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CLINICAL HEALTH PROMOTION

Research & Best Practice for patients, staff and community

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Editorial Office

WHO-CC, Clinical Health Promotion Centre
Bispebjerg / Frb University Hospital, Denmark

The Official Journal of

The International Network of Health Promoting Hospitals and Health Services

The South-eastern European Health Network

CLINICAL HEALTH PROMOTION

Aim

The overall aim of the journal is to support the work towards better health gain by an integration of Health Promotion into the organisational structure and culture of the hospitals and health services. This is done by significant improvement of a worldwide publication of clinical health promotion based on best evidence-based practice for patient, staff and community.

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Editorial

Implementation of health promotion in the clinical daily work

Hanne Tønnesen

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The health care services are continuously implementing new activities, terminating obsolete treatments, undergoing staff changes and organizational reconstructions. In spite of the relative high flexibility required in clinical life, the general "knowing-doing gap" also exists in the health services, including when it comes to patient-centered health promotion, i.e. clinical health promotion. Overall, it takes about a decade from establishment of solid evidence until it is implemented in daily life for the benefit of the individual patient and the society at large. This slow implementation has severe consequences and the unused potential for improvement is tremendous.

Barriers for implementation

Numerous barriers have been identified for implementation, involving all levels from policy-makers and managements to the staff and patients. Some barriers are related to the policy-makers not basing policies and strategies on the evidence (1) and others originate from the tops of organizations – especially low management skills and support (2) Important barriers are described as related to the staff, including missing competences in clinical health promotion as well as own healthy or unhealthy lifestyle (3). Another challenge is the often non-existing basic teaching and training in implementation, pre- or postgraduate for the clinical, public health service and administrative staff who is going to do the implementation in real life.

It may be a surprise for both staff, management and policy-makers that the patients often are positive to new interventions – especially when it comes to activities of health promotion, such as being offered smoking cessation intervention in relation to surgery (4-6). Actually, the patients could feel disappointed if not receiving this intervention (7).

Closing the knowing-doing gap

Easy-to-use Kit

In order to move from knowing to doing it is necessary to add an easy-to-use strategy. One of the newest is the step-by-step implementation kit described to support implementation of the WHO Surgical Check List all over the world (8). This list is to be used on the operation theatre as part of an improved patient safety effort, and it has already been implemented in many hospitals (Table 1).

The kit describes a basic management process translated for individual use by the individual surgeon and others, who want to make evidence-based and interdisciplinary tools and guidelines work in real life. It includes a detailed description of each step (9). The process has three phases that start with the preparation, then enter the implementation, and finally nail the implementation with the maintenance phase. Altogether the three phases include a serial of steps. Some of the steps are easy to recognize, because they are well-known elements in the usual daily life.

The line, box and the circle

Another kit to follow-up on the implementation process is actually used to follow the process of change. It is available for download free of charge. The three tools can be applied on oneself for reflection on personal barriers, ambivalence and decision-making, as well as for following the successes and challenges (10).

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Editorial

WHO-HPH Standard recognition process

A new promising way to faster implementation of health promotion standards in hospital departments (11) seems to be described in the new model on the international multi-centre recognition project (12). This model includes a common workshop with teaching and training followed by baseline measurements and description of a quality plan with priorities based on the baseline results. After about 1 year of implementation a new status is collected to be followed up by a site visit, as included in the present issue of this journal.

In general, more teaching and training in implementation on all levels is necessary to use the large potential for implementation for the benefit of the patients, the staff, organization and policy-makers.

Table on the steps related to implementation (8)

Preparation	
	Get familiar with the tools
	Visit others, learn and network
	Inform and train colleagues to create experts
	Start using it yourself, talk broadly about evidence and experiences
Implementation	
	Get interested and supportive colleagues on board to engine the implementation
	Do not spend time on the resistance
	Get endorsement from senior management
	Adjust the tool for your local conditions
	Start small and then grow
Maintenance	
	Follow the compliance to give feed-back and compare
	Identify good stories where an error has been avoided because of the tool
	Celebrate and reward successes
	Update the management and colleagues at the hospital on progress
	Keep up the good work; your lesson learned are essential to others
	Collect best practice and make guidelines

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Review: Web-based brief interventions for young adolescent alcohol and drug abusers - a systematic review

Hanne Tønnesen[1], Henriettae Ståhlbrandt[2], Bolette Pedersen[1]

Abstract

Background Adolescents' use of alcohol, cannabis and other psychoactive substances has significantly increased in European countries. Parallel to this web-based screening and brief intervention have been disseminated. An important question is if it is based on evidence for effect? Therefore, the aim of this review is to evaluate the evidence for effect.

Method A systematic literature search was performed on randomised trials in the following databases: MEDLINE, the Cochrane Central Register of Controlled Trials (CENTRAL) and EMBASE – supplemented by hand search. The target group of young adolescents was defined as 16 to 18 years old.

Results Overall, 35 papers were identified as randomised trials on web-based screening and/or intervention concerning alcohol and drug among young people; however the only identifiable randomised trial to evaluate the young adolescents was a published protocol describing an ongoing study.

Conclusion Young adolescents might benefit from web-based screening and brief intervention on alcohol and drugs; however an effects remains to be established in high quality studies.

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Introduction

Adolescents' use of alcohol, cigarettes, cannabis and other psychoactive substances has significantly increased in European countries since the 1990s (1). The use of alcohol, cannabis, or both, can have severe consequences for adolescents and young people in different domains, including health problems, intentional injuries, traffic violation, early sexual activity, sexual and/or physical abuse (2). Early onset of alcohol use is also a major risk factor for later alcohol dependence or alcohol use disorder (3-5). Similar to alcohol, cannabis consumption in adolescence can also affect the brain development and have long-lasting behavioural consequences that involve dependence. Other health issues are chronic bronchitis and related histopathological changes, impairments of attention and memory as well as dependence (6). Cannabis use is associated with later depression, increased likelihood for psychosis development and might lead to the use of more harmful drugs in vulnerable subjects (7;8). Finally, the combined use of psychoactive substances holds specific dangers, such as an increased severity of effects and heightened toxicity, depending on certain characteristics of the user like existence of tolerance, the route of administration and the quantity and purity of drugs (1).

One especially well-established approach in the field of hazardous alcohol consumption are brief interventions. Internationally, there is a large body of research on brief intervention approaches in alcohol-abusing adults (9;10). While positive research results on brief interventions in heavy drinking adults are abundant, research focusing on brief interventions for adolescents with alcohol or other drug problems has been scarce. This is surprising given the fact that such studies have been called for since the mid nineties (11). But in the last few years, the body of evidence in this area has increased (12-14); although these findings are limited by small sample sizes.

Interestingly, the web-based models of brief intervention for young poly-drug users have been widely disseminated; especially targeting the young adolescents consuming alcohol and cannabis. The question that still remains is if these models are supported by evidence for the young adolescents between 16-18 years of age? The aim of this systematic review

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was therefore to assess the effect of web-based brief intervention for this group of drug and alcohol abusers in randomised designs.

Method

Search methods

The literature search was performed in the following databases: MEDLINE, the Cochrane Central Register of Controlled Trials (CENTRAL) and EMBASE. The search strategy included adolescent* OR young OR teenag* OR child* OR high school OR freshmen AND Alc* OR Beer OR Wine OR Spir* OR Liq* OR Breezer* OR ethanol OR Drug* OR narco* OR medic* OR Cannabis Or Extacy OR amphetamin* OR heroin* OR morphin* OR Opiat* OR hallucinog* OR Cocain* OR Substance*OR Abus* OR misus* OR depend* OR addict* OR intox* OR ebrie*AND Web* OR online OR Computer-based OR inter-active AND Brief Intervention OR Motivational interview* OR Stages of change OR Changing process AND Outcome* OR Effect* OR Follow-up OR Withdrawal OR Abstinence OR Reduct*. The last updated search was performed 28 Nov 2013. No time or language restrictions were set.

Full paper articles, abstracts as well as study protocol were considered. Titles and abstracts were screened to exclude any clearly irrelevant papers as well as duplicate papers. All potentially relevant papers, abstracts and protocols were assessed in accordance with the inclusion and exclusion criteria. Also reference lists and related articles from the included papers were hand-search to identify other relevant studies.

Inclusion/Exclusion

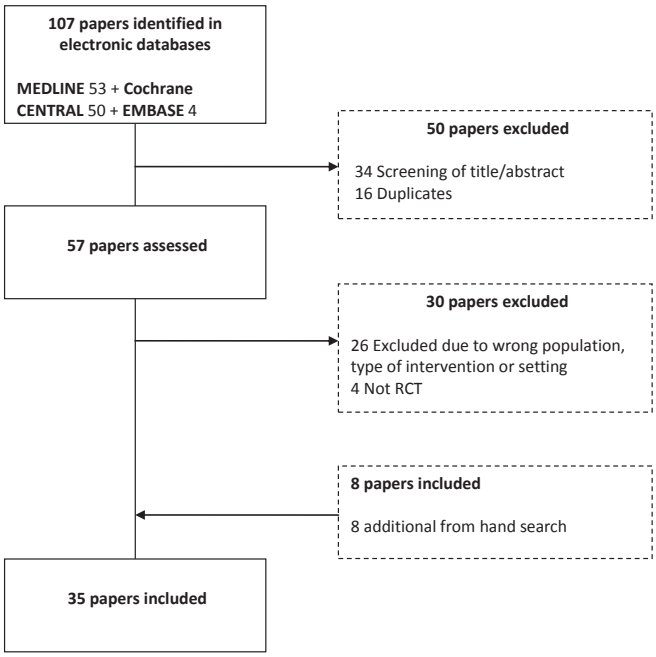
Only randomised clinical trials (RCTs) were included. The target group was the young adolescents aging 16-18 years Studies including young or adolescent drug users/abusers and alcohol abusers were considered. Non-randomised trials, reviews and other types of secondary literature were excluded. Other exclusion criteria were wrong population (e.g. adults), type of intervention (e.g. smoking cessation) or setting (e.g. not web-based). Studies were included if they provided data on the population and age, description of the web-based alcohol and/or drug intervention and comparator(s) and adequately reported alcohol/drug outcomes at follow-up. Interventions of interest were web-based brief alcohol and/or drug interventions focusing on moderation or cessation of their problematic substance use. Comparators could be screening or assessment only or other types of interventions (e.g. leaflets, in-person brief interventions).

Results

Search outcome

The database search resulted in 107 papers of which 16 were duplicates. Fifty papers were excluded after screening of titles and abstracts, while another 8 papers were included after hand search. A total of 57 full article papers were assessed according to the inclusion and exclusion criteria (see trial profile in figure 1). A total of 35 papers were included in the review (15-49).

