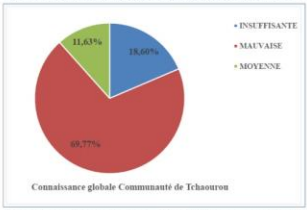

Figure 2 : Connaissance de la Fièvre Lassa par la communauté en 2018 (N=172)

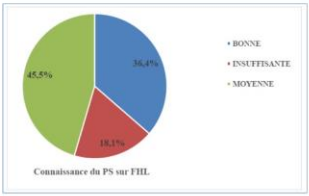

Figure 3 : Connaissance de la Fièvre Lassa par le personnel de santé (N=33)

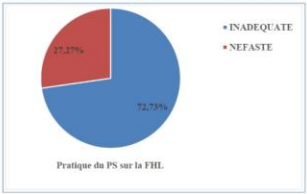

Figure 4 : Niveau de pratique sur la Fièvre Lassa par le personnel de santé (N=33)

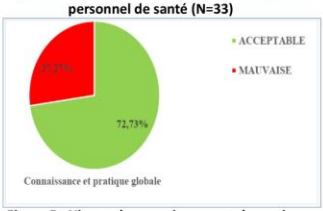

Figure 5 : Niveau de connaissance et de pratique sur la Fièvre Lassa par le personnel de santé (N=33)

Les déterminants majeurs de la survenue de la FHL étaient : la consommation de souris, la pratique de chasse en période épidémique, la pratique de feu de brousse, le manque d'instruction, la non décentralisation des structures de santé, l'inaccessibilité du centre de santé, l'inexistence de centre de santé à la frontière Bénin/Nigéria. Les actions mises en œuvre dans le cadre de la lutte contre la FHL n'étaient pas orientées fondamentalement vers ces déterminants en dehors des épisodes de sensibilisation de la population à ne pas consommer les souris en période épidémique.

Discussion/Conclusion

L'absence d'action sur les déterminants de la survenue de la FHL pourrait expliquer la récurrence des épidémies de la FHL dans la Commune de Tchaourou. Il faut agir sur les différents déterminants sociaux de la survenue de la FHL avec l'appui des autres secteurs et particulièrement la communauté à qui il faut donner le pouvoir et les moyens de prendre en charge sa santé afin de l'améliorer. L'amélioration des conditions de vie de la population contribuera à un contrôle efficace des épidémies de la FHL et par la même occasion réduira le fardeau des autres maladies dans la Commune.

*07BP1411 Sainte-Rita, Cotonou. Email: dhoueto@gmail.com

Title : La Malnutrition en Afrique

Author : Symphorien SANWINGERO

APROSABU - BURUNDI

L'organisme puise son énergie dans les sucres (ou glucides), les corps gras (ou lipides) et les protéines (ou protides). Ces trois nutriments énergétiques forment la classe des macronutriments.

La pauvreté, la faim et la maladie sont les principaux facteurs de malnutrition en Afrique et sont liées aux mauvaises conditions de vie, au manque d'éducation, aux moyens de subsistance précaires et au manque d'accès aux services de base tels que les soins de santé et les aliments sains et nutritifs.

Nombre de personnes souffrant d'insécurité alimentaire grave, mesurée à l'aide de l'échelle de mesure de l'insécurité alimentaire fondée sur les expériences, en 2014-2017[1].

Nombre de personnes (en million)

AFRIQUE	2014	2015	2016	2017
Afrique du Nord	24,6	22,5	26,7	29,0
Afrique subsaharienne	235,4	244,5	284,5	345,9
Afrique de l'Est	100,5	101,7	121,9	136,8
Afrique centrale	50,6	52,7	56,5	79,2
Afrique Australe	13,3	12,9	19,8	20,1
Afrique de l'Ouest	71,1	77,2	86,3	109,8

Aujourd'hui encore, la situation de la malnutrition en Afrique est loin d'atteindre les OMD en matière de nutrition. La lutte contre la faim en général et la malnutrition en particulier constitue un défi majeur afin de réduire considérablement la mortalité chez les enfants. Du reste, de nombreux efforts, tant du côté des autorités que des acteurs de la recherche, sont menés pour combattre ce fléau ; en témoignent sa désignation comme premier des OMD. La Prise en Charge communautaire de la Malnutrition Aiguë (PECMA) a été reconnue comme une clé de l'atteinte des OMD (FANTA, 2010).

Donc, les gouvernements africains peuvent et doivent prendre des mesures pour prévenir et réduire la sous-alimentation en créant des environnements favorables à l'amélioration du nourrisson et du jeune enfant, à l'amélioration de l'approvisionnement en eau et de l'assainissement, et pour offrir des aliments plus sains dans les écoles, entre autres mesures.

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[1] **La sécurité alimentaire et la nutrition dans le monde en 2018/FAO**

La Route du lait de Montréal: unir des commerces pour changer la norme

Auteurs: Julie Béland, Naomie Colin, Émilie Corriveau, Oscar Dibala Tshiabembi et Jezabel Dumas

Affiliations: Institut de Recherche en santé publique de l'Université de Montréal, Montréal, Canada; Université de Montréal, Montréal, Canada; École de santé publique de l'Université de Montréal, Montréal, Canada; Nourri-Source Montréal, Montréal, Canada

IUHPE 23rd World Conference on Health Promotion

La Route du lait de Montréal

Un projet de **Nourri-Source**

Organisme communautaire d'entraide et soutien à l'allaitement[1]

- **>500** commerces et établissements publics
- **aucune** obligation d'achat
- endroit **calme**, loin des toilettes

But: Normaliser l'allaitement maternel (AM) en public[1]

Objectif: D'ici 3 ans -> 75% arrondissements -> 1000 commerces

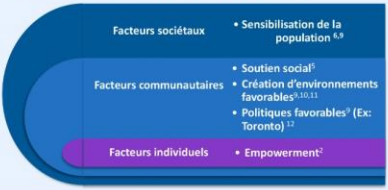
Les enjeux de l'AM en public

- Mondialement promu par l'Initiative Ami des Bébés[2]
- Taux d'allaitement exclusif jusqu'à 6 mois mondial 38%[3]
- Objectif de l'OMS pour 2025 est de 50%[3]
- À Montréal le taux est actuellement de 6%[4]

AM en public

- Accès égal au bien commun[5]
- Les mères se sentent stressées, jugées et non acceptées [6,7]

Influence de facteurs nécessite des actions à divers niveaux[8] :

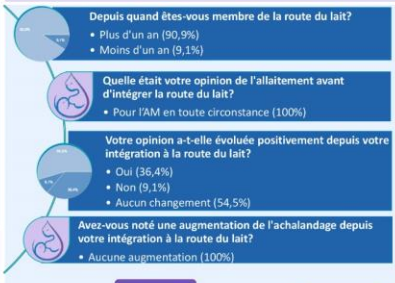


Question de projet

« Quels sont les **facteurs favorisant l'adhésion des commerçants** à la Route du lait? »

Méthodologie

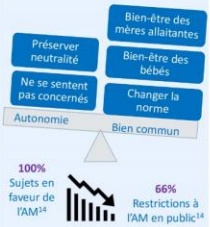
Résultats



Analyse des résultats

- Opinion des commerçants déjà positive de l'allaitement et inchangée pour la majorité.
- L'achalandage n'augmente pas
- Les commerçants apprécient Nourri-Source
- Suggestion -> la promotion de la Route du lait

Éthique



100% Sujets en faveur de l'AM[14]

66% Restrictions à l'AM en public[14]

Limites

- Projet en émergence et novateur
- Accès difficile aux données
- Délais courts
- Désirabilité sociale
- Petit échantillon non aléatoire et représentatif des plus engagés
- Pas de saturation des résultats
- Résultats peu généralisables

Recommandations

- Sonder les commerçants qui ont refusé
- Permettre le réseautage entre les commerçants de la route
- Faire davantage de promotion (rallye, média sociaux, etc.)

Un environnement favorable n'est pas seulement physique; il est aussi social et surtout libre de discrimination.

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Pour plus d'information

contactez: corriveau.emilie@gmail.com

Visitez: https://nourri-source.org/fr/montreal

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Université de Montréal | Direction des affaires internationales

Title : L'environnement et la santé

Author: Mr Jean de Dieu Dusabe

APROSABU

L'environnement est un facteur déclenchant de nombreuses maladies par les agressions de l'environnement physique (pollution, nourriture malsaine, gigantisme urbain, destruction des espaces verts) et les carences de l'environnement social (solitude, famille en miettes, chômage) et idéologique (vide spirituel). L'environnement est un facteur facilitant l'invasion de la maladie en créant de multiples stress qui affaiblissent les défenses immunitaires.

Le lien entre la qualité de l'environnement et l'état de santé des populations est reconnu par les communautés scientifiques de manière plus fréquente qu'avant, mais les questions restent plus nombreuses que les réponses. À titre d'exemples, évoquons quelques liens environnement-santé récemment établis.

L'augmentation des allergies est frappante. Un groupe d'experts japonais a travaillé sur l'allergie au pollen[1] :

Milieu fréquenté	Fréquence de l'allergie au pollen	Cèdre
Au Japon	9,6%	Avec cèdre
Dans la rue à forte densité	13,2%	Sans cèdre
Dans les quartiers moins fréquentés par les voitures	5,1%	Avec cèdre
Dans un trafic dense mais pas de trafic automobile	9,6%	Sans cèdre

En définitive, l'impact de la dégradation de l'environnement sur la santé humaine est à la fois une des préoccupations majeur de la santé publique.

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[1] *Myamoto T. Increased Prevalence of pollen allergy in Japan. In: Gordard P., et al. (eds.). Advances in Allergol Clin Immunol. London : Parthenon Publ. : 343-7.*

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"LIVING IN THE PARKS"PROJECT: A GREEN EDUCATIONAL APPROACH FOR IMPROVING HEALTH AND WELL-BEING AMONG INDIVIDUALS

Quaranta A^, Balducci MT^, Lopuzzo MG*, Tommasi A*, Zampano F*, Montagna MT^

^ Dpt. of Biomedical Science and Human Oncology - University of Bari-Italy
*Dpt. of Health Promotion, Social Welfare and Sport for all- Apulia Region- Italy

Background

"Living in the parks" is a two-year project promoted and financed by the Apulia Region, Southern Italy. The main goals of this plan are i) to improve lifestyles, ii) to reduce chronic-degenerative diseases, iii) to ensure health equity, iv) to promote individual empowerment and enhance the territory.

Methods

From April to October 2017, 48 meetings were planned in 10 protected areas (Parks and Nature Reserves) distributed throughout the Apulia territory. All meetings were structured in two weekly events lasting two hours each (1h of physical activity, 1h of educational activity aimed to increase knowledge on environmental, food and cultural heritage of the region). The accession to the project was free, designed for families and individuals, particularly focused on the participation of people with physical/sensory/relational disabilities. The data of the participants, collected through the compilation of questionnaires, were processed by STATA software.

Results

Overall, 516 individuals joined the initiative (50 from families): 16% declared at least one disability and 11.5% chronic-degenerative diseases. Initially, 41% of the participants were overweight (28.2%) or obese (12.8%); the daily fruit/vegetable consumption was 1-2 portions *versus* 5 recommended by WHO; the participants claimed to do a sedentary job (75%), to move by car (46.2%) and not to engage in any physical activity (45%). After six months of project activities, the consumption of sweets/snacks decreased by 3%, while the fruit/vegetable consumption increased by 3-4 portions a day. The participants said they had reduced the use of the car in favour of walking (6%).

Discussion

The first phase of this project highlights an improvement in lifestyles, including a better perception of one's own psycho-physical well-being, thus improving the level of socialization both within the family and outside.

PARENTAL MOBILE DEVICE USE IN PLAYGROUNDS: CONVENIENCE OR DISTRACTION?

Curtin University

Ms Keira Bury, Dr Justine Leavy, Associate Professor Jonine Jancey
Collaboration for Evidence, Research and Impact in Public Health (CERIPH), School of Public Health, Curtin University Western Australia

BACKGROUND

For parents of young children, mobile device use (MDU) offers limitless opportunities for multitasking, and a range of benefits including social networking, photography, personal organisation and work flexibility[1, 2]. However, research has also found detrimental effects on parent-child interaction[1], the supervision of children[2], and an association with child injury[3]. The impacts of parental MDU are indicated to be most prominent for children aged 0-5 years[4]. This mixed method research explored MDU by parents of children aged 0-5 years in the Perth metropolitan playground setting.

METHODS

Naturalistic observations of parent-child dyads (n=85) and intercept interviews (n=20) were conducted in the playground setting. The duration and mode of MDU and coinciding behaviours of parent supervision, parent-child interaction and child injury potential were recorded in one minute blocks. Cross tabulations with Pearson chi-square tests were conducted to test the association between *MDU, MDU Mode, MDU Duration* and the outcome variables; *Supervision, Interaction* and *Injury Potential*. Interviews obtained parents' perspectives on parental MDU and strategies for limiting their own MDU around children.

Convenience
"You can get those little things done when you have a chance."

"If there's an emergency, I can just call someone."

"Having some kind of social interaction and connection with other people."

"Documenting her life in pictures and having information at hand when I need it."

Distraction
"I'm drawn to answer that beep and that takes me away from my kid."

"You can feel obligated to check work emails

"You can't have your eyes on two things at once, it's impossible."

"It just takes away from the quality time that you could be spending with them."

NATURALISTIC OBSERVATIONS (RESULTS)

- The majority of parental MDU was for short glances of up to 10 seconds or for the entire one minute block.
- Scrolling/typing (76%) was the most commonly observed mode of MDU followed by phone calls (14%) and camera use (10%).
- A statistically significant association (P=<0.001) was found between parental MDU and child supervision, parent-child interaction and child injury potential.
- Longer MDU duration and phone calls were more likely to coincide with 'No Supervision' and 'Increased Injury Potential' and less likely to coincide with 'Parent-child Play'.
- MDU in camera mode offered the most benefits as it enabled 'Constant Supervision', 'Parent-child Play' and 'Decreased Injury Potential'.

	NO MOBILE DEVICE USE	MOBILE DEVICE USE
Parent-child play	40%	20%
No child supervision	5%	30%
Increased injury potential	6%	22%

INTERCEPT INTERVIEW (RESULTS)

- Mobile devices facilitate the multitasking of work, life admin and social networks which is both convenient and distracting.
- There is an awareness of the potential impacts of parental MDU on supervision and interaction with children, and concern for role-modelling appropriate technology use.
- MDU distraction in the playground is likened to other settings e.g. when driving or watching children around water.
- High value is placed on making memories using mobile device cameras.

PARENTS' STRATEGIES FOR LIMITING MDU

The strategies that parents used for limiting their MDU around children fell into three categories:

- *Restricting*, limiting MDU to specific functions such as the camera mode;
- *Abstaining*, avoiding MDU while supervising children; and
- *Timing*, engaging in MDU during periods of 'downtime'.

SO WHAT?

- MDU offers parents the convenience of multitasking parenting, work and life admin on the run.
- Parental MDU reduces parent-child play which is important for child development and attachment.
- Parental MDU reduces supervision quality which is important for young child injury prevention.
- A stronger focus on limiting technology interference is needed for parenting in early childhood.
- Parents offer good strategies for limiting their MDU around children – let's share them!

"I guess that you have to be conscious that it doesn't distract you from spending this time with the kids, you want to be interacting, you want to be there with them in the moment."

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Ethics approval was obtained from Curtin University's Human Research Ethics Committee no: **HRE2016-0027**

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CONTACT :
KEIRA.BURY@CURTIN.EDU.AU

Māori Youth Less Isolated

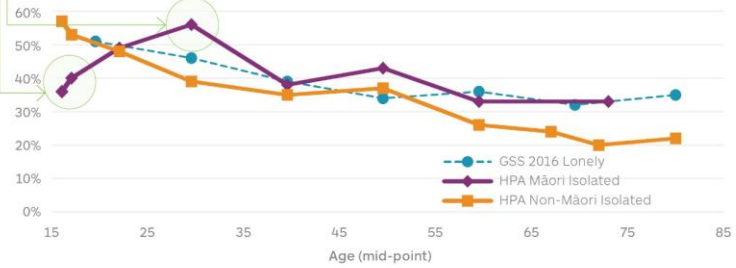
Brendan Stevenson, Craig Gordon, and Mokalagi Tamapeau

Research indicates isolation is associated with poor wellbeing and increased distress for young people[1]. However, we found less isolation for 15-19 year-old Māori, revealing a key gap in our understanding of isolation for this group.

Māori aged 15-19 were **less isolated** than non-Māori aged 15-19 (37% vs 56%).

Māori aged 25-34 were **more isolated** than non-Māori aged 25-34 (56% vs 39%).

Overall, **Māori were more likely to be isolated** than non-Māori (43% vs 35%). Isolation was felt most by younger adults, decreasing over time until well after the age of retirement[2]. This echoed findings from the General Social Survey (GSS)[3].



These differences in age-related isolation for Māori could not be explained using measures of connectedness (cultural connection; whānau connection) or wellbeing (life satisfaction; life is worthwhile).

Importantly, measures of support (rely on friends/whānau and able to find help) *was significantly* related to reduced isolation for Māori aged 15-19, but made no difference for non-Māori. Support wasn't significant for Māori or non-Māori aged 25-34.

Next steps: To understand how support is related to isolation for ages 15-19 and what is qualitatively different in the experience of isolation for both 15-19 and 25-34 year olds.

Data: Pooled HPA Mental Health Monitor (2015+2016) and Health and Lifestyles Survey (2016) for n of 1,515 Māori and 5,262 non-Māori. Some age groups were combined. | **Isolated:** Felt isolated 'a little' or more in the last four weeks (Loneliness defined similarly). | **Analyses:** STATA 15.0, adjusting for the survey design, significances' tested with GLM.

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[1] Kvalsvig (2018); [2] The Social Report (2016); [3] stats.govt.nz/information-releases/well-being-statistics-2016;

If you wish to explore these findings further please contact Brendan at b.stevenson@hpa.org.nz

hpa health promotion agency
TE HIRINGA HAUORA

Media pornography and peers are dominant factors of premarital sex behavior among high school adolescents in Bekasi, Indonesia

Besral Citra Amelia
Faculty of Public Health, Universitas Indonesia, Kampus FKM UI Depok, Jawa Barat 16424,
email: besral@ui.ac.id, phone:+6281282575200

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Background

Adolescence have experienced a dynamic development in their lives, experiencing the transition from children to adulthood, it is characterized by the acceleration of physical, mental, emotional, and social development. They are still looking for identity, tend to follow the trend, still unstable, and very easily influenced by peers, including pre-marital sexual risk behavior.

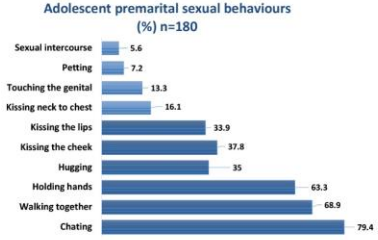
Objectives

The objective of this study was to determine the dominant factor of pre-marital sexual behavior among high school adolescents.

Methods

This cross-sectional study interviewed 180 adolescents during April to June 2018 from 6 (six) high schools (2 public high schools, 2 private high schools, dan 2 vocational high schools) that was selected by cluster random sampling in Kecamatan Jatiasih, Kota Bekasi, Indonesia. Both dependent variable (premarital sex behavior) and independent variables was measured by interviews using structured questionnaires. Dependent variables were age, gender, knowledge, attitude, exposure of porn media, peer roles, and parenting roles. Multiple logistic regression was applied to determine dominant factors.

Results



The results showed 5.6% of adolescent high school student in Bekasi ever had sexual intercourse and most of them come from Vocational High School, which is 10%. As much as 7.2% students ever had petting, 13.3% touching genital area, 16% kissing from neck to chest, 33.9% kissing the lips. In this study, premarital sexual behavior was categorized as high risk and low risk. It is said to be a high risk if they have kissed the lips, kissed the neck and chest, touched genitalia, or had sexual intercourse. As much as 34.4% of adolescents have high-risk premarital sexual behavior. Most high-risk sexual behavior came from Private High Schools (37%) and Vocational High Schools (35%) compared to Public High Schools (32%).

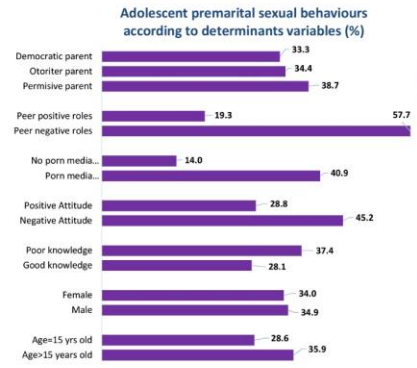


Table 1. Multiple Logistic Regresion Determinants of premarital sex behavior among high school adolescent in Bekasi

Determinant Variables	Odds Ratio	95% CI Odds Ratio		Sig
		LL	UL	
Porn media exposed	2.7	1.0	7.3	0.045
Peer negative roles	4.6	2.3	9.2	<0.001
Negative Attitude	1.9	0.9	4.0	0.076
Poor knowledge	1.8	0.8	3.9	0.145

Multivariat logistics regression analysis confirmed that of the seven variables suspected to be determinants, the variables of exposure to pornographic media and the negative role of peers are the dominant factors associated with pre-marital sexual behavior among high school adolescents.

After controlled by confounding variables, those adolescents exposed to pornographic media at risk 2.7 times higher for pre-marital sexual behavior compared with adolescents who are not exposed to pornographic media (p-value < 0,001). Adolescents exposed to negative things from peers are 4.6 times more likely to perform high risk pre-marital sex behaviors compared to adolescents who are not exposed to negative things from peers (p-value < 0,001). Negative attitude or poor knowledge on reproductive health have two times more likely to experience high risk pre-marital sex behaviors as compared to those who are with positive attitude or good knowledge.

Conclusions

Media pornography and peers are dominant factors of premarital sex behavior among high school adolescents in Bekasi, Indonesia.

It is recommended that parents, schools, and government continue to increase more vigorous protection efforts for teenagers to avoid the threat of pornographic media. Teens to be smarter in choosing peers so as not to plunge into pre-marital sex behavior.

UNIVERSITAS INDONESIA

Intra-Pacific Identity in Aotearoa[1]

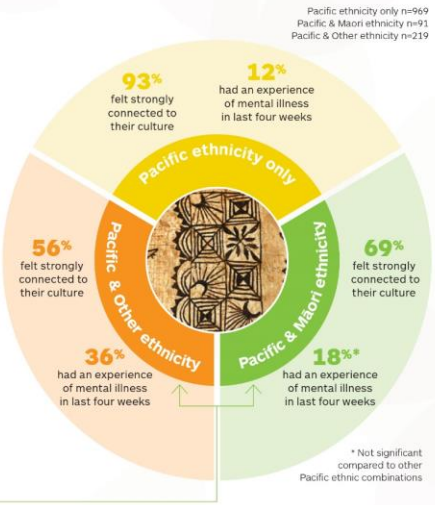
Mokalagi Tamapeau and Brendan Stevenson

Pacific peoples are not one ethnic group; Samoa, Cook Islands Māori, Tonga, Niue, Fiji, Tokelau, and Tuvalu represent statistically distinct Pacific populations.

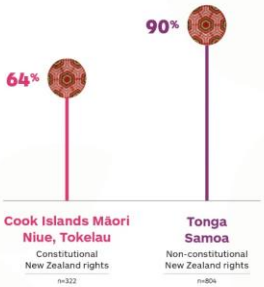
Pacific peoples are from the largest ocean in the world. In Aotearoa, Pacific Peoples are the fourth largest ethnic population group.

Pacific populations in Aotearoa are youthful (median age was 21 in 2013), are predominantly Aotearoa born, and are more ethnically diverse than their parents.

Pacific peoples with more than one ethnicity reported less cultural connection. There were also differences for those who had an experience of mental illness in the last four weeks between sole Pacific and Pacific/ Other ethnicity.



IMPORTANT TO MAINTAIN A STRONG CONNECTION TO CULTURE



Peoples of the Cook Islands, Niue and Tokelau Islands have constitutional relationships with New Zealand.

Maintaining strong cultural connections is important for Pacific peoples, but varies between Cook Islands Māori, Niue and Tokelau when compared with Tonga and Samoa.

Data: Pooled HPA Mental Health Monitor (2015 and 2016) and Health and Lifestyles Survey (2016) for 1,279 Pacific respondents | **Analyses:** STATA 15.0, adjusting for survey design, significances tested with GLM.

[1] Findings from Te Kaveinga 2018

If you wish to explore these findings further please contact Brendan at b.stevenson@hpa.org.nz

hpa health promotion agency
TE HIRINGA HAUORA

Les feuilles comestibles du Pacifique

Mettez du vert dans votre assiette !

Auteurs : Solène Protat[1], Marie-Eve Tefaatau[2], Gabriel Levionnois[3]
[1] Communauté du Pacifique (CPS)
[2] PacificTV Prod Tahiti
[3] Association NEODFOOD, Nouvelle-Calédonie

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Contexte

L'obésité affecte en moyenne plus d'un tiers des adultes Océaniens. Ceci s'explique en partie par le changement du modèle alimentaire des populations qui est passé d'une alimentation traditionnelle composée de poisson frais, végétaux et tubercules à une alimentation moderne comprenant de l'huile, du sucre et des aliments transformés. Aujourd'hui, seulement 20% des habitants de la région consomment au moins 5 fruits et légumes par jour.

Depuis plusieurs années, la Communauté du Pacifique recommande la consommation de feuilles comestibles (ou « légumes-feuilles ») pour augmenter la ration quotidienne de légumes des Océaniens. En effet, les feuilles de plantes cultivées pour leurs tubercules (taro, manioc, patates douces), le chou kanak ou encore certaines espèces de fougères ou de plantes aquatiques sont disponibles à travers toute la région à moindre coût, de façon durable et responsable et possèdent des qualités nutritionnelles intéressantes pour la santé.


Feuilles de manioc


Feuilles de patates douces


Chou kanak


Cresson d'eau


Fougère comestible

Intérêt nutritionnel des feuilles comestibles

Les légumes-feuilles se cultivent facilement mais on les trouve également couramment à l'état sauvage ou sous forme de mauvaises herbes dans les jardins. Ils se consomment crus ou cuits et sont une excellente source de vitamines A, C et K ainsi que d'acides foliques et de minéraux (calcium, magnésium, potassium). Ces aliments ne renferment que très peu de glucides et sont riches en fibres. Par conséquent, ils sont peu caloriques et possèdent un index glycémique très faible.

Description du projet

Autrefois largement consommés par les Océaniens, les légumes-feuilles semblent aujourd'hui être quelque peu délaissés. C'est pourquoi, la Division santé publique de la Communauté du Pacifique a décidé de produire 60 émissions télévisuelles pour encourager la consommation de feuilles vertes. Chaque épisode, d'une durée de 3 minutes, présente une plante comestible, les caractéristiques permettant de l'identifier et une recette facile pour la cuisiner. Le tournage a été réalisé en Polynésie française, à Vanuatu, en Nouvelle-Calédonie et aux îles Fidji afin de garantir une représentativité des différentes plantes, ethnies et langues de la région. L'ensemble des épisodes a été gratuitement mis à disposition de toutes les chaînes TV de la région et diffusé sur les réseaux sociaux.

Face au succès rencontré par les émissions TV, un livre reprenant l'ensemble des recettes a été publié. Il est disponible gratuitement sur le site web www.spc.int - rubrique « documentation ». Ces différents outils (vidéos, livre) peuvent être utilisés par les agents communautaires et professionnels de promotion de la santé pour la réalisation d'ateliers culinaires ou de séances d'éducation sanitaire.

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Mobile gaming, online violence exposure, and low literacy predict aggression among children

Authors: Fong-Ching Chang, Chiung-Hui Chiu, Yi-Pin Lin, Chen-yu Chen
Affiliations: Department of Health Promotion and Health Education, National Taiwan Normal University

IUHPE 23rd World Conference on Health Promotion

Abstract

Objectives: This study examined the relationship among children's mobile gaming, online violence exposure, literacy, and aggression.
Methods: Responses from 2,155 fifth-grade children recruited from 30 primary schools in Taipei were assessed, and a follow-up was performed in the 6th grade. Self-administered questionnaires were collected for each year.
Results: About one-tenth of children engaged in school bullying and cyberbullying, while children's mobile gaming and online violence exposure increased from 5th grade to 6th grade. Multivariate analysis results showed that after controlling for demographic factors the children who reported higher levels of online violence exposure and lower Internet safety literacy in the 5th grade coupled with an increase in time playing mobile games and violence exposure from 5th grade to 6th grade were more likely to engage in cyberbullying perpetration by 6th grade, while children who reported higher levels of mobile gaming and online violence exposure in the 5th grade predict cyberbullying perpetration persistence in the 6th grade. In addition, children who had higher levels of online violence exposure in the 5th grade and cyberbullying perpetration coupled with an increase in online violence exposure and cyberbullying perpetration predicted school bullying occurrence and persistence in the 6th grade.
Conclusion: Higher mobile gaming, online violence exposure and lower Internet safety literacy predict children's aggression.

Introduction

Children spend more time with new media (computers, tablets and smartphones) than with traditional media (television (TV), printed publications and radio)(Ofcom, 2017). Unlike traditional media violence exposure, new media provide children more interactive way to play violent games with others. An experimental study indicated that playing violent video games lead to more aggression than watching television violence (Polman, de Castro, & van Aken, 2008). Experts and parents worried the influence of children's exposure to violent video games on increasing aggressive behaviors and decreasing prosocial outcomes in long-term.

Violent video games has been a controversial issue during the past two decades. Academics, politicians, and the media debated whether violent video games cause aggression. Some meta-analytic studies found that violent video games increased aggressive cognition, aggressive affect, physiological arousal, hostile appraisals, aggressive behavior, and desensitizing to violence and decreased empathy and prosocial behavior (C. A. Anderson et al., 2017; C. A. Anderson et al., 2010; Ferguson, 2015).

Despite studies have documented that the relationship between media violence exposure and aggression. A very few studies have examined the influence of children's mobile gaming, online violence exposure, and Internet safety literacy on aggression. Children may be more susceptible than adolescents to developing aggression cognition and aggressive behaviors. Thus, this study applied the concept of general aggression model and cognitive information–processing model to examine the relationship of mobile gaming, online violence, Internet safety literacy, cyberbullying and school bullying perpetration.

Methods

Participants and Procedures

A probability-proportionate-to-size sampling method was used to systematically draw a random sample of schools. A total of 30 schools agreed to participate. A total of 2155 students completed the questionnaire in both the 2015 and 2016 surveys. About 18% of students dropped out of the follow-up survey, because some students refused to participate and some transferred to other schools or were absent on that day.

Instrument

The self administered questionnaire was developed based on previous. A group of 8 experts were invited to assess the content validity of the questionnaire. Experts reviewed the draft questionnaire and provided comments and suggestions for improvement. In addition, a pilot survey was conducted to examine the students' responses to the survey and to evaluate the reliability. The dependent variable in this study was the change pattern of cyberbullying perpetration and school bullying behaviors from grades 5 to 6. The independent variables in this study included mobile gaming, exposure to online violence, and Internet safety literacy at 5th grade and the change from 5th grade to 6th grade.

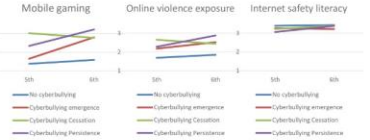
Data analysis

SAS software was used to perform the statistical analysis. Percentages and means were calculated for all variables. Multiple logistic regressions were conducted to examine the influence of mobile gaming, exposure to online violence, Internet safety literacy in grade 5 and changes from grade 5 to 6 as they related to the occurrence and persistence of children of cyberbullying perpetration and school bullying.

Results

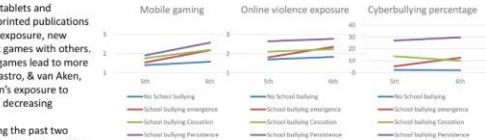
Factors by cyberbullying emergence, cessation and persistence status

- The group of persistent cyberbullying perpetration exhibited the highest weekly mobile gaming days and online violence exposure.
- The group of no involvement in cyberbullying perpetration had the highest Internet safety literacy



Factors by school bullying emergence, cessation and persistence status

- The group of persistent school bullying exhibited the highest weekly mobile gaming days and online violence exposure.
- The group of school bullying occurrence, weekly mobile gaming days and cyberbullying increased.



Predictors of children's cyberbullying emergence and persistence

	Emergence vs. No cyberbullying perpetration		Persistence vs. No cyberbullying perpetration	
	OR	95%CI	OR	95%CI
Gender	1.43	0.78-2.62	0.41	0.14-1.25
Household income	0.74	0.40-1.36	0.90	0.29-2.82
Academic Performance	2.59	1.06-6.30	0.73	0.22-2.50
Parent marital status	1.27	0.58-2.80	0.51	0.16-1.58
Mobile gaming (5th grade)	1.08	0.91-1.29	1.52	1.16-2.00
Mobile gaming (6th-5th grade)	1.21	1.06-1.38	1.16	0.91-1.49
Online violence exposure (5th grade)	1.69	1.29-2.21	1.88	1.17-3.04
Online violence exposure (6th-5th grade)	1.35	1.06-1.72	1.51	0.97-2.35
Internet safety literacy (5th grade)	0.55	0.35-0.85	1.03	0.38-2.79
Internet safety literacy (6th-5th grade)	0.71	0.48-1.04	1.05	0.47-2.37

Predictors of children's school bullying emergence and persistence

	Emergence vs. No school bullying perpetration		Persistence vs. No school bullying perpetration	
	OR	95%CI	OR	95%CI
Gender	1.29	0.84-1.99	1.42	0.60-3.38
Household income	1.06	0.66-1.70	2.27	0.83-6.24
Academic Performance	0.98	0.58-1.66	0.79	0.30-2.13
Parent marital status	0.81	0.48-1.37	1.19	0.42-3.37
Mobile gaming (5th grade)	1.01	0.88-1.16	0.96	0.76-1.22
Mobile gaming (6th-5th grade)	1.09	0.97-1.21	1.05	0.85-1.29
Online violence exposure (5th grade)	1.34	1.07-1.69	2.24	1.56-3.21
Online violence exposure (6th-5th grade)	1.37	1.15-1.64	1.38	1.00-1.91
Internet safety literacy (5th grade)	0.85	0.60-1.20	0.70	0.37-1.31
Internet safety literacy (6th-5th grade)	0.74	0.55-1.00	0.63	0.38-1.07
Cyberbullying perpetration (5th grade)	5.56	1.70-18.20	84.04	22.17-318.55
Cyberbullying perpetration (6th-5th grade)	4.05	1.92-8.55	11.10	4.26-28.91

Conclusions

This study found that more than one-tenth of 5th-6th grade children ever engaged in school bullying and cyberbullying. Children's mobile gaming and online violence exposure increased from 5th grade to 6th grade. Multivariate analysis results indicated that mobile gaming, online violence exposure and low Internet safety literacy predict the occurrence and persistence of children's cyberbullying perpetration, while children's violence exposure and cyberbullying perpetration predicted school bullying occurrence and persistence. Violence prevention interventions could include strategies to reduce children's exposure to media violence and strengthen digital and media literacy to reduce aggressive behavior.

Contact: Fong-ching Chang
Email: fongchingchang@ntnu.edu.tw

Modèle de mise en œuvre de la santé communautaire en Côte d'Ivoire : contraintes et limites

ANOUA Adou Serge Judicaël, Socio-anthropologue de la santé, Université Alassane Ouattara, Côte d'Ivoire

INTRODUCTION

La mise en œuvre de la santé communautaire en Côte d'Ivoire a été traduite par une forme de gestion collectiviste de la santé depuis plus de deux décennies. Cependant, ce mode de fonctionnement reste insuffisant. D'autant que les maladies infectieuses, parasitaires, chroniques, dégénératives, nouvelles et les problèmes de santé reproductive apparaissent aujourd'hui encore préoccupants. De même, l'absence d'une perspective citoyenne n'est pas faite pour réduire cette charge de morbidité. Une telle situation n'exclut pas des contraintes et des limites effectives dans cette démarche communautaire. Cette recherche vise à un éclairage sur les contraintes et les limites de la santé communautaire en Côte d'ivoire.

METHODES

Une visite des structures à charge de la promotion de la santé suivi d'entretiens semi-structurés avec dix (10) acteurs institutionnels aux niveaux national et local et une observation des fonds documentaires ont permis de s'imprégner de l'expérience ivoirienne et d'élaborer les difficultés rencontrées puis les limites en l'état.

RESULTATS

1. L'expérience ivoirienne en santé communautaire

Elle s'appuie sur une approche systémique dans laquelle s'implique les formations sanitaires et les centres de santé urbains à base communautaire.

- Les formations sanitaires urbaines à base communautaire représentaient des appuis institutionnels. Elles avaient pour objectif la déconcentration de la gestion du secteur publique de santé, le développement de nouvelles modalités de gestion administrative et financière dans la production de soins et la planification sanitaire, la mise en place de la gestion communautaire, du système régional d'informations et de plans sanitaires, la réalisation d'un programme d'étude socio-économique et épidémiologique et le suivi de l'exécution des programmes de santé publique.
- Les centres de santé urbains à base communautaire proposaient la mise en œuvre d'activités de prévention et de soins dans les établissements sanitaires intégrés au programme prioritaire de la santé. Elles reposaient sur les soins et suivis actifs des maladies chroniques, parasitaires et les problèmes de santé reproductive (le VIH/SIDA, les maladies sexuellement transmissibles, la tuberculose, la lèpre, le diabète, l'hypertension artérielle, le paludisme et la qualité du suivi pré et post natal, la planification familiale, l'avortement clandestin), les soins avec suivis actifs des groupes vulnérables (femme en âge de reproduction, jeunes enfants et enfants scolarisés), les activités promotionnelles (eau et assainissement), le dialogue et la participation à tous les niveaux de contact avec la population (comité de gestion, communication pour le changement de comportement), la gestion des centres de santé (système d'information, financement, logistique) et la formation des personnels de santé, la recherche action et l'évaluation des études.

2. Les limites de l'expérience ivoirienne en santé communautaire.

Elles sont de deux ordres :

- D'un point de vue épidémiologique, la santé communautaire est médicalisée puisqu'elle est organisée pour faire face à des charges de morbidités infectieuses et parasitaires, des problèmes de reproduction et de santé maternelle et des problèmes nutritionnels.
- D'un point de vue structurel, la santé communautaire est confrontée au problème de la disponibilité des médicaments essentiels sous forme de générique, de l'organisation de la responsabilisation et de la participation des communautés, de l'organisation de la mutualisation de la prise en charge de la maladie, de l'intégration progressive des programmes verticaux, de la décentralisation de l'action sanitaire et de la formation et du statut des agents de promotion de la santé.

CONCLUSION

La santé communautaire nécessite que la mobilisation et l'organisation communautaire favorisent l'articulation entre l'agent de promotion de la santé représentant le système de soins officiels, l'agent de santé communautaire servant d'agent de liaison et la communauté. Ce qui pourrait contribuer à l'émergence de pratiques citoyennes et de réponses collectives aux problèmes de santé.