Figure 1 Trial profile



Study characteristics

Characteristics of the 35 RCTs are presented in table 1 (Appendix). The majority of the studies originated from the United States (n=24). The remaining were from New Zealand (n=4), the Netherlands (n=3), Sweden (n=2), United Kingdom (n=1) or multiple countries (n=1). The trials were published from 2004 to 2013. The 35 studies had a total of 21,433 participants (ranging from 17 to 5,227). Most studies were conducted among college or university students. The age range was from 14 to 29 years, and only one paper (a protocol) matched our specific criteria regarding the target group at 16-18 years of age (15). Four study protocols were included; three concerning web-based alcohol interventions (24;45;46) and one poly-drug intervention programme (15). Among the 31 full papers articles, one trial focused on marijuana use exclusively (30) and the remaining were web-based brief alcohol interventions. The most common comparator was assessment/screening only. Follow-up was conducted after 4 weeks (n=16), 6 weeks (n=1), 2 months (n=4),

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3 months (n=10), 5 months (n=2), 6 months (n=11), 12 months (n=5), 18 months (n=1) and 24 months (n=1). In 23 trials the patients were compensated for participation in terms of money, vouchers, course credit or entry to a lottery.

Alcohol and drug outcomes

Eight trials found no effect of the interventions on alcohol outcomes (16-19;33;34;44;47). The remaining trials found significant reductions in alcohol intake or alcohol-related consequences, but in some the effect was limited to specific subgroups (21;38;41) or secondary outcomes (39:40). Finally, the effect of web-based personalised feedback on marijuana use was only significant for the selected group having a family history of drug problems (30).

Discussion

Evidence for the effect on alcohol and drug outcomes following brief interventions was mixed, and none of the included studies specifically assessed the effect among the 16-18 year olds, except for one ongoing trial targeting poly-drug use among teenagers (15). This project WISEteens ("Web-based Screening and Brief Intervention for Substance using Teens") aims at reducing these risks by creating and evaluating a web-based brief intervention (web-BI) that will motivate adolescents with risky consumption patterns to moderate or cease their problematic substance use, and to seek referral to treatment if necessary.

Also, since most of the studies were conducted among older college or university students, generalisation of the effect to adolescents is not straightforward. The major methodological problem in all the web-based studies was that the alcohol and drug outcomes were self-reported without further validation. This may have damaged the validity of the results, especially since underreporting of alcohol and drug use is common in general, and increasing with higher consumption (50). Thus, the underreporting may not influence the intervention and control groups similarly. Validation may be improved by attendance or follow-up visits that allow for the use of biochemical validation, the risk of course being a lower follow-up rate due to extra time spent and unwillingness to for example provide blood or urine tests.

The effectiveness of internet-based psychotherapeutic interventions in general was most recently examined in a meta-analysis by Barak and colleagues (51). The authors included 92 studies involving 9,764 clients treated for a variety of problems, and reported an overall medium effect size. For substance use problems, literature on web-based interventions is only just evolving. Copeland & Martin found signs of effectiveness of web-based interventions in this specific area (52). In a more recent investigation, only one of 10 studies matched inclusion criteria and could not prove efficacy, although the authors found that web-based interventions were generally well received (53). In contrast to this, another review that included 17 studies focused on internet- and computer-based interventions for college drinking, found promising results for web-based approaches to substance consumption reduction (54).

Computer-based intervention seems attractive for young people, because screening and brief intervention in health care are often limited by constrained resources. A qualitative study identified several barriers that complicate screening for young people's problematic substance use in primary care: insufficient time, lack of training in how to manage a positive screen, insufficient time to manage a positive result during the visit, lack of treatment resources and tenacious parents who would not leave the room for a confidential discussion (55). Adolescents report concerns regarding confidentiality, lack of information about services, unsuitable appointments and opening times, unfriendly environment and staff, difficult access due to geographical barriers, language barriers and difficulties to obtain parental consent (56). In a European study, factors were identified that lowered adolescents` access to primary care: older age (than aged 8-11), lower level of parental education, and lower socioeconomic status (57). Due to these barriers to health care for adolescents or vulnerable subgroups of adolescents, alternative and low-threshold ways of delivering screening and brief intervention could be attractive. However, this review has shown that evidence has to be established on the effect for young adolescents with alcohol and drug abuse through high quality studies with sufficient validation of the outcomes.

In conclusion, young adolescents might benefit from internet-based screening and brief intervention on alcohol and drugs; however, randomised trials have not yet been performed for this important group.

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Contributions details

HT and HS designed the study, HT and BP performed the research, collected and analyzed data, HT and BP wrote the paper, and HT, HS and BP edited the paper.

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The deadline for submitting nomination to the HPH Awards has been postponed to February 16th, 2014

As decided by the HPH General Assembly and HPH Governance Board, the HPH awards will again be handed out at this year's HPH Conference. The purpose of the HPH awards is to promote HPH visibility, recognize extraordinary fulfilment of WHO standards, recognize extraordinary fulfilment of strategic goals and improve the number of published scientific articles.

The HPH awards are given in three categories:

International HPH Award - Outstanding Fulfilment of WHO HPH Standards
(NB: Only Hospital/HS members eligible for nomination in this category)

International HPH Award - Outstanding Fulfilment of HPH Strategy
(NB: Only Nat/Reg HPH Networks eligible for nomination in this category)

International HPH Award - Outstanding Scientific Publication
(NB: Only an author/group of authors eligible for nomination in this category)

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Walter Grassmann, Hartmut Berger & Oliver Christ


Last year's winners in Gothenburg, Sweden.

Appendix: **Table 1** (1 of 3) Characteristics of 35 web-based alcohol and/or drug interventions in RCT designs

Study	Population age (mean / range)	Web-based Intervention	Comparator(s)	F-U rates (months)	Compensation	Alcohol/Drug Outcomes (significant results)
1) Arnaud et al. 2012 PROTOCOL (4 EU countries)	800 adolescents, 16-18 y	Motivational Alcohol and Drug Feedback	Assessment only	3 m	Lottery to win IT equipment	Plan to compare frequency and quantity, consumption per occasion
2) Barnett et al. 2007 (USA)	225 college students, 18.8 y	Alcohol 101 session	Brief Intervention	3 m: 95% 12 m: 95%	Max $95	No effect on alcohol problems
3) Bendtsen et al. 2012 (Sweden)	5,227 university freshmen, unknown age	Routine practice assessment	Assessment only Feedback only	2 m: 45%	Lottery to win cinema tickets	No differences between the groups on alcohol parameters
4) Bersamin et al. 2007 (USA)	622 college freshmen, 18 y (18-20)	College Alc	Assessment only	3 m: 59%	Max $100	Reduction in heavy drinking, drunkenness and alcohol-related consequences
5) Bewick et al. 2008 (UK)	506 university students, 21.29 y	Feedback on alcohol	Assessment only	3 m: 63%	Printer credit values (max. £225)	No effect on units of alcohol/week or for CAGE scores
6) Butler & Correia 2009 (USA)	84 college students, approx 20 y	Single session alcohol intervention	Face-to-face intervention Assessment only	1 m: 100%	Credit + raffle for a $50 prize	No differences in recidivism between groups
7) Carey et al. 2009 (USA)	198 college students, 19.2 y	Alcohol 101 plus	Brief intervention	1 m: 96% 6 m: 72% 12 m: 70%	Monetary compensation	The intervention reduced quantity and frequency
8) Croom et al. 2009 (USA)	3,216 college students, 17-19 y	AlcoholEdu course	Knowledge test Postcourse survey	1 m: 56%	Lottery to win tickets	Alcohol-related harm was not lower in the intervention group, except for playing drinking games
9) Doumas & Hannah 2008 (USA)	124 from a workplace, 18-24 y	Check Your Drinking	Assessment only	1 m: 63%	Movie tickets or monetary compensation	Lower levels of drinking in the intervention group
10) Doumas et al. 2009 (USA)	135 college students, 19 y (18-24)	Normative feedback on drinking	None	1 m: 88%	None stated	Lower weekly drinking quantity, peak intake, and intoxication in the intervention group
11) Elgán et al. 2012 PROTOCOL (Sweden)	183 adolescents, 15-19 y	web-ICAIP	Access to support groups (TAU)	2 m: - 6 m: -	None stated	Plan to compare frequency and quantity
12) Hendershot et al. 2010 (USA)	200 college students, 20.2 y	Genetic alcohol feedback	Attention-control feedback	1 m: 90%	None stated	Significant reductions in drinking frequency and quantity
13) Kypri et al. 2004 (New Zealand)	167 university students, 17-26 y	Normative feedback on alcohol	Leaflet only	6 w: 80% 6 m: 70%	Lunch voucher (NZ $4.95)	The intervention reduced hazardous drinking
14) Kypri et al. 2008 (New Zealand)	576 university students, 17-29 y	Personalised alcohol feedback	Leaflet only	6 m: 84 % 12 m: 82 %	Lunch voucher (NZ $4.95)	The intervention reduced hazardous drinking, and the effect lasted 12 months
15) Kypri et al. 2009 (New Zealand)	2,435 undergraduates, 17-24 y	Motivational alcohol feedback	Screening only	1 m: 78 % 6 m: 65%	Chance to win gift vouchers (NZ $40)	Screening and intervention reduced drinking in undergraduates
16) Kypri et al. 2013 (New Zealand)	17 university students, 17-24 y	Personalised feedback	Screening only	5 m: 79%	Chance to win a NZ $500 price	Web-based screening and brief intervention reduced hazardous and harmful drinking
17) Lee et al. 2010 (USA)	341 college students, 17-19 y	Personalised feedback on marijuana use	Assessment only	3 m: 95% 6 m: 94%	Max $105	Intervention effected only those with a family history of drug problems

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Appendix: **Table 1** (2 of 3) Characteristics of 35 web-based alcohol and/or drug interventions in RCT designs

Study	Population age (mean / range)	Web-based Intervention	Comparator(s)	F-U rates (months)	Compensation	Alcohol/Drug Outcomes (significant results)
18) Lewis and Neighbors 2007 (USA)	316 freshmen university students, 18,53 y	Normative alc feedback (gender specific or neutral)	Assessment only	1 m: 89%	Max $150	Results showed efficacy of the computer delivered intervention
19) Lewis et al. 2007 (USA)	85 university students, 20.1 y	Freshmen-specific personalised feedback	Assessment only	3 m: 94% 5 m: 85%	None stated	Reduced perceptions of typical freshmen drinking behaviour and personal drinking behaviour
20) Maio et al. 2005 (USA)	329 injury patients, 14-18 y	Program on alcohol misuse	Assessment only	3 m: 91% 12 m: 86%	Max $50	No effect on alcohol misuse
21) Moore et al. 2005 (USA)	116 college students, 18-25 y	Binge drinking prevention	Postal leaflet only	1 m: 81/68 %	Course credit + max $10	No differences on outcome measures
22) Murphy et al. 2010 (USA)	74 from student health centre, 21.2 y + 133 freshmen, 18,.3 y	BASICS BASICS + Check Up to Go	Alcohol 101 Plus Assessment only	1 m: 97/91/89 84/93%	Max $25	Effect on typical weekly and heavy drinking compared to assessment only
23) Neighbors et al. 2004 (USA)	252 university students, 18.5 y	Normative feedback on drinking norms	Assessment only	3 m: 79% 6 m: 82%	Course credit + max $40	Effect on changing perceived norms and alcohol consumption
24) Neighbors et al. 2006 (USA)	214 university students, 19.7 y	Normative feedback	Assessment only	2 m: 86%	None stated	Effect on drinks per week
25) Neighbors et al. 2009 (USA)	295 college students, 21 y	Personalised feedback before 21st birthday	Assessment only	1 w: 96%	None stated	Drinking intentions moderated the effect; effective in those intending drinking to intoxication
26) Neighbors et al. 2010 (USA)	818 freshmen students, 18.7 y	Gender-specific versus gender-nonspecific normative feedback	Attention control only	6 m: 92% 12 m: 87% 18 m: 84% 24 m: 81%	Max $135	Modest effects on weekly drinking and alcohol-related problems but not on heavy episodic drinking
27) Neighbors et al. 2012 (USA)	599 college students, 21 y	BASICS interventions (web/friend/in-person)	Attention control only	1 w: 91%	Max $80	Web-based interventions varied by drinking outcome and whether a friend was included
28) Palfai et al. 2011 (USA)	119 university students, 18.6 y	Alcohol feedback + Motivational assessment	Alcohol feedback Motivational assessment Screening only	1 m: Unknown	None stated	Lower alcohol use and heavy drinking episodes for those with most alc consequences
29) Paschall et al. 2011 (USA)	200 first year students > 18 y	College Alc	Assessment	1 m: 56/63 %	$10	A beneficial short-term effect on hazardous drinking behaviour
30) Saitz et al. 2007 (USA)	408 college students, > 18 y	Individualised minimal brief intervention	Extensive individual brief intervention	1 m: 75%	$50 gift certificate	Unhealthy alcohol use decreased after brief intervention
31) Spijkerman et al. 2010 (Netherlands)	575 adolescents, 15-20 y	Brief intervention + normative feedback	Brief intervention Assessment only	1 m: 56% 3 m: 48%	None stated	No effect was found for alcohol use or moderate drinking
32) Voogt et al. 2011 PROTOCOL (NetherLands)	908 college students, 18-24 y	What Do You Drink (WDYD) brief intervention	Assessment only	1 m: - 6 m: -	None stated	Plan to compare weekly consumption, binge drinking

Appendix: **Table 1** (3 of 3) Characteristics of 35 web-based alcohol and/or drug interventions in RCT designs

Study	Population age (mean / range)	Web-based Intervention	Comparator(s)	F-U rates (months)	Compensation	Alcohol/Drug Outcomes (significant results)
33) Voogt et al. 2012 PROTOCOL (Netherlands)	750 low-educated adolescents, 15-20 y	What Do You Drink (WDYD) brief intervention	Assessment only	1 m: 6 m:	None stated	Plan to compare weekly consumption, binge drinking
34) Walters et al. 2009 (USA)	279 university students, 19,8 y	Personalised feedback	Motivational interview +/- feedback Assessment only	3 m: 90% 6 m: 86%	Course credit	Personalised feedback did not reduce drinking outcomes
35) Weitzel et al. 2007 (USA)	40 college students, 19.2 y	Daily messaging on alcohol-related consequences	No messaging	2 w: 100%	None stated	A small but positive effect on alcohol-related attitudes and behaviours

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Self-Efficacy, Outcome Expectation and Health-Promotion Practice among Nigerian Physiotherapists

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Abstract

Background Health-promotion (HP) practice among African physiotherapists has not previously been assessed despite the central role that physiotherapists play in HP. This survey therefore explored HP practice, self-efficacy and outcome expectation (OE) among Nigerian physiotherapists, regarding arthritis and low-back pain (LBP), nutrition and overweight, physical fitness and activity (PF-PA), and heart disease (HD) and stroke.

Methods This survey involved 110 physiotherapists from 12 randomly selected tertiary hospitals across Nigeria. Information on demographics, practice characteristics, HP practice, self-efficacy and OE from HP was collected using a pilot-tested questionnaire.

Results The physiotherapists reported that during the last month, half of the cases they had assisted in concerned arthritis and LBP, PF-PA, and HD and stroke. The number of cases concerning nutrition and overweight issues was somewhat lower. However, they only listened to, educated, developed and set goals for, and referred patients to HP in less than half of the cases for all health areas. Significant associations were found between time spent listening to patients, and self-efficacy ($r=0.27$; $p=0.004$) and OE ($r=0.20$; $p=0.03$) in HD and stroke cases, as well as for self-efficacy and OE in cases concerning nutrition and overweight ($r=0.20$; $p=0.02$), PF-PA ($r=0.77$; $p<0.001$), arthritis and LBP ($r=0.58$; $p<0.001$) and HD and stroke ($r=0.71$; $p<0.001$).

Conclusion There are needs to improve self-efficacy and OE regarding HP practice among Nigerian physiotherapists when handling patients with multiple health issues.

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Introduction

Health is a dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility (1). Health promotion (HP) is the process of enabling individuals and communities to increase their own control over the determinants of health, and thereby improve their health and quality of life (2;3). The physical dimensions of health comprise nutrition and bodyweight, disease and injury, exercise, rest and relaxation, stress, sports and fitness, and recreation, which are areas usually addressed during a physiotherapy consultation (4). A combination of different approaches to HP programmes is now becoming the norm (5).

Despite the central role which physiotherapists play in HP, reports on the practice of HP among African physiotherapists are sparse. This is also the case in Nigeria even though guidelines for physiotherapists' education and practice emphasize HP. This emphasis is in a bid to strengthen physiotherapists' professional role in prevention, diagnosis, and treatment of physical and functional disabilities for patients and communities (6). Indeed, an important part of physiotherapists' practice is to help individuals prevent diseases and promote health, wellness and fitness (7), which suggests that physiotherapists should be involved in primary, secondary, and tertiary care. This was demonstrated in the inclusion of American Physical Therapy Association in the Healthy People Consortium that assisted in creating the Healthy People 2010 goals for disability and its secondary psychosocial problems, nutrition and overweight, physical fitness and activity (PF-PA), tobacco use, arthritis, osteoporosis, and chronic low-back pain (LBP), heart disease (HD) and stroke among others (8). For the purpose of this study, four of these health areas were explored; LBP and arthritis, nutrition and overweight, PF-PA, and HD and stroke,

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which are all common problems related to physiotherapy in Nigeria.

Social cognitive theory (SCT) refers to a psychological model of behaviour that emphasizes acquisition of social behaviours and learning through observation (9). SCT describes a multifaceted causal structure in which self-efficacy beliefs operate with outcome expectation (OE) in the regulation of human motivation (10). The theory has been applied broadly to areas such as career choice, organizational behaviour and motivation (11-13). In SCT, a person's on-going functioning is a product of a continuous interaction between cognitive, behavioural and contextual factors. In addition, learning and the demonstration of what has been learnt are distinct processes (14). This suggests that an individual may have acquired knowledge in an area of practice but may not be able or willing to apply it. This could be due to low self-efficacy in the skills and expertise required, or to perceived negative OE from the application of the knowledge. For example in school nurses' practice to prevent childhood obesity, perceived barriers was found to partially mediate the influence of self-efficacy (15). Thus, the SCT model can provide an understanding of the of HP practices among physiotherapists, and for developing strategies to manage any possible barriers.

According to Bandura (16), self-efficacy is the confidence in being able to make the behaviour changes necessary to reach a desired goal. It influences the likelihood of a behaviour being initiated and sustained despite poor outcomes (17). For instance, a physiotherapist with high self-efficacy in prescribing exercises for osteoarthritis or low-back pain may be more consistent in making the prescription. Contrary, low self-efficacy due to lack of confidence or preparation may lead to withdrawal from the practice (17). Poor self-efficacy has been found to be a common barrier to adherence to practice guidelines among physicians (17). OE is the extent to which a health professional believes that a particular task or behaviour change will result in a specific outcome (16). For example, many smokers are not counselled to quit during a physician visit (18) despite the fact that most physicians agree with the recommendation to provide smoking cessation counselling (19;20). An important reason for this non-adherence is a belief that the intervention will not have an effect (21). This negative OE may hinder health professionals in following the recommended practice even when self-efficacy is high.

The aim of this study was therefore to explore HP practice, self-efficacy and OE among Nigerian physiotherapists in addressing arthritis and LBP, nutrition and overweight, PF-PA, and HD and stroke.

Methods

Design and Participants

This cross-sectional survey involved 110 physiotherapists out of about 200 clinical physiotherapists who had practised for at least two years in 12 randomly selected Nigerian federal teaching hospitals across the six geographical zones of the country. The hospitals were selected out of a total of 20 federal teaching hospitals using a proportionate stratified random sampling method. All the participants gave informed consent to participate in the study.

The Yaro Yamane formula (22) was used for estimating the sample size for the study (0.05 level of significance). This resulted in a total of 133 participants, so unfortunately the study fell short in reaching the required sample size.

Procedures

An adapted questionnaire originally developed by Rea et al (23) was used in this study. Initially, the questionnaire was pilot-tested among 10 Nigerian physiotherapists, who gave feedback regarding ease of understanding and answering the items in the questionnaire, and their suitability for the Nigerian setting. A second administration of the same questionnaire was carried out to ascertain the consistency of the questionnaire sum scores. A total of 150 questionnaires were sent out to physiotherapists in the selected hospitals through identified contacts, who were also physiotherapists in the hospitals. A cover letter was included explaining the purpose, procedures, risks and benefits, and the voluntary nature of involvement in the study. The questionnaires were also accompanied with addressed and stamped envelopes to facilitate the return of the questionnaires. Out of the 150 questionnaires, 110 were returned (73% response rate).

The questionnaire included four sections: demographic and practice characteristics, HP practice, self-efficacy for HP and OE from HP. The questionnaire was adapted to the four health areas (nutrition and overweight, PF-PA, arthritis and LBP and HD and stroke) examined in this study. The demographic and practice details included age, sex, qualifications, area of interest and years of practice.

The Ethics Committee of the Nnamdi Azikiwe University Teaching hospital Nnewi approved the procedures employed in this study.

HP Practice

The HP practice section encompassed the percentage of patients that, in the last month, had a particular problem (e.g. what percentage of your patients do you asses

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to have low PF-PA?), percentages of time the patient with such a problem was assisted (e.g. what percentage of time do you assist patients with low PF-PA to get more physically active?), listened to (e.g what percentage of time do you listen to patients with low PF-PA?), referred (e.g what percentage of time do you refer patients with low PF-PA to appropriate experts?), educated (e.g what percentage of time do you educate patient with low PF-PA on being physically active?), and goals were developed and set for them (e.g what percentage of time do you develop and set goals for patients with low PF-PA?).