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Monitoring compliance with the smoking ban in health facilities' outdoor areas in Italy: the *ENFASI-ospedali* study

Enrico Simoncini[1], Giuseppe Gorini[2], Simona Verdi[2], Barbara De Mei[3], Maria Masocco[3], Valentina Minardi[3], Daniela Galeone[4], Lorenzo Spizzichino[4] & MADES Working Group*

[1]Università degli Studi di Firenze, Florence, Italy; [2]Cancer Research & Prevention Institute (ISPRO), Florence, Italy; [3]National Institute of Health (ISS), Rome, Italy; [4]Italian Ministry of Health, Rome, Italy; *Roberta Pacifici, Claudio Mortali, Luisa Mastrobattista, Rosilde Di Pirchio (ISS), Francesco Barone-Adesi, Fabrizio Faggiano (Università del Piemonte Orientale, Novara, Italy), Silvano Gallus (Istituto di Ricerche Farmacologiche "Mario Negri", Milan, Italy), Paolo D'Argenio

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INTRODUCTION

- In Italy, **Legislative Decree 6/2016** introduced the ban on smoking in health facilities' outdoor areas with gynaecology and paediatric services.
- The **ENFASI-ospedali** study aims to monitor the application of this ban.

INTERVENTION

Observational study carried out by local health units technicians between November 2017 and February 2018 on:

- Effective compliance with the ban in hospital outdoor area;
- Presence of smoking detection parameters (cigarette butts, ashtrays);
- Indications of the smoking ban (visible smoking ban signs).

OUTCOMES

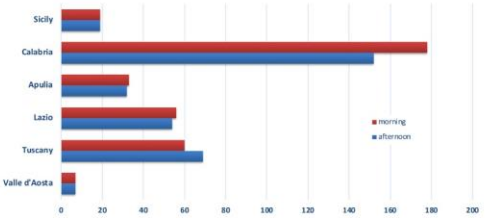
The study involved 38 hospitals in 6 Regions (Valle d'Aosta, Tuscany, Lazio, Apulia, Calabria, Sicily), with 686 observations. Excluding the two Calabrian hospitals, where almost half of the observations were carried out, the average number of inspections was around 10 per hospital.

There was a wide North-South gradient on citizens non-compliance with the ban: 7% in Valle d'Aosta, 9% in Tuscany, 21% in Lazio, 36% in Apulia, 32% in Sicily, 67% in Calabria. In 41% of inspections citizens smoked at the hospital entrance, while in 32% in the inner courtyards.

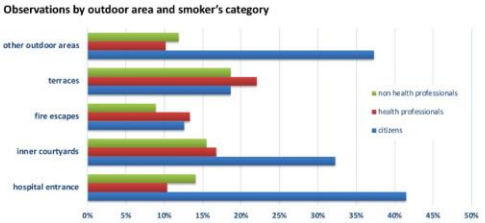
Health professionals smoked in hospital outdoor areas during inspections from a minimum of 3% in Tuscany, to a maximum of 18% in Calabria. In 22% of the inspections they were seen smoking on the terraces and in 17% in the inner courtyards.

Cigarette butts were detected in 74% of the observations (minimum: Valle d'Aosta 43%; maximum: Apulia 89%), while there were outdoor smoking ban signs in external areas in 39% of observations only (maximum 100% in Valle d'Aosta and 87% in Tuscany; minimum 11% in Sicily and 19% in Calabria).

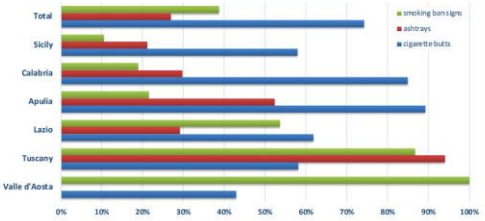
Number of observations by Region



Observations by outdoor area and smoker's category



Observations by Region and smoking detection parameters



CONCLUSIONS

- The geographical area covered by this study is not representative of the whole Italy.
- This pilot study shows that compliance with the smoking ban in health facilities' outdoor areas is still low in Southern Italian Regions.
- More communication efforts are needed with both staff and citizens in order to increase compliance with the ban.

ISPRO Istituto per lo studio, la prevenzione e la rete oncologica
Istituto Superiore di Sanità
Ministero della Salute
Università degli Studi Firenze

WAIORA: Promoting Planetary Health and Sustainable Development for All

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Motivational Interviewing Training for Intimate Partner Violence Intervention Providers

Authors: Sara Soleymani[1], Dr Eileen Britt[2], Dr Mark Wallace-Bell[3]

[1] PhD Candidate, School of Health Sciences, University of Canterbury

[2] Associate professor, Department of Psychology/School of Health Sciences, University of Canterbury

[3] Senior lecturer, School of Health Sciences, University of Canterbury

Background

Client engagement is an essential component in Intimate Partner Violence (IPV) intervention. Studies show that engagement is low in IPV programs, which leads to failure to attend or early drop-out. Motivational interviewing (MI) may be particularly well suited for IPV perpetrators as it has been found to increase treatment engagement, reduce dropout, and improve outcomes among clients who are reluctant to attend treatment and/or change their behaviour. However few practitioners in the IPV field receive formal training in MI. If practitioners learn how to provide MI-consistent practice, and this leads to increased engagement, and reduced drop out; then there are potential significant benefits to the participant, whānau, hapū and iwi.

Motivational Interviewing

Methods

A 2-day MI training workshop was provided by a member of Motivational Interviewing Network of Trainers (MINT), and was attended by 10 practitioners from Aviva Family Violence Services (Aviva for short) and Stopping Violence Services (SVS) in Christchurch. Pre and post-training the Aviva and SVS practitioners were administered a NZ version of the Video Assessment of Simulated Encounters-Revised (VASE-R), referred to as the VASE-R NZ. The participants were also asked to audio-record at least two MI sessions post-workshop training which were coded using the Motivational Interviewing Treatment Integrity (MITI) rating system. They also received feedback and coaching to further develop their MI skills post-workshop training.

Table 1: VASE-R scores for participants who completed the workshop (n=7)

	Minimum	Maximum	Std. Deviation	Mean	Sig. (2-tailed)
pre-full score	14	24	3.93	19.14	0.027*
post full score	18	31	5.20	27.14	
Pre Reflective Listening	1	8	2.42	5.71	0.28
Post Reflective Listening	5	8	1.21	6.85	
Pre Responding to Resistance	1	7	2.19	4.14	0.018*
Post Responding to Resistance	6	10	1.39	8.42	
Pre Summarizing	0	3	1.21	2.14	0.08
Post Summarizing	2	4	0.69	3.14	
Pre Eliciting Change Talk	0	4	1.25	2.28	0.07
Post Eliciting Change Talk	1	6	1.95	3.85	
Pre Developing Discrepancy	4	6	0.95	4.71	0.71
Post Developing Discrepancy	0	6	2.26	4.85	

Results:

The mean of full VASE-R score increased from pre to post training (19.14 to 27.14) which was statistically significant ($p < 0.02$). However, of the subscales, only responding to resistance (i.e., responding to difficult moments in clinical sessions without increasing confrontation or arguments) was statically significant, and practitioner's skill was increased from 4.14 at pre-training to 8.42 at post-training ($p<0.018$). The MITI 4.2.1 results showed that by Audio 2 all of the practitioners demonstrated at least a fair level of proficiency on measures of reflective listening (a core MI skill). Also, 3 out of 4 of the participants achieved at least a fair level of proficiency on the technical and relational aspects of MI, suggesting MI-consistent practice.

Discussion

The results suggest that the MI training produced measurable gains in the MI skills of practitioners working in IPV. These results are consistent with other research on MI training suggesting that practitioners are able to develop MI consistent skills from workshop-based training. Feedback and coaching is also recommended to facilitate the transfer of these skills to the workplace. Given that engagement is a significant issue for IPV perpetrators, IPV intervention providers may consider training their staff in MI to increase engagement.

Table 2: Descriptive Statistics for MITI 4.2.1 results

Behaviour Counts (n >5)	Mean	Standard Deviation	% Does Not Meet Threshold First Audio	% Fair Level of Competency First audio	Good Level of Competency First audio	% Does not Meet Threshold Second Audio	% Fair Level of Competency Second Audio	% Good Level of Competency Second Audio
Reflection to Question Ratio (R:Q)	1.21	0.52	25	75	0	0	100	0
Percent Complex Reflections (%CR)	62.37	19.42	0	25	75	0	25	75
Technical Skills	3.37	0.82	25	75	0	25	25	50
Rational Skills	3.49	1.08	25	25	50	25	25	50

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NECESSITY FOR INNOVATIVE FORMS OF INTERACTIVE EDUCATION FOR TEENAGERS TO PROMOTE MENTAL HEALTH AND DEVELOP SOCIAL SKILLS

Prof. Zaharina Savova, DM | **Ass. prof. Evgeni Ivanov, DM**
Medical College at Medical University, Sofia, Bulgaria | Faculty of Public Health at Medical University, Sofia, Bulgaria

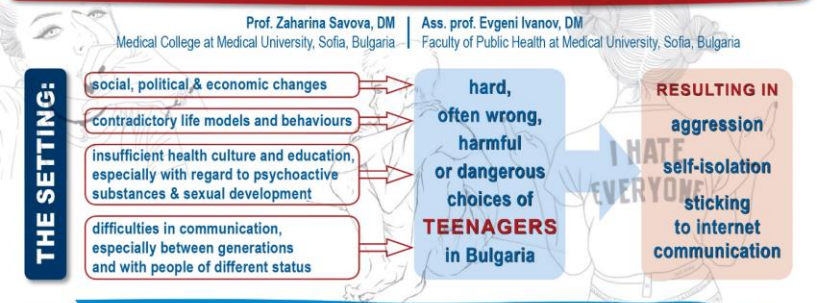
THE SETTING:

- social, political & economic changes
- contradictory life models and behaviours
- insufficient health culture and education, especially with regard to psychoactive substances & sexual development
- difficulties in communication, especially between generations and with people of different status

→ **hard, often wrong, harmful or dangerous choices of TEENAGERS in Bulgaria**

→ **RESULTING IN**

- aggression
- self-isolation
- sticking to internet communication



WHAT IS NEEDED?

new educational forms for risk prevention and health promotion

INTERVENTION:

✓ **development** of an innovative form of interactive trainings *Mental Health and Social Skills*

✓ **designed for** teenagers 14-19, their parents and teachers

✓ **the goals:**
- increasing of self-awareness
- development of individual potential
- building of effective communication skills

✓ **the format:**
- participation through personal experience
- role plays & dramatisation
- talks and free discussions on topics, chosen by participants

✓ **implementation:**
1 school year, 3 targeted groups,120 participants

THE OUTCOMES:

- for 92% of the participants the interactive training was useful and effective and it has definite practical orientation and applicability
- participants opened to each other, were emotional and succeeded to find out some of their hidden resources and qualities
- teenagers, parents and teachers succeeded to hear each other, to understand others' position and to try to find acceptable decisions for tough situations
- 86% confirmed that they expanded their knowledge and understanding about the discussed issues
- the training gave useful information in accessible way to get over the deficits in knowledge and skills and to make teenagers capable of identifying risks and dangerous behaviours
- the format enabled participants to discuss important and pressing issues freely

IMPLICATIONS:

The necessity the innovative form of interactive trainings *Mental Health and Social Skills* to be continued as a policy to provide grounds for work with real needs and problems of teenagers was confirmed.

‘O’ofaki: A Pacific centred approach to community development and health promotion

Dr Malakai ‘Ofanoa, University of Auckland

IUHPE 23rd World Conference on Health Promotion

Aim: To empower the community through ‘O’OFAKI– a new participatory action research method for health promotion and community development

1.‘O’OFAKI

Indigenous concept
Tongan metaphor (relationship of hen and her young chicks)
Collective action

2.HOW ‘O’OFAKI EMERGED

From Indigenous methodologies: Kakala Model (Thaman, 1993) and Talanga (‘Ofanoa, 2015) in two qualitative studies.

a) To explore the Kava use and consumption by Tongan men in Kava clubs (Ofanoa, 2017).

b) Loto‘i Tonga: A participatory action research to identify health needs of Tongans living in urban areas (Ofanoa, 2010).

3. FINDINGS

1.‘O’ofaki brings people together TO IMPROVE DETERMINATS OF HEALTH

2. ‘O’ofaki provides moral, spiritual and social support

3.Like the Mother Hen (researcher) provides security, love, caring and safety for chicks (participants)

’O’OFAKI

4.PACIFIC VALUES

RELATIONSHIPS

Pacific values weave together (lalanga) to produce ‘o’ofaki. .

5. LESSONS LEARNT

Useful for health promotion practices.

Welcomes communities with open arms to feel EMPOWERED.

Enables PLANNING, IMPLEMENTATION AND EVALUATION

Enables CULTURALLY SENSITIVE PRACTICES.

‘O’OFAKI needs an awareness of CULTURE..

6. CONCLUSION

‘O’ofaki brings health practitioners TO ACT FOR HEALTH through EMPOWERMENT!!

THE UNIVERSITY OF AUCKLAND NEW ZEALAND
MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

Operationalising Undergraduate Nurse Education and Training Programmes to empower young people's health promotion and education developments within UK school settings.

Dr Maxine Holt & Professor Susan Powell.
Manchester Metropolitan University, UK

Background

One of the key priorities of the UK Government Five Year Forward View[1] is the need for a radical upgrade in prevention and health promotion in order to ensure the future health of millions of children.

Such initiatives will be supported by a future healthcare workforce, which contributes to improving health, and reducing health inequalities.

The imperative for all nurse disciplines to support the five year plan and further develop health promotion and prevention skills are expanded within the 2018 UK Nursing and Midwifery Council Standards[2]

Project aims

- To support the ambitions of UK government health policy to engage nurses in public health interventions for young people.
- To upskill undergraduate nurses to be Health Ambassadors to prevent illness, protect health and promote wellbeing in children.
- To involve and support young people in their own health and wellbeing.

Methods

Undergraduate general nurses designed and delivered interactive workshops to young people in schools on topics including:

- Emotional wellbeing and resilience
- Healthy Eating and Nutrition
- Exercise and living a healthy lifestyle
- Hygiene
- First Aid

Findings

- Undergraduate nursing students experienced an intervention in a setting outside of the hospital environment.
- Informed future curriculum development for the pre and post registration nurses
- Raised awareness of public health issues in young people
- Young people were actively engaged in measuring their own health and wellbeing

References
[1]NHS (2017) The review of the NHS Five Year Forward View
[2]NMC (2018) Standards for pre-registration nursing education

Contacts: m.holt@mmu.ac.uk or s.Powell@mmu.ac.uk

Oral Health and Health Literacy: tobacco use among adolescents as a field of intervention for health promotion

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Background/Objectives

In 2013, a study was carried out among adolescents in the 9th grade of 16 municipalities belonging to the Portuguese Network of Healthy Cities. It was verified that 52% of adolescents had tried smoking. In this group, 44,1% are boys and 55,9% are girls. During adolescence, individuals tend to adopt the same behaviors that are followed by their peers (e.g. tobacco use). This use has a direct influence on the individual's oral health.

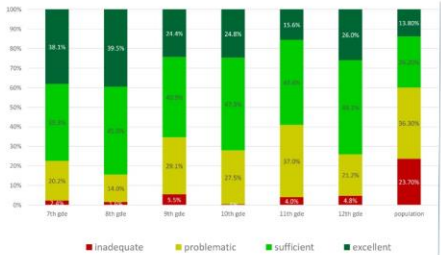
Methods

A preliminary analysis of the literature of the past 5 years was developed in order to identify research and best practices that would explore he use of health literacy in smoking prevention in oral health. HLS-EU-PT®-survey among adolescents to determine their health literacy level and smoking behaviors was assessed.

Results

No research has been published in the country that relates oral health to smoking and explores the influence of health literacy. In 2008, 10.2% of boys and 9.1% of girls are regular smokers. Smoking increases with age. At 15 years old 12.3% of the boys and 8.6% of the girls are regular smokers and 6.1% of the boys and 4.0% of the girls are occasional smokers. Looking at prevalence by region, the highest prevalence of regular smoking is found in Alentejo (14.7%), followed by Azores (11.8%) and the lowest is found in Algarve (4.1%). Health literacy levels of adolescents decrease with age.

HLS•EU•PT



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source CrAdLiSa project n= 832
www.literacia-saude.info

Tobacco use among adolescents is increasing in the Region, and in some countries (e.g., Czech Republic, Latvia or Lithuania) tobacco use among youth is very similar to that among adults. According to the 2013/2014 round of the Health Behaviour in School-aged Children (HBSC) study, the percentage of boys who smoked at least once a week at the age of 15 years old ranges from a low of 5% in Armenia to a high of 51% in Greenland. The percentage of girls who smoked at least once a week at the age of 15 years old ranges from 1% in Armenia to53% in Greenland. The average for all countries represented in the report was 12% for boys and 11% for girls.

Current Tobacco Smoking in Europe

No room for complacency

WHO Region	Male prevalence	Female prevalence	Both sexes
Europe	38%	19%	28%
Western Pacific	48%	3%	26%
Eastern Mediterranean	37%	3%	20%
America	22%	13%	17%
South-East Asia	32%	2%	17%
Africa	25%	2%	13%
Global	36%	7%	21%

Source: WHO report on the global tobacco epidemic, 2015: Raising taxes on tobacco.

Discussion

Among the WHO regions, Europe has the highest prevalence of tobacco smoking among adults (28%) and some of the highest prevalence of tobacco use by adolescents

Health has a central place in United Nations Sustainable Development Goal (SDG) 3 – "Ensure healthy lives and promote well-being for all at all ages" – one of the 17 SDGs that all UN Member States collectively aim to achieve by the year 2030. Target 3.a of SDG 3 refers particularly to strengthening the implementation of the WHO Framework Convention on Tobacco Control (WHO FCTC) in all countries.

In order to set a strong agenda of oral health promotion, a study that would focus on this topic is considered urgently needed. In order to achieve this, a qualitative study explores the oral heath/smoking binomial in order to better contextualize the topic and thus contribute to the young people's awareness about the implications that tobacco use has on oral health.

Saboga-nunes L [1] , Afonso, C. [2]

[1] ProLiSa; CISP - National School of Public Health, Universidade Nova de Lisboa; University of Education Freiburg, Germany; Isamb-FML; Portugal; (saboga@prosalus.com; +351 914747066)

[2] National School of Public Health, Universidade Nova de Lisboa;

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Organizational sense of coherence and psychological well-being: its relationship with the employee's burnout and compassion Index

John Alexander Castro Muñoz M.Sc.
Sanitas University Fundation & Keralty Organization– Colombia

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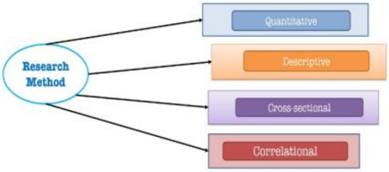
Abstract

The aim of this study, was to assess the possible meaningful relationship between the Organizational sense of coherence (Work – SOC) and the psychological – eudaimonic well-being with the presence of burnout and the level of compassion within employees of an organization from the health area. The sample was composed by Six thousand three hundred thirty-one men and women with an age between 18 to 60 years old. In order to measure all of the variables, specific cultural validated psychometric scales were used for every single one of them. The results in general showed meaningful correlations between all of the variables, representing the importance of the work sense of coherence as a predictor of the level of burnout.



Sample

N= 6331
Age: Between 18 to 60 years old
(M= 37,30 & SD= 9,03

Measures

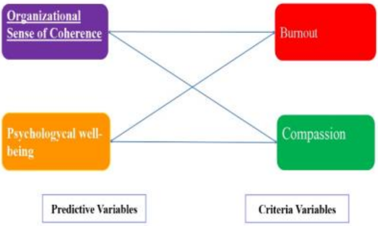
Organizatipnal Sense of Coherence – Work - SOC (Bauer)
Chronbach's Alpha: 0,83

Psychological well-being
Eudaimonic Well-being Scale (Ryff, 1995) Spanish Traslation, Validate in Colombia by Pineda, Castro y Chaparro (2018)
General Cronbach's Alpha: 0,86

Burnout – Maslasch Burnout Inventory
Chronbach's Alpha: 0,79

Compassion – By using a scale created by and organization in order to measure the perception of interpersonal compasion
Chronbach's alpha: 0,73

Correlational - Model Variables



Results

Correlations R Spearman

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. Organizational Sense of Coherence													
2. Purpose of Life	,330**												
3. Self Aceptance	,197**	,347**											
4. Positive relations	,330**	,622**	,398**										
5. Autonomy	,254**	,542**	,336**	,528**									
6. Environmental mastery	,348**	,828**	,358**	,860**	,569**								
7. Personal Growth	,394**	,794**	,564**	,825**	,715**	,817**							
8. Eudaimonic Well-being (Ryff)	,398**	,794**	,556**	,827**	,714**	,816**	,966**						
9. Burnout (MBI) Aemonal Exhaustion	[illegible]	-,285**	-,156**	-,280**	-,220**	-,305**	-,326**	-,324**					
10. Burnout (MBI) Depersonalization	-,363**	-,219**	-,139**	-,263**	-,215**	-,225**	-,311**	-,312**	,438**				
11. Burnout (MBI) Personal fulfillment	[illegible]	,416**	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	,472**	-,273**	-,226**			
12. Burnout Total (MBI)	[illegible]	-,482**	-,281**	-,431**	-,356**	-,431**	-,491**	-,500**	,727**	,882**	-,711**		
13. Interpersonal Compassion Index	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	-,302**	-,361**	,282**	-,380**	
**. P < 0,01 (bilateral)													

Lineal regression

Model				
Modelo	R	Adjusted R	Adjusted R Squared	Estimated Standard Error
1	,613a	0,375	0,375	7,594

Coeficients						
Modelo	Non Standard coeficients	Standard Coeficients				
B		Beta		t	F	
1		82,943	1,208	68,681	0	
1. Organizational Sense of Coherence	-0,45	0,012	-0,355	-36,735	0	
2. Purpose of Life	0,209	0,105	0,041	1,986	0,047	
3. Self Acceptance	0,107	0,056	0,025	1,923	0,054	
4. Positive relations	-0,118	0,079	-0,028	-1,495	0,135	
5. Autonomy	0,037	0,076	0,008	0,493	0,622	
6. Environmental mastery	-0,046	0,084	-0,012	-0,548	0,583	
7. Personal Growth	-0,387	0,159	-0,43	-2,436	0,015	
8. Eudaimonic Well-being (Ryff)	0,055	0,15	0,064	0,368	0,713	
a. Dependent variable: Burnout Total (MBI)						

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WAIORA: Promoting Planetary Health and Sustainable Development for All

Participatory design and testing of an adaptive e-coach for leaders for health promoting team development

Bauer GF, Brauchli R, Grimm L, Jenny GJ; Center of Salutogenesis, University of Zurich, Switzerland

IUHPE 23rd World Conference on Health Promotion

1. Background

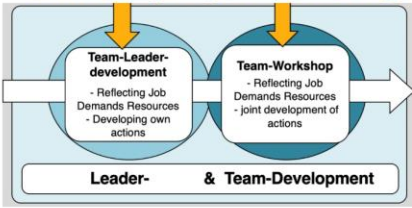
- Increasing relevance of **psychosocial factors** at work
- Increasing flexwork requires **decentral solutions**
- **Collective tools** are lacking
- Build on proven two step-capacity building on team level (Bauer & Jenny 2018)

2. Aims

- **Participatory** development & testing of an e-coach for leaders & their teams
- **building the capacity** of leaders and teams for a team development process
- **improving the balance** of job demands and resoures in their teams (JDR Health Model, Brauchli et al. 2015)

3. Mental model

4. Two-step capacity building



5. Participatory design

- **Script** of previously tested change process
- **Rapid prototyping** of app incl. focus groups with 12 leaders

6. Testing

- **Usability testing** remote & in lab – 2/3 favorable rating
- **Field testing**: 18 leaders - diverse companies; 12 leaders - 1 company

7. Product www.wecoach.ch

8. Digital coach? - Chatbot

1. **Guides** through change process
2. **Coaches:** Tasks, self reflection e.g. about boundary conditions, barriers / facilitators
3. **E-learning: K**ey knowledge
4. **Instruments:** Surveys, Workshop-Planning, Controlling

9. Conclusions

- **Motivation:** Shared mental model
- **Sustainability:** Capacity building and self-determined tool
- **Dissemination:** Fully automated and adaptive; User linkage
- **Effectiveness:** Automatic collection of rich context, process, outcome data; Ongoing RCT effectiveness study

WAIORA: Promoting Planetary Health and Sustainable Development for All

Schweizer Radio Organisation · UniversitätsSpital Zürich · Center for Digital Health Interventions ETH Zürich / Universität St. Gallen · Universität Zürich · CH Solutions GmbH

Patient Empowerment in the Management of Hypertension in Sub-Saharan Africa: A Systematic Review

Amélie Mogueo[1,2]; Charity Omenka[1,2], Marie Hatem [1] & Barthelemy Kuate Defo [1,2]
1. Université de Montréal, Ecole de Santé Publique;
2. Institut de recherche en santé publique de l'Université de Montréal

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Introduction

Hypertension is one of the highest preventable contributors to the global burden of disease and death, with an estimated 7.5 million deaths (**12.8% of the total)** worldwide. If left untreated, it is a major risk factor for cardiovascular events, leading to myocardial infarction, stroke, renal failure, and death. The World Health Organization (WHO) estimates the prevalence of **hypertension at 46% to be highest in Africa**.

Patient empowerment (PE), "a process through which patients gain greater control over decisions and actions affecting their health", is one principle of WHO's Global Plan of Action for the prevention and control of noncommunicable diseases (NCD) 2013-2020.

Interventions based on PE have proven to be cost-effective for controlling hypertension and have shown a considerable impact on patients self-efficacy, allowing for better control of biochemical parameters (e.g. Blood pression), physical parameters (e.g. Body Mass Index) and life quality (e.g. diet).

No study has been done in SSA on the effects of interventions based on PE in the control of hypertension. This systematic review aims to fill this gap.

Method

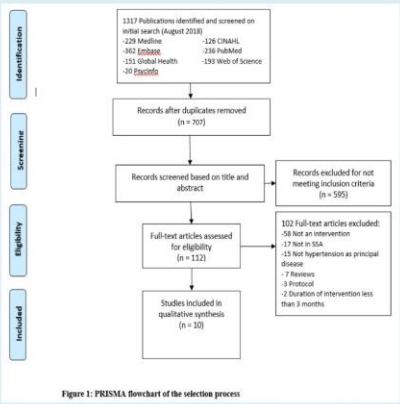

Figure 1: PRISMA flowchart of the selection process

PICO

P: hypertensive patient ≥ 15 years old,
I: intervention based on PE,
C: standard diabetes care,
O: personal ability, biochemical & physical parameters, quality of life and Cost-effectiveness.

Characteristics of included studies :

Publication year: from 1991 to 2018.

Study design: cohort (**6**), RCT (2), quasi experimental (1), cross-sectional (1).

Type of the intervention: clinic (**8**) & community (2) based.

Country: South Africa (**4**), Nigeria (3), Cameroon (1), Ghana (1), Côte d'Ivoire (1).

Quality of studies: poor (4), medium (4), good (2).

Place of residence: Urban (**6**), mixed (3), rural (1).

Participants: N= 3227, Women (43.88%), Age: ≥ 18 years old.

Lost to follow up at the end of the intervention: n=383

Mode of delivery: individual education (**8**) & group education (2).

Duration of the intervention: 3 (2), 6 (4) & 12 (4) months.

Results

Effects of the interventions:

Several studies found significant difference between control and intervention groups in favor of intervention for **knowledge** on medication & salt reduction/restriction (n=2), for **patients satisfaction** with means score > 4="satisfied" and 97.5% "very satisfied" (n=2), for **hospital attendance or** days of treatment received (n=1), for **return visits** (n=2), for **SBP** (n=1), **DBP** (n=2), **BMI** (n=1), for **quality of life** in terms of smoking cessation & fruit consumption and vegetable consumption (n=1) and for **Cost-effectiveness ratio** $320/DALY, were the intervention was cost-saving (n=1).

Other studies also found no significant difference between group for k**nowledge** on weight control, alcohol reduction, stroke, heart attack / angina, heart failure, salt use by patients (n=1), for **awareness** on blood pressure control (n=1), for **medication compliance** (n=1).

One study reported significant difference between groups for **DBP** in favor of control group.

Conclusion & Recommendation

Although the approach of patient empowerment is increasingly being used worldwide to control NCD including hypertension, this review show that **there is insufficient evidence** to say whether interventions based on PE for hypertensive patients in SSA are effective in improving personal ability, physical parameters, quality of life and Cost-effectiveness.

There is a need to **contextualize and standardize** the implementation of patient empowerment intervention in SSA, first by using the same definition of PE and second by using the same indicators to evaluate the effects of the intervention.

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Plastics Upcycling Solution for Hospitals

Connie Cai Ru Gan[1], Ying-Fang Pan[2]
[1] Centre for Environment & Population Health, Griffith University
[2] Taichung Tzu Chi Hospital, Tzu Chi Medical Foundation

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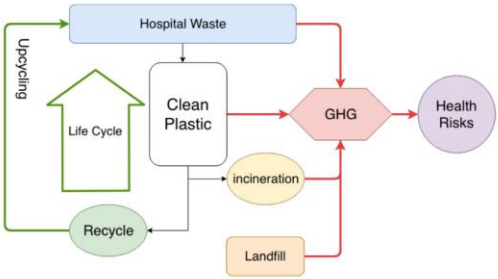
Problem & Aim

- Hospitals produce tons of plastic waste which end-up in landfills and incinerated in hazardous waste disposal plants which significantly harm the environment and the health and wellbeing of the community.
- Anthropogenic pollution is undeniable as hospital plastic audits revealed that medical waste containing about more than 46%-72% of plastic (Health Care Without Harm, 2018).
- Clean plastic used in drugs packaging in hospital rarely been recycled due to the lack of successful action models.
- This research aimed to examine the opportunities and challenges through need-based inter-sectoral partnership and stakeholder engagement.

(Source: Health Care Without Harm, "Plastic in Healthcare Technical Report" 2018)

Intervention

- Need assessment and process evaluation of plastic waste management in a hospital pharmaceutical warehouse was conducted and analysed.
- Additional cartons were installed for all handlers to place recyclable plastic waste. Cleaners shred all bulky plastics to minimize the volume and transport to a neighbouring recycling station periodically.
- Designated plastic recycling bins were placed with a scheduled weekly inspection to monitor the implementation.
- Problems and challenges in sorting, shredding, temporary storage and transportation has been identified.



Outcomes

- In 2016 to 2017, a total of 1.07 metric tons (average of 40kg every month) of plastic waste was recycled and equivalent saving 4.922e+17 amount of dioxin formation in exhaust gasses from an incinerator.
- Clean plastics were recycled and made into useful new by-products such as boomerang bag, covers, moneybox.

Implications

- The project concludes that significant environmental and economic benefits could be achieved by improving hospital plastic waste handling management.
- A step-by-step action plan with active participation from stakeholder is crucial.
- This should also cover from hospital procurement policy, involvement of health promotion steering committee aiming to reduce the amount of plastics use, stretch out to the collection and sorting of waste requiring efficient logistic arrangement.

Potential psychological mechanism of well-being in migrations: a structural equation models analysis

Authors: Chen Hao[1], Wang Lei[1], Wei Yanxia[1], Ye Bo[1], Junling Gao[1], Wang Fan[2], Dai Junming[1] and Hua Fu[1]

Affiliation: [1]Fu University, Shang hai, China [2]Huazhong Normal University, Shang hai, China

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Objectives:

The aim of this study is to identify the potential psychological mechanism of well-being in migrations of Shanghai, China, a cross-sectional study was conducted in 2018.

Methods:

Study population and settings

In total, 2573 migrant workers were randomly sampled through two procedures. Occasional sampling were used to select population , totally 471 workers or salesmen, from shopping malls, restaurants, barbershops and other type stores in 6 urban districts. The rest of 2120 migrant workers were selected from 6 large workplaces large workplaces (staff number ≥ 300) .

Figure 1. The distribution of sampling setting

Measurements

SOC: The sense of coherence (SOC) was measured by short version of SOC scale, which contained three dimensions: comprehensibility (5 items), manageability (4 items) and meaningfulness (4 items).

Depression: The patient health questionnaire (PHQ-9) is a diffusely used instrument, which quantifies the frequency of being bothered by 9 evaluative items over the past 2 weeks.

Well-being: Personal well-being index (PWI) was selected to measure the subject well-being which had been validated in different countries and cultural background. It contains eight different domains.

GRRs: This present study selected five level of GRRs according to Chinese character, including: income ratio, education attainment, marital status, family accompany, preventive activity.

Results 1:

The specific association among demographic characteristics, PWI, SOC, and PHQ were described in Table 1.

Table 1. The PWI, SOC, and PHQ in different demographic characteristics

	PWI	SOC	PHQ
Gender			
male	49.60(13.17)**	63.07(11.13) **	6.45(4.98) *
female	47.11(12.62)	60.98(10.57)	6.89(4.50)
Age			
18-24	48.06(0.43) *	61.09(0.36) *	6.82(0.16) *
25-39	48.01(0.35)	62.59(0.30)	6.96(0.13)
40-49	49.80(0.81)	62.76(0.68)	6.66(0.29)
50-59	50.98(1.48)	61.19(1.14)	5.18(0.48)
Jobs			
Direct labor	48.62(0.42)	62.74(0.35) *	6.16(0.15) *
Administrative staff	49.14(1.18)	62.76(1.01)	6.59(0.40)
Clerk	48.81(0.73)	61.70(0.58)	6.59(0.23)
Professional	49.01(0.61)	63.01(0.53)	6.49(0.23)
Service staff	46.88(0.58)	59.94(0.48)	7.92(0.23)
Others	48.03(0.58)	61.38(0.76)	6.82(0.31)
Education			
Secondary school and below	49.90(0.56) **	62.11(0.50) **	6.12(0.21) **
Senior high school	48.74(0.47)	63.25(0.38)	6.55(0.17)
Junior college	47.89(0.55)	61.66(0.42)	6.81(0.19)
Undergraduate College and above	46.84(0.47)	60.72(0.42)	7.19(0.18)

Results 2:

PWI show the moderately positive relation to total score of SOC, while the negative correlation to PHQ score .There are also negative correlation between PHQ and SOC .

Table 2. The Pearson correlation of PWI, SOC and PHQ

		M	SD	Cronbach'α	1	2
1	PWI	48.35	12.95	0.92		
2	SOC	62.02	10.90	0.81	0.46**	
3	PHQ	6.67	4.75	0.88	-0.49**	-0.53**

The ultimate module totally contributed the 33.3% variance to the PWI and did not exists multicollinearity which VIF coefficient all below 1.5

Table 3. Adjusted associations SOC, PHQ, GRRs between and well-being

Variate	Association with case-level personal well-being(β,95%CI)		
	Model 0	Model 1	Model 2
SOC			
Comprehensibility	0.10(0.13,0.38) **	0.08(0.10,0.34) **	0.09(0.10,0.36) **
Manageability	0.09(0.13,0.41) **	0.09(0.15,0.42) **	0.09(0.13,0.40) **
Meaningfulness	0.15(0.37,0.66) **	0.15(0.37,0.65) **	0.15(0.36,0.65) **
PHQ	-0.35(-1.05,-0.84) **	-0.32(-0.97,-0.76) **	-0.32(-0.98,-0.77) **
GRRs			
Marital status			
Spinsterhood	-	Reference	Reference
Married	-	0.04(0.02,2.85) *	0.06(0.45,2.70) *
Income ratio			
Enough income	-	0.16(4.84,7.54) *	0.16(4.74,7.50) *
Balanced income	-	0.11(1.99,3.81) *	0.11(2.01,3.86) *
Insufficient income	-	Reference	Reference
R^2	0.30	0.33	0.33

** p<0.001,* p<0.05

Results 3:

Comparing to the criteria of goodness-of-fit statistics, it was greater fit to the data (χ^2/df = 264.68, RMSEA = 0.08, CFI = 0.95) and all the paths were statistically significant (P < 0.05) with estimates are shown in Fig. 2

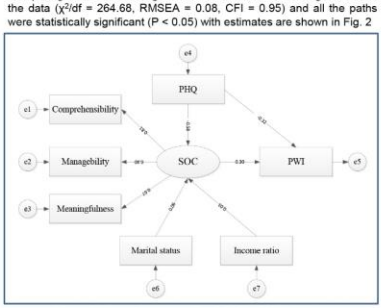

Figure 2. The paths among PHQ, SOC, GRRs, PWI

Conclusion:

- The present study, using a representative sample of migrant worker, expounded the potentials of GRRs(income ratio, marital status), mediating effect of SOC between depression and GRRs by establishing pathways to better well-being.
- Such domains as fostering social bonds and developing activities aimed at promoting marital relations and social welfare would seem to have special function for well-being initiated from the results of present study.

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Prep vision screening outcomes reflect the social gradient

Roche, E[1], Wiseman, N[1], Sofija, E[1], Lee, P[1], Asper, L[2], Duffy, S[3], Keel, R[3], Harris, N[1]

[1] Griffith University [2] University of New South Wales [3] Children's Health Queensland Hospital and Health Service

INTRODUCTION

- Early detection of vision issues in children has been linked to improved wellbeing, school performance, social and economic outcomes.
- Children's Health Queensland Hospital and Health Service implemented a state-wide vision screening program to promote early detection of vision abnormalities among prep students.

AIM

This paper reports on the prevalence and distribution of vision abnormalities among Queensland prep students for 2017.

METHODS

- Vision screening of Queensland prep students conducted by community Registered Nurses
- Two screening tools: Parr 4m Visual Acuity Test and Welch Allyn Spot Vision Screener.
- Participant screening results, together with community socio-demographic data were reported.
- Descriptive statistics for schools screened, prep students screened and screening outcomes.
- Chi-square test to examine the association between number screened, number referred and Socio-Economic Indexes for Areas (SEIFA).

RESULTS

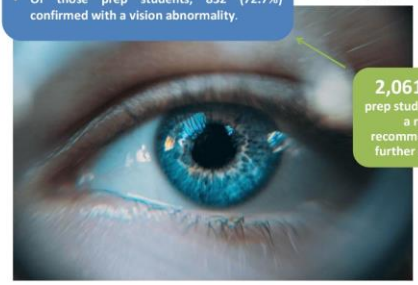
10 Hospital and Health Services (HHS) of 14 HHSs implemented the program

738 of 1,473 schools participated

33, 705 prep students screened

2,061 (6.1%) prep students received a referral recommendation for further assessment

- Of the students who received a referral recommendation, referral outcome data was available for 1,145 (55.5%).
- Of those prep students, 832 (72.7%) confirmed with a vision abnormality.



Referral rate for further assessment was negatively associated with SEIFA quintile (χ^2 = 105.24, p <0.001). See Table 1.

Table 1: SEIFA quintiles by vision screening outcome
(1 = most disadvantaged locations, 5 = most advantaged locations)

SEIFA quintile		Vision screening outcome			
		Passed	Referred	Total	Percentage referred from total screened
1.0	Count	5233	460	5693	**8.08**
	% within status	16.5%	22.3%	16.9%	
2.0	Count	3454	274	3728	**7.35**
	% within status	10.9%	13.3%	11.1%	
3.0	Count	6607	466	7073	**6.59**
	% within status	20.9%	22.6%	21.0%	
4.0	Count	7606	469	8075	**5.81**
	% within status	24.0%	22.8%	24.0%	
5.0	Count	8744	392	9136	**4.29**
	% within status	27.6%	19.0%	27.1%	
Total	Count	31644	2061	33705	**6.11**
	% within status	100.0%	100.0%	100.0%	

CONCLUSION

- The prep vision screening referral rate of 6.1% was consistent with other comparable vision screening programs conducted in Australia and internationally.
- This suggests the program was effectively identifying children displaying signs of vision abnormalities.
- The association between referral of prep students and SEIFA scores evidences the social gradient.
- This suggests that vulnerable populations may be more likely to experience undetected vision problems and the associated negative impacts on wellbeing.
- Program implementation should prioritise vulnerable populations.