Self-Efficacy

The self-efficacy section covered 12 items including the level of confidence the physiotherapist had in assisting the patient: 1) when the patient was aware of the problem, 2) when the spouse or partner was not supportive of the patient, 3) when more time was allotted per patient than currently available, 4) when the physiotherapist was adequately educated to address the problem, 5) when the physiotherapist had observed another colleague helping the patient for the problem, 6) when the physiotherapist did not have the support of the referring clinician, 7) when the physiotherapist had the proper supportive materials to assist the patient, 8) when the problem interfered with a physiotherapy goal, 9) when the patient was already seeing a professional for the problem, 10) when the physiotherapist had an appropriate source to refer the patient to for assistance, 11) when the patient had low socioeconomic status and 12) when there was a language barrier. The self-efficacy score was measured on a four-point-likert scale with the highest score indicating that the physiotherapist was very sure he or she could assist. Self-efficacy items that were inherently negative such as “when partner/family is not supportive” were conversely coded.

Outcome Expectation

The OE section included four items. These items were likely perceived outcomes of intervention that might influence the extent to which the physiotherapist would be ready to assist the patient for HP: 1) the patient develops more positive feelings and increased satisfaction with life, 2) the patient is able to address and achieve physiotherapy goals more readily, 3) the physiotherapist feels he addresses an issue that is beyond the normal scope of practice 4) the patient’s rapport with the physiotherapist is weakened or hindered. The OE score was measured on a five-point-likert scale with the higher score indicating a good outcome and the lower score indicating a bad outcome. Scores for negative outcomes such as “patient rapport is hindered/weakened” were conversely coded to indicate a higher sum as a positive or “good” outcome.

Statistical Analysis

The data were summarized using mean and standard deviation (SD) or frequency and proportion. The percentage scores for self-efficacy and OE were measured on the total item scores contra the total score by the maximum obtainable score for each. Relationships between each of the components of HP practice in the four health areas, and each of self-efficacy and OE scores, were tested using the Spearman-rank order correlation. Similarly, relationships between self-efficacy and corresponding OE were tested using the Spearman-rank order correlation. A p-value < 0.05 was considered significant. All analyses were carried out in SPSS version 20.

Results

Table 1 shows the characteristics of the 110 physiotherapists included in the study. The mean age was 34.9 years (SD±6.47years). About half of the physiotherapists (53%) had practised for less than 10 years. 53% of the physiotherapists were men and had interest in orthopaedic conditions (38%). A vast majority had the basic degree (84%).

Table 2 shows the mean percentage of the different health problems which the patients who the physiotherapists had seen in the last month were referred with; nutrition and overweight (32.6±21.9%), PF-PA (59.5±23.6%), arthritis and LBP (56.7±21.8%), and HD

Table 1 Demographic and Practice Characteristics of Participants

Age (Mean ± SD)		34.90 ± 6.47	
Sex		**n**	**%**
	Men	59	53.6
	Women	51	46.4
Years of Practice (Mode)		2	
Years of Practice		**n**	**%**
	<10	58	52.7
	≥10	46	41.8
	Missing Data	6	5.5
Qualification		**n**	**%**
	Basic Degree	92	83.6
	Higher Degree	13	11.8
	Missing Data	5	4.5
Area of Interest		**n**	**%**
	Paediatrics	13	11.8
	Orthopaedics	42	33.2
	Neurology	14	12.7
	General Practice	26	23.6
	Missing Data	15	13.6

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Table 2 Mean percentage of patients seen by the physiotherapists in the four health areas

Health Areas	Mean	±	SD
Nutrition/Overweight			
% of time the patient was assisted	39.38	±	26.42
% of time the patient was listened to	43.87	±	26.39
% of time the patient was educated	41.38	±	28.17
% of time goals were developed and set	33.74	±	26.04
% of time the patient was referred	27.30	±	27.11
Physical Fitness/Activity			
% of time the patient was assisted	58.33	±	25.15
% of time the patient was listened to	43.44	±	25.91
% of time the patient was educated	45.57	±	24.60
% of time goals were developed and set	38.58	±	25.97
% of time the patient was referred	18.66	±	21.61
Arthritis/Low-Back Pain			
% of time the patient was assisted	65.94	±	24.30
% of time the patient was listened to	46.26	±	27.80
% of time the patient was educated	48.65	±	29.47
% of time goals were developed and set	47.10	±	29.02
% of time the patient was referred	20.42	±	23.05
Heart Disease/Stroke			
% of time the patient was assisted	61.86	±	27.86
% of time the patient was listened to	46.77	±	28.43
% of time the patient was educated	46.78	±	27.25
% of time goals were developed and set	44.26	±	25.30
% of time the patient was referred	23.10	±	26.47

and stroke (41.5±25.9%). The physiotherapists reported that they had assisted the patients in more than 50% of the cases for all health areas except for nutrition and overweight (39.4±26.4%). However, the proportion of times the physiotherapist listened to, educated, developed or set goals for and referred patients when assisting them was below 50% in all the areas (Table 2).

Table 3 shows that the physiotherapists' self-efficacy and OE were about 70% for all health areas. Significant relationships were only found between the percentage of time the patient was listened to on HD and stroke issues, and self-efficacy (r=0.27; p=0.004) and OE (r=0.20; p=0.03) scores in assisting the patient in such issues (Table 4). Significant relationships were also found between self-efficacy and corresponding OE in cases concerning nutrition and overweight (r=0.20; p=0.02), PF-PA (r=0.77; p<0.001), arthritis and LBP (r=0.58; p<0.001) and HD and stroke (r=0.71; (p<0.001) (Table 5).

Table 3 Scores on self-efficacy and OE of physiotherapists in the four health areas

Characteristics	Mean	±	SD
Self-Efficacy (%)			
Nutrition/Overweight	71.36	±	9.22
Physical Fitness/Activity	70.13	±	14.57
Arthritis/Low-Back Pain	71.51	±	13.28
Heart Disease/Stroke	69.96	±	14.83
OE (%)			
Nutrition/Overweight	72.36	±	10.06
Physical Fitness/Activity	71.36	±	15.37
Arthritis/Low-Back Pain	72.50	±	13.37
Heart Disease/Stroke	71.32	±	15.69

After adjusting for area of interest and OE, years of practice was inversely correlated with only SE for nutrition and overweight (r= -0.22; p= 0.02) (Table 6). Although the relationship between year of practice and SE in the other health areas was not significant, they showed tendency towards inverse relationships (PF-PA: r= -0.08; arthritis and LBP: r= -0.10; HD and stroke: r= -0.09) (Table 6).

Discussion

This study examined the relationships between HP practice behaviour, self-efficacy and OE in patient cases concerning overweight and nutrition, PF-PA, arthritis and LBP, HD and stroke in a population of Nigerian physiotherapists. The physiotherapists assisted patients in the different health areas more than half of the times with the exception for issues regarding nutrition and overweight. However, the proportion of times the physiotherapists educated, listened to, developed and set goals for the patients, and referred patients in of the other areas was below 50%. The reported self-efficacy and OE scores on issues concerning all the health areas were about 70%. However, only the proportion of times the physiotherapist listened to the patient's issues concerning HD and stroke was significantly related to both self-efficacy and OE scores. Contrary, self-efficacy was significantly related with the corresponding OE for issues concerning all the health areas. Finally, the results showed an inverse relationship between self-efficacy for nutrition and overweight issues and years of practice.

Demographic and Practice Characteristics

The dearth of similar studies makes comparison of the findings in this study difficult. In this study the majority of the physiotherapists only had a basic degree. This could be explained by the fact that post-graduate studies in physiotherapy have only been offered in the last de-

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Table 4 Relationships between scores on percentage of time physiotherapists assisted in a problem and each of the scores on self-efficacy and OE

	NUT/OW		PF/PA		ART/LBP		HD/STR	
Self-Efficacy (%)	**r**	**(p-value)**	**r**	**(p-value)**	**r**	**(p-value)**	**r**	**(p-value)**
% of time the patient was assisted	-0.04	(0.36)	0.08	(0.22)	1.00	(-)	0.07	(0.24)
% of time the patient was listened to	0.15	(0.08)	0.14	(0.10)	0.14	(0.09)	0.27	(0.004)*
% of time the patient was educated	-0.03	(0.38)	0.10	(0.17)	-0.04	(0.36)	0.15	(0.08)
% of time goals were developed and set	0.02	(0.44)	0.15	(0.07)	-0.06	(0.28)	-0.01	(0.48)
% of time the patient was referred	-0.13	(0.10)	0.15	(0.08)	0.07	(0.25)	0.16	(0.06)
OE (%)								
% of time the patient was assisted	-0.09	(0.47)	0.07	(0.26)	0.06	(0.30)	0.09	(0.19)
% of time the patient was listened to	-0.01	(0.47)	0.12	(0.13)	0.10	(0.17)	0.20	(0.03)*
% of time the patient was educated	-0.15	(0.07)	0.04	(0.34)	0.10	(0.17)	0.16	(0.06)
% of time goals were developed and set	0.02	(0.44)	0.11	(0.14)	-0.08	(0.23)	0.03	(0.40)
% of time the patient was referred	-0.08	(0.22)	0.13	(0.11)	0.16	(0.07)	0.15	(0.08)

* p < 0,05

Table 5 Relationships between self-efficacy and OE of physio-therapists' on the four health areas

Focus Areas	**r**	**(p-value)**
Nutrition/Overweight	0.20	(0.02)*
Physical Fitness/Activity	0.77	(<0.001)**
Arthritis/Low-Back Pain	0.58	(<0.001)**
Heart Disease/Stroke	0.71	(<0.001)**

* p < 0.05, ** p < 0.001

Table 6 Relationships between Self-Efficacy and Year of Practice of the Physiotherapist

Focus Areas	**r**	**(p-value)**
Self-Efficacy for Nutrition/Overweight	-0.22	(0.02)*
Self-Efficacy for Physical Fitness/Activity	-0.08	(0.22)
Self-Efficacy for Arthritis/Low-Back Pain	-0.10	(0.17)
Self-Efficacy for Heart Disease/Stroke	-0.09	(0.20)

* p < 0,05

cade in Nigeria, although a current increase in the number of schools that are offering this education. In addition, the health area in which the physiotherapists in this study most often assisted patients was arthritis and LBP, which relates to orthopaedics being the most commonly practised specialty where physiotherapy is included in the treatment and prevention of arthritis and LBP.

Health Promotion Practice, Self-Efficacy and Outcome Expectation

The physiotherapists rarely assisted in referring patients in any of the health areas, probably because the practice of physiotherapy on a first-contact basis is not common in Nigeria (24). As the Nigerian physiotherapists depend largely on referrals from medical doctors from different areas of medical practice, the seldom second-contact referral practice, usually necessitated by the need for the patient to consult another professional, can explain the low proportion of referrals seen in this study.