Griffith UNIVERSITY · UNSW · Children's Health Queensland Hospital and Health Service

Prevalence and Combining Patterns of Metabolic Syndrome in Korean adults

Jiwan Kang*, Eunhee Nah**, Hyekyeong Kim*,***
*Expert Group on Health Promotion for Seoul Metropolitan Government
**Korea Association of Health Promotion, Health Promotion Research Institute,
***Department of Health Convergence, Ewha Womans University, Seoul, Korea

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BACKGROUND & OBJECTIVE

- Metabolic syndrome (MetS) refers to a condition with three or more of the five risk factors for type 2 diabetes and cardiovascular disease (CVD).
- In Korea, metabolic syndrome has increased due to rapid changes in lifestyle in a short time. As one out of five Korean adults has MetS now, detailed and personalized aspects of management content for MetS should be developed.
- MetS consists of three or more out of five CVD and diabetes risks, thus 16 variant compositions are possible. However specific characteristics of the varying compositions have often been neglected in clinical practice.
- The aim of this study is to examine the prevalence and patterns of metabolic syndrome among Korean adults.

METHODS

- Data was extracted from the database of Korea Association of Health Promotion(KAHP), the organization of health screening.
- The data included sex, age, and 5 MetS parameters of adults (age ≥ 20). A total of 123,424 Korean adult participants' data were included to investigate the patterns of prevalent MetS.
- MetS is defined by the National Cholesterol Education Program – Adult Treatment Panel III (NCEP-ATP III) criteria and the Korean standard for abdominal obesity. MetS means having 3 or more of the followings
  1. Abdominal obesity(AO): Waist circumference ≥ 90 cm for men and ≥ 85 cm for women
  2. High triglyceride(HTG): Triglyceride ≥ 150 mg/dL
  3. Low HDL-Cholesterol (LHDL-C): HDL-C < 40 mg/dL for men and < 50 mg/dL for women
  4. High blood pressure(HBP): Systolic blood pressure ≥ 130 mmHg or Diastolic blood pressure ≥ 85 mmHg
  5. High fasting blood glucose(HFG): Fasting blood glucose ≥ 100 mg/dL
- We The prevalence and composition of MetS were presented in frequencies and proportions, stratified by sex and age groups.
- Statistical differences are evaluated by chi-square tests at significance level of 0.05 using SPSS 23.

RESULTS

Figure 1. Age-adjustment prevalence of MetS components by sex in Korean adults 30 years of age and over, 2015

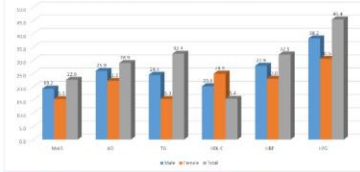
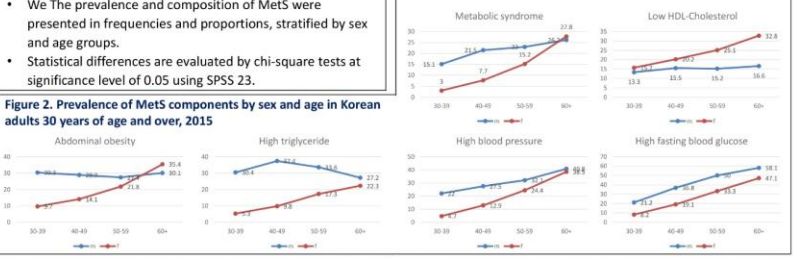


Table 1. Combining patterns of metabolic syndrome components in Korean adults 30 years of age and over, 2015

Combinations	Sex				Total	
	Male		Female			
	n	(%)	n	(%)	n	(%)
Three components						
AO + HTG + LHDL-C	681	4.9	457	5	1138	5
AO + HTG + HBP	850	6.2	264	2.9	1114	4.9
AO + HTG + HFG	1765	12.8	430	4.7	2195	9.8
AO + LHDL-C + HBP	228	1.7	402	4.4	630	2.8
AO + LHDL-C + HFG	461	3.3	752	8.3	1213	5.3
AO + HBP + HFG	1954	14.2	1478	16.2	3430	15
HTG + LHDL-C+ HBP	332	2.4	399	4.4	731	3.2
HTG + LHDL-C + HFG	990	7.2	928	10.2	1918	8.4
HTG + HBP + HFG	1962	14.2	372	4.1	2334	10.2
LHDL-C + HBP + HFG	273	2	576	6.3	849	3.7
Four components						
AO + HTG + LHDL-C + HBP	355	2.6	302	3.3	657	2.9
AO + HTG + LHDL-C + HFG	770	5.6	657	7.2	1427	6.2
AO + HTG + HBP + HFG	1869	13.6	466	5.1	2335	10.2
AO + LHDL-C + HBP + HFG	257	1.9	526	5.8	783	3.4
HTG + LHDL-C + HBP + HFG	423	3.1	508	5.6	931	4.1
Five components						
AO + HTG + LHDL-C + HBP + HFG	615	4.5	600	6.6	1215	5.3
Number of MetS components*						
Three	9496	68.9	6056	66.4	15552	67.9
Four	3674	26.7	2459	27	6133	26.8
Five	615	4.5	600	6.6	1215	5.3
Total	13785	100	9115	100	22900	100

MetS: Metabolic syndrome; AO: Abdominal obesity; HTG: High triglycerides; LHDL-C: Low high density lipoprotein cholesterol; HBP: High blood pressure: HFG: High fasting blood glucose
* Gender difference in the number of MetS components was statistically significant (P<0.001).

Figure 2. Prevalence of MetS components by sex and age in Korean adults 30 years of age and over, 2015



Conclusion

- The overall MetS prevalence in Korean adults (age ≥ 30) was 19.2% in 2015. Among the five MetS components, high fasting blood glucose was most prevalent and high triglyceride was least. Prevalence of MetS and all of its components except low HDL-cholesterol was higher in men than in women. The most frequent combination of three MetS components was 'Abdominal Obesity + high blood pressure + high blood glucose'. The combination of inclusion factors of MetS was different according to gender. (p<.001)
- Even those with the same metabolic syndrome may exhibit different aspects of their factors. MetS is rather a heterogeneous entity than homogeneous one, thus MetS control strategies should consider gender differences in MetS prevalence, and the implication of the type of its composition.

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Professional Learning and Development in Health and Equity: A Spiral Model

Cecilia Zhang

Equity in health is an important issue. It is an ethical principle; Equity also is consonant with human rights principles. It has been proposed that the pursuit of equity in health is being hampered by the dominance of individualism. This practice presentation provides philosophical foundations for solving equity challenges in health. The purpose of this practice research is to illustrate a model to improve individuals' equity.

Equity may imply everyone receives the same amount of resources regardless of individual needs (Paquette, 1988). In tertiary education, equity may also imply each learner receives educational services that correspond with his/her particular needs, and, therefore, that some learners may receive more resources than others (Jencks, 1988). In other words, choosing between these two perspectives often depends on public resources and the educational system. Indeed, public educational system find it hard to take a clear stand on a matter between to ensure the academic level of all learners meets a certain criterion and to ensure excellence mainly through supporting those who are capable of attaining the highest achievements possible.

Intervention

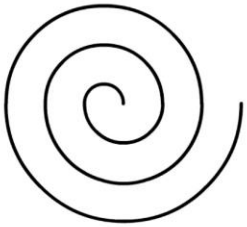
A covenant relationship spiral model has been developed in an Institution to ensure learner's health and equity. There are four elements in the spiral model – covenant, advices, empowering and family-ship can be represented as a cyclical process or feeding into each other on a spiral to a mature relationship. They do not necessarily run only one after another but can function simultaneously.

Outcomes

To improve quality and achieve equitable care for adult learners
To close the gap between individual equity and public resources
To improve the equity in practical ways
To build up a healthy educational society

Implications

Theoretically and practically implement equity in health
A model which is based on philosophic analysis



Professional literacy on health promotion and equity

Simone Tetu Moysés[1], Juliana Schaia Rocha Orsi[1], Sandra Katsue Guiotoku[1], Fernanda Costenaro[1], Larissa Deldotto[1], Samuel Jorge Moysés[1]

[1]Pontifical Catholic University of Paraná, Curitiba, Brazil

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Background/Objective

A competent workforce, with the knowledge, skills and abilities to translate policies, theories and research into effective actions, is considered a critical factor for health promotion and equity. The objective of this research was to analyze professional literacy processes in health promotion and equity in undergraduate training and in primary health care (PHC).

Methods

Phase 1

- Systematization of experiences by thematic documentary analysis

Phase 2

- Perception of competencies for health promotion and equity by undergraduate students (n = 106) and PHC professionals (n = 8)
- Questionnaire dimensions: professional literacy in public health (Freedman et al. 2009) and CompHP (Dempsey et al. 2011)

Phase 3

- Perception of professional literacy process and opportunities for health promotion and equity in PHC. Content analysis

Results

Professional literacy experiences

Undergraduate training
Challenge Based Learning
Understanding the socio-ecological determinants of health

Good Practices in Heath Promotion Group in PHC
Post 22th IUHPE Conference 2016

Competencies for health promotion and equity

Students

- ✓support needs assessment
- ✓prioritization of health promotion actions
- ✓fostering changes on health promotion
- ✓health advocacy
- ✓political action to guarantee health and equity
- ✓partnerships to promote health and equity

Health professionals

- ✓development of strategies for health promotion and equity
- ✓ actions to increase participation and empowerment
- ✓ involvement of partners from different sectors
- ✓ evaluation of results

Professional literacy

The evaluated experiences may have expanded the opportunities for professional literacy in health promotion and equity, supporting the qualification of PHC and health promotion actions, and more resolutive public policies that improve the quality of life of the community.

Conclusions

The analyzed experiences have had an impact on the participants' involvement in new experiences in health promotion and equity, as well as opportunities for conceptual expansion, critical capacity development and professional empowerment, being effective processes for professional literacy in health promotion and equity .

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Disclosures
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PUCPR

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Promote healthy eating among adolescents from low social economic class in Hong Kong

Kara Chan, *Hong Kong Baptist University*; Judy Y.M. Siu, *Hong Kong Polytechnic University*; Albert Lee, *Chinese University of Hong Kong*

A 10-month education program was implemented at a secondary school located in a low income districtwith health talks, parent-child healthy cooking workshop, a public service announcement design workshop and competition. A team of film school students helped to shoot a professional commercial with students as talents, based on the creative idea of the winning team in the public service announcement design competition.

Public service ad design workshop and competition

Film school students produced a professional version with students as talents

OUTCOMES

FOOD DAIRY	FOCUS GROUP	AD DESIGN COMPETITION	FACEBOOK
No major changes in number of meals consumed in a consecutive 3-day period	remarkable increase in knowledge about healthy eating and consequences of unhealthy eating; perceived healthy eating more accessable	considered the most enjoyable activity of the program; learned how to draw a story board; appreciated the creativity of other teams	the public services advertisement produced uploaded on the event page recorded 2,100 views

Promoting Healthy Weight with a Life Skills-Based Program among Middle School Students in Taiwan

Authors:[1]Yu-Zhen Niu,[2]Yen-Jung Chang,[3]Li-Ling Liao,[4]Han-Yang Huang,[5]Chih-Ning Lung, [6]I-Ju Lai,[7]Ying-Wei Wang,[8]Li-Hui Yu,[9]Li-Ju Lin,[10]Chen-Su Lin,[11]Chiung-Dan Chang,[12]Heng-Cheng Lin
Affiliations:[1] National ChiaoTung University, Hsinchu, Taiwan; [2]National Taiwan Normal University,Taipei,Taiwan; [3]I-Shou University, Kaohsiung,Taiwan;[4]New Taipei Municipal Guang Rong junior High School, New Taipei ,Taiwan; [5]New Taipei Municipal Ji-Sui junior High School, New Taipei ,Taiwan;[6]I-Shou University, Kaohsiung,Taiwan; [7-12]Health Promotion Administration, Ministry of Health and Welfare, Taipei, Taiwan

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Background/Objectives

Typically, middle school students are insufficiently active, engage in excessive sedentary behavior, and have sub-optimal nutritional intake. This study aimed to develop and evaluate a life skills-based program on healthy weight for middle school students in Taiwan. The program with six units focused on healthy eating behaviors, regular physical activity, and healthy weight management. Students' knowledge about healthy weight, intention to engage in healthy behaviors, and self-efficacy regarding life skills are expected to be enhanced after the intervention.

Methods

A quasi-experiment was conducted in this study. Six middle schools were selected from northern, central, and southern regions in Taiwan (two schools each). Two classes in each school were randomly divided into two groups. The experimental group (n = 167) received the life skills-based program on healthy weight. The control group (n = 164) did not receive any education on healthy weight. Data were collected before and after the intervention using self-administered questionnaires. ANCOVA was used to examine the effects of the program between groups.

Results

Table 1. Differences in knowledge, behavioral intentions and life skills self-efficacy between experimental group and control group

Item	Group	n	Pre-test		Post-test		T value	F value
			M	*SD*	*M*	*SD*		
Knowledge of Healthy Weight	E	167	2.57	1.50	3.12	1.45	4.69***	19.69***
	C	164	2.82	1.38	2.55	1.50	-2.02*	
Intention of Behaviors	E	167	16.76	4.96	17.54	5.44	1.86	6.13*
	C	164	16.54	4.83	16.07	5.44	-0.97	
Self-efficacy of Life Skills	E	167	68.66	19.90	73.94	23.42	3.22**	4.98*
	C	164	65.52	19.02	67.11	23.18	0.84	
Life Skill Scenario-based Test	E	167	3.70	2.09	4.53	1.93	4.72***	8.74**
	C	164	3.54	1.79	3.89	1.96	2.08*	

E= experimental group, C=control group
*p<.05, **p<.01, ***p<.001

Table 2. The Varying Parameters Difference of Self-efficacy between Experimental Group and Control Group

Item	Group	n	Pre-test		Post-test		T value	F value
			M	*SD*	*M*	*SD*		
Self-awareness	E	159	10.88	3.01	11.62	2.78	3.68***	7.64**
	C	152	10.85	2.97	10.88	2.86	0.11	
Decision- Making Skills	E	159	6.81	2.03	7.25	2.19	2.60*	1.93
	C	152	6.53	2.01	6.81	2.03	1.74	
Problem-Solving Skills (Diet)	E	159	10.06	3.08	10.37	3.22	1.31	0.76
	C	152	9.46	2.94	9.76	3.23	1.21	
Problem-Solving Skills (Physical activity)	E	159	9.84	3.19	10.88	3.19	4.48***	7.41**
	C	152	9.51	2.89	9.90	3.01	1.60	
Setting Goals (Physical activity)	E	159	3.45	1.18	3.78	1.13	3.70***	8.25**
	C	148	3.35	1.25	3.41	1.11	0.66	
Self-management Skills (Physical activity)	E	159	9.20	3.28	10.54	3.28	4.97***	9.05**
	C	152	8.75	3.03	9.32	3.29	2.23*	
Critical Thinking Skills	E	159	6.92	2.29	7.96	2.09	5.62***	7.63**
	C	151	6.62	2.22	7.22	2.25	3.22**	
Self-management Skills (Healthy weight)	E	158	9.71	3.28	10.80	3.36	4.34***	5.83*
	C	152	9.15	2.82	9.72	3.14	2.31*	

E= experimental group, C=control group
*p<.05, **p<.01, ***p<.001

The experimental group showed significantly better knowledge of healthy weight (F=19.69), greater positive intention to engage in healthy behaviors (F=6.13), higher self-efficacy regarding life skills (F=4.98), and better performance on life skill scenario-based test (F=8.74) at post-intervention than the control group.

Discussion

The life skills-based approach was found to be effective for promoting healthy weight among middle school students. The intervention in the present study could be used as a reference for school educators to cultivate students' abilities to improve or maintain their healthy weight.

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Promoting Healthy Weight with a Life Skills-Based Program

Videos Made for the Teaching

Director of Health Promotion Administration - Mr Ying-Wei Wang accepted a media interview at the press conference in 2018 to introduce Healthy Weight Promotion with Life Skills-Based Program.

Students Practice the Refusal Skills to Sugary Drink in the Class

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Promoting workplace safety in research on workers' unsafe behaviours in Iran

Azita Zahiri Harsini[a,b], Fazlollah Ghofranipour [a], Hormoz Sanaeinasab[c], Farkhondeh Amin Shokravi[a], Philip Bohle[d,e], Lynda R Matthews[d]

[a] *Department of Health Education, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran*

[b] *Faculty of Health Sciences, The University of Sydney, Sydney, Australia*

[c] *Health Research Center, Life style institute, Baqiyatallah University of Medical Sciences, Tehran, Iran*

[d] *Work and Health Research Team, Faculty of Health Sciences, The University of Sydney, Sydney, Australia*

[e] *Tasmanian School of Business and Economics, University of Tasmania, Private Bag 84, Hobart, Tasmania 7001, Australia (Professor Philip Bohle now works at University of Tasmania)*

Background: Accidents and injuries have been a regular occurrence in the petrochemical industries, because of the particular conditions dependent on its nature, over the last decade. Major occupational accidents that occur in this industry frequently result in significant financial and social losses. In this context, workers' unsafe behaviours are the main causes of work-related accidents and injuries. The first step to promote safe behaviours and reduce accidents and losses in petrochemical industries is identification of the influencing factors associated with workers' unsafe behaviours. The aim of this study was to (a) explore participants' perceptions of workplace safety; and (b) to identify the factors that impede safe behaviours by workers.

Methods: A qualitative study was conducted and reported according to analysis steps as described by Graneheim and Lundman for qualitative research. Eighteen participants were recruited using purposive and snowball sampling techniques, from petrochemical industry in Iran. Individual face-to-face semi-structured interviews were conducted to gain in-depth understanding of factors acting as a barrier for workers' safe behaviours and transcribed in Persian and then translated into English. Conventional content analysis was performed.

Results: Main themes emerging from the interviews were: (i) poor direct safety management and supervision; (ii) unsafe workplace conditions; (iii) workers' perceptions, skills and training; and (iv) broader organisational factors. They give insights into the effective measures which managers can implement to improve safe behaviours.

Discussion: These measures can eliminate the risk of work accidents and improve safety in other parts of the world where these are issues for workers.

Keywords: Unsafe behaviours, Workplace safety, Petrochemical industry, Workers

Providing Better Smoking Cessation Care during Pregnancy – A Qualitative Exploration of Australian General Practitioners Knowledge, Attitudes and Practices

Yael Bar-Zeev[1], Eliza Skelton[1], Billie Bonevski[1,2], Maree Gruppetta[1] Gillian S Gould[1,2]
[1]University of Newcastle [2]Hunter Medical Research Institute
Contact: yael.barzeev@uon.edu.au @yaelbarzeev

This work was supported by the Hunter Cancer Research Alliance PhD scholarship (YBZ).

Background:

Smoking during pregnancy remains a significant problem. Surveys show that health providers report lacking knowledge and skills to provide smoking cessation care during pregnancy.
Barriers include fear from harming the relationship with the patient, lack of confidence in using Nicotine Replacement Therapy (NRT) during pregnancy (safety concerns), and lack of time and resources.
Qualitative studies are sparse, and none have been previously undertaken in Australia with general practitioners (GPs).

Aims:

To explore GPs thoughts on the management of smoking in pregnancy, and what would enable them to provide better care.

Methods:

Participants were recruited from a sample of GPs that participated in a national survey on managing smoking during pregnancy; and through a national GP conference.
Semi-structured interviews were recorded and transcribed. The interview and analysis were guided by the theoretical domains framework, covering previously reported barriers, and specific components of care that were lacking, such as using nicotine replacement therapy (NRT).
Analysis used a general inductive thematic approach.

Results:

Out of a total of 122 that were contacted, 19 participants were interviewed.
Participants came from all Australian states, except the Australian Capital Territory.
Sixteen (84%) were female, eight worked in practices that cared for over 30% Aboriginal and Torres Strait Islander patients
Interview length was, on average, 26 minutes (range 18-46).

Current practices were suboptimal:

1. GPs focused on providing information on the harms of smoking
2. Offering treatment options only to those they perceived as 'ready'
3. Accepting 'cutting down' as enough

Needing better communication skills - Participants expressed a need to learn 'how' to have that conversation, and wanted this shown to them explicitly

Mixed feelings regarding managing smoking during pregnancy – some felt optimistic, others pessimistic

"I suppose I feel defeated by the people's condition, too pessimistic about the people's condition. So much needs to change in terms of changing tobacco." (Female, over 60, Northern Territory)

"I don't feel like I know that very well because we don't really learn that in med school. We learn a lot of the medical issues with smoking, but we're not learning the psychology of smoking. It could even be just we watch a DVD and watch someone pattern a role model." (Female, 31-44 years, West Australia)

"I give them the information ... make sure they knew about the harmful effects of smoking ... If they were ready to quit, then we talk about the different ways of doing so." (Female, 45-60 years, West Australia)

Barriers for NRT prescription:

1. Women did not want to use them
2. Safety concerns
3. Appropriate only for highly addicted smokers

They expressed a need for clear guidelines on NRT use, with visual resources for the patients

"for the person who says 'Well I'll just smoke the minimum and that's the best I can do', I accept that." (Male, 45-60 years, Victoria).

"I always feel a bit concerned about doing actually more harm than good insofar as you know these women that appear to not be smoking very much" (Female, 31-44, Northern Territory).

"I suppose we need sort of like training modules ... like an algorithm about 'This is what you use. This is how you start it. These are the benefits'." (Female, South Australia, age unknown)

"Handouts that are appropriate for my patients, Aboriginal and Torres Strait Islander women... as you're explaining it, you've got these visuals to point to." (Female, 31-44, New South Wales)

Summary:

Australian GPs report lack of knowledge and skills to treating pregnant women who smoke. Focusing their time on providing information on the harms of smoking, while not offering treatment options to all pregnant patients who smoke, may be contributing to low cessation rates, and GPs pessimism.

Specific training explicitly showing 'how to have this conversation', with practical detailed clinical guidelines on 'when' and 'how' to use NRT, may help GPs to better support pregnant patients who smoke.
Clinical guidelines for smoking cessation care in pregnancy need to move beyond the 5As and emphasize not using the 'stages of change', offering all pregnant smokers treatment options regardless of their current motivation to quit.

Bar-Zeev Yael, Skelton Eliza, Bonevski Billie, Gruppetta Maree, Gould S Gillian. **Overcoming Challenges to Treating Tobacco use During Pregnancy - A Qualitative study of Australian General Practitioners Barriers.** BMC Pregnancy and Childbirth. 2019; 19:61.

Conflict of Interest: YBZ has received funds in the past (2012-2015) from Novartis NCH who used to distribute NRT in Israel. She has not received any funding from pharmaceutical companies in Australia.

Reception of new Medical students after six years of intervention in the hazing culture: challenges that remain

Marco Akerman
Silmara Conchão

Post-graduate program in public health at the University of São Paulo, Brazil

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Introduction

Hazing are trials applied to new students entering the University as a ritual of initiation. Since 2010, the research "bullying with the university" studies hazing in Medicine. This study revealed the hierarchical and power relations existing among students. Its results triggered measures adopted in a Paulista Medical School.

Objective

This article analyzes the changes that occurred after six years of interventions in the hazing culture.

Methodology

In 2015, 89 new students entering Medical School made a narrative stimulated by the question: "What did you see, live and feel related to your reception in college?".

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Results and Discussion

The vast majority of women, 70%, and men, 64%, reported that there is still much discomfort in the reception of the new students. Despite allegations of discomfort, many see no pressure and scolding as forms of violence. Naturalize these episodes by saying that the hierarchy that exists in Medicine supports this type of treatment and with this position endorse and perpetuate this relationship of superiority promoted by the veterans.

There seems to be no hazing with the same aggressiveness as before and people are not being forced to participate when they do not want to, but there is segregation when that happens and the message is that it could threaten the academic and professional future of these newcomers

Conclusion

Some changes are really noticeable, because nothing we have done in these years has been in vain, and we will continue our crusade against the hazing. The asymmetric relations of power are still organized, structured and present in the daily routine of Medicine in the FMABC. In a context where some people in the academic community play down the importance of this by claiming normality, and others, like us, insist on pointing out the effects, discomfort, pain, fear and suffering that still run through the corridors of our school and silence what is more perverse in human relations: the perpetuation of inequalities and social injustice that limit freedom, human rights, and the creative and participatory potential of people.

Reclaiming the First 1000 Days: Aboriginal and Torres Strait Islander communities getting it right

Authors: Emma Brathwaite[1,2] , Christine Horn[2], Kerry Arabena[2], John Burton[1], Rachel Atkinson[3], Emma Beckett[4]
Affiliations: [1]SNAICC National Voice for our Children, [2] University of Melbourne, [3]Palm Island Community Company, [4] Nikinpa Aboriginal Child and Family Centre

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Project background:

The First 1000 Days is a conceptualization of child nutrition that evolved into international policy consensus. The underpinning science demonstrates the period from conception to two years is a "golden interval" to improve child development.

First 1000 Days

There has been significant evolution of the First 1000 Days movement within Australia. The focus on Indigenous children is important as there is consistent evidence of the disproportionate levels of disadvantage these children experience in comparison to non-indigenous Australians.

The role of Aboriginal centres

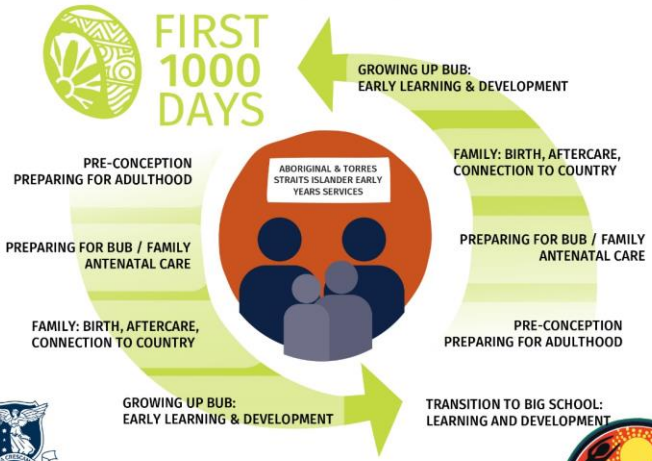
This research recognises the contribution of the global evidence on greater emphasis of comprehensive life cycle programming, however it acknowledges the Aboriginal Child and Family Centres (ACFC) services already offer promising, strength-based initiatives that seek to position the family and child as central to programming efforts.

Outcomes

Results demonstrate that integrated services are responding to the needs of families however there are critical program components that remain largely unfunded. There remains a disconnect in the policy sentiment, resourcing and implementation.
Policy reform needs to accommodate greater respect for place-based community programming which includes adequate resourcing for Indigenous leadership, governance, partnerships and connection to culture as key determinants of health for Indigenous children and families.

Cyclical model of service integration

Main themes for the operation of Aboriginal early years services:



THE UNIVERSITY OF MELBOURNE

SNAICC National Voice for our Children

Reducing availability of cigarettes at the point of sales to reduce tobacco consumption in Anuradhapura, Sri Lanka

Authors: Najith Duminda Galmangoda Guruge,[1] Samantha Kumara Kithalawaarachchi,[2] Sansfca Marlyn Young[3] Health Promotion students[1]

Affiliations: [1]Department of Health Promotion, Faculty of Applied Sciences, Rajarata University of Sri Lanka, Mihintale; [2]Sri Lanka President's Task Force, President Secretariat, Colombo, Sri Lanka; [3]Department of Environmental Technology, Faculty of Technology, University of Colombo, Colombo, Sri Lanka

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Background/Objectives

- Reducing availability of cigarette is a common strategy used to reduce usage of tobacco.
- The aim of this study was to reduce availability of tobacco at the point of sales in Anuradhapura district through health promotion approaches intended for the wellbeing of the entire population in the district.
- After discussions with societies, all stocks in shops were sold, and several sellers stopped selling cigarettes for three months, with the intention of reducing the future sales and thereby the consumption.

Methods

1. Government field officers (n=52) with technical knowledge on drug prevention were trained monthly for eight months from Anuradhapura district and were trained to address six key factors related to tobacco use – including reducing availability.
2. Concurrently, they presented their progress to the forum.
3. Training programs facilitated increases in scientific knowledge about strategies of companies and long and short- term harm of usage.
4. Subsequently, empowered communities were grouped by the government officers to work together using discussions, awareness programs and innovative tools to reduce availability of cigarettes in their divisions.

Results

- Main shops (n=259) from 8 divisions stopped selling cigarettes in Anuradhapura district.
- Number of shops that stopped sales on tobacco products were 72, 45, 36, 35, 27, 17, 15 and 12 from Padaviya, Nachchaduva, Galnava, Horowpothana, Ipalogama, Kakirava, Madavachchiya and Mihintale respectively.

Action	Cost Estimation/Savings
Average **number** of **sticks** sold **per day** in **one shop**	300
Average **cost** for **selling cigarettes** **per day** in **one shop** thus is	15,000 (300*Rs.50.00)
Average **cost** for **selling cigarettes** **per day** in **259** shops	3,885,000 (20,000*259)
Average **savings** in **eight Divisional Secretariats** **per month**	116,550,000 SLRS (3885000*30) which is 751,935 US$.

Discussion and Conclusions

Through health promotion approaches, providing proper scientific knowledge and training for government filed officers on drug prevention to empower the community was successful in reducing the availability of cigarettes.

Reduction of tobacco consumption among military groups using interventions to increase knowledge of industry strategies and harm

Authors: Najith Duminda Galmangoda Guruge,[1] Sansfca Marlyn Young,[2] Samantha Kumara Kithalawaarachchi,[3] Health Promotion students[1]

Affiliations: [1]Department of Health Promotion, Faculty of Applied Sciences, Rajarata University of Sri Lanka, Mihintale; [2]Department of Environmental Technology, Faculty of Technology, University of Colombo, Colombo, Sri Lanka; [3]Sri Lanka President's Task Force, President Secretariat, Colombo, Sri Lanka;

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Background/Objectives

- Tobacco use is still a main risk factor among military services.
- A study was carried out using 235 military personal who consume tobacco from three regiments in North Central province, Sri Lanka.

Aim was to reduce tobacco consumption among participants using health promotion interventions where the main components addressed in a one day community empowerment program were understanding the strategies used by tobacco industry, harm from tobacco use and methods to deglamorize tobacco.

Methods

- Group discussions were conducted educating participants on tobacco industry strategies, with evidence, short and long term harm and calculations on expenditure for tobacco and estimating things that they could have done instead.
- With a view of reducing the attractiveness of tobacco, methods of de-glamorizing the image of tobacco were discussed.
- A self-administered questionnaire was used to collect data after three months.

Results

Understanding on industry strategies improved by 63%, number that quit smoking completely was 70 while reduced smoking at least by 2 sticks was 133. Total consumption of cigarettes has reduced by 30%.

Action	Cost Estimation/Savings
Daily consumption (at least 5 sticks per-day)	**Rs.58,750.00** (235*5*Rs.50.00 per-stick)
Savings due to quitting smoking	**Rs.17,500.00** (70*5*50.00) per day
Savings because of reducing smoking (at least 2 sticks)	**Rs.13,300.00** (133*2*50.00)
Thus, total savings per day Rs.30,800.00 and per month	**Rs.924,000.00**
Total cost to conduct one day's program	**Rs.59,500.00**
Per-person total cost for the program is	**1.63 US$**
Total cost for quitting smoking	**5.4 US$**
Total cost for reducing smoking per day	**2.8 US$**

Discussion and Conclusions

- Implementing health promotion interventions is cost effective and resulted in
  - **Understanding about tobacco Industry strategies**
  - **Tobacco related harm** and
  - **Methods of deglamorizing tobacco use** and
  - **Reduction of tobacco consumption among participants**.
- Thus, using health promotion interventions for community empowerment on tobacco use was found to be highly effective.

Required Notification Illnesses Act – Reality verses Requirements

Stahl Z[1,2,3]*, Hassan Y[3], Zivi R[3], Dukhan L[1] and Gdalevich M[1,4]

Ben-Gurion University of the Negev

1. Objectives:

Public health and infectious disease prevention within Israel is done through a mandatory reporting system of infectious diseases, allowing epidemiological surveillance, prevention and detection of outbreaks.

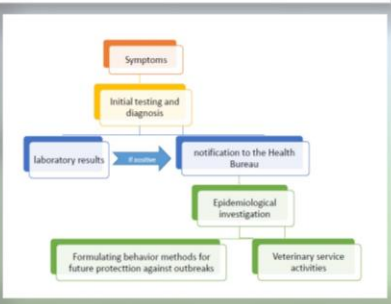
The Israeli "Public Health Act - Notifiable Diseases" requires physicians and medical laboratories to report cases of notifiable diseases to the Ministry of Health's local District Health Office (DHO). However, reporting is incomplete for some diseases, rendering their monitoring problematic.

2. AIM:

To examine the level of under-reporting of Brucellosis and Rickettsial Diseases to the Southern DHO.

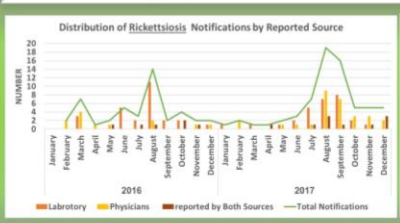
3. Methods:

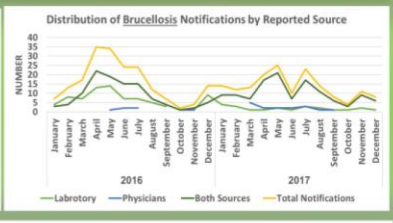
We analysed Brucellosis and Rickettsial Diseases data, collected from the infectious diseases mandatory reports to the Southern DHO, for the years 2016-2017.



4. Results:

- **Brucellosis:** 26 notifications solely by physicians, whereas the solely laboratory notifications listed 100 cases, 355 total case notifications.
- **Rickettsial Diseases:** 42 reports from physicians and 56 notifications from the laboratory were received, 111 total case notifications.
- **Verified notifications from both sources:** included 229 Brucellosis and 17 Rickettsial Diseases cases.
- **The data demonstrates that the general number of notifications, originating from the attending physician, was lower than the number of laboratory notifications**





5. Discussion:

Our findings show a substantial gap between different report sources, with physicians being less compliant. To further substantiate these findings, a national *follow-up study* would be appropriate to examine the reporting of these two diseases and the factors affecting them.

Reporting of additional notifiable diseases can be added to such a study.

Implementation of digital health record will automatically facilitate reporting from the attending physician to the DHO directly from the computerized medical record according to diagnosis

1. Ministry of Health Israel, Southern District Health Office
2. Department of Community Health, Joyce and Irving Goldman Medical School, Ben Gurion University of the Negev, Israel
3. Department Health Systems Management, Faculty of Health Sciences, Guilford Glazer Faculty of Business and Management, Ben Gurion University of the Negev, Israel
4. Department of Public Health, Joyce and Irving Goldman Medical School, Ben Gurion University of the Negev, Israel

Contact person- Dr Ziva Stahl, Ministry of Health Israel, Southern District , Hatikva 4, 84001 Beer-Sheva , Israel, **Email** : ziva.stahl@bsh.health.gov.il

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Residential environments and smoking behaviour in young adults: A study of 4-year smoking trajectories using data from the ISIS cohort

Adrian E. Ghenadenik[1,2,3], Lise Gauvin[1,3], Katherine L. Frohlich[1,2]
[1]École de santé publique, Université de Montréal, Montréal, Canada; [2]Institut de recherche en santé publique de l'Université de Montréal, Montréal, Canada; [3]Centre de recherche du Centre Hospitalier de l'Université de Montréal, Montréal, Canada

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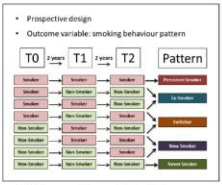
Introduction

- **Young adults (YA) tend to have the highest prevalence of smoking**
  - **Prone to frequent changes in smoking behaviour**
- **Living environments significantly influence health behaviours among YA**
  - **Characteristics of residential environments associated with smoking prevalence/quit attempts**
- **Limited knowledge about potential to influence specific smoking behaviour patterns (SBP) over time**
- **Objective: to examine associations between smoking-facilitating features and SBP among young adults.**

Methods

- **4-year SBP for 1,383 young adults aged 18-25 years at baseline residing in Montreal, Canada**

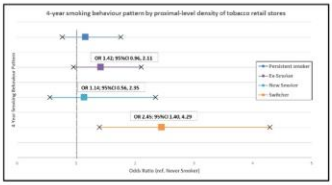


- **Associations with residential proximity/density of tobacco retail and presence of smoker accommodation facilities**

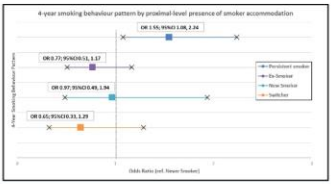
- **Multilevel multinomial models used to account for clustered observations**

Results

- **In fully-adjusted models, YA residing in areas with higher density of tobacco retail were more likely to be *switchers*, i.e.: to have repeatedly changed their smoking status within a 4-year timeframe**



- **YA residing in areas with presence of smoker accommodation facilities were more likely to have been smokers during the entire follow-up period**



Discussion

- **Residential-level smoking-facilitating features are associated with SBP among young adults**
- **Higher densities of tobacco retail may contribute to switching patterns**
  - **Exposure to environmental and social cues**
  - **Exacerbation of urges and cravings**
- **Presence of smoker accommodation facilities may help sustain smoking behaviour**
  - **Normalization of smoking**
  - **Creation of smoking-enabling spaces**

Conclusion

- **Future research should explore the viability of interventions seeking to create healthier residential environments by limiting the presence of these features at the local level**
  - **Policy regulating the tobacco retail landscape (e.g.: retailer caps, zoning)**
  - **Outdoor smoking bans**

ISIS
ESPUM
INSPQ Université de Montréal

Acknowledgments: the *Interdisciplinary Study of Inequalities in Smoking* (ISIS) is funded by the Canadian Institutes for Health Research (CIHR, grant #MOP-110977 to KLF). I would like to thank the ISIS team, the Canadian Cancer Society and Université de Montréal's École de santé publique and Direction des affaires internationales for their support.

Risk Factors associated with Body Mass Index increase in women 18 - 49 years in rural Anuradhapura, Sri Lanka

Authors: Matilde Breth-Petersen[1], Holly Edwards[1], Lalith Senarathna[2] Michael Dibley[1], Tanvir M Huda[1]
[1]*Sydney School of Public Health, University Of Sydney,* [2] *Department of Health Promotion, Rajarata University of Sri Lanka*

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Introduction

- Non-communicable diseases (NCDs) have emerged as the leading causes of mortality in Sri Lanka
- Increasing rates of overweight and obesity have been attributed to this disease burden
- For reproductive-aged women, high BMI effects are two-fold, increasing the risk of NCDs and pregnancy, postnatal and neonatal complications
- Public health efforts have responded by orienting towards the prevention of unhealthy weight gain; however, limited research exists on specific prevalence within different communities and the associated risk factors

Objective

- To identify the extent of, and risk factors for, high BMI in reproductive-age women attending child-weighing clinics in Anuradhapura district; to inform the development of appropriate health promotion interventions

Methods

- Design: A community-based cross-sectional survey
- Study Site: Selected Public Health Midwife (PHM) areas in Anuradhapura district
- Sampling: convenience sampling method used to recruit mothers attending child-weighing clinics across a two week period
- Sample size: 129 women of 18 to 49 years
- Data collection: Data collected on demographics, weight perceptions, diets & lifestyle factors.
- Statistics: Descriptive and inferential statistics were used to describe the prevalence of high BMI and its risk factors in the community

Results

- Of the 129 participants, 20.3% were underweight and 22.7% were overweight/obese
- 50.0% of participants classified as overweight/obese perceived themselves as being about the right weight, and 50.0% were happy with their weight.
- In Bivariate analysis, education of mothers, number of household members, mode of transport, presence of obesity in the household, history of obesity among family members, and habit of eating when not hungry were found to be associated with increase BMIO
- Eating when not hungry, having a family history of obesity and using automobile transport methods remain significant in the adjusted model

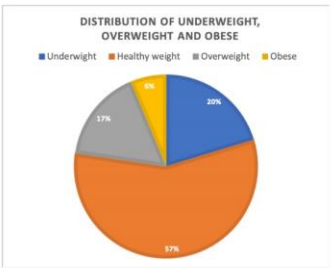

Table 2: Un Adjusted and Adjusted Risk Factors for Increasing BMI

Factors	Unadjusted Coefficient (95% CI)	Adjusted Coefficient (95% CI)
Age	.18 (.04, .32) **	.08 (-.19 - .35)
Total number of children under care	.80 (-.20, 1.8)	77 (-1.1, 2.6)
Total number of household member	.76(.02, 1.50)**	.42 (-.79 - 1.62)
Usual mode of transport		
Motor Vehicle	Reference	
Walking Cycling	-1.72 (-3.46 .01)**	-2.86 (-5.60, -.12)**
Household Food Security		
No	Reference	
Yes	.76 (-1.61, 3.15)	1.11 (-2.17 4.40)
Any obesity in your household		
No	Reference	
Yes	3.97 (1.47 6.48)**	.16 -3.68 3.99
History of obesity amongst family members		
No	Reference	
Yes	6.00 (3.28, 8.74)**	5.53 (1.38 9.7)**
Vegetarian		
Yes	Reference	
No	-1.19(-3.90, 1.5)	.70 (-2.6, 6.0)
Number of hours sitting per day	.50 (-.34, 1.34)	.05 (-1.24, 1.35)
Habit of eating even not hungry		
No	Reference	
Yes	1.82 (.084, 3.56)**	2.57 (-.22, 5.36) *
Household wealth quintile		
Lowest	Reference	
Second	.69(-2.95, 4.34)	.54 (-3.12, 4.20)
Middle	-.33(-3.80, 3.13)	-1.76 (-5.40, 1.89)
Fourth	3.06(-2.61, 8.73)	-2.33(-8.03, 3.38)
Highest	1.06(-2.93, 5.06)	-2.14(-6.52, 2.25)

Discussion & Conclusions

- Amongst reproductive-age women in rural Anuradhapura, high BMI is a significant problem, however, there is also a high prevalence of low BMI, which too has adverse health implications
- Misperceptions and lack of concern of unhealthy BMIs was found to be common, which may affect the uptake of health promotional messages and activities
- Strengths: the findings highlight the prevalence of unhealthy BMIs in the area and the critical need for further research to inform public health interventions
- Limitations: findings cannot be generalised to all reproductive-aged women in Anuradhapura district since participants were sampled from child-weighing clinics, therefore presenting characteristics particular to this study setting

Recommendations

- Further research is needed to more accurately identify trends in sub-population groups which may be hidden by national averages
- Health promotion interventions in this community should focus on changing unhealthily eating behaviours.
- The policy makers should also improve pedestrian or bicycle transportation systems in order to encourage women to walk or ride bicycle
- Finally, improving knowledge should be a primary and core component of any obesity prevention interventions

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Acknowlegements

Thank you to our supervisors, Lalith Senarathna, Michael Dibley and Tanvir M Huda, Provincial and Regional Directors of Health Services Anuradhapura, MOH and PHMs from Rambeva area, our interviewers, translators and participants, who all made it possible for us to conduct this research and to present our findings at the IUHPE conference

THE UNIVERSITY OF SYDNEY

WAIORA: Promoting Planetary Health and Sustainable Development for All

Poster presented at IUHPE 23rd World Conference on Health Promotion, Rotorua, New Zealand, 9th April 2019

Contact mpet8585@uni.sydney.edu.au or hedw2005@uni.sydney.edu.au

Role of major agencies in changes of physical activity policy and practice in Korean health promotion

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Professor Kwang Wook Koh, Kosin University
Chair of Korean Society for Health Education and Promotion
Chair of Korean Healthy Cities Partnership Academic Committee
Mrs. JunRyung Park , Korean Health Promotion Institutes

한국보건교육건강증진학회

Backgrounds: Physical inactivity is **emerging new problem** for Korean health promotion. **Daily walking rate** of Korean **decreased dramatically** but researches about policy and practice promoting physical activity for Koran health promotion are few.

Methods: We reviewed major Korean policy documents about physical activity and health promotion. Documents of *Korean ministry of health(**KMOH**)* , *Korean Health Promotion Institutes(**KHPI**)*, *Korea Human Resource Develop Institute for Health and Welfare(**KOHI**)* and *Korean Health Cities Partnership(**KHCP**)* were major agencies.

Results

KMOH established the first **National Physical Activity Guideline** in **2013** through ***KHPI*** and has published yearly guidebook for Physical Activity Intervention since then according to new paradigm. **Health Plan 2020** including physical activity promotion plan has made firstly in 2011(The 3rd Korean Health Plan 2020) and and upgraded in 2016(The 4th Korean Health Plan 2020)

한국건강증진개발원
KOREA HEALTH PROMOTION INSTITUTE

KHPI's major history in physical activity for public health
2011: started **technical assistance** to physical activity for public health
2012:supported **physical activity counseling** to health examinee
2013:published **separated guidebook** for physical activity intervention
2014:started **physical activity campaign**
2015:analyzed national physical activity policy and issued report
2016:developed Physical Activity **Information System**(PHIS)
2017:held national symposium for physical activity promotion
2018:held discussion in National Assembly amend Health Promotion Act

KOHI has educated about physical activity for public health to public health workers.
- ✓ 3 courses in 2013,
- ✓ 1 course in 2014,
- ✓ 4 courses in 2016,
- ✓18 courses in 2017
- ✓14 courses in 2018

대한민국건강도시협의회

KHCP which consists of 97 Korean cities has awarded yearly good active healthy cities since 2015 .

KCDC has introduced International Physical Activity Questionnaire(IPAQ) and Gobal Physical Activity Questionnaire(GPAQ) in National Health Survey and Community Health Survey since 2008.

Discussion & Conclusion

Establishment of Korean Physical Activity Guideline was not early.
Physical activity paradigm has spread slowly mainly through public health agencies
Evidence based comprehensive strategies for physical activity promotion are needed in future.

Rwandan Government Family Planning Mobilization Efforts Impact National, Community, and Individual Conversations and Motivations to Utilize Family Planning

Hilary Schwandt[1], Angel Boulware[2], Julia Corey[3], Ana Herrera[4], Ethan Hudler[5], Claudette Imbabazi[6], Ila King[7], Jessica Linus[8], Innocent Manzi[6], Maddie Merrit[1], Lyn Mezier[9], Abigail Miller[1], Haley Morris[10], Uwase Nadine Musekura[11], Diudonne Musemakwell[6], Divine Mutuyimana[6], Chimene Ntakarutimana[12], Nirali Patel[13], Adriana Scantelanu[14], Bigannette Shemeza[6], Madi Stapleton[1], Gi'anna Sterling-Donaldson[15], Chantel Umutoni[6], Lyse Uwera[6], Madeleine Zeiler[1], Seth Feinberg[1]

[1]Western Washington University, Bellingham, USA; [2]Spelman College, Atlanta, USA; [3]Wheaton College, Norton, USA; [4]Northwest Vista Community College, San Antonio, USA; [5]Whatcom Community College, Bellingham, USA; [6]INES, Ruhengeri, Rwanda; [7]Xavier University of Louisiana, New Orleans, USA; [8]UMBC, Baltimore, USA; [9]SUNY Oswego, Oswego, USA; [10]Western Oregon University, Monmouth, USA; [11]Eastern Oregon University, La Grande, USA; [12]University of Kentucky, Lexington, USA; [13]Arcadia University, Glenside USA; [14]Rutgers University, New Brunswick, USA; [15]Drexel University, Philadelphia, USA

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Introduction

Modern contraceptive use among married women increased dramatically in Rwanda from 17% to 52% in 5 years. This study aims to contextualize the impact of the Rwandan government's family planning program mobilization efforts on national, community, and interpersonal/individual levels.

Methods

- Qualitative study conducted in 2018 in Musanze and Nyamasheke Districts of Rwanda
- Eight focus group discussions with FP nurses and CHWs
- Thirty-two in-depth interviews with female current modern contraceptive users

Results

National Level:

Nationwide media campaigns about contraceptives are disseminated via radio, television, newspapers, and billboards. Not only do these platforms help disseminate information, they also help citizens recognize that their government is in support of family planning, and consider contraceptive use to be something that will help the nation develop.

> *The other thing the country helped us in is that they use radio and television and placards to talk about family planning. They put everywhere information about family planning.*
>
> *Nurse, Female, 29, 1 child, Nyamasheke*

Community Level:

Women who lack an informal setting to discuss contraceptive use can go to organized events and hear testimonials from others about the benefits of family planning. Providers emphasized the great impact these meetings and societal shifts have had on the national increase in demand for contraceptive use.

> *It is very important that we teach about family planning during Umuganda because it helps people become open to asking for help.*
>
> *CHW, female, 47, 4 children, Musanze*

Interpersonal Level:

Women and neighbors "mobilize" each other to seek out family planning. Women who are actively using contraceptives share their experiences with others in direct and indirect ways.

> *You can find a woman who has an eight-month-old child at home and is five months pregnant at the time and that serves as an example for us. When you see how this woman is suffering, having to live in this way, you continue using family planning.*
>
> *Female injectable user, 32 years, 3 children, Musanze*

Providers note most new clients come for services because they have seen and/or heard about the benefits of contraceptives from family or friends.

> *I think that those not using family planning services when they see people who do use these services and that they are supported with good health they will start imitating them and then family planning will increase.*
>
> *CHW, female, 39, 3 children, Nyamasheke*

Discussion

The decision to utilize family planning occurs only partially from individual agency - spousal, familial, communal, and national norms all serve to inform each woman's choice. The Rwandan Government's national and community education efforts can indirectly positively influence individual initiation and content of conversations. Open conversations leads to broader support for family planning users from families and neighbors. Expanding national and community support for contraceptive use among sexually active youth and unmarried women could help to combat the current stigmatizing narratives. As these top down efforts find their way into interpersonal communications, barriers will be lifted for those currently underserved and overall demand generation is likely to increase.

434. Salud del trabajador en instituciones de educación infantil

Autores: Mariangela Bitar[1], Francine Coghi[1], Isabella Rodrigues[1]
Afiliaciones: [1]Department of Physical Therapy, Speech Therapy and Occupational Therapy of Faculty of Medicine of University of São Paulo, Brazil Contacto:mlbitar@usp.br

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Antecedentes Y Objetivos

Escuela--espacio de desarrollo de habilidades, competencias y ambiente favorable a la promoción de la salud.

Fonoaudiólogo--creación y mantenimiento de ambientes propicios para el desarrollo integral y saludable, por la promoción de la salud ocupacional, por la escucha colectiva e individual.

Caracterizar signos y síntomas en voz y audición autorreferidos por funcionarios de guarderías.

Métodos

La encuesta fue realizada con funcionarios de siete guarderías en São Paulo/Brasil: cocina, mantenimiento, salud, gestión y educación llenaron cuestionarios relacionados con la audición y la voz.

Resultados

Sujetos: 146. Edad media: 37 años

- 60,3% educadores
- 12,3% gestores
- 11,6% de la cocina
- 11,6% del mantenimiento
- 4,1% de la salud

Signos y síntomas autorreferidos

Audición

- 43% disminuición de la audición
- 61,6% mareo
- 50% tinnitus
- 74% intolerancia a sonidos altos
- 61% alteración de la atención
- 39,7% dificultad de compréns ion del habla
- 33,6% dificultad para identificar sonidos

Voz

- 56,2% dolor de garganta
- 55,5% garganta rasca
- 58,9% garganta seca
- 50% ronquera
- 30,1% fatiga vocal
- 41,8% garganta raspa
- 36,3% tos para limpiar la garganta

Ruído

exposición diária (más de 7 horas, por lo menos 5 años)

Principal fuente: --Utensílios empleados en la cocina

-Voces de los niños

Fumadores (n. 42/ 28%)

- Activos (n. 15/10%) → 67%- dolor en la garganta
- Pasivos (n. 27/ 18%) → 74%-dolor en la garganta

Discusión

Los datos valoran la importancia de fortalecer el cuidado con la salud de los empleados, individual y colectivamente; y para la necesidad de promover discusiones sobre la aplicación de mejoras en el conforto acústico del medio ambiente.

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Scouting and society. Effectively planning your future: methods and proposals to build the life you want.

Affiliations: CADAS - Centro Analisi Documentazione ASSORAIDER - (Italy)[1] ,
Università degli Studi di Cagliari (Italy)[2] , ATS Sardegna ASSL Nuoro (Italy)[3]

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CADAS

Be Prepared

Character formation, Health and physical strength, Manual skill. Empower, developing personal skills.

This must be made possible at school, in the family, in the workplace and in all the organizational environments of the community. Action is needed that involves the educational, professional, commercial and voluntary organizations, but also the institutions themselves.

It emerges from direct testimony how the experience spent in youth in scouting and the skills acquired in the scout group contribute to improving the professional and social life.

The key concepts that constitute a synthesis of the relationship between scouting and society are: road as a path of life and growth, service as a willingness to others with generosity, institutions as places where citizens of the communities can meet their priority needs.

Scan me

To serve

Service to the next.
Create supportive environments.

It would be right to question what scouts can do to help address young and very young people with a successful perspective and if the method proposed by B.-P. which proved to be extraordinary in pursuing this goal more than a century ago, can still today be able to respond to the challenge. This possibility becomes concrete when we recognize scouting as the ability to overcome some barriers typical of modernity, such as the inability to talk with others, the closure and emotional loneliness beyond the evident flowering of scarce relationships from the point of qualitative and poor view from an emotional point of view.

Giving strength to community action

"The strength of the wolf is in the pack, the strength of the pack is in the Wolf "

To improve the quality of life of individuals, communities need to be more aware of their strength and take responsibility for their actions to control their own destinies.

The game of scouting is open, in fact, if the goal is to train "good citizens" of tomorrow, everything that will be learned in scout life, will be exercised in family life, professional and more generally in social life.

We can say that those who have lived a positive scout experience have developed an ethical orientation, scouting stimulates a propensity to implement "big things", to "dare", but without losing touch with reality.

A **Bridge that of Leonardo da Vinci**, chosen as a symbol of the relationship between **Science and Nature**, a balanced construction in which each juxtaposed piece helps to firm the structure and ideally protrudes towards that other shore, otherwise distant and unreachable, symbol of **communication, union and dialogue**.

The research, in this case, of the **strong points of contact between the scout method and the principles of health promotion.**

Two seemingly distant worlds, but actually very similar to each other, working on common themes, even if with different approaches and languages.

Scan me

Lines of action

Be prepared is the scout's motto. In that age group (12-16), it represents the challenge for young people, a model of life in which to recognize each other, in this evolutionary moment, "We do the backpack" accumulate useful and expendable skills in the future life, to be lived, it needs a conscious preparation and the necessary skills to carry on this journey.

Health literacy implies the achievement of a level of knowledge, personal skills and self-confidence that can act to improve individual and community health, through the modification of individual lifestyles and living conditions. Health literacy improves individuals' access to health information and their ability to use them effectively.

The **scout law** contains the rules of life followed by all scouts in the world, they are committed to observe it at the time of the Scout Promise, it is always expressed in a positive key (the scout is, the scout does) and never with prohibitions (the scout it's not, the scout does not).

Life skills are personal, interpersonal, cognitive and physical skills that make people able to control and direct their lives and to develop the ability to coexist in their environment, managing to modify it. Life skills are fundamental elementary components for the development of personal skills useful for health promotion.

The aim of **the scout movement** is to contribute to the development of young people, fully realizing their potential physical, intellectual, social and spiritual as individuals, as responsible citizens and as members of their local, national and international community. It does not propose to replace the family, the school, the religious or social institutions, but it is conceived as a complement to the educational characteristics of these institutions.

Health-friendly environments make them able to improve their skills and increase self-confidence in terms of health. These environments include the place where individuals live, work and spend their leisure time, their local community, their home, access to health resources and empowerment opportunities.

_ **Reconcile** the distance between the scientific community, the social context and the scout movement, relocating the scout movement to a position of dialogue and active listening, not only is it possible but necessary to ensure the continuation of that role as a stakeholder and engine of ideals and positive principles for the youth of the community.

_ **Updating** the languages of Scouting, so that the nature of "movement" is an expression of constant and positive change, not to change to change, but to change to grow and update.

_ **Building** a common language becomes imperative for the creation of meaningful dialogue, mutual understanding of the fields of study and analysis. To create a common ground for meeting and confrontation in which all the parties can share and draw heavily from the experience of others.

_ **Start** a process of identification and evaluation of the skills acquired with practice and within the voluntarist context of Scouting, represents a fundamental step of the inclusion of different worlds, through the recognition of skills acquired, translatable in daily contexts of study, work and sociality.

Scan me

WAIORA: Promoting Planetary Health and Sustainable Development for All

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Secure care of pregnancy: A Grounded Theory of the Process of Response to Pregnancy in Iranian Adolescent women

Maryam Moridi[1], Farkhondeh Amin Shokravi[2*]

1.PhD candidate of Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, Iran; Email: Maryam.moridi@modares.ac.ir

2.PhD, Department of Health Education and Health Promotion, Faculty of Medical Sciences, Tarbiat Modares University, No. 7, Jalal Al Ahmad Street, Tehran 14115-116, Iran. Tel: +09821 82884506; Fax: 009821 82884555; E-mail: aminsh_f@modares.ac.ir

Background/Objectives: Although a substantial body of research examines adult perceptions of teenage pregnancy, relatively few studies have explored adolescents' perspectives. Considering the importance of the matter and conflict perceptions about adolescent pregnancy, this study with the aim of exploring the process of response to pregnancy in Iranian adolescent women was designed.

Methods: Given the exploratory nature of the research, the grounded theory study with Corbin and Strauss's mode of analysis (2008) was used. In this study unstructured interviews were conducted with 31 purposefully and theoretical selected participants including 24 adolescent pregnant women, 3 spouses, 2 mothers' of adolescents women and 2 mothers in low who lived in urban and rural society of Guilan, north of Iran, from November 2015 to March 2017. Four criteria (credibility, dependability, confirmability, and transferability) were used to evaluate trustworthiness or rigor in this study.

Results: Findings indicate that the main concern of adolescent women was to provide the best health status for fetus and best future for their child. The main strategy of adolescent pregnant women for response to this concern was secure care of pregnancy. Female adolescent would use "intelligent self-care" and "accustom to pregnancy" as the strategies in the responding to pregnancy until achieving "ambivalent perception". "Paradox of acceptance" and "sociocultural texture of the society" were the contextual conditions and the influence of "family", "peers" and "health care providers" was the interventional conditions in the secure care of pregnancy in female adolescent.

Discussion: This finding will help health educators to develop additional programs, activities and educational opportunities related to many sociocultural factors affecting teenager's decisions and behaviors during pregnancy.

Keywords: Pregnancy, Adolescence, Women's health, Grounded theory.

Service integration for Aboriginal and Torres Strait Islander early childhood development: A multiple case study from New South Wales and Queensland

Authors: Emma Brathwaite[1,2], Christine Horn[2], Kerry Arabena[3], John Burton[1], Rachel Atkinson[2], Emma Beckett[4]
Affiliations: [1]SNAICC National Voice for our Children, [2] University of Melbourne, [3]Palm Island Community Company, [4] Nikinpa Aboriginal Child and Family Centre

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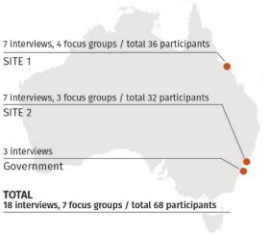
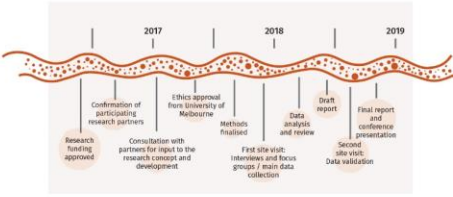
Data collection / methodology



Research timeline:



First 1000 Days

The vulnerabilities and intergenerational poverty experienced by Indigenous children cannot be ignored. Disadvantage begins early with rates of infant/child mortality more three times higher than non-Indigenous Australians; twice as likely to be developmentally vulnerable early in life and ten times more likely to be removed from their families by child protection authorities than non-Indigenous children in Australia.

Integrated service delivery approaches led by Indigenous organisations are central to addressing the challenges facing many Indigenous families in Australia. They are a key access point for families and link families to a range of services based on community needs.

The research seeks to understand the extent to which services are available and integrated to meet the needs of Aboriginal children and families.

Research themes

Models of governance included groups of elders, elected boards, community advisory bodies and others. Inclusive community control was seen as an important organisational aim but difficult to achieve in many communities.

Efficient Aboriginal leaders were seen as crucial for the sustained success of an organisation, but are subject to multiple pressures from community and organisations.

Financial sustainability was seen as hardly achievable. Lack of reliable funding complicated sustaining existing services. Respondents reported lack of foresight in funding processes.

Partnerships with mainstream services were reliant on staff's personal relationships. Cultural awareness was seen as a prerequisite for collaboration along with a specific but hard to define personal attitude.

Outcomes

Processes of early childhood service integration can concurrently support community empowerment if:

- Time is taken to properly understand who community is and acknowledging the diversity that exists within community and the power structures and disparities of families and kinship, which means acknowledging who is already participating but importantly who is not
- Services and programs are to prioritise the relational dimensions of coordination, leadership, community liaison, community participation, community consensus, community commitment, community conflict resolution, community healing
- Aboriginal leaders (and emerging leaders and community networks of leaders) are supported to represent their community and who develop/demonstrate leadership that espouses values of fairness, equity, integrity, honest and respect, and to develop/demonstrate capabilities in decision-making, financial management, accountability
- Partnerships, including partnerships with mainstream providers, deliver a high quality services that are culturally safe and are agile enough to quickly respond to the needs of children and families. That means programs and services are deemed acceptable, equitable, accessible, affordable and safe from the perspective of children and families who use them

SNAICC National Voice for our Children

THE UNIVERSITY OF MELBOURNE

Sex Education in Taiwan and Thailand

Kay, Noy S. [1], Fu-Li Chen [2], Sudgasame Jantaraweragul [1], and Niu, Jingjing [3]
[1] Indiana University School of Public Health, Bloomington, IN; [2] Fu-Jen Catholic University, Taiwan; [3] Iowa Healthcare Collaborative, Des Moines, IA

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Background

Educating children, pre-teens, and teenagers about sex is important to help decrease the amount of unwanted pregnancies, sexually transmitted infections (STIs) and HIV/AIDS cases in Thailand. Sex education includes classes or presentations that discuss human reproduction, dating relationships, abstinence, STIs, HIV/AIDS, pregnancy prevention, contraception, family planning, and related sexual activities. Past research has shown that peer programs that are based on reproductive health have provided knowledge and increased positive attitudes in students about the subject Evaluating current school sex education programs can help design proper and effective education programs.

Purpose

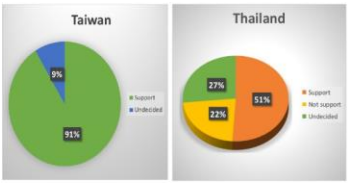
The purpose of the current study is to: 1) To evaluate current sex education programs and health educators' perceptions of sex education in Taiwan and Thailand 2) identify ways to improve sex education in schools in Taiwan and Thailand.

Methods

Sample

School health education teachers were surveyed on sex education related status and perceptions. Data of 70 teachers in Taiwan and 44 teachers in Thailand were analyzed.

Graph 1: Perceived support to sex education from other teachers



Measurements

School health educators were interviewed with structured questions. These questions evaluated current sex education coverage and teaching methods in schools; and assessed health educators' perceptions regarding changes in sex education, priorities in sex education topics, barriers to teach sex education, and support from parents, students, and other school teachers. The questions have been validated, and adjusted to ethno-cultural aspects.

Methods

Analysis

School health educators were interviewed with structured questions. These questions evaluated current sex education coverage and teaching methods in schools; and assessed health educators' perceptions regarding changes in sex education, priorities in sex education topics, barriers to teach sex education, and support from parents, students, and other school teachers. The questions have been validated, and adjusted to ethno-cultural aspects.

Patterns of current programs and teachers' perceptions were presented in frequency by location and educators' demographic factors, such as gender, age, degree, teaching experiences. Significant differences were tested using Independent t-Test or Analysis of Variance.

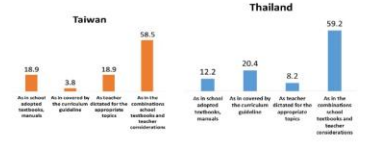
Results

All participating health educators believed it is necessary to provide sex education. Over half of the Taiwanese educators and most of the Thai educators identified significant curriculum changes regarding sex education in the past two years. Over three quarters of the educators from both locations found that sex education had become more controversial in the community.

Table 1: Sex education topic developed

Component	% developed	
	Taiwan	Thailand
HIV/AIDs and other viruses	100	100
Human sexuality	100	95.9
Infectious disease prevention	100	95.9
Pregnancy prevention	98.6	87.8
STD and prevention	100	100

Graph 2: In your school, how is sex education taught?



Significant differences exist in health educators' backgrounds, current sex education programs, and health educators' perceptions; comparing health educators from Taiwan and Thailand. Top barriers to teach sex education include: lack of up-to-date human sexuality education in schools, celebrities and media distributing examples of bad sexual behaviors, and wrong sexual values from peers in Taiwan; the traditional beliefs that have more liberal values on sexual behavior for men than women, lack of up-to-date human sexuality education in schools, and lack of teaching material in Thailand.

Using updated sex education curriculum and teaching material; as well as teaching ways to resist incorrect social or cultural beliefs on human sexuality can greatly benefit school students in Taiwan and Thailand.

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SmokeFreeNZ: Designing and Evaluating the Effectiveness of a Mobile Application in Reducing Cigarette Consumption

Lian Wu*, Nilufar Baghaei, John Casey, Jayne Mercier, Karen Hicks, Daniel Stamp, Bin Su

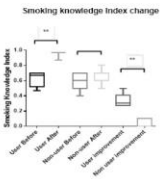
Background: Smoking is one of the leading causes of mortality and morbidity in New Zealand and the greatest burden of disease in the health of New Zealanders. A novel mobile application, SmokeFreeNZ, was developed for Android phone systems.

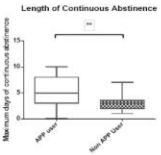
Objective: To investigate the efficacy of the SmokeFreeNZ app on prevalence of abstinence, self-reported number of cravings per day and Smoking Knowledge Index Measures.

Methods: Forty Unitec smokers (30 Android users and 10 controls) were recruited. Smokers' demographics and their smoking information were investigated at baseline. The efficacy of the mobile app was evaluated by measuring prevalence of abstinence, self-reported number of cravings per day and Smoking Knowledge Index Measures.

Results: After the mobile app use, mean Smoking Knowledge Index Measures increased from 62(±9)% to 96(±3)% (P<0.001) compared to the control group. Maximum number of days of continuous abstinence was 5.2 (±0.5) days in the app user group and 2.1 (±0.5) days in the control group (P<0.02). The prevalence of seven days' abstinence in users of SmokeFreeNZ was also improved significantly in comparison to the control group (26.7% in the app user group compared to 10.0% in the control group, Chi-square tests; P<0.05). These findings indicate that the SmokeFreeNZ app did help smokers at Unitec to quit smoking.

Conclusions: The SmokeFreeNZ app provided flexible and effective approach to coach smokers about the health risks of smoking and also improved seven days' abstinence rates in the study period. Future investigation is required to compare the cost-benefit effects and to evaluate the efficacy in smoking cessation in a larger-scale trial.





*: Corresponding Author, Dr. Lian Wu, Associate Professor, BHSD, Unitec Institute of Technology, New Zealand. lwu@unitec.ac.nz

So Right That It Is Wrong

Successful health promotion initiatives failing to eliminate health inequity.

Matthew Clay
The University of Auckland School of Population Health
261 Morrin Rd, St Johns, Auckland 1072

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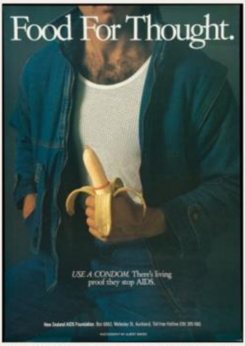
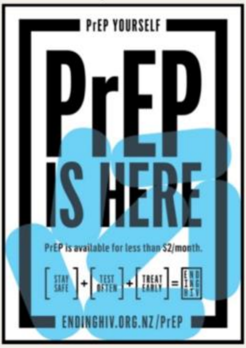
Are successful health promotion campaigns able to create unforeseen negative health issues within the communities targeted by such promotions?

Historically, HIV prevention has focussed on condom use. However in recent years, there has been a shift towards encouraging the use of PrEP to prevent HIV transmission.



New Zealand Aids Foundation. (1986). Food for thought: use a condom. There's living proof they stop AIDS [Poster]. Retrieved from https://www.theatlantic.com/health/archive/2011/11/30-years-of-aids-4-200-iconic-posters-100-countries-1-collection/248737/#slide5



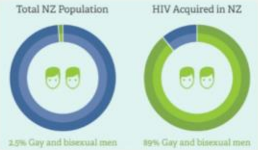
New Zealand Aids Foundation. (2018). PrEP yourself [Poster]. Retrieved from https://awards.agda.com.au/finalist/11002/1010

Ending HIV. (2016). Be in control [Poster]. Retrieved from https://endinghiv.org.au/blog/is-prep-for-you-campaign/

After the outbreak of HIV, health promotion was used to try and eliminate barriers of condom access and use by gay and bisexual men (Hughes & Saxton, 2015). Now there are more modern ways to prevent HIV transmission such as pre-exposure prophylaxis, also known as PrEP.

Using a critical review of research on HIV/AIDs programmes, programme documents and evaluation reports as well as grey literature from key agencies such as NZAF and Ending HIV this poster will present how health promotion initiatives can sometimes create worse health outcomes for some populations.

Results



Retrieved from https://www.nzaf.org.nz/hiv-aids-stis/hiv-aids/hiv-in-new-zealand/

Due to inequitable rates of HIV in gay and bisexual men (GBM), it seems all sexual health promotion for GBM has been left to NZAF and Ending HIV.

No more HIV 2020. (n.d.). Retrieved from https://www.gaytimes.co.uk/community/8477/shock-tactics-posters-melbourne-say-can-fuck-raw-prep/

The relationship is not causative. But it is important to consider what factors could be having an impact on negative health outcomes. What is certain is that recently HIV rates among GBM have been decreasing while rates of other STIs have remained around 40%. A possible cause is the increase in promotion and awareness of PrEP with some campaigns around the world promoting condomless sex.

Implications

Ending HIV. (image). Retrieved from https://endinghiv.org.au/blog-events/five-ways-to-be-an-awesome-prep-user

This is not to undermine the great work that PrEP has done. PrEP is extremely effective and was found to have reduced HIV acquisition risk among GBM by 86% (Saxton et al., 2018).

However, looking to the future it is important to remember how some campaigns may have negative effects. There needs to be more awareness of the potential negative outcomes that successful health promotion has. Campaigns which are more general may lead to people using methods of prevention for a range of STIs rather than one in particular.

SAMESH. (n.d.). Drama down under [Poster]. Retrieved from https://www.samesh.org.au/sexual-health.html

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Azariah, S., & Perkins, N. (2010). Prevalence of sexually transmitted infections in men who have sex with men presenting to Auckland Sexual Health Service. *The New Zealand Medical Journal, 123*(1322). Retrieved from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2010/vol-123-no-1322/article-azariah

Gay Times. (2015, September 21). Shock tactics: Posters in Melbourne say you can 'fuck raw' on PrEP. Retrieved from https://www.gaytimes.co.uk/community/8477/shock-tactics-posters-melbourne-say-can-fuck-raw-prep/

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POZ. (2017, January 6). "F*ck w/out Fear" urges this bold HIV prevention campaign. Retrieved from https://www.poz.com/article/prep-here-hiv-prevention-campaign

Saxton, P. J., Giola, M., Coughlan, E. P., Rich, J. G., Azariah, S., Ludlam, A. H., ... Myers, J. M. (2018). Implementing HIV pre-exposure prophylaxis (PrEP): let's not get caught with our pants down. *New Zealand Medical Journal, 131*(1482). Retrieved from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1481-31-august-2018/7683

Acknowledgements: Thank you to the fantastic population health teaching staff for guiding me through this research, especially Debbie Hager who has fostered my passion for health promotion.

Specific health issues of children who continue to receive pressure under the childhood impoverishment in Japan: Predicted child image

Noi S[1], Shikano A[1], Tanaka R[2,3], Noda K[4], Noi T[5]
[1] Nippon Sport Science University; [2] Nippon Sport Science University, Doctoral Degree Program; [3] Japan Society for the Promotion of Science; [4] Kurume University; [5] Tama University Hijirigaoka High School and Junior High School

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Background

In Japan, after the 1960s in the rapid economic growth, new physical and mental health issues of children had begun to be observed. We established the 'National Network of Physical and Mental Health in Japanese Children' in 1979. The network has been holding an annual conference "Annual Meeting on Physical and Mental Health in Japanese Children" to solve such health problems with many teachers, yogo teachers, physicians, parents and children etc. In this annual meeting, various health issues of children are discussed including "abnormalities" which are not diseases and/or disabilities but are not health. In addition, the 'Annual Report of Physical and Mental Health among the Children' as discussion materials of the meeting continued to be edited from 1989. However, the health issues of Japanese children (e.g. bullying, long absentee, violence, suicide, visual acuity, allergy, back strength, fatigue, Internet addiction, autonomic nervous system, executive function, sleep problems, defecation etc.) are going ahead more and more in a direction of intensification.

Therefore, the purpose of this study was to predict the Japanese children's future image under pressure of the highly competitive public education system based on evidence published in "Annual Report of Physical and Mental Health among the Children."

Table 1 Main events about education and child behavior in Japan

1960s	Doubling national income plan Nationally achievement test (until 1966) Introduction of deviation value Examination war intensified
1970s	'Dropout' was social problem
1980s	'School violence,' 'bulling,' 'suicide,' and 'management education' was social problem.
1990s	Breakdown in classroom discipline' was social problem
2000s	Nationally achievement test (in progress)

Methods

We predicted the Japanese children's future image under the pressure based on evidence (suicide, long absence, bullying, violence action, poor visual acuity, back strength, sleep deprived) published in "Annual Report of Physical and Mental Health among the Children."

Results

Two future images in Japanese children were predicted by seven figures shown in this presentation. One of the two images showed that Japanese children were the possibility of becoming increasingly worried. Therefore, Japanese children were faced with such a crisis they have never experienced before.

Conclusion

From the above facts, we reached the conclusion that loss of childhood due to pressure of the highly competitive public education system lead Japanese children to the more crisis future image.

Reference

The National Network of Physical and Mental Health in Japanese Children, *Annual Report of Physical and Mental Health among the Children*. 2018.

Fig. 1 Annual trends of poor visual acuity (under 1.0)

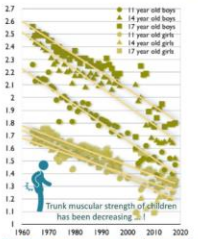


Fig. 2 Annual trends of back strength index (back strength / body weight)

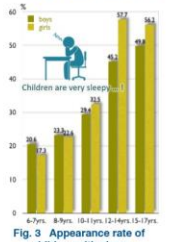


Fig. 3 Appearance rate of children with sleep deprivation

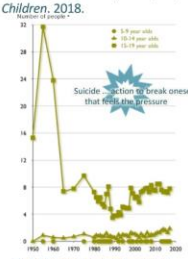


Fig. 4 Annual trends of suicide
* the number of suicides per 100 thousand people

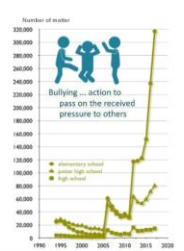


Fig. 5 Annual trends of bullying

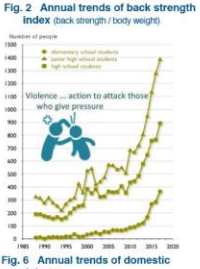


Fig. 6 Annual trends of domestic violence

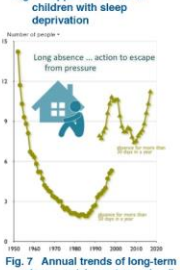


Fig. 7 Annual trends of long-term absences (elementary school)
* the number of absences per 1,000 people

Contact us:
Noi Shingo, PhD
Nippon Sport Science University
e-mail: nois@nittai.ac.jp

Strategies for sun-safety in youth to reduce New Zealand Melanoma rates

Maral Ghamkhar
The University of Auckland

THE UNIVERSITY OF AUCKLAND — MEDICAL AND HEALTH SCIENCES — SCHOOL OF POPULATION HEALTH

IUHPE — 23rd World Conference on Health Promotion

Introduction

- New Zealand has the **highest incidence rates** of melanoma worldwide
- A combination of dangerously high UV and a lack of awareness amongst New Zealanders leads to sun over-exposure, resulting in diseases such as skin cancer
- This will only continue to worsen due to climate change.
- **Almost 80% of skin cancer deaths** are due to Melanoma, with over 350 Kiwis dying every year due to the preventable disease (Melanoma NZ, 2018)
- The majority of Melanoma cases affect people over the age of 50, as the disease **develops over time** (Ministry of Health, 2018)
- Melanoma is a preventable disease with rates that can be reduced through the implementation of primary prevention programmes for young people
- There is currently a shortage of health promotion and information about sun-safety, especially in high schools
- This poster will discuss methods for engaging youth in life-long sun-smart behaviours
- The focus will be on an ongoing project I initiated in 2015

Incentive

- Despite New Zealand's high Melanoma rates, there is not enough information or education on the topic
- To interfere with the progression of a disease that develops over time, it is best to intervene at the earliest stage possible
- This requires us to educate our youth and and provide them with essential resources to take precaution when exposed to New Zealand sun
- Currently, New Zealand lacks a sun-smart school programme in secondary schools; the current focus is on providing children with hats and enforcing sun safety measures in young children
- Adolescents spend a lot of time outdoors- this age group (15-24-year-olds) is capable of making independent decisions
- Teenagers are more aware of the dangers of UV over-exposure; however, unlike primary school children, they do not have parents constantly reinforcing sun-safety
- Due to a lack of sun-safety awareness and resources, teenagers are exposed to **dangerously high levels of UV radiation**, leading to complications later in life such as late-onset Melanoma
- It is vital to provide New Zealand youth with adequate education on the risks and harms associated with excessive amounts of time spent in the sun without protection
- Information must be accessible and will be most effective if shared through social media campaigns and in schools
- The goal is to introduce optional school hats in secondary schools across New Zealand in conjunction with other sun-smart interventions and alongside sun-smart education
- Together, these interventions can **prevent early development** of Melanoma

Current Situation

- As of present, New Zealand lacks an effective sun-smart safety programme for youth aged 15-24 years of age
- Most campaigns regarding sun smart behaviour revolve around the **'slip, slop, slap, wrap'** campaign. This follows Australia's 'Slip, Slop, Slap, Seek and Slide' campaign, which includes seeking shade as an additional protective stage in preventing sun over-exposure
- There is information available regarding skin cancer screenings, however it is better to focus our attention on primary prevention strategies to beat the development of Melanoma from a young age
- Despite Melanoma rates being lower in Australia, there are more resources to aid in sun-smart behaviour
- Currently, most Australian high schools have an optional hat as part of their school uniform
- Executing a sun hat project in New Zealand can be a leading step in improving skin cancer rates and reducing the number of people who are affected by the disease

Melanoma Risk Factors

- Use of sunbeds
- Fair complexion
- Lack of protective measures such as covering up, using sunscreen and seeking shade
- Family or personal skin cancer history
- Skin damage due to sunburn

Ministry of Health, 2018
Melanoma NZ, 2018

Prevention

- Follow the slip, slop, slap, wrap guidelines
- Ensure sunscreen is **SPF30+**
- Ensure your hat fits the Cancer Society regulations; that is, wear a broad brimmed hat which covers the face, neck and ears
- Avoid spending excessive amounts of time in the sun, particularly between **10am and 4pm** when UV rays are at their peak
- Avoid sunbeds or tanning

Melanoma NZ, 2018

Method/Intervention

- After leaving Australia to move to New Zealand in 2015, I noticed the lack of sun-safety education and resources available in my high school
- I approached the Cancer Society to gain more information about the current sun-smart campaigns and resources in New Zealand. Considering our skin cancer rates, I found our country to be lacking in youth-focused interventions
- I signed on as a **Cancer Society youth ambassador** with a mission: to introduce resources such as shading and hats in secondary schools to fight UV exposure, and to ensure adolescents are well informed of the risks and harm associated with too much time spent in the sun
- I am currently involved in a **pilot project** in Palmerston North that aims to introduce sun hats as an optional addition to high school uniforms and increase sunscreen stations and shading on school grounds. This project also focuses on educating youth on **physical consequences** and the **'beauty perspective'** harms of sun over-exposure to incentivise sun-smart behaviour
- By focusing on the development of **wrinkles, moles, freckles and flakiness of the skin** due to sun burn, it is possible to convince youth to avoid spending excessive time under the sun's harmful rays. As physical appearances tend to be a priority for young people, this strategy is one which will allow for greater wide-spread adoption of sun-safety practices amongst our youth
- The objective is to eventually successfully implement this project nation-wide

Barriers / What Now?