Furthermore, as most of the health conditions managed by the physiotherapists are preventable, HP should constitute a large proportion of the physiotherapy practice. The findings that HP practice in all health areas was generally low during physiotherapy visits may have a negative impact on patient and population well-being and health in Nigeria. If HP practice is more fully integrated in physiotherapy management this may in turn help to reduce the cost and burden of treatment. The physiotherapists displayed reasonably high levels of self-efficacy and OE across all the four health areas, which was a positive finding of this study.

Relationships between HP Practice Behaviour, Self-Efficacy and Outcome Expectation

Contrary to the findings in this study, Rea et al (23) found significant relationships between assistance rates and self-efficacy in the same health areas in a population of American physiotherapists, but just as in our study no relationship was found between the assistance rate and OE within any of the health areas. These findings somewhat contradicts the social cognitive theory of Bandura (25), where high levels of self-efficacy and OE should enhance productive and aspiring behaviours that result in personal satisfaction and vice versa. Although, this study did not examine levels of satisfaction and aspiration among the physiotherapists, their productivity, examined in terms of their assistance rate, might be influenced by a number of factors. Firstly, the organization characteristics of the work setting such as the motivational and staff-friendly nature of the setting may influence self-efficacy and OE. For example, when

a physiotherapist has more patients to attend to than he or she can manage, a result may be a compromise in the standard of services delivered in terms of time spent with each patient and the accuracy of treatment. Secondly, despite that appropriate knowledge and attitudes are necessary for practice they are not all-sufficient (17). For example a physiotherapist may be confident about his HP practice skills, but may be influenced by external barriers such as time limitations that prevent him from adhering to professional practice guidelines. Under such circumstances even though initial levels of self-efficacy and OE are high, the persistence of these barriers may eventually reduce self-efficacy, OE and even motivation required to carry out the practice (17). Still, with adequate resources the physiotherapist may be able to compensate for possible external barriers. Thirdly, self-efficacy and OE may wane with more years of practice if continued education is not available to ensure adherence with the current standard practice. Although nutrition/overweight was the only area where a significant inverse relation between self-efficacy and years of practice was observed; there were tendencies for similar relationships in the other three areas.

Strengths and Limitations of the Study

The questionnaire used in this study had not been subjected to validity or reliability tests and this may have limited the findings in this study. However, the instrument was pilot-tested and verified to be applicable to Nigerian physiotherapists. The sample in this study was considered representative of the Nigerian physiotherapist as members from the six geographical zones of the country were involved. Further, the high response rate was adequate to detect actual HP practice. However, the number of participants involved in this study fell short of the estimated sample size, and this may limit the findings in this study. In addition, no causal inferences about self-efficacy, OE scores and HP practice can be made as this study was a cross-sectional design. Another limitation could be that the responses varied according to the physiotherapists' interests in a particular health area. Finally, there could be a risk of recall bias in terms of self-reported HP practice in the last month.

Conclusions and perspectives

Physiotherapy practice in Nigerian hospitals is characterised by patients with problems concerning PF-PA, and arthritis and LBP, and to a lesser extent nutrition and overweight, and HD and stroke. In all health areas except for nutrition and overweight the physiotherapists spent an adequate amount of time assisting the patients. However, little time was spent listening to, educating, developing and setting goals for, and referring patients in all the health areas and here is much room for improvement. Self-efficacy was directly related to OE in all the areas. Both self-efficacy and OE was very high in all the areas, and it is important that this is sustained. Future research should examine HP practice behaviour in relation to self-efficacy and OE.

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Contributions details

Conception and design: FA
Acquisition of data: AK, OO, NC
Analysis and interpretation of data: FA
Drafting the article: NC, FA
Revising the article critically for important intellectual content: AK,OO
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Female genital mutilation between culture and health: a quanti-qualitative study

Ilaria Simonelli[1], Alice Barbieri[2], Francesca Beraldo[3], Fabrizio Simonelli[4]

Abstract

Background There are multiple impacts of Female Genital Mutilation (FGM) on Health Care services in immigration countries, both culturally and regarding human rights violations. The understanding of social representations of FGM, and the development of strategies in which health care services play a crucial role, are fundamental to abandon FGM practices. The aim of this study was to investigate how different study populations (in particular immigrant women, Italian women and health professionals) perceive the social representations of FGM.

Methods a quanti-qualitative analysis, based on the comparison of questionnaires, and on the development of focus groups for the above mentioned study populations.

Results The social representations of FGM expressed by immigrant and Italian women presented several convergences, highlighting changes of immigrant-related attitudes for women who had lived in Italy for more than 5 years. Health care services are essential players in the pursuit of abandoning the practice.

Conclusion The convergences in the social representations of FGM represent an important and relatively quick cultural change in the attitude of immigrant women. Health care services, inspired by multidimensional models (therapeutic, preventive and salutogenic), cross-sectional activities (cultural integration), and models such as the Rights-based approach to health, represent a crucial asset for the abandonment of FGM.

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Introduction

Migration flow produces social and cultural changes affecting both the provenance and migration countries. Traditions, social conventions, mind settings and behaviors of communities are a reflection of cultural systems which can be individuated through representations of social phenomena, events and processes. Their comparison allows a better understanding of their framework through convergences and divergences.

Migration processes offer new social and cultural challenges and new opportunities for mutual understanding and the strengthening of human development. A perfect example of these dynamics is the issue of Female Genital Mutilations (FGM). When comparing the values of FGM within its traditional culture, it is difficult to accept the cultural reference system from which it emanates in respect of universal declaration of human rights, child and women protection. On December 20th 2012 the UN General Assembly approved the *Draft Resolution "Intensifying Global Efforts for the elimination of female genital mutilation,"* hereby expressing a clear and definitive condemnation of harmful practices carried out on girls and children with particular reference to FGM, supporting all the necessary legislative measures to protect women and children from all forms of violence. The social and cultural impact of the above-mentioned declaration, concerns countries where FGM is performed, as well as countries receiving immigrants subjected to FGM.

The practices of FGM imply different issues, both for health care services and health care providers, concerning physical, psychological, relational and sexual issues, together with human rights affirmation. (1-4).

In order to abandon damaging and risky traditional practices like FGM, a multisectorial approach that combines cultural and health care actions is fundamental.

From a cultural standpoint, this issue can

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be addressed through the re-modeling of social representations which influence hereditary practices and social habits (5). The study of FGM and the comparison of social representations of migrant and native people might be useful to understand features and trends of the practice, as well as to find an effective approach for the definitive abandonment of the practice.

Considering the health care standpoint, the local authorities and the health professionals assume an outstanding role: they are in a privileged position for establishing contacts with women who have undergone the rite and, therefore, they are able to start therapeutic, preventive and health promotion interventions in accordance with cultural actions.

Conceptual framework of the research

FGMs are established practices carried out in specific ethnic groups. They include diverse types, which vary from excision to the partial or total removal of external genitalia.

In 1997 WHO defined four types of FGM, subsequently updated in 2008 (6;7):

- *Clitoridectomy* (type I): it consists in the removal, complete or partial, of the clitoris and of the clitoral prepuce (type Ib). In rare cases, it consists in the clitoral prepuce removal only (type Ia);
- *Cutting* (type II): partial or complete removal of the clitoris and of the labia minora, with or without excision of the labia majora;
- *Infibulation* (type III): removal of the clitoris, the labia minora, part of the labia majora with cauterization, followed by the stitching of the vulva, leaving a hole, with or without removal of the clitoris;
- *Other* (type IV): all other procedures of female genital mutilation performed in absence of therapeutic needs: cutting, drilling or cutting of the clitoris and/or labia, stretching of the clitoris and/or labia, cauterization of the clitoris and surrounding tissues, scraping of tissue surrounding the vaginal orifice or cutting of the vagina; introduction into the vagina of salt, corrosive substances or herbs to shrink it.

To understand the extent of this phenomenon, it suffices to report that the Agencies estimate that between 100 and 140 million of women have been subjected to FGM. Most of the girls and women are to be found in 28 African countries and a minority of them lives in Asia. DHS and MICS data for Africa updated to 2010 indicate that the states, in which the practice is most widespread for the age-group 15-39 years of age, are Burkina Faso, Djibouti, Egypt, Eritrea, Guinea, Mali, Sierra Leone and Somalia (8).

The practice of FGM is, however, presently forbidden by International and European law and by various Declarations and Recommendations to the states:

- The *Universal Declaration of Human Rights* Article 25 establishes that everyone has the right for a standard of living adequate for the health and well-being of himself and of his family, and that motherhood and childhood are entitled to special care and assistance;
- The *Convention of New York* on the rights of the child, 1989, protects the gender rights of girls as equal to those of boys (art. 2) by establishing that 'member States might adopt all effective measures towards the abolition of all traditional practices that endanger the health of minors (art. 24.3);
- The *EU Parliamentary Resolution on FGM (2001/2035 – INI)* strongly condemns female genital mutilation as a violation of basic human rights and considers it a serious problem for society; it urges the EU and other member States to work together to bring uniformity to existing laws and, if this prove inadequate, to work out new specific legislation.
- The Recommendation *n. 1371 of 1998 of the Council of Europe*, on child abuse, recommends that member States' governments ensure that effective measures are taken against female genital mutilation and provide penalties in their regulations;
- The Council of Europe '*Convention on preventing and combating violence against women and domestic violence*', which is a strong declaration for the prevention of violence against women (Istanbul, 2011);
- The *European Parliament Resolution* of *14th June 2012* on the abolition of female genital mutilation declares that, since female genital mutilation is mostly practised in developing age (up to 15 years of age), it constitutes a violation of children's rights;
- *The sentence of the District Court of Colonia of 26th June 2012* established that circumcision of children for religious reasons violated the fundamental human right of physical integrity. The Court compared the child's right to the physical integrity of his/her body, the parents' right to religious freedom, and the right of the latter to educate their children in accordance with their own convictions. The conclusion was that the child's rights inevitably constitute a limit to those of the parents, and that «they are not unacceptably compromised if the parents must wait until their offspring can decide for themselves whether to be circumcised or not»
- The *Draft Resolution "Intensifying Global Efforts for the elimination of female genital mutilation"* This Resolution was adopted by the UN General Assembly on 20th December 2012.

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The appearance of this problem in the territory of Emilia-Romagna has brought health professionals to face a new series of needs with substantial cultural implications. In 2001 a regional project co-ordinated by the Local Health Authority of Forlì (9) highlighted some meaningful data: health professionals' difficulties in identifying the mutilations; women's difficulty in perceiving circumcision as a risk in childbirth; special need for interdisciplinary approaches for dealing with the practice within health services; the need to formulate guidelines for treatment as well as for prevention. The current research was rooted in these needs, and the aim is to deepen the social representations of FGM, to find different resources and actors for cultural exchange, and define possible interventions.