Meeting with Judy McIntyre from the Cancer Society (centre) with my supportive mother, Mojgan Sadighi (right)

Cancer Society — Te Kāhui Matepukupuku o Aotearoa

- Initially I recruited a committee at school to help with the design and planning stages of this project. This proved difficult to continue as I graduated and many members were not fully committed
- Late last year I made the decision to continue with my project- I plan on collaborating with the Cancer Society throughout the process before approaching secondary schools with my project proposal
- I am currently in the **design stage**, sketching sun hat ideas that fit the fashion ideals of my peers yet still meet the safety guidelines of the Cancer Society in terms of protective material and brim measurements

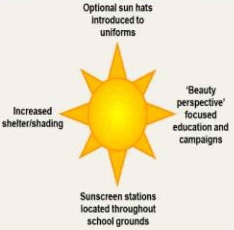
Findings

- Based on my own research via surveys in Palmerston North Girls High school, adolescents (young women in particular) are more likely to take sun-safety precautions if they are aware of the **beauty-related harms** that come with sun over-exposure
- Teenagers are more concerned with **immediate risks** such as the development of moles, freckles and sunburn, than they are with **future consequences** such as developing Melanoma
- The most effective way to address sun-smart issues and encourage sun-safe behaviour among adolescents is to approach the topic from a beauty perspective.

Design Plans

- The hats are being designed with the intention of being introduced as an optional addition to secondary school uniforms
- They will be:
  - → Broad-brimmed
  - → Block colours that will work well with uniforms (black, navy, red)
  - → 'Floppy' hats to be easily stored in school bags and lockers
  - → 'Floppy' hats also received the most votes in the survey conducted at school, as they were seen as a more 'fashionable' option
  - → Possibility of adding school logos will be up to each school

Future Directions in Schools



Conclusion

- As melanoma is a disease which develops over time and will increase with climate change, it is important to instil sun-smart behaviours as early as possible
- The pilot project is currently being evaluated; there has been success in introducing shading and educating students on sun-safety
- The current intended outcome is to provide students with access to hats as a resource for sun-safety
- The implication for health promotion practice is to continue finding new ways **to implement sun smart processes which are accessible and sustainable**
- Using schools as a setting ensures all youth are **exposed** to sun-safety practices at a pivotal point in development

Acknowledgements

A huge thank you to the following people for supporting or taking part in this ongoing project:

- Palmerston North Girls High School
- Kerry Hocquard
- Lorna Johnson
- Judy McIntyre

Thank you to The University of Auckland for making this poster possible, with special thanks to:

- Debbie Hager
- Ravi Reddy

Hon. Nikki Kaye (left) presenting me with a National Youth Week 'Change-Maker Award, which I was nominated for by Lorna Johnson (right)

Contact Information

Maral Ghamkhar

110 Grafton Road, Grafton, Auckland, 1010

Email: mgha818@aucklanduni.ac.nz

Strengthening opposition to alcohol licensing applications through successful partnership with Māori Wardens

Hangaia Ngaa Tikanga Me Ngaa Kawanatanga o taatou ma taatou

Setting

Alcohol was first brewed in Aotearoa (New Zealand) by Captain Cook's men in 1773. Māori at the time were unimpressed by alcohol, which held little significance, naming it **Waipiro** –"stinking water".

Since then, Māori have faced land loss, discrimination and increased pressure to attain European status commodities, all of which have radically altered their relationship with waipiro.

Compared to other New Zealanders, Māori are now more likely to die of alcohol related causes, and as a result of drinking are more likely to face injuries, legal problems and harms to their financial position, work, study and employment.

Unidentified Child. Northwood Bros (1920) Alexander Turbull Library

In 1949, Māori Wardens were appointed to mitigate the harmful effects of alcohol on Māori.

Māori Wardens. Pacific Trades Union Conference, photographer,May,PH-2015-2-GH1382-11

Intervention

To sell alcohol in New Zealand, a licence is required. Auckland Regional Public Health Service (ARPHS) is one of the three licensing enforcing agencies in Auckland that enquire into and can oppose licensing applications. ARPHS responded to a call to action from the Māori Wardens, concerning alcohol-related harm particularly in south Auckland, where the proliferation of alcohol outlets have been the greatest.

Face to face discussions with Māori Wardens initiated a change in the licensing process enabling Wardens to become more involved in opposing licensing applications. Priority areas in south Auckland were collectively identified. Any application and data related to these areas are shared with the wardens prior to compliance officers reporting on an application. Legal training for Māori Wardens have also been provided, strengthening legal participation.

Problem Identification	Consultation	Face to face meetings	Reviewing reporting process
Prioritisation	Priority areas in south Auckland identified	Māori Warden expertise incorporated	Legal training for Māori to foster better participation
Long-term changes	Changes incorporated in ARPHS regulatory protocol	Equity	Partnership	Active protection

1 2 3 4

Outcomes

Prince Harry performing a traditional Māori hongi greeting. Source: Getty Images

With Māori Wardens being notified of every licensing application, area knowledge and experience has been strengthened helping to minimise alcohol-related harm. This is a commitment to the Te Tiriti o Waitangi (translated as the Treaty of Waitangi) and the Ottawa Charter.

Implications

This has become a model for successful collaboration with Māori upholding the principle of active protection in accordance with the Treaty of Waitangi.

Korru design representing New Beginnings, inspired by Reina Cottier Art.

Auckland Regional Public Health Service
Ratonga Hauora ā-Iwi o Tāmaki Makaurau

Student Perspective On The Health Promoting University' Initiative: A survey among undergraduate health and non-health student at Universitas Gadjah Mada, Indonesia

Yayi Suryo Prabandari[1], Tika Amimah Hasibuan[2] & Zaenab[2]
[1]Department of Health Behavior, Environment and Social Medicine, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Indonesia [2]Graduate Program of Public Health, Majoring on Health Promotion and Health Behavior, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Indonesia

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Background

University should provide services and facilities that cover health aspects related to health services, places to eat, as well as buildings and greening of the campus to improve healthy life style. Physical activity can be elevated through the provision of sports facilities, bicycle lanes and safe pedestrian walkways (Snelling, 2014). The results of Holt's research in 2015 on student perceptions of healthy universities stated that healthy universities would promote student health in every aspect starting from facilities, the environment and curriculum, as well as access to healthy food facilities and sports facilities (Holt et al., 2015). A health promoting university/HPU concept has been introduced since two decades, but the HPU has not been widely applied in ASEAN countries. ASEAN University Network (AUN) has developed Health Promotion Network and they recommended all members of AUN should apply the HPU. Universitas Gadjah Mada (UGM) Indonesia is one member of AUN and started to develop the HPU and there is a need to know students' perspective on the HPU movement

Objective

To assess the opinion of UGM student toward the HPU initiative as a baseline data in the beginning of the program.

Method

- An online survey and qualitative approached through semi structured interview and Focus Group Discussion (FGD) have been conducted in the February to April 2018.
- Sample of survey : 572 non-health sciences students (N-HS) from Social Sciences, Natural Sciences and Agricultural Sciences and 92 health sciences students (HS) from Medical School, Dentistry, Nutrition, Nursing, Pharmacy and Dental Hygiene
- Sample of qualitative study: 57 health students (HS) from Medicine, Pharmacy and Dentistry (H) at the UGM
- Data analysis: descriptive analysis

Result

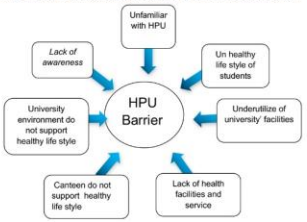
Table 1. Characteristics of Survey' Participant

	Non Health Sciences Students		Health Sciences Students	
	Frequency	%	Frequency	%
Age				
<20 years old	223	38,99	45	48.91
>=20 years old	349	61,01	47	51.09
Gender				
Male	186	32,52	8	8.70
Female	386	67,48	84	91.30

Table 2. Attitude toward HPU of HS partisipants

No	Statement	Positive	Negative
1	I will support UGM as HPU	98.91	1.09
2	I will not smoke inside campus and if I see my friend smoke, I will warn him/her	100	
3	I will eat healthy food in the campus	92.39	7.61
4	I will support mental health in campus by taking care of my self	98.91	1.09
5	I will do psychological counseling that served by the university for protecting from depression	86.96	13.04
6	As student I will responsible for promoting health and welfare of the university staffs and students	100	0
7	I will use campus bicycle for exercise	95.65	4.35
8	I will use facility that served by the university for activities that related with my interest	100	0

Figure 1. Perceive of students on barrier of HPU implementation



Students' expectation on the HPU initiative

- *It would be nice if the university is now starting to promote or build HPU and health promoting university should be started from the university level"* (P1, female, 20 years, 4th semester, Faculty of Pharmacy)
- *"Maybe what should be given, the important of why we should go to health promoting university. If we know more about the need of HPU inniitiative, maybe we will be more interested "*(P4, female, 20 years, semester 4, Faculty of Medicine).
- *"UGM is one of the best universities in Indonesia, so it can be a model for implementing promoting university "*(P6, female, 21 years, semester 6, Faculty of Medicine, Nursing Study Program).

Discussion

- This study showed that health sciences (HS) students were more supported toward HPU, compared to the non health sciences (NHS) students.
- World health organization (1998) states that universities are places where many people have activities and experience various aspects of life such as learning, working, and enjoying their free time, and in some cases people use various services available at universities such as catering and transportation. Therefore, the university has a lot of potential to protect health and improve academic and non-academic well-being and the wider community through health policies and practices in every aspect of the university such as a course scheduling system and providing recreational facilities
- Dorris and Doherty (2009) stated that everyone interpreted health promoting university or a healthy university concept in different ways, ranging from relatively narrow meanings to broader ones (Dooris and Doherty, 2009 cit. Sirakamon, et al., 2017)
- Research conducted by Holt, et al. (2015) reported that students related healthy university policies in terms of healthy food choices with facilities and the environment (Holt, et al., 2015)

Conclusion

- This study reveals students were having mixed attitude toward HPU
- Health sciences students were more supported than non health sciences student
- There were a few of barriers that challenge the implementation of HPU

Recommendation

- University is suggested to support implementation of health promoting university (HPU) with strict policy regarding healthy cafeteria, campus building and green environment, elevate ``sport facility, bicycle station and parking lot to create a healthy learning environment.
- Students are expected to improve health literacy by updating health information from trusted sources and live healthy lifestyle.

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Te Aka Mauri's Health Literacy Framework: a collective approach to community health

Authors: Bridget Wilson, Joanne Dillon, Anna-Marie Schopp
Affiliations: Lakes District Health Board, Rotorua Lakes Council, Toi Te Ora Public Health

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Our Story

The co-location of the city's library and the hospital's community child health services is a collaborative project between Rotorua Lakes Council and Lakes District Health Board. A key aspect of the project has been engagement with strategic partners, the community, iwi and government agencies.

'Te Aka' means 'the vine or interconnection' and 'mauri' means the life force or essence, so Te Aka Mauri refers the shared vision to create a facility of excellence to advance community wellbeing and understanding.

Our situation

"The Lakes District Health Board population exhibits some of the highest levels of health inequality in the country, with children particularly affected. With the correlation between social deprivation and health status well established, the impact of Lakes DHB's community deprivation profile is reflected in a number of areas where our children and their families are struggling to attain good results. Negotiating care between fragmented services is challenging, and many children are lost to the system because of poor coordination and integration practices.

Mainstream and traditional approaches are not making enough of a difference to our children at a fast enough pace or magnitude to meet the needs of our most vulnerable." [1]

What we needed to do was:

1. change the overall culture of the city with respect to children and young people
2. develop multi-agency partnerships
3. develop the model of care for the new Children's Health Hub in the Rotorua Library.

Whakatauki (proverb) guiding project decision-making:
Ka mauri nui te tamariki,
ka mauri roa te whānau.
Ka mauri tū te hapū,
ka mauri ora te Iwi.

As children are nurtured,
the family will flourish.
As relationships are enhanced,
the people will prosper[2]

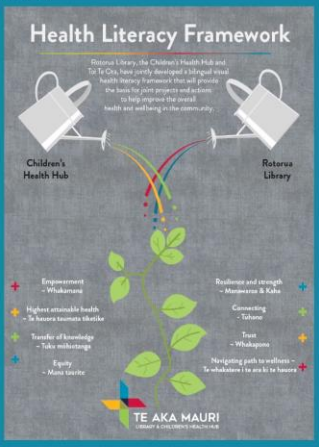
What we did

As professionals we decided to be proactive and take a child-centred approach in ensuring the well-being and safety of children; however we recognise that children are part of a whānau/family and therefore we also needed to support the family of these vulnerable children.

Following consultation with multiple agencies, consumer groups, iwi and colleagues we developed the Children's Health Hub; a collaborative approach to a community's holistic health and wellbeing. It is a place to learn and grow, a place to gather, a place to get advice and a place to heal.

A team of passionate individuals from Rotorua Lakes District Health Board, Rotorua Library and Toi Te Ora Public Health came together to form the health literacy team. This team became health literacy champions and created a framework of principles to guide both strategic direction and service delivery.

The shared goal of the team is to create a space of wellbeing and learning for our community, by breaking down barriers and empowering providers and those they serve.



Where to next?

A number of initiatives are being developed and delivered, aiming to reduce inequity and pushing health literacy beyond the walls of Te Aka Mauri: Library & Children's Health Hub.

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2. Gifted by Ngā Mahinga Toi

Credits

Photo courtesy of Lakes District Health Board

Acknowledgements

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WAIORA: Promoting Planetary Health and Sustainable Development for All

TOI TE ORA PUBLIC HEALTH
LAKES DISTRICT HEALTH BOARD
ROTORUA LAKES COUNCIL

Teacher's Capacity Building for Health Promoting School Implementation in Taiwan

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Authors: Chieh-Hsing Liu, Fong-Ching Chang, Li-Ling Liao, Yu-Zhen Niu, Chi-Chia Cheng, Shu-Fang Shih
Affiliations: Department of Health Promotion and Health Education, National Taiwan Normal University

Abstract

Objective: This study aims to examine the effects of teachers' participation in HPS training courses on their HPS knowledge, HPS efficacy, and HPS implementation.
Method: A total of 649 teachers (primary school: 334, middle school: 159, high school: 156) from 122 schools completed the questionnaire in 2016.
Results: About 82% of teachers reported that they participated in HPS training workshops in past 3 years. Multiple regression results showed that after controlling for teachers' gender, age, work years as a teacher, school level, and HPS funding, teachers who participated in HPS training had higher levels of HPS knowledge. In addition, teachers who participated in HPS training reported higher levels of HPS efficacy, while teachers who participated in HPS training also reported higher levels of HPS implementation.
Conclusion: In conclusion, this study revealed the positive effects of HPS training courses on enhancing teacher's HPS knowledge, efficacy and HPS implementation.

Introduction

Health Promoting Schools (HPS) are advocated by the World Health Organization (WHO) as an effective approach to enhancing the health of students and staff and combat global chronic disease burden (World Health Organization, 1986, 2018). HPS offer a holistic approach to organizational and systemic change with respect to health and wellbeing in schools (Deschesnes, Martin, & Hill, 2003). Teachers are crucial resources for an improvement in students' health (Jourdan et al., 2008; St Leger, 1998), and teachers are the best resource in identifying children who face physical and psychological problems (Imran, Rahman, Chaudhry, & Asif, 2018). Research has shown, however, that teachers often lack the capacity and resources to implement HPS (Reddy, 2019).

Teachers are vital "drivers for change" to ensure efficient HPS implementation and promote the health and wellbeing of students (Jourdan, Samdal, Diagne, & Carvalho, 2008; St Leger, 2004). More counties such as France (Pommier, Guevel, & Jourdan, 2011) and Austria (Flaschberger, Nitsch, & Waldherr, 2012) have implemented teacher training to facilitate HPS adoption and implementation. The WHO and the International Union of Health Promotion and Education, as well as many researchers, have recognized the need for capacity-building in schools and teachers in order to achieve effective whole-school approaches that will promote students' emotional and social wellbeing (Jourdan et al., 2008; Reddy, 2019; Tang et al., 2009; World Health Organization, 2018).

Taiwan Ministry of Education and Ministry of Health collaboratively launched an HPS program in 2002, while Taiwan government announced that all primary and middle schools would be required to implement HPS in 2008. Taiwan Ministry of Health and 22 city/county education bureaus provided several capacity building strategies such as HPS support network and ongoing professional development for continuous improvement for HPS. However, a very limited amount of research has focused on examining the influence of teacher HPS training workshops on HPS implementation. Since teachers are key change-makers to HPS implementation, this study examined teachers' participation in HPS training courses and measured the effect on their knowledge of HPS, their perceptions of HPS efficacy, and their levels of HPS implementation.

Methods

Participants

The participants in this study included teachers from primary, middle, and high schools. A probability-proportionate-to-size sampling method was used to systematically draw a random sample of 154 schools in Taiwan. In each sample school, the persons who were in charge of HPS and teachers were invited to join the questionnaire survey. A total of 649 teachers (primary schools, 334; middle schools, 159; and, high schools, 156) from 122 schools completed the questionnaire in 2016. The questionnaire used was online and self-administered. The response rate was 91%.

Instruments

A self administered questionnaire was developed to assess teachers' perceived efficacy of HPS and its implementation based on the WHO Western Pacific HPS framework and the results of our prior study (Chang et al., 2014). Experts were invited to assess the content validity of the questionnaire. In addition, a pretest survey was conducted to examine teachers' responses to the survey and to evaluate the reliability of the data yielded by the questionnaire. Approval was obtained from the Institutional Review Board at National Taiwan Normal University.

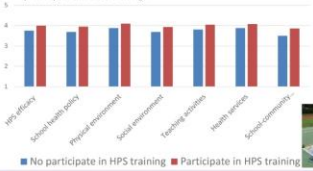
Data analysis

SAS software was used to perform the statistical analysis. Percentages and means were calculated for all variables. Chi-square tests were conducted to analyze teachers' characteristics by whether teachers' participation in HPS training. A series of t tests were performed to compare teachers' HPS knowledge, HPS efficacy, and HPS implementation. In addition, multiple regression was used to examine the influence of HPS training on teachers' HPS knowledge, HPS efficacy, and HPS implementation.

Results

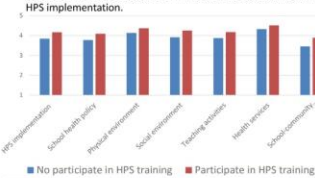
Teachers' HPS knowledge and efficacy

- Teachers who had participated in HPS training reported high levels of knowledge of HPS with a greater understanding of HPS topics compared with teachers who did not participate in HPS training.
- Teachers who had participated in HPS training reported high levels of perceived efficacy of HPS compared with teachers who did not participate in HPS training.



HPS implementation by teachers' participation in HPS training

- Compared with teachers who did not participate in HPS training, teachers who had participated in HPS training reported higher levels of HPS implementation.



Effects of HPS training on teachers' HPS knowledge, efficacy, and implementation

	HPS knowledge		HPS efficacy		HPS implementation	
	β	p	β	p	β	p
Intercept	0.820	<.0001	3.632	<0.0001	3.672	<.0001
Teacher's HPS training (no=0, yes=1)	0.029	0.0047	0.186	0.0031	0.240	<.0001
Teachers' gender (female=0, male=1)	-0.009	0.2837	0.099	0.0439	0.092	0.0431
Teachers' age (<40 y/o=0, >=40 y/o=1)	-0.006	0.4903	-0.040	0.4575	-0.015	0.7565
Teachers' work year (<10 y=0, >=10 y=1)	0.020	0.0319	-0.043	0.4644	-0.056	0.3006
School level (middle/high=0, primary=1)	0.002	0.8183	0.242	<0.0001	0.269	<.0001
School HPS funding (no=0, yes=1)	-0.007	0.3456	0.108	0.0253	0.182	<.0001

Conclusions

This study provides an important context for understanding the effect that HPS training exerts on teachers' as well as their knowledge of, their perceived efficacy of, and their implementation levels of HPS. Multiple regression results showed that after controlling for teachers' gender, age, work years as a teacher, school level, and HPS funding, teachers who participated in HPS training had higher levels of knowledge concerning HPS. In addition, teachers who participated in HPS training reported a higher level of perception for the efficacy of HPS, and they also reported higher levels of HPS implementation. This study revealed the positive effects of HPS training courses on enhancing teachers' knowledge of HPS, their perceptions of the efficacy of HPS, and higher levels of HPS implementation. Continuously enhancing teachers' HPS capacity through training is important for effective HPS implementation, while governments could continuously provide technical support and financial resources for schools to sustain HPS implementation. Future longitudinal research is needed to assess the long-term impact of teachers' influence on the implementation and sustainability of HPS.

Contact: Fong-ching Chang
Email: fongchingchang@ntnu.edu.tw

Teachers' Engagement at work, and teacher's physical activity: the Taiwanese experience

Dih-Ling Luh, Ying-Wei Wang*, Kai-Yang Lo, Shy-Yang Chiou, Fu-Li Chen
* Presenter : Ying-Wei Wang, Director Genderal of Health Promotion Administration, Taiwan, R.O.C.

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Background

From the perspective that recognizes teachers as an important human resource for school setting, improving their health related behaviors could be effective means for human resources management. Studies found teachers have performed worse on their physical activity (PA) behaviors, along with gender differences. In Taiwan, the Health Promoting School Accreditation (HPSA) Program has been launched and conducted with purposes to improving students' health, and also teachers' health.

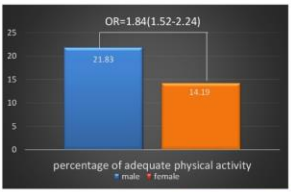
Objective

The objective of this study is to identify gender differences among HPSA awarded schools, Health Promoting School teachers' engagement at work, and teachers' PA behaviors in Taiwan.

Methods

Data was collected from "A Study Health Behaviors Survey among Students and Teachers after Health Promoting School Accreditation" in 2014, which was a cross sectional design and surveyed teachers from 192 schools attending HPSA and 55 schools without attending HPSA in 2012. A total of 4,213 teachers responded. Adequate PA was refer to a minimum of 30 min on five days each week. Multivariate logistic regressions were conducted to answer the objective.

Results



In general, male teachers showed higher adequate PA than females (Odds Ratio = 1.84, 95% C.I.=1.54-2.24) after adjusting for teachers' age, experience of health promotion related training, school level, HPSA Awards, school ownership, and engagement at work of health promoting school.

For male teachers, adequate PA was related with

1. HPSA Awards

- the adequate PA of those who worked in the gold medal school (as reference group) were better than silver(OR = 0.45, 95% C.I.=0.25-0.81) and bronze(OR = 0.39, 95% C.I.=0.22-0.72) medal schools

2. Engagement at work of health promoting school

- higher engagement, more likely have adequate PA. (OR = 1.08, 95% C.I.=1.03-1.13)

For female teachers, adequate PA was related with

Engagement at work of health promoting school

- higher engagement, more likely have adequate PA. (OR = 1.05, 95% C.I.=1.02-1.08)

Conclusion

Though the correlated factors with teacher's PA varied with genders, teachers' engagement at work of health promoting school seemed positively related to teacher's adequate PA.

Poster presented at 23rd IUHPE World Conference on Health Promotion, Rotorua, Aotearoa New Zealand, 7- 11 April 2019

The Assoraider Adult Scout Experience in Health Promotion: the "Trail del Marganai"

Alessandra Sotgiu1, Monica Piras 3, Alessio Decina 2, Claudia Sardu 1, Paolo Contu1,
1 Università di Cagliari, 2 CADAS, 3 Assoraider Raid Karalis

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Background/Objectives

Raid Karalis is a community of adults Scout from the Assoraider of Cagliari and Quartu Sant'Elena in Sardinia.

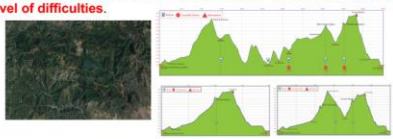
The Raider methodology, peculiarity of the Italian scout association Assoraider, is Scouting for adults and includes all people who want to continue their Scout life after 19 years old.

1ST EDITION | 2ND EDITION | 3RD EDITION

In 2014 the Raid Karalis started an empowerment project that had as main goal to develop project ability.

The "Challenge" touch and involve a Sardinian local community in a very deprived area, Domusnovas, in the south-west of Sardinia.

The "Challenge", titled **"Trail del Marganai"**, consist in an international run race with **3** different traces routes with **different level of difficulties**.



Methods

Challenge include 3 phases:

1° a training course in project management. In this phase they involved also a researcher of university of Cagliari expert in Health Promotion planning and Scout itself.

2°implementation of the activity by the work groups organization, defined "Pro" in Raid method.

3°local community involvement and citizen training, in order to deliver the organization to the local community.

After one year they presented the first "Trail del Marganai" edition to the local community and to the public.

The aim of Raider's method is people empowerment, through the tool of the "Challenge", with particular reference to the project cycle management by a capacity building process.

In addition, the Trail has set itself the goal of raising funds for the support of children in difficulty. in 2017 donated 40 portable dvd players for the local hospital pediatric wards and in 2018 bought, in collaboration with other associations, inclusive games for disabled children

Results

The Trail first edition took place in March of 2016. After the first edition, the Trail had other 2 edition, in 2017 and in the 2018.
The Trail passed from a number of registered athletes of about 150 to a number of about 500 in the third edition.

With the third edition the Raid has started to train a few citizens of Domusnovas, who collaborated in the organization of the event.
Activity main results consist in new skills in management, mediation and community involvement.

March 10th 2019 took place the fourth edition organized together by the citizens of Domusnovas and the Raid Karalis.
this edition also included the participation of people with prosthetics

Social Impact of local community has been evaluated, and include touristic, and services business development.

Discussion

In conclusion Trail of the Marganai, born as an activity organized ad promoted by scouts for civil society, has built a bridge between scout method and the community empowerment.
This activity highlighted the difficult to involve the local government in activity that involve all citizen.

In this activity also the last arrivals were welcomed by winners, because "Only those who dare fly can fly" (cit. Sepulveda)

Keywords
Empowerment, Scouting, project management, social impact

The context of history for the perspective of Urban Planning of the Healthy City

Author(s): Ana Maria Girotti Sperandio [1] Pamela Shue Lang Lin,[1] José Agoncillo Caldeira[1]

Affiliations: [1]Laboratory of Urban Investigations - College of Civil Engineering, Architecture and Urbanism of the State University of Campinas

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Historical facts that converge to the Healthy City

The historical context has been accompanied as an important factor for the development of analysis of the relationship between health promotion and cities, through the identification of preponderant facts of public health and urban planning.

The objective of the work is to build a timeline that organizes the historical aspects that influenced international politics and converged towards the construction of a potentially healthy city. Placing the knowledge frames produced under this theme reveals how the active actors in this process were articulated before the events of the world.

Timeline of international events

1788 - Medical Policy developed by Johann Peter Frank

First book published in Central Europe which addressed public health for cities under the title "System einer vollständigen medicinischen Polize" (Frank, 1788).

1844 - City Health Association founded by Edwin Chadwick

Through a Royal Commission of Inquiry into the State of Large Cities and Population Districts, poverty, crime, ill health and high mortality were associated with the poor environmental conditions of industrial cities.

1890 - "Garden Cities" in Great Britain developed by Ebenezer Howard

Important urban current based on the critical analysis of the liberal city and the unhealthy conditions of life due to the high population density and bad circumstances of the space offered by industrial cities.

1928 - International Congress of Modern Architecture

Urbanism was defined as an organization responsible for collective life, involving the city and the countryside, stablishing that the main functions of the city were: housing, work and leisure.

1933 - Charter of Athens

The city appears as an organism to be conceived in a functional way, in which the needs of man must be clearly placed and resolved. It advocates the separation of residential, leisure and work areas, proposing a low density compared to traditional cities.

1945 - United Nations (UN) foundation

With the intention of promoting international cooperation comes after the end of World War II. Its goals include maintaining world peace and security, promoting human rights, helping with economic development and social progress.

1946 - World Health Organization (WHO) foundation

Specialized agency in health and subordinate to the UN. Its aim is to develop the health of all people, defining it as a "complete state of physical, mental and social well-being and not just consisting of the absence of disease or infirmity."

1956 - First conferences on environmental , social and physical variables as determinants of mental health organized by John B. Calhoun.

Experiments that revealed the problems of overpopulation and megacities.

1971 - Theory of the epidemiological transitions of Omran

It was found that the changes that characterize the epidemiological transition are strongly associated with the demographic and socioeconomic transitions. In this way, man is the main responsible for the diseases, aggravations and the current pandemics.

1974 - Lalonde Report, Canada

Known as "The New Perspective on the Health of Canadians", it is considered the first government report that proposed improvements in health through changes in the physical-social environment and the lifestyle of the population, which was a milestone for the construction of this understanding.

1978 - Alma Ata Declaration

Made during the International Conference on Primary Health Care, it was held by the WHO in Alma Ata, Republic of Kazakhstan, and expressed the need for health promotion urgently by all governments, especially in developing countries.

1981 - Concept of city compared with organism and ecosystem developed by Lynch

The essence of the city is the set of individual manifestations that become collective that makes the body of the city a living organism and, above all, that gives it identity.

1986 - I International Conference on Health Promotion, Ottawa Charter

The role of citizens has been established to deal with complex health problems and to create a "healthy" city. Connecting the relationship between the parties and the common sense of the whole community is essential for healthy city formation.

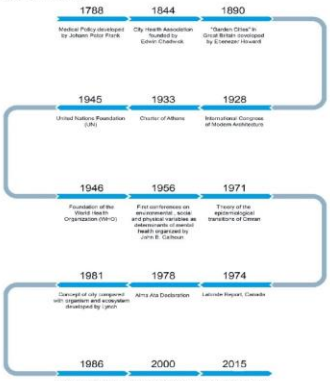
2000 - Millennium Development Goals

Consisting of recommendations that drive global development, foster quality of life and eradicate poverty by 2015.

2015 - Sustainable Development Goals

Developed to mantain the aspirations of the Millennium Development Goals. The main objectives are to reduce poverty, ensure social and environmental promotion so that human rights are respected and prosperity and world peace can be achieved by 2030.

Healthy City Timeline



Conclusions

- For the convergence of the facts that contributed to the development of the concept of Healthy City, in the context of international evolution for the promotion of health, aspects such as social participation and favorable physical and biological environment have attained prominence, sharing the focus that was previously only in the engagement against the disease.
- International institutions, with these issues as priorities, committed themselves to meeting development goals for world welfare, transcribing those goals into international policies, plans and strategies that underpinned each nation's commitment to those goals. The formalization of this commitment builds evidence that structures the history towards the healthy city.
- As already pointed out earlier, in September 2015 the UN, as a proposal for Agenda 2030, launched the seventeen Sustainable Development Objectives and considered that each country would be responsible for formulating its development and aligning with the one hundred and sixty-nine goals that ensure the quality of life. Such goals clearly converge with the Healthy Cities movement, since they establish the relationship between well-being and other areas of urban daily life, broadening the understanding that well-being does not depend only on physical health.

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Promoting Healthy Weight with a Life Skills-Based Program among High School Students in Taiwan

Authors: [1]Yen-Jung Chang,[2]Yu-Zhen Niu, [3]Li-Ling Liao, [4]Chih-Ning Lung , [5]Ju Lai ,
[6]Han-Yang Huang,[7]Ying-Wei Wang,[8]Li-Hui Yu,[9]Li-Ju Lin,[10]Chen-Su Lin,[11]Chiung-Dan Chang,[12]Heng-Cheng Lin
Affiliations: [1]National Taiwan Normal University,Taipei,Taiwan;[2] National ChiaoTung University, Hsinchu, Taiwan;
[3]I-Shou University, Kaohsiung,Taiwan;[4]New Taipei Municipal Ji-Sui junior High School, New Taipei ,Taiwan;
[5]I-Shou University, Kaohsiung,Taiwan;[6]New Taipei Municipal Guang Rong junior High School, New Taipei ,Taiwan;
[7-12]Health Promotion Administration, Ministry of Health and Welfare, Taipei, Taiwan

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Background/Objectives

Surveillance data indicated that nearly one-third of high school students in Taiwan were overweight or obese. This study aims to develop and implement a life skills- based program for healthy weight among High School Students in Taiwan. Life skills including self-awareness, critical thinking, decision-making, and problem-solving were incorporated in the 4-unit program. Teaching materials covered 3 topics: healthy eating behaviours, regular physical activity, and healthy weight management.

Methods

The program was implemented in 6 high schools in 3 cities in Taiwan in 2018. There were 220 students participating in the intervention group, and 219 students in the control group. Intervention effects were assessed using self-administrated baseline and follow-up questionnaires concerning healthy weight knowledge, intention of behaviours about healthy weight maintenance, and self-efficacy of life skills practice. Data were analyzed using SPSS.

Results

Table 1. Differences in knowledge, behavioral intentions and life skills self-efficacy between experimental group and control group

Item	Group	n	Pre-test		Post-test		T value	F value
			M	*SD*	*M*	*SD*		
Knowledge of Healthy Weight	E	212	4.33	1.76	4.67	1.64	2.65**	3.88*
	C	198	4.54	1.66	4.46	1.82	-0.61	
Intention of Behaviors	E	220	15.91	4.78	15.09	4.92	-2.10*	5.52*
	C	219	15.46	5.21	13.80	5.77	-3.63***	
Self-efficacy of Life Skills	E	220	76.10	22.17	82.10	22.24	3.57***	15.39***
	C	219	75.00	23.82	73.27	25.85	-0.91	

E= experimental group, C=control group
*p<.05, **p<.01, ***p<.001

Table 2. The Varying Parameters Difference of Self-efficacy between Experimental Group and Control Group

Item	Group	n	Pre-test		Post-test		T value	F value
			M	*SD*	*M*	*SD*		
Self-awareness (Healthy Weight)	E	211	11.32	2.87	11.61	2.76	1.38	5.76*
	C	196	11.04	2.74	10.92	2.59	-0.59	
Critical Thinking Skills	E	210	6.57	2.12	7.29	2.09	4.80***	4.36*
	C	196	6.63	2.13	6.94	1.91	2.06*	
Decision-making Skills (Diet)	E	211	6.69	2.17	7.26	1.98	3.84***	9.73**
	C	197	6.69	2.02	6.75	1.81	0.41	
Problem-solving Skills (Diet)	E	210	9.92	2.89	10.87	2.70	5.22***	18.91***
	C	196	10.15	2.90	10.03	2.70	-0.66	
Self-awareness (Physical Activity)	E	210	7.17	1.92	7.50	1.91	2.53*	4.85*
	C	197	7.08	1.93	7.10	1.91	0.12	
Problem-solving Skills (Physical Activity)	E	207	9.95	2.95	10.77	2.93	4.19***	9.19**
	C	196	9.91	2.94	10.01	2.94	0.53	
Decision-making Skills (Physical Activity)	E	210	6.73	1.89	7.20	1.92	3.34**	2.75
	C	198	6.84	1.93	6.98	1.88	1.11	
Problem-solving Skills (Healthy Weight)	E	210	9.56	2.95	10.54	2.94	4.81***	6.89**
	C	198	9.60	2.88	9.92	2.84	1.73	
Advocacy Skills	E	210	2.85	1.19	3.30	1.16	5.20***	3.64
	C	198	2.97	1.18	3.17	1.10	2.33*	

E= experimental group, C=control group
*p<.05, **p<.01, ***p<.001

Comparing to the control group, the intervention group showed a significant improvement on healthy weight knowledge (F=3.88), and on the intention of taking behaviours of healthy eating and regular physical activity in the next 3 months (F=5.52). In addition, the intervention group scored higher on the self-efficacy of life skills practice at the follow-up than the control group, and the difference between pre- and post-test results was statistically significant (F=15.39).

Discussion

The life skills-based approach to promote healthy weight could be effective for high school students. Long-term follow-up on changes in behaviour and weight status is recommended for future study.

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Promoting Healthy Weight with a Life Skills-Based Program

Videos Made for the Teaching

Director of Health Promotion Administratiom - Mr Ying-Wei Wang accepted a media interview at the press conference in 2018 to introduce Healthy Weight Promotion with Life Skills-Based Program.

Students Practice the Decision-making Skills in the Class

The experiential learning theory of high level wellness, health and happiness

Author: Dr Connie Allen Affiliations: [1]Relationships Australia Queensland, Logan, Australia; [2]Menzies Health Institute Queensland, The Hopkins Centre and Griffith University, Logan, Australia

IUHPE
23rd World Conference on Health Promotion

Research questions

1. What is high level wellness?
2. How do people attain and maintain this way of being?

Why do we need to focus on high level wellness?

- The World Health Organization recognises that everyone has the right to enjoy the highest possible standard of physical, mental and social wellbeing (high level wellness, health and happiness), regardless of their socioeconomic circumstances, ethnicity or beliefs.[1]
- Decades of research have provided a good understanding of the factors that facilitate high level wellness, including healthy food,[2] physical activity,[3] supportive relationships,[4] and equitable access to money, power and resources.[5]
- However, relatively few people appear to be flourishing,[6,7] suggesting that this growing body of knowledge on wellness determinants has not translated into 'high level wellness for all'.
- Qualitative research on the lived experience of high level wellness could enhance the evidence base, by providing new perspectives on what this way of being is, and how people attain and maintain it. These types of studies are quite rare, as most health researchers conduct qualitative (words/pictures) research into disease/disadvantage or quantitative (numerical) studies across the health continuum (e.g., psychology and positive psychology).[8,9]
- This is the first study that has sought to understand high level wellness from interviews with people who consider themselves to have a high (or very high) level of wellness, health and happiness.[8,9]

How was this study conducted?

Participant recruitment and selection

- This study was advertised through newspapers, radio and television, as well as Email, Facebook, LinkedIn and Twitter
- 25 Australian adults were selected based on three criteria:
  1. Over the age of 18
  2. Lived in South East Queensland
  3. 'High' or 'very high' level of wellness, health and happiness (self report on a five point scale ranging from very low to very high)

Participant characteristics

- 20 females aged 25 to 65 (M=43.6); 5 males aged 41 to 60 (M=53.4)
- Residential locations: Brisbane (n=14), Gold Coast (n=7), Logan (n=2), Ipswich (n=1) and the Sunshine Coast (n=1)
- Income: low (n=7), medium (n=12) and high (n=4), with two not stated

Data collection and analysis

- *Constructivist grounded theory method with semi-structured interviews*
- Participants were asked to describe what high level wellness meant to them, their wellness journeys, what helped (and what made it harder), how they were similar to (and different from) less healthy, happy (and well) people, and how others could become more healthy, happy and well. They also reflected on the type of day that made them feel particularly healthy, happy and well, and one that did not.
- This data was audio-recorded, transcribed and sent to participants prior to data analysis, with pseudonyms used to conceal their identities.
- Data patterns were identified and compared to create a new theory, and participants provided feedback and ideas for improvement.

Results

This study produced a new understanding (theory) of high level wellness, including a definition, process and model. This health promotion theory was labelled, '**The Experiential Learning Theory of High Level Wellness**'.[8,9]

What is high level wellness? Definition

- High level wellness is the sense of peace (wellbeing) that comes from knowing, liking and being your best (not perfect) self. This feeling can be fleeting, fluctuating or fixed. The presence of inner peace enables people to savour the most enjoyable aspects of their lives, and manage everything else. Its absence lets them know it is time to try something different, by becoming more: (i) present, self-aware and self-determined, (ii) respectful of their needs, and (iii) aligned with their unique values, strengths, energisers and joys. Inner peace is an important inner compass.

How do people attain and maintain this way of being? Process

- There are three steps in this circular experiential learning process: (1) assessing the situation, (2) trying an action and reviewing the consequences, and (3) integrating lessons. This self-initiated learning process requires self-commitment, reflection on inner and outer circumstances, and the ability to become one's best self—including access to relevant resources. Figure 1 shows this in pictorial form (model).
- People can initiate many learning cycles throughout their lives, in relation to a wide range of factors. Over time, this can result in the adoption of several qualities and actions, which they express in their own unique ways (e.g., spending time with positive people and/or pets, doing something of value for themselves and others, finding a way of eating and moving that works for them, and not taking themselves too seriously).

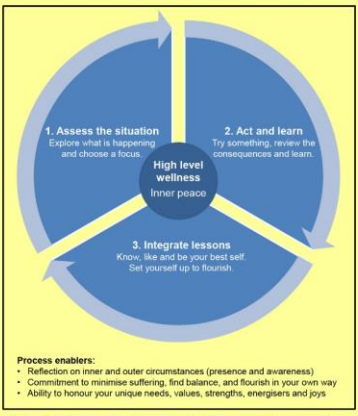

Figure 1: High Level Wellness Experiential Learning Theory model

Conclusions

- This new health promotion theory links and extends literature on salutogenesis, eudaimonic wellbeing, self-actualization and experiential learning; positioning everyday people as the leaders of their own life-long wellness journeys. It also suggests a new dimension for Antonovsky's salutogenic theory[10]: **aspiring** towards high level wellness/wellbeing, not just **adapting** to stressors.
- The 'Experiential Learning Theory of High Level Wellness' could help people wishing to understand, attain and maintain high level wellness for themselves and others, by creating a better appreciation of the distinctive, evolving nature of each person's sense of wellbeing, and the need to ensure that everyone has what they need to flourish. It could also help to balance the 'health promotion pendulum' by inspiring a greater focus on 'holistic, ecological, salutogenic'[11] initiatives to complement the current emphasis on disease prevention.
- Future research could explore the utility of this innovative research method and/or theory with a range of populations and professions, progressing towards '**high level wellness for all**'.
- A sustainably funded community of practice would help to support high level wellness initiatives, and strengthen bonds with related approaches (e.g., positive psychology and positive deviance).

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Disclosures

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Poster presented at the IUHPE World Conference, Rotorua NZ, April 2019

THE HEALTH PROMOTION AND WORK SAFETY BEHAVIORS IN PERSONNEL, RAJAVITHI HOSPITAL

Wannakorn Homsuwan[1], Charuwan Manmee[1]

[1] Rajavithi Hospital, Bangkok, Thailand

Background

Health promotion and work safety behaviors are one of the major concerns of most organizations globally. But few research studies have been conducted in hospital.

Objectives

To evaluate in health promotion and determine factors associated with work safety behaviors in personnel, Rajavithi Hospital.

Methods

A cross-sectional study was carried out from July 2017-June 2018. Of 400 staff had worked in Rajavithi Hospital at least one year were recruited, and completed a self-administered questionnaire, for a response rate of 100%. The questionnaire consists of 3 parts: demographic factors, health behaviors, and work safety behaviors. Data were analyzed using descriptive statistics in percentages, means and standard deviations and using multiple logistic regression to test the relationships. This study was reviewed and approved by the ethics committee, Rajavithi Hospital.

Results

Of these 400 staffs, 64.1% were female, 65.6% worked in academic cluster, and the mean age was 33.54±8.85 years. Most of staffs had moderate health behaviours and high level of work safety behaviours were 68.25% and 65.5%, respectively. Two factors significantly associated with work safety behaviors were female (p=0.008), and married (p=0.012).

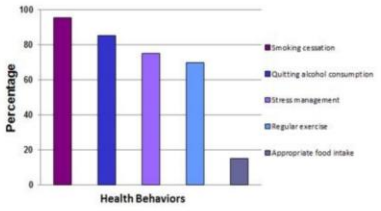

Figure 1. Health Behaviors in personal at Rajavithi Hospital

Table 1. Factors associated with work safety behaviors

Factors	B	Std. Error	p-value	Partial Eta Square
Gender				
Male	0.128	0.048	0.008*	0.020
Female	Ref			
Age (years)				
≤ 35	-0.026	0.085	0.756	0.000
> 35	Ref			
Status				
Single	-0.145	0.058	0.012*	0.018
Married	Ref			
Cluster				
Academic cluster	-0.029	0.098	0.764	0.000
Health system development cluster	-0.034	0.130	0.791	0.000
Directing cluster	-0.144	0.119	0.226	0.004
Nursing cluster	0.050	0.106	0.637	0.001
Others	Ref			
Work experience (years)				
≤ 10	0.001	0.088	0.992	0.000
> 10	Ref			

Discussion

The situation of health promotion and work safety behaviors in Rajavithi Hospital as moderate and high level, which are similar to literature. Female and married were associated with work safety behaviors, which are in line with previous studies. In order to achieve the health promotion and work safety behaviors, the executive should be provided multi-sectorial activities such as exercise, appropriate food intake policies, and healthy environment to decrease the consequences like chronic disease and mortality. In addition, a positive work safety attitude of staff should promoted to prevent risks from working.

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Poster presented at the 23rd World Conference on Health Promotion, Rotorua, New Zealand dated 7-11 April 2019

We acknowledge the traditional custodians of the land throughout Australia.
We pay our respects to the Elders both past, present and the future leaders of tomorrow.

THE HEALTHWISE PRIMARY HEALTH CARE NURSING PROGRAM

Education, promotion and screening in rural NSW, Australia

SUPPORTED BY

phn HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

The Primary Heath Care Nursing (PHCN) program aims to address health inequity and overcome barriers to accessing health including isolation, health literacy, low socio-economic status. PHCNs engage with small, rural communities to identify and address local health care needs with a focus on the National Health Priorities, social needs and community capacity building. The program model is based on community engagement, screening, education and evaluation.

SETTING

- The service area is 99,145 sq km, or 12.4% of NSW
- Aboriginal and Torres Strait Island Peoples average population of 9.6% in New England North West (State average 2.9%)
- The program supports the health of residents in 50 communities of 2000 people or less
- PHCNs work in partnership with other agencies to promote health and wellbeing

INTERVENTION

- The program is a Federal Government initiative, supported by the Hunter New England and Cental Coast Primary Health Network
- PHCN's work with community and other stakeholders to provide and maintain access to health screening, health education, capacity building and health promotion services
- Services include but not limited to general health screening, skin checks, oral hygiene, mens' and women's health, puberty, nutrition & dementia
- Community and individual participants are encouraged to adapt or modify behaviours to better manage their health and wellbeing and improve health literacy
- Settings can include schools and community forums

New England North West, NSW, Australia

OUTCOMES

- In 2017-18 4 PHCN's (3.2 FTE) delivered 205 health promotion, health education and health screening events to 50 towns of populations less than 2000
- 5941 people participated and 20% were Aboriginal or Torres Strait Island people
- Participant experience and outcomes are measured through pre and post questionnaires
- Participants report a high level of satisfaction and increased knowledge and particularly appreciate the PHCN's bringing the service into their small communities.

IMPLICATIONS

Improved access to primary health care including linkages to service providers, education, health promotion and screening services for people living in rural and remote communities can lead to positive outcomes for health.

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7 - 11 APRIL 2019 ROTORUA, AOTEAROA NEW ZEALAND

The impact of a comprehensive health promotion approach to Tobacco control among young people in Myanmar

Aung Tun[1], Mya Lay Nwe[1], Phyu The Han[2],Thandar Win[2], Thuzar Chittin[1]
[1]Ministry of Health and Sports,[2]Tun Khit Foundation,Myanmar

INTRODUCTION

LOCATION
-Myanmar is located between South + South-East Asia

POPULATION
- Population about 53 million (2018)
- 70% residence in rural area
- Made up of 135 national groups
- over 100 languages & dialects
- 89.4% of population are Buddhist, the rest- Christians,Hindus and Muslims
- Administratively divided into 14 States and Regions

EDUCATION STATISTICTS
- Schools- 40,725
- Student Population - 8.9 million
- Primary School – 35,611
- Primary school student population- more than 5.0 million

MAP OF MYANMAR

BACKGROUND

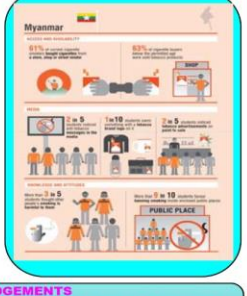
The study aims to describe the impact of a comprehensive health promotion approach to tobacco control among young people in Myanmar by reassessing the health, knowledge and practice of students, (9-11 Grades) after the introduction of New National Tobacco Control program for 5 years. This study includes data on prevalence of cigarettes and other tobacco use as well as information on five determinants of tobacco use: access, exposure to secondhand smoke (SHS), cessation, media and advertising, and other indicators.

METHODS

The study was based on two Global Youth Tobacco Surveys (GYTS) that have been conducted in five year interval between 2011 and 2016. Multi-stage, school-based, two-cluster surveys were conducted in 2011 and 2016 by Ministry of Health and Sports using a pre-tested modified questionnaire. In 2016 study, a total of 3633 eligible students in Grade 9-11 completed the survey, of which 2621 were aged 13-15 years. A total of 1058 students ages 13-15 participated in 2011 GYTS study.

RESULTS

Between 2011 and 2016, a reduction in the proportion of students currently use any tobacco products is observed (a fall from overall prevalence among 13-15 year olds of 18.6% to 14%).Currently use any smokeless tobacco products had decreased (9.8% to 5.7%).74.5% of current smokers tried to stop smoking in the past 12 months.33.2% are exposed to tobacco smoke at home as well as 28.4% are exposed tobacco smoke inside any enclosed public place. 61% of current cigarette smokers bought cigarettes from a store, shop or street vendors.42.3% of students noticed tobacco advertisements on point of sale.65% of students thought other people's smoking is harmful to them



INTEGRATING TOBACCO USE PREVENTION INTO VARIOUS COMPONENTS OF HEALTH PROMOTING SCHOOLS

- -Designation of all basic education schools as tobacco free since 2002
- -Myanmar GYTS in 2001,2004 ,2007 and 2016
- -Inclusion of dangers of tobacco in the main curriculum of all basic education schools, medical and paramedical schools since 2004 in collaboration with Ministry of Education
- -Integrating Tobacco use prevention within relevant health promoting school program components is the main strategy of Myanmar Tobacco Free School Initiative Program
- -1998 -Myanmar has implement the "Health Promoting School Program " in line with the National Health Policy guidelines
- -New Comprehensive School Health Strategic Plan(2017-2020) was introduced
- -Include Tobacco Free Youth Program in Myanmar WHO 2030 Project in 2018

CONCLUSION

Myanmar Tobacco Control Program needs to set in place mechanisms to strengthen implementation and enforcement of existing tobacco control laws in Myanmar and to develop new regulations needed on key tobacco control policies to bring them in line with WHO FCTC provisions and best practices. The program is also required to build Myanmar's capacity for tobacco control in the long-term. Myanmar Youth Tobacco program should strengthen in all schools to be 100% tobacco-free and also incorporate training of school personnel on tobacco control, specifically youth-focused programs as joint efforts between Ministry of Health and Sports and Ministry of Education in collaboration with related ministries.

ACKNOWLEDGEMENTS

We thank the Ministry of Health and Sports and The Ministry of Education for allowing to conduct Myanmar GYTSs. We thank also WHO/HQ, SEARO, CDC(USA) , Bloomberg Initiatives and The Union for the technical support and funding for the tobacco Control in Myanmar.

Address for correspondence:
Dr. Aung Tun
Myanmar Youth Tobacco Control Program, MOHS/Tun Khit Foundation,Yangon, Myanmar
Ph: 9595021300,E.mail: aungtunmm@gmail.com

The morality of sugar consumption: Australian adults' perspectives about sugar in the diet

UNIVERSITY OF WOLLONGONG AUSTRALIA

Adyya Gupta[1], Annette Braunack-Mayer[1,2], Lisa Smithers[2], Jane Harford,[3] John Coveney[3]
[1]School of Health and Society, University of Wollongong, NSW; [2]School of Public Health , The University of Adelaide, SA; [3]Flinders University, SA
email:ag654@uowmail.edu.au *@AdyyaGupta*

BACKGROUND and AIM

- Our everyday choices about food have a large moral component. (1)
- Scholarship on the morality of food suggests that individuals develop a moral understanding of good and bad ways of eating through life experiences, history and social and cultural norms. (2)
- This study explores how Australian adults conceptualise sugar and negotiate with their sugar consumption

METHODS

- A purposive sample of English speaking adults, aged ≥18 years and residing in South Australia, sourced from the Australian National Dental Telephone Interview Survey 2016-2018. (3)
- Sample stratified by sugar consumption levels, age and sex.
- 15 in depth face–to-face interviews conducted using a semi-structured open ended guide.
- Thematic Framework Analysis used to identify key concepts and themes. (4)

THEMATIC ANALYSIS RESULTS

THEME I: Understanding of sugar - Good sugars and Bad sugars
Based on Source, texture/taste, color and impact on health

THEME II: Moral rationalisations for sugar intake

Source of morality located within the individual:
Internal morality

- ✓Emotional and psychological well-being
- ✓Manage sugar intake through restriction, control, self-discipline and vigilance

Using socially evaluative statements to present oneself as morally virtuous:
External morality

- ✓Sugar an essential source of energy
- ✓Sugar intake limited to infrequent occasions
- ✓Sugar intake is a cultural obligation

"I guess it tastes nice, it is enjoyable. It is a little bit of relief from things that are not really enjoyable at that time"

"So, to me it's a balance between having a sweet element and having my vegetables, fruits. I think my diet is reasonably healthy and well balanced"

"I mean it is a personal thing. People look after their own lifestyle and are responsible about what they eat"

"Social things sort of drive me, say I am at a social gathering and they had laid out sweet things on the table, then I will have it "

SUMMARY

- Sugar intake has a *moral component*
- interpretation of sugars are based on complex, *multifaceted beliefs* within the realm of the moral space
- *Health and wellbeing reasons* are used to negotiate with food choices

IMPLICATIONS

- Creating environment that promotes healthy eating, as the 'new normal' may be beneficial
- Research investigating different strategies that allows individuals to make food choices with minimal moral conflict is warranted

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Dossier Santé Populationnel
POPHR
Population Health Record

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POPHR: a computing platform to guide decision making

David Buckeridge*, Nikita Boston-Fisher*, Mengru Yuan*, Maxime Lavigne*, Guido Powell*, Anya Okmatovskaia*
*McGill University, Department of Epidemiology, Biostatistics and Occupational Health

Problem

Public Health Practitioners engaged in health promotion and policymaking need an integrated perspective on population health to make sound decisions. While there are many data available for creating a community health profile, data sources tend to be disjointed. Examples include, clinical & administrative data such as drug dispensing, hospital records, births & deaths, surveys, & census data. This lack of integration presents a barrier to practicing evidence-based public health.

Intervention

The Population Health Record (POPHR), a data analysis, visualization and decision support tool. The PopHR integrates data from multiple sources into one platform, generates health indicators, & then uses computable epidemiological knowledge, in the form of an ontology, to describe the relationships between risk factors, diseases, & their indicators. This knowledge is used by the system to organize indicators in terms of a determinants of health framework, helping users to identify & interpret the interdependency of health indicators within a population. Simple visualizations are also available, e.g. *maps, time series & barcharts*. An R library was also created to allow direct interaction with the PopHR server through statistical software to obtain health indicators & query the ontology.

Outcomes

We have produced a platform which aims to be *"intelligent"* by combing computable epidemiological knowledge with quantitative analyses of health indicators to make suggestions about population health patterns that merit further exploration. PopHR automates the calculation of health indicators from different data sources & allows users to compare indicators across health districts and over time. A unique feature is a view called the causal graph which shows causal relationships between all the health concepts and indicators in the system. The graph shows the strength of those causal relationships e.g. strong positive, weak negative etc. This allows us to present concepts and indicators relevant to social determinants of health.

Implications

In usability tests with 30+ PHPs, >90% of users had a favourable impression of the system. Due to its versatility in handling diverse types of data, PopHR may also be suited to other public health applications, such as monitoring marketing of unhealthy foods to children. We are currently working on incorporating evidence about interventions into the platform to support practitioners in combining information about a population with relevant evidence about interventions.

Figure 1: Causal Graph; shows causal relationships

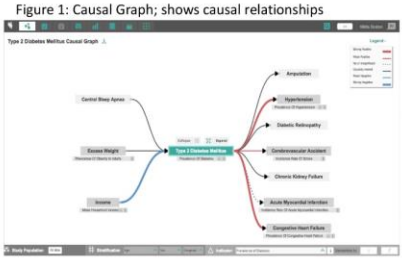


Figure 2: Disease View; dashboard of causally related indicators

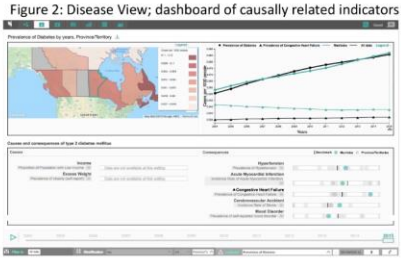
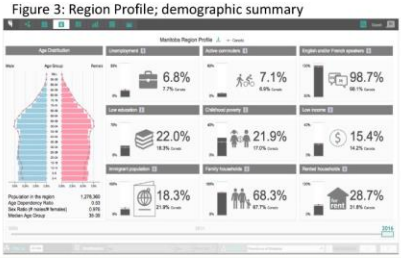


Figure 3: Region Profile; demographic summary



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WAIORA: Promoting Planetary Health and Sustainable Development for All

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The Prevention of Cervical and Breast Cancer at Primary Health Care level in Brazil

Bruna L. F. de Almeida Barbosa[1,2], Franciele M. Costa Leite[1], Rita de Cassia D. Lima[1], Angela Dawson[2]
[1] Postgraduate Program in Public Health, Federal University of Espírito Santo, Vitoria, Brazil. [2] Faculty of Health, University of Technology Sydney, New South Wales, Australia.

BACKGROUND

- Reproductive cancers are preventable. Breast cancer is the leading cause of cancer death in women and cervical cancer is the fourth most frequent cancer in women worldwide.

Brazil's PHC

- Screening
- HPV vaccination
- Referral for treatment

Objective: To examine the implementation of cervical and breast cancer prevention services in the state of **Espírito Santo**, Brazil in 2014.

METHODS

- We undertook a survey of women receiving health care in 520 PHC health services across 71 of the 78 municipalities in Espírito Santo.
- Was used the database of the National Program for Improving Access and Quality of Primary Health Care (PMAQ).
- The survey asked women about the timing of their last cervical screening and receipt of results, the information they had received about breast and cervical cancer screening and when they received their mammogram results after screening.
- The study was carried in 2014 and the analysis was undertaken using the Stata 13.0 statistical program.

RESULTS

1356 women interviewed

- 24% — Reported to have been screened more than 1 year ago
- 44% — Reported to have been contacted with their results more than 30 days after the consultation
- 14% — Reported to have never been given information about cervical screening at the clinic
- 39% — Did not have their breasts examined during the cervical cancer screening consultation
- 22% — Reported to have waited more than 30 days to receive their mammogram results

Of the women who presented at the clinic without an appointment with gynaecological problems 57.8% reported having been turned away and were asked to make a separate appointment. Of these women 64.4% did not make a follow-up appointment.

DISCUSSION

Many health services are not fully adhering to the Ministry of the Health guidelines for the prevention of cervical and breast cancer that requires:

- Health professionals to provide information about the prevention of both breast and cervical cancer and screening procedures to all women.
- Clinics to allow walk-ins for women without appointments and flexible opening hours, as well as the timely communication of screening results.

Greater investment is required at PHC service level to improve the quality of information provided to women, improve screening and reporting practices so that they are be delivered in an efficient manner that responds to the needs of women.

The Invisible Inequity

Melody Lino
University of Auckland

MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

IUHPE
23rd World Conference on Health Promotion

Introduction

The health inequity that is experienced by solo Pacific/Maori parents and their children can be improved through developing effective health policies. This poster will discuss the nature of the relationship between single Pacific/Maori parents and child development. The literature shows that single-parents are one of the most disadvantaged group within society (Ministry of Social Development, 2010). Single parents lack access to social determinants of health, even more so if they are of a Pacific and Maori background, thus affecting child development.

Method

Using a narrative review of research on the relationship between single Pacific/Maori parents in New Zealand and child development, literature was searched particularly in the areas of educational achievement, nourishment, opportunities for community engagement and emotional resilience. The method used was a literature search of ERIK, Scopus and Google Scholar databases for studies done from the time period of 2006 to 2018. The research studies that were found relevant to the topic was mainly qualitative.

Findings

There were only four studies that fit within the criteria set. As is already known, single parent families are in a greater state of disadvantage in comparison to two-parent families, as they have a higher incidence of poverty, which in turn affects their children's development.

Although there were positive themes that were found from the four studies that fitted the criteria, however there were strong themes of isolation, lack of support, and resilience. However, there remains little research done on the relationship between single Maori/Pacific parents and child development. One of the reasons for this health inequity is the lack of information.

Discussion

Figure 1: three themes from studies of pacific/Maori solo parents and child development

Lack of Support: There was a lack of financial and emotional support offered towards solo Pacific and Maori parents which affected their child's development (ie. Education attainment).

Resilience: this was a positive theme which showed solo parents and children learning and having a strong sense of resilience through the struggle of only having a single parent as opposed to two-parent families.

Isolation: There was a strong sense of isolation from social connectedness that was felt by solo Pacific and Maori parents due to lack of support being provided, thus affecting the sense of connectedness that a child needs to develop in a healthy way.

Future directions

This research shows that more studies need to be conducted on solo pacific and Maori parents in order to develop effective interventions and policies to support and aid in their disadvantage/vulnerable state. In the future, research that has been done in international minority groups could be used to advise and develop well-informed policies surrounding solo parents from minority groups in New Zealand. Further research done on this inequity could also help inform community level interventions that could give solo-parents the education and resources needed to enhance health outcomes and access to determinants of health for their children as well.

Conclusion

The health inequity that is experienced by solo Pacific/Maori parents and their children can be improved through more research and action. This would help to influence future policy developments, especially policies focused on beneficiaries, as well as inform community level interventions to cater to the different communities that solo pacific/Maori parents reside in. The literature shows that single-parents are a disadvantaged group within society, even more so if they are of a Pacific and Maori background, thus affecting child development, particularly educationally, community opportunities and more.

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Contact Information

Melody Lino

School of Population Health, Tamaki Campus, University of Auckland

Email: mlin668@aucklanduni.ac.nz

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The Relationship Between Work-Life Balance And Retirement Planning Among Employees In Taiwan

Wang-Chen Hsu[1], Susan C. Hu[1], Ying-Wei Wang[2], Li-Ju Lin[2]
[1]Dept. of Public Health, College of Medicine, National Cheng Kung University, Tainan, Taiwan
[2]Health Promotion Administration, Ministry of Health and Welfare, Taipei, Taiwan

Objectives

Work and life are two major components for the middle-aged people. In the past, research often focused on either work-related variables or life-related variables, and mostly ignored the interaction between work and life.
This study constructed work-life balance variable as a predictor of retirement planning, and examined the relationship and interaction effect between work-life balance and retirement planning.

Methods

This study analyzed 1362 samples aged more than 45 years old from the survey data of "Employees Retirement planning Needs Assessment" in Taiwan. Retirement planning score was measured by the scale developed by Noone et.al in 2010. Work-life balance was measured using the engagement of life items and work satisfaction questionnaire. The scores were computed and divided into 4 types: (1) work-life balance, (2) life imbalance, (3) work imbalance, and (4) work-life imbalance. Descriptive statistics, Chi-Square, T-test and multiple regressions were used in this study.

Results

The results showed that 23.4% of the employees had work-life balance, 19.3% had life imbalance, 25.8% had work imbalance and 31.6% had work-life imbalance. However, work satisfaction and life engagement had significant interaction effect with retirement planning when using interaction analyses. Comparing employees in the group of work-life imbalance group, those who in the groups of work-life balance , work imbalance and life imbalance had significantly higher retirement planning score (β=8.8 , 3.9 and 2.6 respectively).

Table1.

	Beta	SE	P-value
Work Satisfaction*Life Involvement			
Work-Life balance (High-Satisfaction, High-Involvement)	8.84	0.79	<.0001
Life imbalance (High-Satisfaction, Low-Involvement)	2.60	0.81	0.0013
Work imbalance (Low-Satisfaction, High-Involvement)	3.92	0.72	<.0001
Work-Life imbalance (Low-Satisfaction, Low-Involvement)	REF		
Intercept	82.43	1.12	<.0001
Gender (ref: female)			
Male	-1.52	0.58	0.0084
Age (ref: < 49)			
50-54	0.75	0.69	0.2797
>55	3.99	0.70	<.0001
Level of education (ref: ≤12 years)			
> 12 years	-0.77	0.68	0.2550
Spouse (ref: no)			
yes	0.71	0.82	0.3864
Occupation (ref: supervisor)			
Not supervisor	0.93	0.72	0.1955
Annual income(ref: <600,000)			
<610,000-999,999	1.65	0.88	0.0599
≥1,000,000	1.47	0.70	0.0351
Self-rated health (ref=good)			
bad	-5.28	0.57	<.0001
R^2	0.2630		

Discussion

According to the results, employees who have work-life balance tend to have the best retirement planning. The government should encourage employees to actively engage in life, such as domesticity, social participation, health care, cultivate interest, among others. Higher engagement in the life domain can significantly promote employees retirement planning.

This work was funded by the Health Promotion Administration, Ministry of Health and Welfare

The Role of Ideation on Long-Acting Reversible Contraceptive Use in Nusa Tenggara Barat, Indonesia

Weni Kusumaningrum1, John Douglas Storey3, Rita Damayanti1,2

Faculty of Public Health, Universitas of Indonesia1, Centre for Health Research, Universitas Indonesia2, Center for Communication Program, John Hopkins Univesity3

INTRODUCTION

- Contraceptive use in developing country has reduced maternal mortality by 40% in the last 20 years1.
- Long-Acting Reversible Contraception) (LARC) that includes IUD and implant has been proven to be effective in preventing unwanted pregnancy.
- However, contraceptive use in Indonesia was still dominated by short-acting contraception2.
- Nusa Tenggara Barat (NTB) is one example province in Indonesia with higher TFR with low use of LARC.

AIMS

This study aims to identify appropriate strategy to promote the use of LARC using Ideation theory.

METHODS

- A Total 6384 women were included in this study.
- **A logistic regression** was performed to examine the association between 3 dimensions of ideation with LARC use, after adjusting for the covariates.
- **Probability proportionate to size** method with fifty villages from each district were selected randomly among **married women aged 15-49 years old who used LARC**.
- **The ideation component** as **independent variable** derived from 19 items which using CFA, the items reduced into three components; **knowledge, attitude and interpersonal communication.**
- The **dependent variable** is Utilization of LARC.
- Age, education, number of living children, district, and household.

RESULTS (Human Data)

Factor analysis was carried out on 19 variables to determine the ideal ideation elements.
The result of Kaiser-Meyer-Olkin (**KMO**) test was **0.790 with a significance of 0.00**.
Three elements of ideation (attitude, knowledge, and frequency of interpersonal communication) were divided into categories based on quintile scree plots

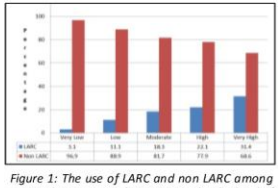

Figure 1: The use of LARC and non LARC among married women aged 15-49 years by the level of ideation in 2015

This study found that in **the lowest quintile only 3.1% of women used LARC**.
On the other hand, the LARC use of women in the **highest quintile was 10 times higher (31.4%) than that in the lowest quintile. LARC users increased** as the **cumulative level** of **ideation increased.**

Table 1: Ideation and the use of LARC

Variable	Unadjusted OR (95% CI)	p value	Adjusted OR (95% CI)	p value
Ideation				
Attitude towards LARC				
Negative	1		1	
Positive	7.41 (6.42-8.55)	0.001	7.18 (6.09-8.24)	0.001
Knowledge				
Low	1		1	
Moderate	0.83 (0.69-0.98)	0.027	0.88 (0.72-1.06)	0.182
High	1.5 (1.24-1.82)	0.001	1.05 (0.84-1.31)	0.657
Interpersonal Communication				
Low	1		1	
Moderate	1.14 (0.94-1.38)	0.190	1.55 (1.25-1.93)	0.001
High	1.53 (1.27-1.84)	0.001	2.40 (1.94-2.99)	0.001
Socio Demographics				
Age				
<20	1		-	
20-34	1.32 (1.05- 1.66)	0.018		
35-49	1.93 (1.56- 2.43)	0.001		
Education				
Low	1		-	
Moderate	0.75 (0.63-0.88)	0.001		
High	1.15 (0.87-1.52)	0.311		
Number of living Children				
0	1		1	
1-2	3.15 (1.38-7.19)	0.007	2.33 (0.97-5.58)	0.058
>3	4.91 (2.14-11.23)	0.001	3.80 (1.58-9.15)	0.003
Household socio-economic status				
Poorest	1		-	
Poor	0.68(0.57-0.81)	0.001		
Medium	0.64 (0.54-0.77)	0.001		
Rich	0.87 (0.70-1.07) 0.85	0.191		
Richest	(0.62-1.16)	0.308		
Districts				
Bima	0.95 (0.79-1.15)		1	
Central Lombok	2.46 (2.09-2.89)	0.601	0.93 (0.76-1.15)	0.519
North Lombok		0.001	2.21 (1.80-2.65)	0.001

- Socio-demographic factors and ideation factors were individually associated with LARC use.
- There was no interaction between independent variables and confounding.
- Only attitudes and interpersonal communication were associated to LARC use after controlling all confounding variables.
- Women with **positive attitude** toward LARC had a **7 times greater odds of using LARC than women with negative attitude**, after controlling for the variable the number of children and districts
- Women with a **high frequency of interpersonal communication** have an odds of **2.4 times higher for using LARC** than women with **low communication frequency.**

DISCUSSION

- **Knowledge variable** was found to be the only ideation variable that was **not associated with LARC use**.
- This study revealed that attitude and interpersonal communication are stronger for women in NTB to choose LARC instead of the short method.
- Knowledge should be supported by positive attitude about LARC and intense interpersonal communication.

CONCLUSION

To improve the use of LARC, a health promotion strategy focus on knowledge was not enough. Message that touch emotion and words mouth to mouth from friends and family are more effective to persuade women to choose LARC

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The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 1 of 7: Childhood Poverty Under Neoliberalism and Nationalism

Authors: Fumiko Tomiyama,[1] Junko Matsumoto[2]
Affiliations: [1]Tokatsu Kango Nursing School, Chiba, Japan; [2]National Network of Yogo Teachers in Japan, Tokyo, Japan

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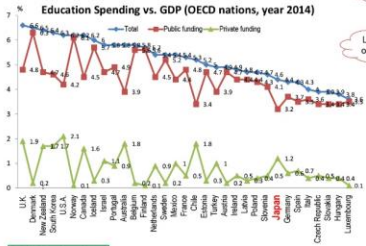
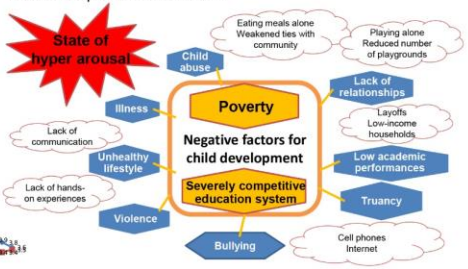
1. Introduction

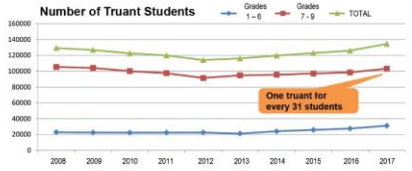
Childhood poverty has become more prevalent in Japan, affecting the healthy development of children. A research indicates dangerously high state of tension in children's sympathetic nervous system—constantly in a state of hyper arousal—presenting concerns. This report will introduce the role of Yogo teachers in supporting children with various issues.



2. Current Issues

Two social problems the children are facing in Japan: poverty and severe competition in education





3. Methods

Yogo teachers help students develop capacity to overcome obstacles on their own while nurturing their independence. → ①, ②, ③, ④, ⑤

Yogo Teachers' Work Methods

Accept each child as a whole.

1. Assess health condition of students.
   Identity health issues in line with reality.
2. Reach out to individual students.
   Combine care and education. Organize collective power of children.
3. Collaborate with school staff, parents, specialists, and the community.
   Connect and expand.
4. Work with policy makers.

Nurture children to take charge of their own health.

① *Hokenshitsu* school health room activities (Refer to Poster No. 383, 392)

② Health education (Refer to Poster No. 384)

③ Student-run health education activities

Research & presentation

Peer education

④ Community involvements (Refer to Poster No. 394)

⑤ Working with policy makers

4. Results

- *Hokenshitsu* activities empowered children to recognize issues and work toward improving their lifestyle, living conditions, and so on.
- Supporting and educating parents strengthened them to face issues.
- Health education and student-run activities nurtured students' will to live healthy life.
- Working with community increased school's capacity for resolving issues.
- *Kodomo Shokudo* ("children's diner") not only provided free meals to children in need, but also a place to make connections and to get academic support—promoting children's independence.
- Lobbying activities through teachers' union and other organizations helped establish free healthcare for children, school lunch in every school, and placements of school social workers.

5. Discussions

A profession like Yogo teachers can play a central role in establishing a support network of school, parents, and community for empowering students with knowledge and tools to become healthy and self-reliant.

The role of Yogo teachers and school health room in promoting health and development of students Part 2 of 7: Current situation of childhood suicide of a competitive society in Japan

Author: Yuko Uchiyama
Affiliation: Toyo University, Saitama, Japan

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1. Background

Japan has a one of the highest mortality rates from suicide among the developed countries. The number of suicides in Japan peaked at 34,427 in 2003, however it has been decreasing lately. Nevertheless, more than 20,000 suicides occurred even in 2017.

The number of suicides among children aged 10 to 14 year olds was the third highest cause of deaths at the beginning of the 2000s, but, it has become the leading cause of death from 2017, before Malignant neoplasms and Accidents.

The purpose of this study is to identify the current situation regarding the suicide of children and to consider strategies for childhood suicide prevention.

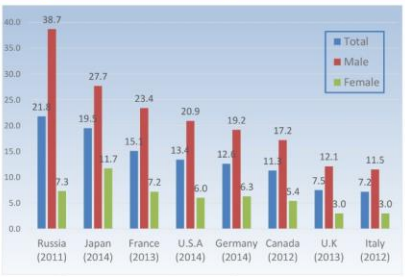

Fig.1 The suicide death rate of developed countries

Table 1 Leading causes of death by age in Japan

	1			2			3		
	Causes of death	Deaths	Death Rates	Causes of death	Death Rates	Rates	Causes of death	Death Rates	Rates
All ages	Malignant neoplasms	373,304	299.5	27.6	Heart dis.	204,837	164.5	15.1	C.V.D.	100,880	80.2	8.2
<1	Congenital malformations, etc.	606	67.1	36.1	Respiratory and cardiovas.dis	238	24.8	13.4	Accidents	77	8.1	4.4
1-4	Congenital malformations, etc.	176	4.8	25.2	Accidents	70	1.8	10.1	Malignant neoplasms	60	1.5	8.7
5-9	Malignant neoplasms	75	1.1	21.4	Accidents	60	1.2	17.1	Congenital malformations, etc.	19	1.0	14.5
10-14	**Suicide**	**100**	**1.9**	**22.9**	Malignant neoplasms	96	1.8	22.7	Accidents	59	0.9	11.7
15-19	**Suicide**	**460**	**7.8**	**39.6**	Accidents	232	3.9	20.0	Malignant neoplasms	125	2.1	10.8
20-24	**Suicide**	**1,064**	**17.8**	**53.1**	Accidents	332	5.7	16.6	Malignant neoplasms	178	2.9	8.9
25-29	**Suicide**	**1,049**	**17.6**	**45.1**	Accidents	266	4.6	12.7	Malignant neoplasms	265	4.5	11.8
30-34	**Suicide**	**1,280**	**18.6**	**39.8**	Malignant neoplasms	616	9.0	19.9	Accidents	262	3.9	8.1
35-39	**Suicide**	**1,266**	**17.8**	**28.8**	Malignant neoplasms	1,161	16.9	26.1	Heart dis.	626	9.4	14.0
40-44	Malignant neoplasms	2,949	39.5	30.4	**Suicide**	**1,625**	**17.6**	**16.8**	Heart dis.	991	10.7	11.2
45-49	Malignant neoplasms	4,784	51.2	34.6	**Suicide**	**1,872**	**20.1**	**13.4**	Heart dis.	1,788	19.2	12.9
50-54	Malignant neoplasms	7,297	80.5	38.1	Heart dis.	2,303	25.4	12.0	**Suicide**	**1,830**	**22.8**	**9.6**
55-59	Malignant neoplasms	12,211	162.7	44.1	Heart dis.	3,977	53.0	14.4	C.V.D.	2,022	26.9	7.3
60-64	Malignant neoplasms	21,238	274.5	47.3	Heart dis.	5,424	70.1	12.1	C.V.D.	3,161	40.7	7.0
65-	Malignant neoplasms	322,666	921.5	26.7	Heart dis.	180,806	542.2	15.1	Senility	101,325	286.0	8.4

Death rates: per 100 000 population

2. Methods

The mortality data of suicides was provided by the Ministry of Health, Labour and Welfare, the Ministry of Education, Culture, Sports, Science and Technology and the National Police Agency.