In particular, the objectives of the current research are divided into two different but correlated groups:

Objectives for the Community level:

- to outline and to examine the social representations of the practice of FGM among foreign women, focusing on cognitive, emotional and behavioural aspects;
- to outline and to compare the social representations of the practice of FGM among Italian women, focusing on cognitive, emotional and behavioural aspects;
- to compare the connotations of social representations for the two different populations, identifying similarities and differences.

Objectives for the local health services:

to analyse the satisfaction of foreign women towards health professionals of the Italian services;

- to analyse the emotional impact on health professionals approaching the problem of FGM and their need for procedures and training;
- to find resources, actions and strategies, and to develop the guidelines for the abandonment of the practice, considering models (therapeutic, preventive and salutogenic) useful in the Italian health system.

The research was conducted within the Emilia Romagna Region, and in particular in the Local Health Authorities (LHA) of Bologna, Forli, Parma and Reggio Emilia. We defined three target population groups:

- *The foreign population*, which comprises 80 immigrant foreign women – interviewed by anonymous questionnaire – of which 46 declared having undergone FGM, and 34 selected for their general knowledge of the issue because their ethnic communities were known to practice FGM;
- *The Italian population*, which comprises women resident in Emilia Romagna Region: in total 268 women from four different cities in the Emilia Romagna area (Bologna, Forli, Parma and Reggio Emilia) answered the questionnaire;
- *Health professionals*, which comprises social and health professionals of the four LHAs; in total 212 health professionals answered to the questionnaire.

In general, the attitude towards the research and the participation to the focus groups was positive, with some difficulties in 'recruiting' foreign women.

Methods

We followed qualitative and quantitative criteria, adding to the traditional methods of statistic data analysis different qualitative methods combining the following methods, theories, models and frameworks:

Survey

A survey method (named "specular research") was used to compare the FGM social representations of foreign and Italian women (two of the study populations). Hence, two different survey questionnaires were prepared for the data collection, targeted specifically to the two study populations. The questionnaires were divided into two sections: the first part focused on personal experience (immigrant women) and perception (Italian women), and the second part focused on general statements and opinions on FGM. This section was the same for the two populations.

As the Social representations theory does not provide a methodological set of tools, indicators and standards, through which monitoring their evolution, we fixed a % standard (≥ 50% for both groups), to be able to extract similarities and differences between Italian and foreign women on key aspects of FGM. After a first empirical standard testing phase, we found some interesting core convergences between the social representations of the two groups. Only in one case ('psychologically offended') the % value was inferior to the standard, but it was reported for its meaning in terms of FGM impact on women's health.

The health professionals' questionnaire was divided into a first section on the professional experience and a second section on their opinions on FGM and the role of health care services.

The theory of cognitive psychology formed the theoretical framework for analyzing social representations of FGM. In fact, the idea of "behaviour" is similar to the one of "social representation", in particular in its articulations of: knowledge aspects (ideas and beliefs), emotional aspects (emotions, reactions, feelings) and behavioural aspects (attitudes) (10). We also added cultural and symbolic aspects to point out principles and causes

of the theme under analysis, to offer a complete research of social representations of FGM;

The health models (*therapeutic*, *preventive* and *health promotion*) (11), formed the framework for defining the role of health systems in the practice of FGM. These models have been used for creating and analyzing both the questionnaires and the focus groups;

The *Child Rights framework* (12;13) and the *Rights-based Approach to Health* (14;15) has guided the collection and the organization of opinions and proposals emerged in health professionals' focus groups. This approach comes by various International Declarations and Recommendations, all of them inspired by the Universal Declaration of Human Rights, that recapture the role of the socio-health services to four principal dimensions: ensuring the availability of the health system, its accessibility without cultural or ethnical discrimination, its social and cultural acceptability, and its scientific quality.

Following this background, we planned (Table 1):

a) Two different surveys with two questionnaires for immigrant and Italian women with the aim of investigating the social representations of FGM. The respondents were selected on a voluntary basis and the recruitment was performed by facilitators and cultural mediators.
b) Questionnaire directed at health professionals, to investigate the professional approaches towards FGM and the role of health care services. The recruitment was performed by the main coordinator of the regional research and by the representatives of the local health services.
c) Four different *focus groups* composed by Italian women to analyse the data collected in the questionnaires and to reflect upon meanings, behaviours, ideas and intervention plans related to FGM. The participants were selected on a voluntary basis and with the help of cultural mediators.
d) Two different *focus groups* with immigrant women to analyse the data collected with the questionnaires, to reflect upon meanings, behaviours, ideas and intervention plans related to FGM. The participants were selected on a voluntary basis.
e) Four different *focus groups* with health professionals to discuss data, analyse issues and collect suggestions on FGM. The participants were selected by the representatives of the local health services.

The first step of the research consisted in a wide literature review on the main declarations and studies on FGM. Subsequently, a questionnaire for the three study populations was carried out and tested involving representatives from each target group. The questionnaires adapted after the testing phase were submitted to Italian and foreign women in their life settings, and to the professional staff after working hours. The collected data were elaborated statistically and standardized for the comparison. The results of the questionnaires elaboration were presented, discussed and validated during the focus groups carried out in different local health authorities. The focus groups were led by the researcher and supported by conceptual maps for the collection and sys-

Table 1 Survey tools

Quantitative tools: Questionnaires				Qualitative tools: Focus groups			
Target population	**Section 1**	**Section 2**	**Modality**	**Elaboration**	**Modality**	**Focus on**	**Elaboration of**
Foreign women	Personal experience of FGM	Opinions on FGM	- Presentation - Self-fulfilment - Collection with the support of a facilitator	Statistical analysis and comparison with the data of Italian women	Led by the Researcher (No.2)	Elaborated questionnaires data and suggestions for action	- Conceptual maps - Synthetic gridlines - Meaningful stories
Italian women	Perception of the FGM experience	Opinions on FGM	- Presentation - Self-fulfilment - Collection with the support of a facilitator	Statistical analysis and comparison with the data of migrant women	Led by the Researcher (No.4)	Elaborated questionnaires data and suggestions for action	- Conceptual maps - Synthetic gridlines
Health care professionals	Professional experience in health care settings	Opinions on FGM	- Presentation - Self-fulfilment - Collection with the support of a facilitator	Statistical analysis and comparison with the data of migrant women	Led by the Researcher (No. 4)	Elaborated questionnaires data and suggestions on health care services role	- Conceptual maps - Synthetic gridlines

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tematization of the comments. The final data collected with the questionnaires and the comments emerged in the focus groups have been systematized into a Research Report.

Strengths and Limitations

Among the strengths in this study, it is important to mention that it was a fundamental asset to be able to work in collaboration with national and international experts who suggested bibliographic sources, thoughts and opinions on the results of the present research with the aim of improving and enhancing the results. This was particularly relevant to be able to compare similarities and differences with other national and international studies and researches dealing with a social approach to FGM.

Moreover, the research followed an approach oriented to empower foreign women in order to find solutions for the complete abandonment of the practice in their own communities and to create an active social role also for circumcised women.

Finally, we followed a multidisciplinary approach, with the participation of different professionals as sociologists, psychotherapists, gynaecologists, obstetricians, paediatricians, health professionals and cultural mediators. The added value of this approach was the possibility to mix different analysis levels of FGM: from health risks and clinical interventions to social and cultural interpretations of the practice.

The main limitation of the research is the non-statistical sampling of the target population interviewed with the questionnaire as it was difficult to find foreign women available to contribute to the research and talk freely about their personal experiences. Another limitation was the lacking possibility to identify the type of FGM that the foreign women who were interviewed had undergone, since they were not examined by a gynaecologist, due to time restraints.

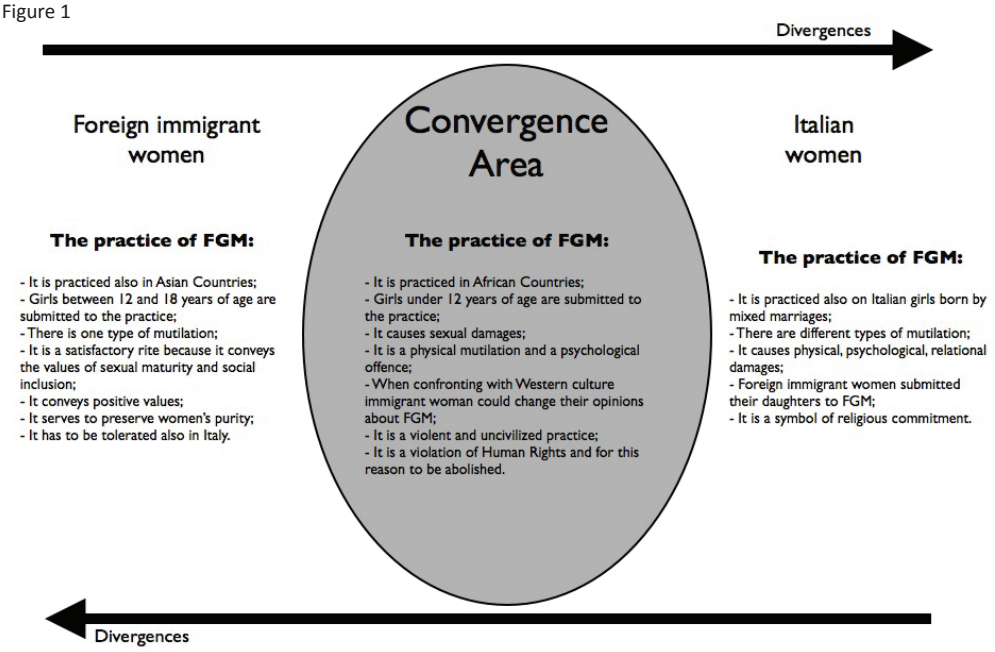
Results

Referring to the objectives on the community level, we observed a meaningful convergence area (Figure 1) between the social representations of FGM given by Italian and immigrant women (Table 2). It clearly emerges that there are 7 main convergences in Italian and immigrant women's opinions about female circumcision:

- it is practiced in African countries;
- mainly to girls under 12 years of age;
- it causes sexual damages;
- it is a physical mutilation and a psychological offence;
- when confronted with Western culture, immigrant women could change their opinion about FGM;
- it is a violent and uncivilized practice,
- it is a violation of Human Rights and for this reasons it should be abandoned and abolished

These convergences constitute an important finding testifying that a radical cultural change in the social representations of FGM can take place, and can do so already within the first 5 years of immigration, thanks to

Figure 1



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the possibility of comparison with the host community. Divergences persist, and in the view of Italian women, lie in the psycho-physical damage and risk to reproduction that the practice causes, the fear that the rite may be imposed also on couples of mixed marriages and the disbelief in the 'positive' values of the practice. For foreign women there is still a belief in the positive aspects linked to the tradition (namely, the socio-cultural significance of the rite, the sense of social inclusion, the preservation of female purity) and the justification of the practice in its original contexts.