3. Results

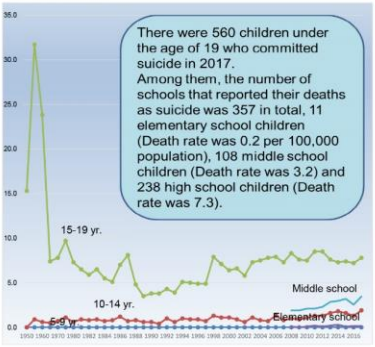

Fig.2 Annual changes in suicide death rate in Japan

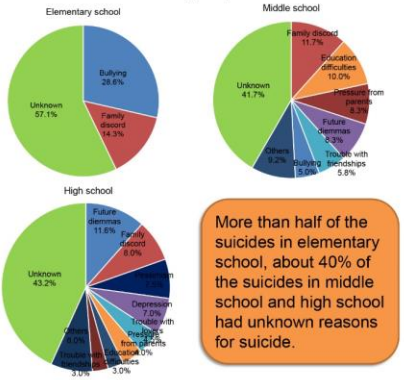

Fig.3 Reasons for suicide

More than half of the suicides in elementary school, about 40% of the suicides in middle school and high school had unknown reasons for suicide.

It is difficult to analyze the real reasons of taking one's life if they don't write a suicide note, we need to identify their feelings and real situation to reduce the number of childhood suicides in competitive society in Japan.

4.Discussion

In Japan, education concerning "suicide" is a slightly taboo subject like "sex education". However, in recent years it is essential to give children the correct knowledge and preventative measures of suicide, including counselling with Yogo Teaches like the suicide prevention education which is taught in Europe and the United States. It is essential to change the school education system and society to create a bully free environment which could be effective for suicide prevention and reduce suicide numbers among school children.

The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 3 of 7: The Important Role of Male Yogo Teachers

Author: Chikage Nakamura
Affiliation: Teikyo Junior College, Tokyo, Japan

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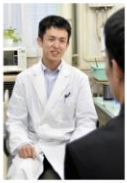
1. Objective



Malaise, mental disorders, problematic SNS and sexual behaviors, poverty, and domestic violence are some of the issues affecting students' well-being in Japan. Almost all schools (1st through 12th grade) have at least one Yogo teacher stationed at *Hokenshitsu* school health room to provide individual support to students. Although it is an occupation currently dominated by females, there is a small number of male Yogo teachers. This report will shine a light on the benefits of having both male and female Yogo teachers at school to handle complicated issues our students are facing today.

2. Methods

Retrieve academic research papers containing a word "male Yogo teacher" from CiNii (Scholarly Academic Information Navigator by National Institute of Informatics). Out of nine dissertations available as of June 3, 2015, use four that contained "students' opinions on male Yogo teachers." Extract short phrases and analyze them using KJ Method or the affinity diagram.

3. Results

(1) Placement rate of male Yogo teachers

Actual number of:	Pre-school	Grades 1 - 6	Grades 7 - 9	Grades 10 - 12	Grades 6 - 12	Schools special-needs	TOTAL
Male Yogo teachers	3	7	12	11	0	16	49
Female Yogo teachers	424	21,763	10,585	6,494	77	1,812	41,155
TOTAL	427	21,770	10,597	6,505	77	1,828	41,204
% of Male Yogo teachers	0.70	0.03	0.11	0.17	0.00	0.88	0.12

Statistical Abstract 2014 edition by Ministry of Education, Culture, Sports, Science and Technology-Japan

Total number of male Yogo teachers increased to 65 in 2016 (0.16%)

Occupations formerly described by gender-specific terms, such as registered nurses and childcare workers in Japan, now have gender-neutral titles, however, the percentage comprised by male workforce is minimal at 6.47% and 6.60%, respectively. The percentage is even lower for male Yogo teachers.

(2) Current conditions and challenges

Out of four dissertations based on survey researches targeting elementary school students to university students, there were 39 opinions on male Yogo teachers. Among them, 13 (33.3%) expressed a sense of uneasiness, and 26 (66.7%) showed positive attitudes toward male Yogo teachers.

Negative opinions (33.3%)

- "Expect motherly care from Yogo teachers (YT)."
- "Feel awkward with male YT."
- "Feel more comfortable with female YT"
- "Prefer female YT to care for injury."
- "Male YT is not as approachable."
- "Feel uncomfortable having private consultation time with male YT."
- "Feel uncomfortable talking about menstruation with male YT." …and so on.

Positive opinions (66.7%)

- "Gender of Yogo teachers does not matter."
- "Being reliable is more important than gender."
- "Character is more important than gender."

Multiple placement of Yogo teacher (YT) would make it possible to:

- "Choose gender of YT according to topics discussed."
- "Have opinions of opposite gender."
- "Choose YT of same gender as mine." …and so on.

Based on this result, one can assume that students expect positive outcomes from having both male and female Yogo teachers stationed at *Hokenshitsu* school health room. Students having relationship issues, those having been raised in a single-parent home, may also benefit from having both genders represented.

4. Discussion

Although Yogo teacher is an occupation currently dominated by females, it is important to have both female and male figures in *Hokenshitsu* to support students with health problems stemming from complicated issues. As the number of schools with multiple placement of Yogo teachers increases, having both male and female Yogo teachers is desirable to provide a better environment for supporting students' physical and mental well-being.

The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 4 of 7: Responsibilities of Yogo Teacher Who Provides Unconditional Acceptance to Children in Order to Reveal Their Hidden Problems for Early Intervention

Author: Hidemi Tachibana
Affiliation: Kitakami Elementary School, Miyagi, Japan

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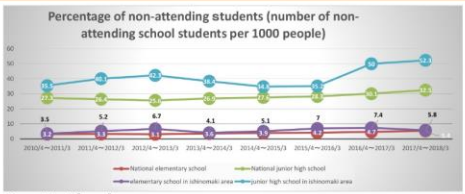
1. Background

Although it has passed eight years since the Great East Japan Earthquake, families in the community of Ishinomaki area have been still struggling for recovery. In a such circumstance, physical and mental health problems among children have become more complex and difficult to find out.

Parents have been busy with their own problems including loss of employment, divorce, or poverty. Therefore, they are not able to provide sufficient care to their children, which makes children feel excessively anxious. Additionally, children have to commute to school for long distance, because many schools were eliminated and consolidated due to decrease of population; many families moved out of the community and they have scattered across the country. Consequently, comparing with before the earthquake, children have no longer time for hanging out together, which affects their physical and mental well-being.

One of the important roles of Yogo teachers would be to identify and intervene children's problems, which school and community rely on them. And in order to deal with these problems, Yogo teachers have been in the same school for several years.



The Ishinomaki area where the earthquake occurred is somewhat higher than the national average in the elementary school, but junior high school shows higher value by jumping more than the whole country.

There is a possibility that truancy at junior high school may influence the subsequent course, which is a big problem.

Although the reconstruction after the disaster is proceeding, there are many aspects such as family problems, economic problems, regional problems, etc. As a refusal at the time of going to junior high school, the child's safety and stability are still insufficient.

Although not shown here, the other problem s in school life is also higher than the national average.

2. Methods

Measures for early discovery of student's health problems

Yogo teacher resides in school and works for 3 to 7 years at the one school.
* Provide a sense of security that you are always (sense of security)
* Find small changes in children and respond promptly (early response)
* Provide continuous guidance support
* Collaborate with faculty and staff to grasp the situation and set up solutions (cooperation)

~after school~
Students talk w i t h friends and Yogo teacher while drawing and shogi or other game in the hokenshitu. Tension is relieved by securing time to relax

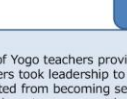
Watching over the morning when students reached school

Concrete efforts
* Noticing the problem early from the response with children
* Case Conference and other measures taken together in cooperation
* Coordination with related organizations
* Watch the student day by day

Measures to share and solve problems.
* Information sharing among school staff
* Understand the situation of the family.
* Understand the situation in the area.
* Collaboration with school counselors / school social workers etc.

Cooperation with external organizations.
*Public health nurse.
* Welfare organization.
* Hospitals (doctors, nurses, social workers, etc.)
* Child consultation center etc.

Not energetic
*Expressionless
*Irritated
*Often being alone
*Frequent coming to the hokenshitsu(medical room)
*Late will and absences increase
*Forgotten items increases
*Getting filthy



Involve child's daily life, accept all children.
*Accept the existence of a student as it is.
* Think about better problem solving for each student.

Guarantee essential elements for physical and mental health of a student.

CASE:
The parents who owned businesses, that were impacted by the disaster, became mentally ill. Recently, there has been attention drawn to the children of these parents as these children have been exhibiting mental health instability. There has been consultations with teams of parents, Yogo teacher, homeroom teachers, counselors, etc. to support these children.

RESULTS

1. Existence of Yogo teachers provided to children feelings of safety and empowered them for living.
2. Yogo teachers took leadership to coordinate with school teachers, enabled to early identify children's health problems, and prevented from becoming severe problems.
3. Continuous long-term support by Yogo teachers increased children's feelings of safety and independence.

Discussion

Yogo teacher who has been working for long years at one school can become a key player to support children to resolve their health problems. The children can be empowered to overcome their challenges and to become independent individuals after the Great East Japan Earthquake. It would be necessary to assign multiple Yogo teachers to one school to deliver effective and fulfilling support to children who have severe and complex health problems.

The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 5 of 7: Introduction of Gender Diversity in Elementary School

Author: Yuko Yanagisawa
Affiliation: National Network of Yogo Teachers in Japan, Nagano, Japan

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① Stagnation of sexuality education and the environment surrounding children in Japan

1990's～ Sexuality education bashing

Public policy not to deal with "genitals" "sexual acts" Stagnation of sexuality education

Children are surrounded by a lot of biased information such as the Internet and SNS

Children have not received sexuality education so they head towards risky sexual behavior and are prone to sexual victims and perpetrators. It is difficult to make a human relationship that protects sexual health and human rights.

Necessity to sexuality education to learn the science about body and health as sexual rights

Japanese children have low self-esteem and high isolated feeling

1. Background

Understanding of gender and sexual diversity is progressing globally. In Japan, people who are Gender Identity Disorder (GID) and homosexuality began to raise their voices.

In Japan, sex education is hardly done because there was bashing against sex education in the 1990s and later. Children have not learned gender and sexual diversity, so they often tease and bully to sexual minorities people at school.

I met a GID person I call W at the "group of talking about sexuality" created by Yogo teachers. I report a practice of sexuality education that students think about gender and sexual diversity through listening the story of W's experiences.

<Percentage of LGBT people>

Japan 8.9% <2018 Dentsu (n)60,000 20to59years of age>

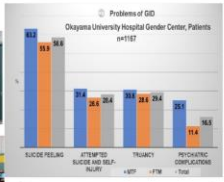
America 6.4% <2012 Gallup (n)120,000 18to29years of age>

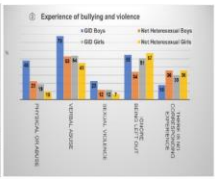
2. Methods of the actual practice

①Development the lesson about Gender and Sexual Diversity with classroom teacher

②Incorporate content that listens to the story of the GID person in the class

③Educate other teachers at the same time through school classroom disclosure





I have seen GID people only on TV until now. I listened to W's story today, so I felt GID people like friends.

I thought it is important to accept various sexuality. I want to respect each others' feelings. To respect the gender identity, I stop bullying and sexual prejudice.

Reactions of students・・・

I understood the difficulties and suffering of transgender. If one of my friends is a transgender, I accept him / her gently. To understand "sexuality" is difficult . I want to learn more.

3. Contents of the actual practice

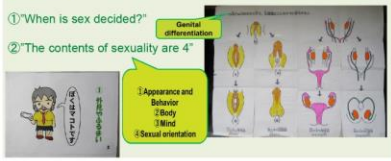
Contents of lesson about Gender and Sexual Diversity
(6th grade in elementary school)

OBJECTIVED Development a sense of human rights for an inclusive society
(Body is a private part/ There are various people)

①"When is sex decided?"

Genital differentiation

②"The contents of sexuality are 4"



③"Gender and sexual Diversity"

- By knowing W's life, students sympathize with the sorrow of hiding the real feelings and the pleasure of accepting the coming out.
- Students think how to change a society to be able to live my own way.

The accumulation of sexuality education helped students understand. I think that elementary school students can eliminate prejudice by learning the gender and sexual diversity.

I noticed my prejudice by listening to the words "I want to return to the original body" of the parties.

Reaction of teacher who participated in class・・・

4. Results

①By listening to the experiences and thoughts of the GID person, the students were able to feel the existence of diverse. In addition, the students were able to think about human relations that respected human rights.
②Teachers were able to understand the Gender and Sexual Diversity by seeing classes.
③Yogo teachers can develop necessary sexuality education for students, because they are familiar with the sexual condition of the students and the situation of the school.
④Learning at the "group of talking about sexuality" made mainly by Yogo teachers can enrich the practice deeply.

5. Suggestion

Reporting and interacting sexuality education by Yogo teachers guarantee the right for children to learn sexuality. It is necessary to aim to realize a society where everyone is guaranteed the right to learn sexuality, by connecting many people.
To learn the diversity is just "learning the meaning of sexuality". From now on, learning that I can realize that I am also one of many diverse is important.

The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 6 of 7: Self-Reliance Support at College Level

Author: Sumi Shishido
Affiliation: Teikyo Junior College, Tokyo, Japan

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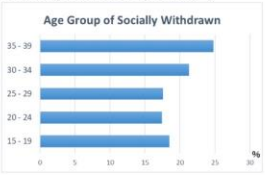
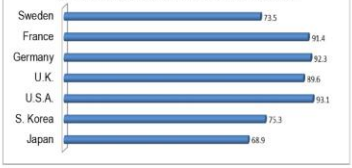
1. Objective

The number of youths with negative self-views, with issues pertaining to truancy, social withdrawal, and suicide is on the rise in Japan due to various social factors, such as severe competition in education, economic disparity, and poverty—resulting in many becoming economically dependent on family members through adulthood. As a way to help students exhibiting both physical and mental issues become more self-reliant, *Hokenshitsu* school health room was established at Teikyo Junior College ten years ago. The benefits of having *Hokenshitsu* at college level will be discussed.

Number of Socially Withdrawn People in Japan: 560,000 (63% male / 37% female)



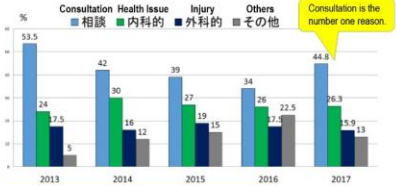
Percentage of People with Positive Self-Views
(2015 Statistics by Japanese Cabinet Office)



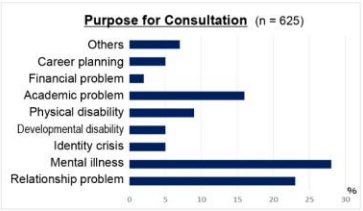
2. Methods

From each student visiting *Hokenshitsu*, Yogo teacher identifies problems, and forms a support network involving faculty, parents, and other organizations to resolve issues.

Purpose for Visiting *Hokenshitsu*



Purpose for Consultation (n = 625)



The Role of Yogo Teacher

Provide private consultation

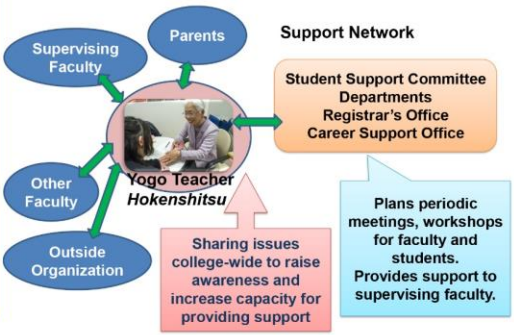
Show acceptance and empathy.
Identify problems.

Organize support network

Build a support network of faculty, parents, and outside organizations.

Utilize support network

Guide students to counselor, academic support system, financial aid program, family support, and so on.



3. Results

- Students with mental disorder were able to return to college after receiving appropriate treatments.
- Students with financial difficulty were able to receive aids to continue attending college.
- Students wanting to pursue a new career choice were able to change their major.
  → Students developed positive self-views, and became more independent.

4. Discussion

Truancy, social withdrawal, and suicides are social problems that need to be addressed with social services and policy changes. Continuously advocating social issues to the government is necessary.

The Role of Yogo Teachers and School Health Room in Promoting Health and Development of Students Part 7 of 7: The Role of Yogo Teachers in the Local Community

Author: Akiko Shirasawa
Affiliation: Kawanakajima No Hokenshitsu, Nagano, Japan

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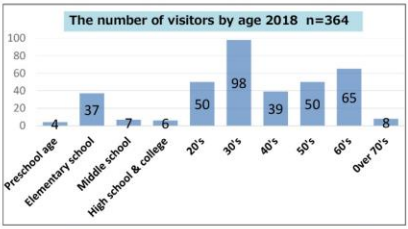
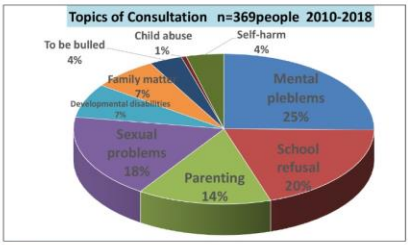
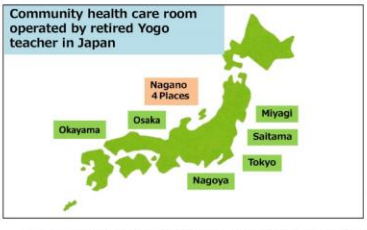
Background

I, a retired Yogo teacher, opened a volunteer-based "Machikado-Hokenshitsu", which literally means "the community health care room. The "health care room" is in the school. I consider the local town as big a school, so using the community health care room is free.

Today, this activity has reached the 10th year. The community health care room are used by drop-in children on the holiday and by people over 19 years old who have graduated from the school. The role of yogo teacher at school in Japan is also required in the local community.







The number of community health care rooms operated by a retired Yogo teachers is increasing in Japan. We have to work together and disseminate a message about the problems affecting the children.

"The Community Health Care Room" at home

Operation

- Drop in elementary school students
- Consultation of parents who have trouble about children
  School refusal
  Developmental disabilities
  Mental problems etc.
- Consultation of People over the age of 19 who graduated from school
  Bullying at work
  Sexual problems
  Mental problems etc.
- Families come to the community health care room and receive sex education

Health instructions offered

- Free consultation at the Community health care room and care for children
- Sexuality education at schools and cram school
- Lecture at Child-rearing salon and community center

Result and Conclusion

The important thing for children is to meet adults who can teach correct information about the body.

When in trouble, it is important to be able to think "Let's ask this person", "Talk to trustworthy adults". Children can feel free to discuss their bodies and troubles with confidence after graduating from school if "health care room" exists in the area as well.

I will endeavor to increase the "community health care room".

Suggestions

Retired Yogo teachers have experience in various activities to support the growth of children. They can support children's growth and development by connecting other experts and communities. In addition, they can support children even after graduation.

We suggest that "small activities involve the community and continuing to change the society".

The school of health

Presenting Author:
Catrine Kostenius 1,2
Co-Authors:
Catarina Lundqvist 2, Lena Nyström 2, Annica Henriksson 2, Annika Nordstrand 3
Affiliations in Sweden:
1.Luleå University of Technology 2.Norrbotten Association of Local Authorities 3.Norrbotten County Council

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"Hälsoskolan"

– the national government, local authorities and university in a joint effort to promote health literacy in arctic children and youth

Background

Children and youth in the arctic region of Sweden face challenges like decreased self-assessed overall health, increased incidence of mental and somatic disorders and few reaches the recommended level of daily physical activity. Vulnerable groups are newly arrived, LGBT persons and young people with disabilities. The Swedish school has been criticized for poor academic results and increased stress among students.

Intervention

The School of Health – "Hälsoskolan" – echo a number of the United Nation's Sustainable Development Goals integrating health promotion, sustainable development and equity. The aim is to increase health literacy and contribute to health equity among children and youth living in the arctic region in Sweden. The Association of Local Authorities and the County Council joined force with Luleå University of Technology to promote health literacy in the 51 thousand children and youth living in Norrbotten. The Swedish government funded 6 health promoting school initiatives in 9 of 14 municipalities totaling 4 million Swedish Crowns.

Outcomes

By making a conscious choice to explore what is well, looking for good examples – success stories – to learn from and build on we identified for example: One municipality involved all students from pre-school to high school, all school staff and politicians to make a plan for health promoting school – participation and empowerment in action. One school increased the physical activity by 100% by making it part of the ordinary school day for all students and staff. Another school decreased the assault reports from 71 to 8 and student safety increased with 17% after building a health promoting school focusing on caring relationships making students and staff proud of their school.

Implications

The results point to the success of collaboration across governments, local authorities and university to promote health in arctic children and youth sharing success stories to promote health literacy in students. The next step is to address sustainability by building an organization involving additional actors such as civil society and local businesses. Additionally, focusing on vulnerable groups making an extra effort to reach youth not in school, training or employment. Continued collaboration will systematically address and enable good conditions to promote health literacy by involving the political arena where education, public health and health promotion come together.

Photo: Melina Granberg, Luleå University of Technology

The transformation of health promotion services in New Zealand's largest public health unit: Making a difference where it matters through focusing on equity, partnerships and influencing.

Why the need for change?

- Auckland's rapidly growing population
- Changing trends in health promotion practice
- Agree the role and purpose of Health Improvement at ARPHS

The following table represents the desired shifts in culture that the leadership team determined at the start of the process:

	Desired
Results	Visible & compelling - shaping Auckland
Action	Collective actions for results
Beliefs	We make a difference because we belong
Experiences	We're supportive, joined up with clear direction

A whole of team approach was used, where all team members contributed.

Why create a backbone?

- Shared vision, values and purpose
- Knowing what you stand for and where you're going

Our vision – ***where we want to go – our ambitious future***

- Wellbeing is at the forefront of all decisions. Everyone is playing their part for Tāmaki Makaurau (Auckland) to flourish

Our bold goal – ***single-minded call to action***

- Decisions that impact Tāmaki Makaurau have wellbeing at the forefront

Our purpose – ***the difference we want to make***

- Shaping Tāmaki Makaurau so all flourish

Our values – ***what we stand for***

- Acting with integrity, building and maintaining relationships, valuing diversity, being action oriented

Our brand – ***our reputation with customers***

- Inspiring wellbeing

Catapult

Our focus areas:

- Flourishing team
- Building brand as leaders
- Making a difference where it matters
- Winning hearts and minds
- Influential partnerships

Our strategic objectives:

- Actively address inequities
- Key partnerships
- Influence how people talk about and make decisions
- Foster a skilled and engaged team

Outcomes

- From settings to environmental and systems approaches
- Integrating equity into our systems
- Stronger partnerships
- Improved performance appraisals and recruitment
- Positive team culture and engagement

Challenges

- Strategy fatigue – takes time and effort
- Letting go of some work areas
- Change management processes
- Need to take risks

89% of HI team members agree that we're making the changes we need to be successful in the future.

Auckland Regional Public Health Service
Rātonga Hauora ā Iwi o Tamaki Makaurau

Theorizing Empathy as the Root of Health Promotion Practice

Sarah Dobrowolski
Queen's University, Kingston, ON, Canada

IUHPE
23rd World Conference on Health Promotion

Background

Health promotion as a field employs diverse psychological and social theory in practice, yet its own theoretical underpinnings remain ill-defined (McQueen & Kickbusch, 2007).

Objectives

The objective is to explore the construct of empathy as a potential theoretical underpinning of health promotion practice.

What is Empathy?

"A way of being" (Rogers, 1980)

An accurate perception of another's experience, while maintaining one's sense of self

Key components of empathy (Cuff et al., 2016):

- **Affective** – Experiencing another's emotions
- **Cognitive** – Understanding another's feelings
- **Self-other distinction** – Is always maintained

Additional dimensions of empathy for health promotion:

- **Relational** – Mutual vulnerability and flourishing (Jordan, 2018)
- **Critical** – Considers social and structural context (Lobb, 2017)
- **Pro-social** – Resultant behaviours are positive (Cuff et al., 2016)

How empathy is created and expressed:

- **Dialogue** – Profound connection of shared meaning (Lobb, 2017)

Methods

Generic discourse analysis is exploring how empathy manifests in health promotion practice at diverse social ecological levels (McLeroy et al., 1988).

Key health promotion texts being analyzed:

- Charters and declarations from the 9 WHO Global Health Promotion conferences (who.int/healthpromotion/conferences/en/).
- Contents of 'Health Promotion in Canada' (Rootman et al., 2017).

Results

Example key concepts in health promotion that relate to empathy:

Empowerment, participation, structure vs. agency, social determinants of health, ecological determinants of health, health literacy, quality of life, reflexivity, policy, behaviour change, justice, equity, ethics, morals, values, decolonization, self-determination, holism, pluralism, transformation.

Example passage:

"Nevertheless, for reasons (of perceived feasibility, political expediency, vested interests, etc.) that remain poorly articulated, the emerging personal wellness industry, large bureaucracies oriented to health education, and (in the main) North America public were not so easily dissuaded from a deep cultural and institutional commitment to individualism." (Rootman et al., 2017; p107)

Figure 1 – A proposed ontological, epistemological and methodological conceptualization of health promotion practice.

Discussion

Preliminary analysis demonstrates that the construct of empathy is embodied in foundational health promotion texts of the last three decades as both an outcome and a method of ethical and effective health promotion practice.

Notably, empathy appears to be both practiced and produced through participatory methodologies, regardless of the level of intervention, ranging from individual-level clinical health behaviour change, to community-organizing approaches and political action.

A notion of empathy that is both critical and relational emerged as a precursor to creating a more relational and transformative health promotion practice.

Conclusion

Empathy ought to be considered a foundational concept in health promotion practice, both as a method and outcome.

Intentionally fostering empathy in and of itself may be an important and effective target for health promotion practice, toward a more relational, ethical and just approach to tackling 'health for all'.

Acknowledgements

Queen's University Clinical Investigator Program.

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Contact: s.dobrowolski@queensu.ca

Queen's University

SKHS School of Kinesiology and Health Studies

WAIORA: Promoting Planetary Health and Sustainable Development for All

"There is no bigger sin than having kids that are close in age": Birth Spacing as a Motivator for Family Planning Use in Rwanda

Hilary Schwandt[1], Angel Boulware[2], Julia Corey[3], Ana Herrera[4], Ethan Hudler[2], Claudette Imbabazi[5], Ilia King[2], Jessica Linus[6], Innocent Manzi[5], Maddie Merrit[7], Lyn Mazer[2], Abigail Miller[1], Haley Morris[10], Uwase Nadine Museluka[11], Dusdonne Musemakweri[5], Divine Mutuyimana[5], Chimene Ntakarutimana[12], Niral Patel[13], Adriana Scanteianu[14], Bigannette Shemeza[2], Madi Stapleton[1], Gi'anna Sterling-Donaldson[15], Chantel Umuton[5], Lyse Uwera[5], Madeleine Zeller[1], Seth Feinberg[1]

[1]Western Washington University, Bellingham, USA; [2]Spelman College, Atlanta, USA; [3]Whatcom College, Norton, USA; [4]Northwest Vista Community College, San Antonio, USA; [5]Whatcom Community College, Bellingham, USA; [6]NCS, Buhengeri, Rwanda; [7]Xavier University of Louisiana, New Orleans, USA; [8]UMBC, Baltimore, USA; [9]UNT Dwango, Dwango, USA; [10]Western Oregon University, Monmouth, USA; [11]Eastern Oregon University, La Grande, USA; [12]University of Kentucky, Lexington, USA; [13]Arcadia University, Glenside USA; [14]Rutgers University, New Brunswick, USA; [15]Drexel University, Philadelphia, USA

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Introduction:

In Rwanda, the desire to space births motivates high family planning (FP) use. About 11% of women in Rwanda have an unmet need to space births and the median interval between successive births is 38.5 months. The high prevalence of modern contraceptive use (52%) has enabled many women to attain their ideal birth spacing.

Methods:

32 in-depth interviews were conducted in Kinyarwanda in the Musanze and Nyamsheke districts of Rwanda. Data analysis was guided by the thematic content analysis approach and executed using Atlas.ti 8 software and group level matrices in Microsoft Excel.

Results:

Birth spacing was a common theme across interviews. Participants were motivated by the difficulty of raising children "close in age" to use family planning for spacing. Family development was usually framed in terms of the extent to which women were able to work and the rate at which children would consume financial resources.

> ***If you have kids close in age, you won't have the strength to work because you often spend your time caring for the babies and the other tasks that need to be done at home. This causes the development of your family to decrease.***
>
> *45, female, 2 children, pill user, Nyamasheke*

Study participants specifically mentioned wanting 5 years of space between their children.

> ***Before when I had two kids and wasn't using contraceptives, the age between the first born and the second born was one year, but when I started using contraceptives the age between the other births I had was 5 years, and I benefited from that because I gave birth when I was strong and that has helped me to improve not only myself but my family, too.***
>
> *41, female, 5 children, condom user, Musanze*

Birth spacing was also important to infant health: when a woman only has one baby to care for at a time, she will have more time to breastfeed and give attention to that one baby.

> ***I decided to use family planning so that my children could grow up well... I did not want to have children that were close in age because I saw that it would be a problem to take care of them well.***
>
> *38, female, 4 children, condom user, Nyamasheke*

Discussion:

In Rwanda, most intervals between births fall within an ideal birth spacing interval. Women reported acting upon their desire to space births by using family planning to avoid having children close in age for financial as well as health reasons. Birth spacing is among the primary motivators for FP use in Rwanda.

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TITIRO WHAKAMURI KŌKIRI WHAKAMUA

Titiro Whakamuri Kōkiri Whakamua is a whakatauaki (Māori proverb) that refers to looking back, and reflecting, so that progression to move forward can occur. Te Rerenga Ake is the name of our cultural education programme; gifted to us by our kaumātua (elders). It aims to reconnect our rangatahi (youth) with the traditions of our tipuna (indigenous ancestors).

Te Rerenga Ake means to "soar to great heights". In order to understand Te Ao Māori (the Māori World) we must first understand our own whakapapa (identity). Our tipuna created many methods for passing on knowledge and skills to the next generation. Māori pedagogy is used throughout our practices.

Rangitāne o Wairarapa Inc.
Mandated Iwi Authority

WHAIORA
In pursuit of wellness

WAIORA: Promoting Planetary Health and Sustainable Development for All

Transforming Mental Health in Canada Through an Equity and Reconciliation Based Upstream Approach

Setting/Opportunity

Founded in 1918, the Canadian Mental Health Association (CMHA) is Canada's most established and extensive community mental health organization. Through a presence in more than 330 communities across every province, CMHA's work serves all health disciplines and mental health diagnoses through our over 16,000 staff, members and volunteers. Canadian society has been shaped by a history of colonization with devastating effects to our First Nations, Métis and Inuit people. We also have a history of cultural and linguistic tension between Anglophone and Francophone Canadian populations that influences mental health system design and impacts health equity. Canada's Mental Health system has been shaped by western medical models of illness and disease with long standing issues of inequitable resource allocations to support positive health and well-being. CMHA recognizes the unique leadership role it has to play in developing mental health programs, policies and practices that address the impacts of colonization, exclusion and disparity. This is being accomplished through a comprehensive equity-based governance and planning structure combined with an upstream population mental health and well-being approach. Mobilizing action in diverse settings including schools, campuses, workplaces, communities, neighbourhoods and in virtual settings online, are strategic priorities for CMHA. The desired outcome is to improve the health and well-being of all Canadians.

Canadian Mental Health Association
Association canadienne pour la santé mentale

100 years of community ons dans la communauté

Approach

CMHA integrated model for analysis and action based on four overarching frameworks

(1) Reclamation of Indigenous knowledge and wisdom using the First Nations Mental Wellness Continuum and guiding wisdom from the Thunderbird Partnership Foundation;

(2) Operationalizing the Dual Continua of Mental Health and advancing flourishing (Dr. Corey Keyes) to support a whole population upstream focus addressing psychological, social, emotional, spiritual, cultural and ecological wellness;

(3) Broad adoption of an equity lens that upholds ways in which actions and their consequences are experienced by and distributed among different groups in our societies to ensure that equity in health is achieved and everyone has equal opportunities for good health; and

(4) Integration of a Two-Eyed Seeing approach which would be further developed to include a western world view, an indigenous world view as well as a **francophone Canadian cultural and linguistic world view.**

Two Continua Model

First Nations Mental Wellness Continuum

Allyship

CMHA's focus is on both the 1 in 5 Canadians who experience a mental illness and the 5 in 5 Canadians who have mental health needs that are to be promoted and protected. Our inclusive upstream approach is informing the organization's strategic plan, governance structure and leadership, program innovations, and community engagement strategies. CMHA strives to create allyships through long-term relationships between Indigenous and non-Indigenous communities in the mental health field using the Two-Eyed Seeing principle.

As described by Mi'kmaq Elder Albert Marshall: "learn to see from your one eye with the best or the strengths in the Indigenous knowledges and ways of knowing ... and learn to see from your other eye with the best or the strengths in the mainstream (Western or Eurocentric) knowledges and ways of knowing... but most importantly, learn to see with both these eyes together, for the benefit of all". The two-eyed seeing approach with multiple world views and perspectives will be a lens that informs all aspects of the organization's work.

The co-development of a national digital mental health Ecosystem will serve to accelerate equitable access to programs and services. This technology-based intervention strategy will be grounded in cultural humility and culturally responsive principles as our virtual Recovery College and Well-Being Learning Centre is created. This will be achieved by leveraging the power of online and offline peer support and national certification through Peer Support Canada. As a result, CMHA will work alongside communities and co-produce/co-deliver more accessible programs that increase self-determination and personal well-being.

CMHA's Response to Canada's Truth and Reconciliation Calls to Action

CMHA recognizes the contributions that First Nations, Métis, and Inuit Peoples have made to Canada. And these contributions continue to be significant and increasing across all sectors and aspects of our national identity and history. We owe a debt of gratitude to the First Peoples of Canada. We are all the recipients of the work of Indigenous Peoples who have been the original trustees of Turtle Island, the land that we call Canada today.

All Canadians are invited to make an individual, organizational, and community commitment to further our conversations, and take action to correct the harm caused by the impacts of colonization and the difficult issues that we have imposed onto Indigenous Peoples of Canada. We must come to terms with the negative and lasting impacts of policies and practices that have traumatized individuals and families, and fragmented and eroded families and entire communities and nations.

Awareness and understanding of the truth about our past is just the beginning. We must engage in commitments, relationships, and actions that correct this harm and heal the hurt. We are obliged to own our history and reconcile our relationships so as to contribute to the restoration of societies, communities, and individuals who were complete and whole before contact and forced assimilation with them. It is to the pressing matter of truth and reconciliation that I speak to each of you in this communication.

A federated, national organization that is celebrating one hundred years of existence and service to Canada, the Canadian Mental Health Association (CMHA) is deeply committed to continuing and increasing our awareness and response to truth and reconciliation. We recognize the need to reflect and analyze how we, as an organization, may have been silent at times about the harm and damage that has been caused to the mental well-being of individuals, their families, and communities who were through policy ravaged by poverty, racism, and ignorance. We watched as children, youth, and adults went through the horrors of residential schools, child welfare apprehension, imposed segregation and lack of meaningful investment and support. We can only imagine how much stronger we would be as a nation if Indigenous knowledge and practice had not been interrupted.

We are authentically committed to learning, sharing our resources and skills, and building new relationships that will guide all of us to a better and stronger tomorrow as a nation. We recognize the resilience of First Nations, Métis, and Inuit Peoples and the power of their knowledge. We must create spaces where this knowledge, experience, and these skills, in collaboration with the capacity and commitment of CMHA, can create and innovate, while restoring and recognizing living and historical Indigenous knowledge and wisdom.

Desired Outcomes

With the adoption of this upstream, equity focused, cultural model, CMHA will continue to see organizational transformation in the following areas:

- Emphasis and focus on upstream well-being promotion knowledge exchange forums including the largest mental health conference in Canada for mental health and addiction providers and system leaders that focus on mental health promotion and prevention.
- Development of a pan-Canadian Indigenous Advisory Council to support the implementation of the Truth and Reconciliation recommendations and support "before contact" cultural reclamation efforts to support mental wellness.
- Commitment and organizational action to uphold francophone linguistic and cultural needs.
- Development of a new equity focused organizational governance model to ensure re-distribution of power in decision making and resource allocation, prioritizing groups and populations most disadvantaged.
- Co-development with Indigenous communities of a digital mental health and well-being ecosystem with inclusive approaches to supporting Canadians to improve their mental health and engage in proactive strategies and early intervention.
- Spread and scale of a Canadian Recovery College model that has a focus on health and well-being and offers an adaption of this model in the Canadian context called Well-being Learning Centres. This new co-designed model serves the entire population across the life span to support lifelong learning.

Implications

At our 100 year milestone we sit at a turning point. As we look ahead to the next 100 years, we commit to embarking on a bold transformational path of reconciliation, equity and whole of population well-being. By doing our own organizational work internally, we aspire to achieve far reaching impact and system transformation in all of the communities we serve.

Contacts: Marion Cooper mcooper@cmhawpg.mb.ca | Greg Kyllo gkyllo@cmha.ca

Understanding the contribution of physical and social environments to healthy aging: an evidence from Chinese aged populations

Bo Ye, Lei Wang, Wenjing Dong, Yongkai Zhu, Junling Gao* and Hua Fu*
Fudan University, Shanghai, China

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Background

To meet the challenges of aging population, world health organization (WHO) proposed the goal of healthy aging. It emphasized the role of individual's intrinsic capacity and related environments, which both affected functional ability.

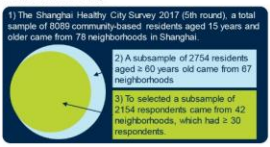
Frailty was occurred by the decline of physiological reserve and is seen as reflecting an interaction among individual factors and a range of environment elements. Moreover, frailty represents a public health priority for its highly and increasingly prevalent condition in the aging populations.