If we look at the specific aspects of Social representations of FGM we can observe the following divergences:

- *Knowledge area:* 17.2% of the Italian women believe that the practice is imposed also to girls born in Italy from mixed marriages vs. 6.3% of immigrant women. 64.9% of Italian women identified more than one type of FGM vs. 32.5 of immigrant women and they recognized physical (82.5% vs. 41.3%), psychological (89.9% vs. 42.5%), sexual (75.4% vs. 62.5%) and relational damages (59% vs. 30%) caused by the practice. Foreign women (25% vs. 12.3% of Italian women) believe that the practice is also performed on Asian girls, and on girls between 12 and 18 years old (42.5% vs. 25.4%) ;
- *Emotions area*: some of the foreign women (28.8%) consider themselves satisfied with the rite for having reached sexual maturity vs. the Italian women's esteem (8.6%);
- *Behavioural area*: Italian women (15.3% vs. 7.5% of immigrant women) believe that the practice could be imposed also to future generations of immigrant women;
- *Values area*: foreign women (8.8% vs. 1.1% of Italian women) stated that the practice also embodies positive values, it preserves women's purity and for these reasons it is justifiable in their countries of birthand in Italy (20% vs. 7.8%). Finally, Italian women (10.4% vs. 5% of immigrant women) believe that the practice represents religious commitments.

Concerning the objective on the role of health care services, from the therapeutic point of view, there is still a widespread demand for healthcare staff regarding specific professional training, the opportunity to compare experiences with peers, and the design of an operative protocol. Moreover, a positive evaluation has been recorded concerning the role of cultural mediation as a factor in improving patient/professional relationships. Under the prevention perspective, health care professionals underline the importance to sensitize foreign women during visits for abandoning the practice for their daughters and to protect younger girls through in-

Table 2 Comparison of Social representations through their aspects (convergences in italic)

	% Answers Italian women	% Answers Foreign women
Knowledge aspects		
Girls of African origin	*87.7*	*98.8*
Girls of Asian origin	12.3	25
Italian girls	17.2	6.3
Girls < 12 years old	*81*	*76.3*
Girls 12-18 years old	25.4	42.5
Only adult women	1.5	0
Only 1 type	6.7	23.8
> 1 type	64.9	32.5
I don't know	26.5	43.8
Physical damages	82.5	41.3
Psychological damages	89.9	42.5
Relational damages	59	30
Sexual damages	*75.4*	*62.5*
Emotional aspects		
Psysically mutilated	*63.1*	*53.8*
Psychologically offended	*60.4*	*46.3*
Satisfied of the rite	3.4	7.5
Satisfied to have reached sexual maturity and social inclusion	8.6	28.8
I cannot imagine	31	0
Behavioural aspects		
They would change their attitudes towards the circumcision rite	*60.8*	*85*
They would maintain their attitudes towards the circumcision rite	22.4	17.5
They will impose the rite to their daughters	15.3	7.5
Values aspects (Cultural and symbolic aspects)		
Positive values	1.1	8.8
Justifiable in its traditional and cultural context	7.8	20
To be condemned	*87.3*	*81.3*
A symbol of religious commitment	10.4	5
A symbol of social and cultural inclusion	25.4	23.8
The preservation of women purity	5.6	10
The intention of making violence to women	23.9	16.3
A trait of uncivilized culture	40.3	50
A violation of the Human Rights	*57.8*	*53.8*
To be accepted in traditional communities and countries	2.2	5
To be accepted in any case. also for immigrant families	0.4	1.3
To be abandoned	*89.9*	*93.8*

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formation and education interventions in schools. Finally, what emerged was the importance of both the health and social care system and of health education, in order to achieve the abandonment of the practice, through the involvement of immigrant women and parents as agents of cultural change (Table 3).

Discussion

The phenomenon of FGM still needs to be investigated in its true scope, mode, cultural and social roots. Considering the impact of social representation on daily cultural traditions and practices, this might be a relevant target in the pursuit of abolishing FGM.

The change in social representations of FGM on the part of foreign women has an "immediate" effect on immigrant communities, but also a similar "distant" effect may be hypothesised on the cultural background of the country of origin. This aspect should be further investigated and demonstrated. Migration phenomena, constitute a "bridge", crossed in both directions, for the passage of goods, services, information and also social representations.

The convergences area observed in this paper concerns mainly the area that condemns FGM (by immigrant women too), judged as a psychological and physical violent act and a violation of human rights. These convergences testify that – thanks to the dialogue and comparison with western contexts – it is possible to reach a change of social representations of FGM and this can be reached in one generation.

As reported in the present study, the direct contact of the immigrant population with Western culture is a factor of strong and rapid change in the social representation of FGM, as are other factors such as the role of mass media and social networks, the positions taken by the institutions and international agencies, and the action of social and health services.

In 2007, Unicef (16) supported this possibility of change, thanks to the study and understanding of social dynamics behind the rite. In this regard, it would be relevant to invest more and more on social and cultural strategies, as stressed by Unicef in 2005 (17), to support communities to abandon the tradition both in immigrant populations and provenience countries.

With reference to social and health care services, particularly those addressed to the protection of maternity and infancy (women's health services, paediatricians, centres for immigrant women and children), the experience in the Emilia Romagna Region highlights that they constitute a particularly powerful *asset* for dealing with the problem of FGM. They can implement not only therapeutic and prevention skills, but also health promotion activities based on specific information, education, empowerment of immigrant women, involvement of immigrants communities, networking with social, educational and judicial services, support for policy makers and institutions, promotion of cultural change, in accordance with the global affirmation of human rights and human development.

In conclusion, to overcome the FGM practice it is desirable to have a common strategy and action based on the implementation of the Child Rights Based approach, inspired by the Convention on the Rights of the Child, which recommends states to respect, protect and fulfill children's right "to the enjoyment of the highest attainable standard of health" and to "be protected from all forms of violence" (18).

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Table 3 Relevant actions for the abandonment of the practice of FGM

Actions	Average value foreign women (from 0 to 10)	Average value italian women (from 0 to 10)	Average value health professionals (from 0 to 10)
Political actions focused on prevention	7.7	8.3	8
Networking between health services. social services and judicial system	8.2	8.2	7
Launch of communication campaigns	7.7	8.2	7
Awareness of immigrant communities	7.5	8.5	8
Educational interventions in the school settings	7.4	8.0	7
Educational interventions for mothers	7.8	8.6	8
Educational interventions for parents in their native countries	8.1	8.8	8
Educational interventions for parents in the immigration countries	7.8	8.6	8
Wise men of villages	7.0	7.4	8

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Contribution details:
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Coordination and work planning of the study: IS
Acquisition of data: AB, FB
Analysis and interpretation of data: IS
Drafting the article: IS
Revising the article critically for important intellectual content: FS
Final approval of the version to be published: IS, AB, FB, FS

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News from the International HPH Network

Get inspired by the Taiwanese HPH Network

After our short news item on the Taiwanese HPH Network in the previous issue (Vol 3, Issue 2), we have been approached by readers who wish to hear more about how the Taiwanese network have achieved their success, and how they organize and communicate with their many member hospitals and health services.

We have set up an interview with Dr. Shu-Ti Chiou, the Taiwanese HPH Coordinator, who invites the readers into the work and process of the largest National/Regional HPH Network.

About the NETWORK

The Taiwanese HPH Network has existed since 2006 and has today a total of 131 members, thus making it the largest National/ regional HPH Network in the International HPH Network.

The network have a strong support from the Taiwanese Government and the administration and secretarial function of the Taiwanese HPH Network is placed at The Health Promotion Administration of Taiwan, a branch under the Taiwanese Ministry of Health and Welfare.

Contact:
Taiwanese HPH Coordinator,
Dr. Shu-Ti Chiou
stchiou@ym.edu.tw

Q: As one of the pioneers on HPH in Taiwan and as the Taiwanese HPH Coordinator, you have been involved since the beginning in 2006.
- How do you see the transformation from a new HPH network to today, where the Taiwanese National HPH Network is the largest within the International HPH Network?

A: The Taiwanese HPH Network was founded in 2006. In the beginning, it was very difficult to tell how many members we could possibly recruit. I was an assistant professor of a medical school at the time, without much power or resource. However, I did make a wish to become top 5 in the world within 3 years and to be the largest one within 5 years. Our progress was actually a little bit behind my initial target.

I started by inviting several outstanding leaders from the fields of healthcare management, public health, health promotion research, etc. Of course, we were all busy people. The reason we came together was for something we believed, and we would like to see good things happen for that. We didn't have time to waste upon unnecessary errors or going nowhere.

We chose to stand on the shoulders of giants instead of re-inventing the wheels. The initiative to implement HPH was based on the HPH Standards developed by WHO. To apply for full membership, healthcare organizations are required to do the self-assessment and to pass the audit. To strengthen capacity building, minimum credits of continuous education and periodic re-assessment were required for membership renewal every 4 years. To benchmark and raise the bar, we held an annual competition to award best practice. To generate and share evidences, we did evaluations and submitted our results to the international conferences. Since 2010, Taiwan has been the network with the highest number of accepted abstracts in the annual HPH International Conferences for 4 consecutive years, and has won the best poster award for 5 consecutive years. We are encouraging our colleagues to submit full articles to scientific journals, too.

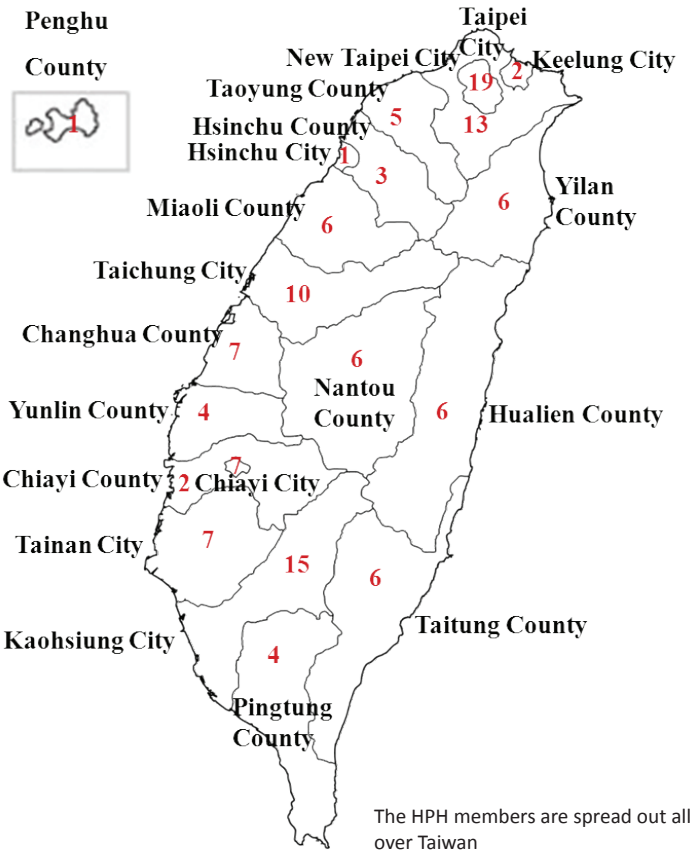
The Government's role is very important in the push-and-pull of this challenging process. The Health Promotion Administration of Taiwan (HPA, formerly the "Bureau of Health Promotion") is a strong advocator for value-adding health care and it has worked hard to help remove barriers and generate facilitating mechanism. HPA expanded payments for preventive services, launched pay-for-performance design, provided project-based grants for HPH-related initiatives, and engaged other key partners such as local public health departments, academia and hospital associations.