Given the current few evidences, this study aims to examine the association between both physical and social environments with frailty among Chinese older people.

Methods

Data were from the Shanghai Healthy City Survey in 2017, a subsample of 2154 respondents aged ≥60 years from 42 neighborhoods, which contained at least 30 respondents, were conducted in current study **(Figure 1)**.

Figure 1 Data in current study



The FRAIL scale (Table 1) was used to assess frailty [1]; and physical and social environments of neighbourhood were assessed using validated and psychometrically tested instruments [2,3]. Sociodemographic characteristics included age, gender, education, marital status, employment, smoking, drinking and physical exercise.

Neighborhood-level environmental characteristics were assessed by estimating mean scale score of all respondents in the same neighborhood [3]. For analysis, both individual- and neighborhood-level environmental characteristics mean scores were converted to quartiles, with the highest quartile indicating the highest level of environmental characteristics.

Multilevel analysis was conducted to examine whether physical and social environments were associated with frailty.

Results

1. The prevalence and compare of frailty among different groups

The prevalence of pre-frail status and frail status were 40.1% (95%CI: 38.0%-42.2%) and 16.2% (95%CI: 14.7%-17.7%), respectively **(Table 1)**.

Those who were aged **(Figure 2)**, unmarried, alcohol dependence and without physical exercise had a higher risk of frailty **(Table 2)**.

Table 1 The prevalence of each FRAIL items and Frail status (n=2,154)

Indicator	N	%
Fatigue	762	35.4
Resistance	763	35.4
Ambulation	271	12.6
Illness	498	23.1
Loss of weight	124	5.8
Frailty status		
Robust (0)	943	43.8
Pre-frailty (1-2)	863	40.1
Frailty (3-5)	348	16.2

Figure 2 The prevalence of frailty among respondents by age group

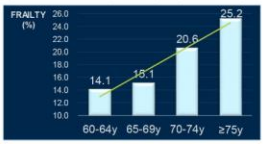


Table 2 comparative analysis of frailty among different groups (Here only showed the significant results) (n=2154)

Variable		Frailty [n (%)]	*Trend* χ^2	*P value*
Marital status	unmarried	60 (23.8)	12.34	<0.001
	married	288 (15.1)		
Drinking	nondrinker	270 (15.5)	8.79	0.003
	drinker	41 (14.2)		
	alcohol dependence	37 (29.6)		
Physical exercise	no physical exercise	126 (20.5)	21.60	<0.001
	irregular physical exercise	167 (16.6)		
	regular physical exercise	55 (10.3)		

2. Multilevel analysis of frailty and environmental characteristics

Multilevel analysis showed that after controlling for all covariates, individual-level aesthetic quality, social cohesion and social participation, and neighbourhood-level walkability were significant negatively correlated to frailty, with the ORs (95% CI) of quartiles were 0.89 (0.80-0.99), 0.90 (0.82-0.99), 0.86 (0.78-0.94) and 0.74 (0.57-0.97), respectively **(Table 2)**.

Table 2 The Odds Ratios for frailty associated with individual- and neighborhood-level variables (n=2154)

Variable	Model 1	Model 2	Model 3[a]
	OR (95%CI)	OR (95%CI)	OR (95%CI)
Fixed effects			
Individual-level variables			
Aesthetic Quality	0.88*(0.80-0.98)		0.89*(0.80-0.99)
Walkability	1.05 (0.95-1.16)		1.08 (0.98-1.20)
Social Cohesion	0.91*(0.83-0.99)		0.90*(0.82-0.99)
Social Participation	0.84***(0.77-0.92)		0.86**(0.78-0.94)
Neighborhood-level variables			
Aesthetic Quality		1.08 (0.83-1.40)	1.15 (0.89-1.50)
Walkability		0.77*(0.59-0.99)	0.74*(0.57-0.97)
Social Cohesion		0.89 (0.69-1.14)	0.92 (0.72-1.18)
Social Participation		0.97 (0.80-1.18)	1.08 (0.88-1.32)
Random effects			
Neighborhood-level variance (SE)	0.42 (0.12)	0.36 (0.10)	0.35 (0.10)
Model fit			
-2LL	4238.15	4260.36	4155.67
AIC	4252.16	4274.36	4197.67

Note: [a] age, gender, education, marital status, employment, smoking, drinking, physical exercise were adjusted; * p<0.05, ** p<0.01, *** p<0.001.

Conclusions

Frailty is probably a highly prevalent health condition among the aged population in China, both individual factors and neighbourhood environments are associated with frailty.

Health promotion on aged populations should be more targeted, and it may decrease frailty among Chinese older people to encourage social participation, health behaviours, and build aesthetic, walkable and cohesive neighbourhoods.

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23rd IUHPE World Conference on Health Promotion
Session: Social capital for elderly
Location: Energy Events Centre - Wai Ora Spa Grand Hall
Date: 8:30 AM - 10:00 AM, Thursday, Apr 11, 2019

23rd WORLD CONFERENCE ON HEALTH PROMOTION
7–11 April 2019, Rotorua, Aotearoa, New Zealand
[Sponsored by International Union for Health Promotion and Education (IUHPE)]

Uplifting the Spiritual Health:

Understanding Cultural Competency for Effective Spiritual Care of HIV infected Children—a Field Study Report

INTRODUCTION

This paper illustrates Culturally Competent Spiritual Care model for Children with HIV infection. Sighting a field study example of Sneha Care Home in Bangalore and Sneha Sadan in Mangalore, India, the author argues for Culturally Competent Spiritual Care as each child comes from a different family background, a particular religious upbringing and a unique set of life experiences.

BACKGROUND/OBJECTIVES

1. To demonstrate culturally competent spiritual care of children with HIV in a multi cultural context.
2. To understand how children conceptualise spirituality that emerge while dealing with HIV.
3. To enumerate how culturally competent team of Sneha Sadan and Sneha Care Home nurture and ignite the flame of Children's Spirituality.
4. To advocate culturally competent spiritual care for health compromised and in poor social condition.

METHODS

1. Thematically reviewed related literature and explored the place of spirituality in HIV infected children.
2. Analysed culturally competent spiritual activities in two care homes of HIV infected children.
3. Presents case study examples of culturally competent spirituality related activities specific to HIV care homes.
4. Examines, 'how' the awakening of spiritual spark in each infected child has nurtured spirituality.
5. Finally, author confirms those culturally competent spiritual care related activities in HIV care come as fostering and igniting spiritual sparks.

RESULTS

1. Snehasadan and Sneha Care Home envisage that igniting the flame of our children's spirituality can support and nurture our children and their future.
2. Culturally competent interventions to spiritual development have been found to improve health outcomes of children and to keep the flame of spirituality lit.
3. The paper affirms the type of culturally competent environment vital for children infected with HIV.
4. The paper proposes appropriate culturally competent context the health care providers must create for children infected with HIV to help them recover wholeness.

DISCUSSION

The paper defines and discusses culturally competent strategies that see the child as part of a family network, not as an isolated patient. It suggests to increase the cultural competence of health professionals and spiritual caregivers to provide a fair opportunity for all HIV infected children to live a long and health life.

Keywords: Culture, Competence, Spirituality, Health, Children.

Presenting Author: Fr. Anthoni Jeorge, MI
Member: Sneha Charitable Trust, [CAMILLIANS] Bangalore, India
Student Affiliation: Ateneo de Manila University, Loyola School of Theology, Philippines
c. +63 9959910713
e. anthonijeorge@gmail.com

Using Intervention Mapping to develop a mobile health application for prevention of metabolic syndrome for South Korean adults

Jiye Kim*, Jiwan Kang*, Harim Kim*, Juyeun Ko*, Yuri Kim**, Kwangsuk Ko**, Minsoo Lee***, Hyekyeong Kim*

* Department of Health Convergence, Ewha Womans University, Seoul, South Korea,
** Department of Nutritional Science and Food Management, Ewha Womans University, Seoul, South Korea,
*** Department of Computer Science and Engineering, Ewha Womans University, Seoul, South Korea

이화여자대학교
EWHA WOMANS UNIVERSITY

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Background

- Intervention Mapping is a process of development of health education program based on a theory. It has been used to plan health intervention programs steadily.
- In 2018, South Korea reached a high rate of 84.2% in smartphone penetration. Health applications are widely used and considered to be a suitable intervention tool for health intervention programs.
- There was a lack of prior research on metabolic syndrome mediation and the application of mobile health applications.

Purpose

We aimed to develop a mobile health application for a health intervention program to prevent metabolic syndrome for South Korean adults using Intervention Mapping.

Results

Step 1. Needs Assessment

- Need of multiple behavioral intervention programs for the prevention of metabolic syndrome was identified. Physical activity, diet, drinking and smoking were selected for target behaviors. Also, height, weight, waist circumference, blood pressure, fasting blood sugar, HDL cholesterol, and triglyceride were selected for anthropometric and biochemical factors to be improved by intervention.

Step 2. Matrices

Table 1. Matrix

Stages of change	Performance objectives	Determinant: Knowledge	Determinant: Decisional balance
From PC to C or P	Have an intention to increase physical activity Have an intention of healthy diet Have an intention to be moderate in alcohol drinking	- Can mention one's current healthy state - Know about the metabolic syndrome - Distinguish healthy and unhealthy behaviors - Know that healthy behaviors can make one become healthy and improve one's QOL - Explain the risk and damage of each unhealthy behavior	- Accept disadvantages of healthy physical activity, healthy diet, and drinking moderately - Express that the benefits of healthy physical activity, healthy diet, and drinking moderately exceed the disadvantages of them
		Knowledge	**Self-efficacy**
From C or P to A	Decide & start to increase physical activity	- Know that healthy physical activity, healthy diet, and drinking moderately are needed to become healthy or prevent social problem - Identify the possibility that one can make a mistake after initiation of healthy physical activity, healthy diet, and drinking moderately	- Express confidence regarding an ability to increase physical activity - Can set the date to increase physical activity - Can set the personal objectives - Can exercise in real life - Find the person who support you to increase physical activity
	Decide & start to have healthy diets		- Express confidence regarding a ability to have healthy diets - Can eat alternative food rather than unhealthy food - Can cook healthy diet and use healthy food ingredients - Can calculate the calories of food
	Decide & start to be moderate in alcohol drinking		- Express confidence regarding a ability to drink moderately - Can set the date to start to drink moderately - Can make a detailed plans about the amount of drinking - Can write a drinking diary - Find the person who support you to drink moderately
		Self-efficacy	
From A to M	Maintain regular exercise and active daily life	- Express confidence that one can resist temptation - Express confidence that one can go back from slips - Can develop alternative actions or methods of lazy lifestyle - Can enjoy healthy life - Can become a role model	
	Maintain healthy diets	- Express confidence that one can resist temptation - Express confidence that one can go back from slips - Can monitor one's own eating habit - Can reward oneself when they have a desirable change of diet habit - Can have healthy diets with family, friends, or colleague	
	Maintain moderate alcohol drinking	- Express confidence that one can resist temptation - Express confidence that one can go back from slips - Can register the high risky situation that can lead a heavy drinking - Can prevent heavy drinking - Find the person who can consult you to cope with the temptation of heavy drinking	

PC : Precontemplation stage, C : Contemplation stage, P : Preparation stage, A : Action stage, M : Maintenance stage

Step 3. Theory-based Methods and Strategies

- Guidelines for anthropometric and biochemical factors focus on overall lifestyle to improve and maintain a health status. Guidelines for health behavioral factors include appropriate methods and strategies to improve stages of change based on the TTM.

Anthropometric and biochemical factors: Ideal	Intermediate	Poor
- Health status with normal value - Encouragement for maintenance	- Health status with abnormal value - Meaning of each factor and numerical value - Physical harm and damage to personal quality of life - Lifestyle and stress management methods needed for improvement - Abnormal medical conditions that cause MetS and total number of abnormalities - Recent studies related to MetS	

Theoretical application	Health behavior factors: Ideal : Action & Maintenance	Intermediate : Contemplation & Preparation	Poor : Pre-contemplation
Methods	- Counterconditioning - Helping relationships - Reinforcement management - Stimulus control - Self liberation	- Self re-evaluation	- Consciousness raising - Dramatic relief - Environmental re-evaluation
Strategies	- Self monitoring - Plan for dealing with high risk situations (temptation) - Avoid false attribution of a temporary mistake experience - Become a role model for others - Provide incentives after self-assessment	- Set the behavior practice starting date - Develop health behavioral skills - Predict risk situation - Suggest specific strategies for countermeasures - Make an opportunity to start and have a healthy lifestyle - Self re-evaluation - Environmental re-evaluation	- Provide data on risky impacts on health - Make an opportunity to review their own situation - Provide information about the danger of current lifestyle and the personal benefits of change

Table 2. Guidelines for improvement of physiological and behavioral factors

Methods

- We applied 6 steps of Intervention Mapping sequentially to design development of a mobile health application.

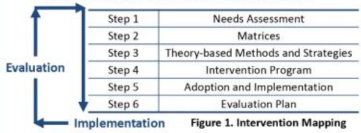

Figure 1. Intervention Mapping

- Transtheoretical model's concepts such as stages of change, decisional balance, and self-efficacy were applied to develop contents of mobile health application.

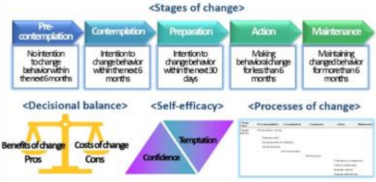

Figure 2. Transtheoletical Model(TTM)

Step 4. Intervention Program

- Contents for mobile health application were developed with some features of personalization, data storage, and self-monitoring. Mobile health application can make users input their physiological and behavioral factors and get recommendations tailored to their results.

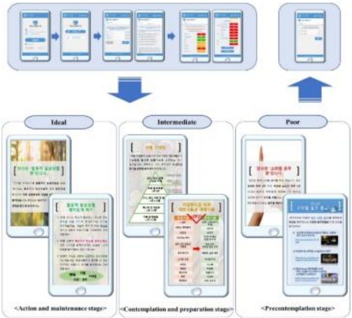

Figure 3. Procedures and screen shots of mobile health application

Step 5. Adoption and Implementation & Step 6. Evaluation plan

- We planned for adoption and implementation to provide information of mobile health application and promote this program. Also, we made a plan to evaluate it based on RE-AIM (reach, effectiveness, adoption, implementation, maintenance) framework.

Conclusion

This study planned and developed a mobile health application to prevent metabolic syndrome regardless of time and space for South Korean adults based on Intervention Mapping and TTM which are effective to systematically design an health intervention. In the future, the use of Intervention Mapping should be activated for the planning of high quality metabolic syndrome program and development of mobile health applications.

- Keywords : Intervention Mapping, health intervention, mobile health application, metabolic syndrome

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Contact email : hkkim@ewha.ac.kr

WAIORA: Promoting Planetary Health and Sustainable Development for All

Using Participatory Action Research to explore workplace health promotion strategies using digital technologies for nutrition and physical activity with truckies: An at-risk, hard-to-reach group.

Marguerite Sendall, Toby Pavey, Cameron Newton.

Dr Marguerite C Sendall
School of Public Health and Social Work
Queensland University of Technology
Brisbane, Australia
+61 7 313 83526
m.sendall@qut.edu.au

Aim

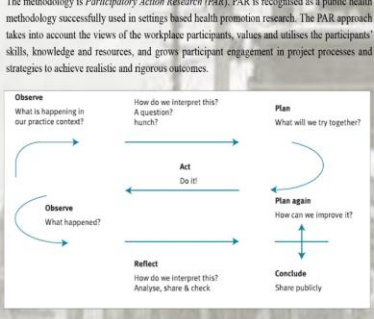
This workplace health promotion research project aims to understand how road transport companies can support their truck drivers to improve nutrition and increase physical activity.

Background

Blue-collar workplaces can be challenging environments. Drivers in the road transport industry have been identified as being at risk of chronic diseases like diabetes and heart disease because they have limited opportunities to make healthy food choices, spend long periods sitting down and often have irregular work patterns. This poster presents preliminary findings from a health promotion project currently being conducted to improve nutrition and increase physical activity in Australian truck drivers.

Methodology

The methodology is *Participatory Action Research (PAR)*. PAR is recognised as a public health methodology successfully used in settings based health promotion research. The PAR approach takes into account the views of the workplace participants, values and utilises the participants' skills, knowledge and resources, and grows participant engagement in project processes and strategies to achieve realistic and rigorous outcomes.



Sample

A medium-sized family-owned transport company (general and bulk haulage freighters, no line haul) in southeast Queensland with a potential reach of 80 company and 100 subcontracted truck drivers. A smartphone-based app is used to communicate between drivers and depots.

Methods

As part of a broader ongoing intervention about the use of digital technologies for health promotion in the road transport industry, truck drivers self-completed a baseline (pre-intervention) survey about their nutrition and physical activity habits and use of digital technologies. In conjunction with findings from driver and key informant focus groups, the survey data will help the workplace develop an effective intervention for improving drivers' ability to make healthy choices. The intervention will be conducted over 4-6 weeks, with a 1 month follow-up.

Findings

** Only a selection of findings are presented here. Seventeen (17) surveys completed.*

DRIVER CHARACTERISTICS: Most drivers (70.6%, n=12) operate locally and most (88.2%, n = 15) work for nine or more hours per day. Drivers' average age is 42.4 years, and all drivers are male except one. The majority 70% (n=12) rate their health from *good* to *excellent*. Nearly all (88.2%, n=15) drivers are *thinking about, planning to, currently making* or *have recently made* lifestyle changes to improve their health. Most drivers (76.5%, n=15) believe drivers should be responsible for their healthy lifestyle choices, not the workplace.

BMI: Drivers' average BMI is 33.1 (within the *obese* range). Only 2 drivers have a BMI within the *normal* range (18.5-24.9).

INTAKE OF FRUIT AND VEGETABLES: 88.2% of drivers (n=15) eat at least one piece of fruit per day, on average. 11.8% (n=2) eat 4-5 pieces of fruit per day and the same proportion don't eat any fruit. All drivers eat at least one serve of vegetables each day on average. Almost all drivers (94.1%, n=16) eat two or more serves of vegetables per day. 17.6% (n=3) eat the recommended intake of 4-5 serves of vegetable per day.

INTAKE OF UNHEALTHY FOODS: 64.7% of drivers (n=11) eat unhealthy food (high in saturated fat, added salt or added sugar) on at least two days per week. 11.8 % of drivers (n=2) eat unhealthy food on 5 days per week. The same proportion don't eat unhealthy food.

INTAKE OF SUGARY DRINKS: 41.2% of drivers (n=7) consume sugary drinks (soft drink or energy drink) on at least two days per week. 35.3% (n=6) don't consume sugary drinks.

PHYSICAL ACTIVITY: The majority of drivers (70.6%, n=12) perform moderate intensity physical activity (such as brisk walking) on at least three days per week. About half of the drivers (52.9%, n=9) perform vigorous activity on at least three days per week. 11.8% (n=2) and 29.4% (n=5) report they don't ever undertake any moderate or vigorous exercise, respectively. On a typical work day, most drivers spend 5-6 hours per day seated, 2-3 hours standing and 2 hours walking.

USE OF DIGITAL TECHNOLOGIES: All drivers have a phone with mobile internet. Facebook is the most commonly used (80% of drivers) social media technology, followed by Instagram (40%), Snapchat (35.7%), and Twitter (0.7%).

Conclusion

While it is too early to draw any conclusions, the preliminary findings reveal interesting information about this under researched, at-risk and hard-to-reach group. Baseline data will be provided to the road transport company to direct co-created and contextually relevant interventions to improve nutrition and increase physical activity for truck drivers. Post intervention data will be collected, provided to the road transport company and presented in academic journals.

Validation française d'une échelle de mesure des compétences psychosociales pour les jeunes dès 9 ans : compétences émotionnelles, sociales, cognitives, motivation et satisfaction scolaire

C. Simar[1], C. N'Sambu[1], J. Pironom[1], D. Tessier[2], D. Berger[3], J. Masson[3] (Carine.simar@uca.fr)
Université Clermont Auvergne – Laboratoire ACTé EA4281 / Université Grenoble-Alpes – Laboratoire Sport et ENvironnement Social (EA 3742) / Université Lyon 1 – Laboratoire HESPER EA 7425

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INTRODUCTION

Un élève sur quatre se déclare insatisfait par ses expériences scolaires (Huebner et al., 2000), et le mal-être se développe tout particulièrement pendant la période du collège (Godeau et al, 2010). Au vu de ces résultats, une attention grandissante a été accordée aux compétences psychosociales (CPS). Il a été démontré que « l'insuffisance du développement des compétences psychosociales est l'un des déterminants majeurs de comportements à risque tels que la prise de substances psychoactives, les comportements violents et les comportements sexuels à risque, qui sont eux-mêmes des déterminants de pathologies » (Luis & Lamboy, 2015, Imène Hammami, 2013 ; Rollande Deslandes, 2008 ; Dupras, 2012 et Ginette Berteau, 2006). Quelque soit le public visé (enfants, adolescents, adultes), il est admis qu'elles jouent un rôle sur le bien-être et les relations des individus (Luis & Lamboy, 2015).
Les compétences ont tendance à être définies en référence à des compétences sociales, cognitives et émotionnelles (Lamboy & coll., 2011).

CATEGORISATION DES COMPETENCES PSYCHOSOCIALES

- Problèmes / décisions
- Créative / critique
- Communiquer / relations
- Conscience de soi / empathie
- Emotions / stress

OMS, 1997, 5 binômes

- Compétences sociales
- Compétences cognitives
- Compétences émotionnelles

OMS, 2001,2010, 3 dimensions

- Compétences sociales (résolution de problème, coping, attitude pro-sociale, communication…)
- Compétences cognitives (gestion des pensées négatives, raisonnement, connaissances scolaires, esprit critique…)
- Compétences émotionnelles (connaissances des émotions, régulation émotionnelle, gestion du stress…)

OBJECTIF DE L'ETUDE

Tester les propriétés psychométriques (validité, fiabilité, sensibilité) d'un outil de mesure est essentiel afin de s'assurer de la qualité des données recueillies.

Un premier recueil a permis de valider l'échelle de mesure des compétences émotionnelles en langue française :

- La version traduite de l'Assessment of Children's Emotion Skills : consistance interne modérée, niveau de fiabilité modérée , forte validité prédictive
- La version traduite du Life Skills Transfer Survey : consistance interne satisfaisant, niveau élevé fiabilité temporelle, bonne validité convergente et divergente, faible validité prédictive (satisfaction scolaire)

Encinar P, Tessier D, Shankland R (2017)

Quelle validité et quelle fiabilité accorder à l'échelle de mesure de la compétence sociale ?

METHODOLOGIE

Outils

- Questionnaire auto-administré en classe, composé de trois parties (105 items) :
  - Un test de Compétence émotionnelle : photos ou situations + réponse en 5 points (Heureux, Triste, Colère, Peur, Rien)
  - Une mesure auto-rapportée des capacités de régulation émotionnelle et des compétences sociales et cognitives : affirmations + échelle de Likert en 5 points (Non/Jamais, Rarement, Parfois, Souvent, Oui/Toujours)
  - Une mesure auto-rapportée de la motivation , de la satisfaction scolaire et du bien-être : affirmation + échelle de Likert en 5 points (Non/Jamais, Rarement, Parfois, Souvent, Oui/Toujours)
- Compétences sociales composées de 14 items répartis en 3 sous dimensions : gérer les conflits (items C1 à C4), demander de l'aide (DA1 à DA5) et aider les autres (A1 à A5).

Suivi longitudinal des élèves de cycle 3 de 13 écoles avec profils variés, 3 recueils sur l'année

311 ont participé aux 3 recueils

Analyses des données T1

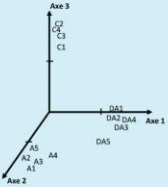
- Validité de construit : Analyse Factorielle exploratoire, Analyse factorielle confirmatoire
- Validité concourante : Corrélations avec d'autres mesures théoriquement liées
- Fiabilité : alpha de Cronbach et rhô de Jöreskog

Logiciels : SPSS version 23 et AMOS version 21

RESULTATS

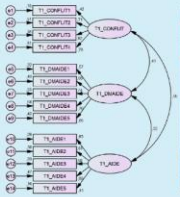
VALIDITE DE CONSTRUIT

Analyse factorielle exploratoire (AFE)



	Dimension 1	Dimension 2	Dimension 3
CONFLIT1 (C1)	,040	,185	,536
CONFLIT2 (C2)	,129	,102	,792
CONFLIT3 (C3)	,135	,159	,690
CONFLIT4 (C4)	,146	,140	,792
DMAIDE1 (DA1)	,671	,041	,152
DMAIDE2 (DA2)	,717	,094	,200
DMAIDE3 (DA3)	,769	,147	,147
DMAIDE4 (DA4)	,791	,153	,113
DMAIDE5 (DA5)	,685	,344	-,084
AIDE1 (A1)	,119	,728	,137
AIDE2 (A2)	,091	,707	,151
AIDE3 (A3)	,124	,693	,087
AIDE4 (A4)	,205	,674	,220
AIDE5 (A5)	,136	,369	,299

Analyse factorielle confirmatoire (AFC)



Critères	Seuil	Modèle 1
Chi-2 (CMIN)		150,008
DDL		74
P(Chi-2)		<0,0001
GFI	> 0,90	0,966
AGFI	> 0,90	0,952
RMSEA	< 0,05	0,041
NFI	> 0,90/0,95	0,936
TLI	> 0,90/0,95	0,958
CFI	> 0,90/0,95	0,966
Chi-2 / DDL	Plus faible	2,027
AIC	Plus faible	212,008
BIC	Plus faible	349,079

L'AFE indique une **répartition des items en 3 catégories** ; celles définies à priori (53,4% de variance expliquée). Chaque item contribue à **une et une seule sous-dimension**. L'AFC confirme que la répartition en 3 sous-dimensions **s'ajuste aux données** (les valeurs de l'ensemble des indices sont conformes aux seuils retenus).

VALIDITÉ CONCOURANTE

Corrélations avec…	Dimension sociale
Estime de soi scolaire	0,216***
Satisfaction scolaire	0,313***
Motivation intrinsèque	0,339***
Motivation identifiée	0,306***
Motivation contrainte	0,041
Proximité sociale	0,311***

Les corrélations montrent qu'il existe une **relation positive significative** entre la dimension sociale et l'estime de soi scolaire, la satisfaction scolaire, la proximité sociale et les différentes formes de motivation (exceptée la motivation contrainte) conformément aux résultats disponibles dans la bibliographie.

FIABILITÉ

Dimensions	Nombre d'items	Alpha de Cronbach	Rhô de Jöreskog
Seuil recherché		Entre 0,7 et 0,9	
Conflit	4	0,724	0,793
Demande d'aide	5	0,806	0,832
Aide	5	0,709	0,830

Les coefficients alpha de Cronbach et le rhô de Jöreskog sont tous les deux **supérieurs à 0,7**, indiquant une bonne consistance interne, et **inférieurs à 0,9**, signifiant l'absence d'items redondants.

CONCLUSION ET PERSPECTIVES

L'étude consistait en la validation d'une échelle de mesure des compétences sociales en 3 sous-dimensions chez les élèves de cycle 3. Les résultats montrent **une fiabilité élevée** et une **bonne validité de construit et concourante**, indiquant ainsi des qualités psychomotrices satisfaisantes.

Ce recueil permettra également d'évaluer la validité et la fiabilité cette échelle avec les données recueillies aux deux autres temps de mesure et d'étudier la validité prédictive de l'échelle. Le même processus sera appliquée à l'échelle de mesure des compétences cognitives en vue de sa validation.

Remerciements : coordonnateurs CPS, les équipes et les élèves des écoles ayant participés à l'enquête, F. Terfous et J. Degbe.

Waiora and Wellbeing: Amplifying action for healthy public policy

Nicky Welch,[1] Kiri Waldegrave,[2]
[1]Auckland Regional Public Health, NZ; [2]Regional Public Health, NZ.

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Working together for healthy housing

Healthy housing for a sustainable future #Waiora

- Housing was on everyone's lips. But the messaging and agendas were slightly different
- Key stakeholders got together and formed the Wellington Regional Healthy Housing Response Group
- Collaboration saw coordinated and amplified messaging. *Everyone in the Wellington Region lives in warm, dry and safe housing by 2025*

Wellington Regional Healthy Housing Response Group

- Never waste a good crisis[1]
- Mid 2016 a housing crisis was recognized, that is, growing shortage in affordable good quality rental housing and an emergency housing programme began with some urgency[2]
- Councils, central government agencies and not for profit organizations were all keen to be part of a solution. Joined up messaging and collaboration and coordination were recognized as key tools to work towards a solution.

Wai Ora

Healthy Environments

Public Health Units have core contracts with the Ministry of Health. One of the Ministry of Health's core documents is He Korowai Oranga – the Maori Health Strategy.

Pae Ora – Healthy futures is the overarching goal of He Korowai Oranga. Wai Ora contributes to this.

Structural housing indicators of Wai Ora could be:

Whanau have choices about their living arrangements and in all cases, their living environment is safe, secure, warm, dry[3], and

Increase number of whanau accessing services to improve the health or their home

Working together for wellbeing

Wellbeing

- The New Zealand government's wellbeing agenda promotes wellbeing as a common goal for policy makers to work across silos toward
- Achieving flourishing wellbeing at a population level will rely on the mobilsation of a much broader workforce than health alone and the explicit contribution of both central and local government to address the wider determinants of wellbeing
- Communities support and nourish wellbeing but often place-based policy is disconnected from prevention
- Public health effort in Auckland to with engage spatial planning opportunities to improve wellbeing has required enduring relationships across the social sector and beyond, playing a long game and knowing the opportunities and constraints of partners. Achieving even partial results has relied on building the capacity of leaders outside of health to championing wellbeing
- The ambitious task of achieving wellbeing and addressing inequity will require strong partnerships and trust in the community to take a leadership role in coming up with solutions
- A supportive environment for change includes the political will of elected representatives to take a leadership role, wide collaboration and the opportunity for innovation.

Conclusions

- This mahi has direct implications and lessons for collective action in addressing the policy and structural factors that affect health
- We want to encourage others to take advantage of the current opportunities offered to bring about real change in the way we conceive of, value and invest in wellbeing and how these translate into better and more equitable health outcomes and habitats
- We are enabling wellbeing principles to be integrated and recognised in policy and planning
- Interdisciplinary policy making is possible with health on the agenda of agencies that hold some of the levers to influence health outcomes
- A healthier future is shared work that needs both leadership and local action

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Acknowledgements

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Disclosures

The authors have no conflict of interest.

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Weight Associated Literacy for Youth (WALY)- Development and Validation of a Weight-Specific Health Literacy Tool

Padmanabhan Uma[1], Lim Zi Xiang[1], Tan Mae[1]
[1] Republic Polytechnic, Singapore

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Introduction and Aims

Health literacy is the ability to access, understand, critically evaluate and communicate information to promote and maintain good health (Nutbeam, 2000).

One in three adolescents and young adults (AYAs) aged 15-25 years has poor health literacy (Sansom-Daly et al., 2016).

AYAs with low health literacy are 5 times more likely to be obese than those with higher health literacy and more likely to lead sedentary lifestyles (Chari et al., 2014).

This study aims to develop and validate an objective measure of weight-specific health literacy for AYAs aged 15-25 years.

Methods

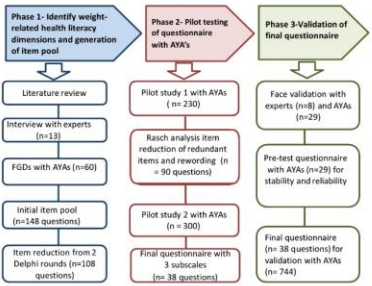


Figure 1- Flow chart of questionnaire development and validation

- Responses to Access subscale was in the form of a 5 point Likert scale from Strongly Disagree to Strongly Agree.
- Responses to Understand subscale was in the form of Multiple Choice questions.
- Evaluate section had a case scenario followed by multiple choice questions related to the case scenario.
- Psychometric properties of the subscales were assessed using Rasch analysis in Winsteps (version 4.3.1) software.
- Fit statistics (Table 1) were used to determine fit of the data to the Rasch model

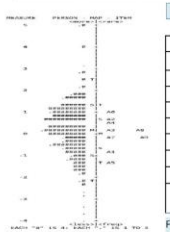
Rasch analysis	Limits of acceptability
Principal Component Analysis (PCA) variance explained for first factor	> 50%
Unexplained variance by first contrast (Eigenvalue)	< 2.0
Item misfit	0.5 - 1.5
Person Reliability	> 0.8
Person separation index	> 2.0

Table 1: Rasch model limits of acceptability

Results

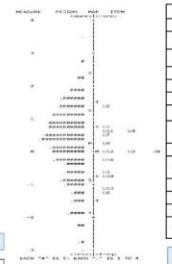
Subscales	PCA Variance explained	Unexplained variance by 1st contrast	Item Fit (MnSQ)	Person Reliability	Person separation index
Access	51.3%	**2.21**	0.8 – 1.3	0.87	2.55
Understand	**44%**	1.78	0.7 – 1.3	0.76	**1.80**
Evaluate	53.2%	1.50	0.7 – 1.3	0.80	2.01

Table 2: Psychometric properties



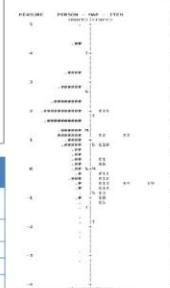
Access	
A1	Can find information that is helpful.
A2	Get advice from Family
A3	Get advice from Friends
A4	Get advice from School
A5	Get advice from Internet
A6	Get advice from Other sources
A7	Look at the Nutritional information
A8	Look at the Cooking methods
A9	Look at the ingredients

Figure 2: Wright map of Access subscale



Understand	
U1	How many calories from fat? (Nutritional label) (NL)
U2	How many grams of sugar? (NL)
U3	Highest fibre per 100g? (NL)
U4	MAIN sources of energy in raw peanuts
U5	Drinks having EMPTY calories
U6	Strategies to help in weight loss
U7	Recommended physical activity for weight loss
U8	Recommended servings of fruits and vegetables
U9	Healthier fats
U10	Main source of energy in minced meat noodles
U11	Statement about sleep
U12	Meaning of good aerobic fitness
U13	Meaning of good muscular endurance
U14	Examples of aerobic activity

Figure 3: Wright map of Understand subscale



Evaluate	
E1	Risk as per the BMI chart
E2	Healthier cooking methods
E3	Suggestions to improve diet during recess
E4	Suggestions to improve diet during dinner
E5	Drinks with no calories
E6	Lose weight in a healthy and safe way
E7	Choosing healthier snack
E8	Choosing healthier recess options
E9	Choosing healthier dinner options
E10	Choosing healthier cooking options
E11	Choosing types of physical activity
E12	Choosing a balanced diet
E13	Snacks to choose to aid weight loss
E14	Dishes to choose to aid weight loss
E15	1 serving of potato chips

Figure 4: Wright map of Evaluate/Apply subscale

Results and Discussion

- This is the first objectively measured weight-specific health literacy tool for AYAs. Each phase of the development progressively improved the questionnaire from original 148 questions to the final 38 questions.
- Access, understand and evaluate subscales demonstrated good precision and targeting, were unidimensional and there were no misfit items (Table 2). High item reliability in each scale suggesting consistency of these inferences.
- Differential Item Functioning (DIF) scores suggested that there were no differences in responses between male and female respondents (DIF contrast < 0.64 for all items in the 3 subscales.
- Questions in WALY have a good spread from easy to difficult questions targeting a range of literacy levels for weight management in AYAs. It can obtain a valid and responsive measurement of weight-specific health literacy in AYAs.

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Where new life meets death: A research based best practice model for palliative and bereavement care

Claudia Meier Magistretti Prof. PhD[1], Valerie Fleming PHD[2], Marco Schraner BSc[1], Michael Mikolasek MSc[1]
[1]Lucerne University of Applied Arts & Sciences, Switzerland [2]John Moores University, Liverpool, UK

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Background

- Switzerland: 26 different health systems in three language regions.
- Wide disparity in quality of provided care for stillbirth, abortion after 22 weeks and perinatal deaths.
- Recent studies indicate a dissatisfaction with care [1,2], major gaps in care after diagnosis [3], large regional differences and inconsistent quality of care. [1]

Aim

To describe quality of care for parents:

- who are confronted with stillbirth,
- whose babies are given a diagnosis incompatible with life,
- whose babies die within the first month of life.

To develop a best practice model

- of palliative and bereavement care

Methods

Qualitative study in 3 cultural regions in Switzerland (German, French, Italian)

1. Semi-structured interviews (30-90 min) — 20 mothers from various settings
2. Focus group interviews in every region — Parents, professionals, health insurers

Results

Gaps in care

Diagnostic process

- Parents show complete confidence in the medical processes of diagnosis.
- In cases of wrong diagnosis resulting in stillbirth, no legal actions were taken.

"Everybody can make mistakes"

Decision making process

- Mothers report a lack of empathy and of consistent, non-contradictory information.
- Mothers feel left alone when they have to make decisions and they wish for support of partners and health professionals.

"You can't think, you feel paralyzed and helpless"

Birth process

- Staff was perceived as experienced, sensitive, caring, and able to adapt to individual needs.
- Hospitals foster the creation of lasting memories (e.g. symbolic actions, photographs).
- In some cases, the bodies of the babies got lost.

"we were encouraged to hold him in our arms, my parents and my family could join, we took pictures. It was beautiful in spite of all"

Postnatal and bereavement care

- Self-aid groups were very helpful supporting bereavement processes.
- Psychological and spiritual care was sought for, but mothers report a lack of available specialized counsellors.

"when my son makes a drawing of our family, he always draws two children"

Conclusion

- Parents are competent actors and should be supported (not hindered) in their coping.
- They need freedom of action and sensitive acceptance in their individual ways of managing the situation.
- Most psychological symbolic care is provided by volunteers and has to be compensated.
- Focus group discussion will have to elaborate models to improve quality of psychological and other care mainly in the decision making and in the bereavement process.

Literature: www.hslu.ch/IUHPE

Working together to clear the air in Rotorua: A collaborative success story

Background

Smokefree outdoor spaces (SFOS) policies de-normalise smoking and reduce second hand smoke.

Through a collaborative approach, Rotorua Lakes Council (RLC) has introduced one of the most comprehensive SFOS policies in NZ.

Public Support

There was strong public support for SFOS, and many organisatons were voluntarily introducing smokefree areas.

Intervention

RLC's SFOS policy was extended to include the majority of council owned public spaces and council funded events.

Implementation

As an educational policy, compliance is not enforced by council. Good signage and communication are used to encourage behaviour change with public support.

Evaluation

Evaluation showed 97% compliance in areas surveyed.

View the policy at:
rotorualakescouncil.nz/smokefreepolicy

Learnings

Multi-agency collaboration is an effective way to bring about local government policy change. Effective and early communication is important and needs to be ongoing. Encouraging smokefree outdoor areas in bars is harder than restaurants.

ROTORUA LAKES COUNCIL Te Kaunihera o ngā Roto o Rotorua · TOI TE ORA PUBLIC HEALTH · LAKES DISTRICT HEALTH BOARD · TIPU ORA · healthy families Rotorua · Cancer Society · Heart Foundation