Q: With so many member hospitals and health services it must be somewhat of a challenge to organize the overall work of the National HPH Network. How do you organize such a high number of members?

A: A non-governmental organization, the Taiwan Society of Health Promoting Hospitals and Health Services, was set up in 2007 and worked closely with the government on domestic coordination, such as collecting membership fees, arranging site visits for auditing, providing training activities, publishing newsletters, organizing domestic annual conferences, maintaining the website, taking care of questions and requests, sending out and receiving emails, etc. The Health Promotion Administration provided some grant support on these activities.

Q: How do you see the future of HPH in Taiwan?

We see HPH as one of the most important and timely solutions to the NCD tsunami. Domestically, Taiwan's HPH Network continues to expand, not only in its number but also in types of services. New members include large university hospitals, public health centres and long-term care facilities. The nationwide efforts made it possible to examine its impact on population health. We have seen some positive results, which we hope to publish soon. Internationally, Taiwan actively participated in working groups and task forces. It is coordinating a new task force on age-friendly health care with representatives from more than 10 countries. We are keen to support other networks on training arrangement and exchange programs.



The HPH members are spread out all over Taiwan

Transformation was no easy task. It is not just about the number of members, but more difficultly and more importantly, the internal change in how healthcare organizations see themselves, manage themselves, and deliver their services and care. Our transformation process is on-going and still has a long way to go. We continue to be confronted by questions like why hospitals have to do health promotion or whether this may hamper hospitals' total income. The radical transformation of healthcare delivery cannot and will not happen without the reforms of healthcare payments and healthcare accreditation towards a more outcome-driven and value-based design.

Q: Do you have any good advice to pass on to other National HPH Networks who wish to learn from Taiwan?

A: The more I'm involved in the International Network, the more I see the differences between Taiwan's approach and the approach of other networks. Such differences seem critical to some networks' development. There are certain irrefutable rules of effective changes. The problem is, do you really want a change to happen?

Communication and support of members

Q: With 131 members, the National Taiwanese HPH Network is by far the biggest in the International HPH Network. In the administrative process, how do you communicate with all members?

A: We communicate with HPH members through regular email correspondence, telephone conversations, and official letters to disseminate HPH related announcements. Both HPA and the HPH Society have websites, of course. We held workshops for education and training. The annual conference and general assembly meeting are the most important events for everyone to get together.

Q: When you think of Taiwan, you think of high-tech and technological innovation. Do you use special technological features to facilitate the administrative process?

A: Official letters are either sent electronically to each HPH members or through traditional post. Information regarding HPH is also presented on the HPH sub-section on the HPA's main website. Email newsletters from both the International HPH Network and the Society (E-Journal) are also sent to each member hospital on a regular basis. We also conduct video- or teleconferences

with HPH members who cannot personally attend workshops or meetings.

Q: How do you support and encourage the members to share information and learn from each other?

A: Upon entry into the network, new members will receive core course training and on-site visits, offering them advice and methods on how to improve. The annual conference provides platform to share best practices from the award winners. Many members or members-to-be invited the winners to speak in their hospitals or organizations. The HPA promotes the HPH model and give examples through multiple media outlets, such as news releases, press conferences, and articles in magazines with high circulation. The Taiwan Network organizes large campaigns on health-promotion issues to engage patients, staff, communities and the public.

Q: Do you have any good advice to pass on to other National HPH Networks who wish to learn from Taiwan?

A: We highly recommend getting strong support from your government; setting up an organization that is tasked specifically into managing HPH network; organizing regular workshops to build visibility and capacity, as well as educating new members by sharing experiences with existing members; inviting member hospitals from other networks to come and exchange experiences, as well as making the effort to participate in the annual International HPH conferences. Lastly, we welcome interested networks to invite member hospitals from Taiwan to share their experiences in promoting HPH work!

Thank you Dr. Chiou, for this comprehensive insight in the work and organization of the Taiwanese HPH Network.

22nd International HPH Conference, Barcelona, Spain (April 23-25, 2014)

Under the title "Changing hospital & health service culture to better promote health," the conference will focus on a number of topics to further develop the hospital culture, including health literacy, salutogenic workplaces, and cooperation between hospitals and other settings for better health.

High-ranking international experts and speakers including Georg Bauer (Zurich), Oliver Gröne (London) Ilona Kickbusch (Geneva), Hans Kluge (WHO-Euro), Chi-Hung Lin (Taipei), Eric de Roodenbeke (International Hospital Federation) and Agis Tsouros (WHO-Euro) have confirmed their participation.

The conference will also host a number of accompanying events including a module by ENSH-Global on tobacco control in health care services, a workshop on children's rights in hospitals, a HPH school, a workshop for HPH network coordinators, and a HPH newcomer's workshop. And many more topics will be covered in the parallel and poster sessions of the conference.

For a continuously updated program overview, please visit:

www.hphconferences.org/barcelona2014/programme/intinary-details.html

Prolongation of deadline for abstract submission

Please note that the deadline for abstract submission will be prolonged until January 17, 2014.

Make sure that you submit your paper in time at:

http://www.hphconferences.org/barcelona2014/abstract-submission/view-abstract.html

In addition to a splendid program, Barcelona is the ideal venue for a short-term pre or post conference vacation and will provide more than one good reason to attend this event!

Photo: Pixabay

News from the International HPH Network

Czech hospitals become first in the world to complete the WHO HPH Recognition Process

The very first site visits of the WHO HPH Recognition Project were conducted in mid December 2013 in all participating intervention group departments of the Czech Republic. These site visits are the final step of the process, and auditors validate results from the departments own assessments and measurements as well as conduct sampling of staff and patient perspectives.

About the PROJECT

The WHO HPH Recognition Project is a multicentre RCT, aiming for 88 included hospital departments from all over the world, to have adequate sample size. All clinical hospital departments are eligible for participation (except palliative and paediatric).

All interested parties are encouraged to make contact.

Contact:
Jeff Kirk Svane
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The 3 intervention group departments in the Cezh Republic, who have now officially completed the entire process, are the Orthopedics Department at Pelhrimov Hospital, the Department of Pneumology at Jihlava Hospital and the Internal Medicine Department at Valasske Mezirici Hospital.

The Czech Republic has a total of 8 hospitals taking part in the WHO HPH Recognition Project and the remaining (control group) participants are scheduled for site visits in June 2014 – when they will have completed their implementation period and both measurements, which the project consists of.

Site visit at Valasske Mezirici Hospital with WHO Country Office (CZ), Ministry of Health (CZ) and WHO CC (DK)

Other participating countries (there are currently 8 countries in total) will also be site-visited as per the timeline of each country.

In the Czech Republic the site visits to all of the intervention group departments generated a lot of interest and support, both internally in the hospitals with staff

Site visit at Jihlava Hospital

Site visit at Pehlrimov Hospital

and with management but also externally in the country; with the Ministry of Health and with the WHO Country Office. Furthermore, the departments have clearly shown that the process, which the project tests, is both realistic and interesting.

Although at present only the 3 Czech intervention group departments have completed the entire project process from start to finish, it seems the project holds great promise by way of understanding and recognizing HPH performance.

The project's Principal Investigator, Prof. Hanne Tønnesen, says: "The project consists of a baseline measurement, a quality plan made on basis of the departments' own results, a follow-up measurement and finally the site visit itself. The visits to the Czech intervention group departments have been really exciting for all of us, and they underpin the great potential of this project in terms of finding a good model for fast-track HPH implementation and a connected way of recognizing performance".

Overall, the WHO HPH Recognition Project is at about 50% inclusion with 40 participating departments from a total of 8 countries. The aim is 88 departments, and the project group now warmly invites all interested countries and all interested HPH hospitals to make contact with a view join the project.

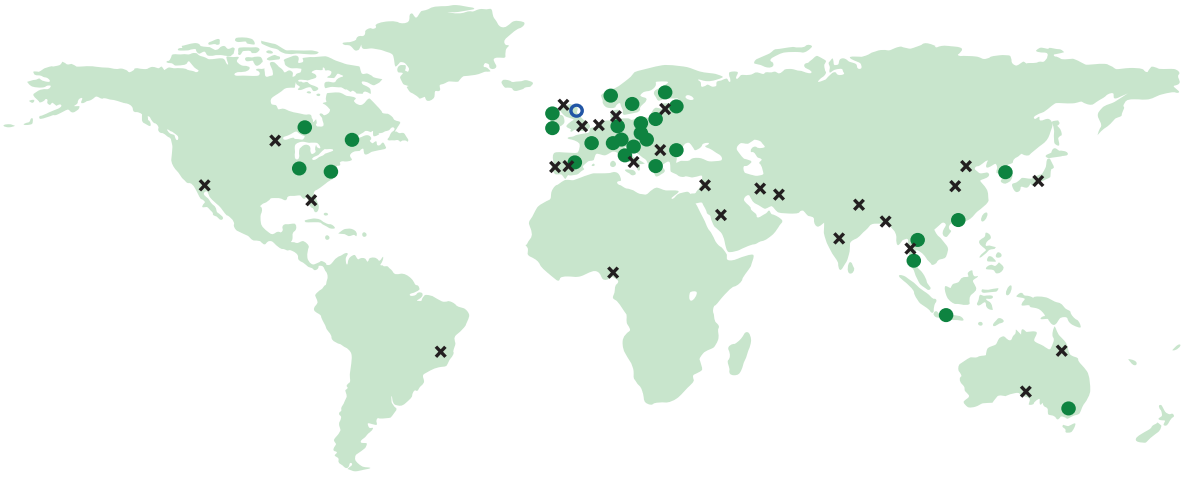
Become a member of the International HPH Network

If your hospital or health service is interested in joining the International HPH Network, go to www.hphnet.org and read more on what HPH can do for your organisation and why health promotion is vital for the improvement of health for patients, staff and community.

For further questions about the HPH Network, feel free to contact the secretariat: info@hphnet.org.

The International HPH Network has members in 40 countries spread out over all six continents.

HPH members 2013



= Affiliated Member(s)

= Country / Region with HPH Network(s)

= Country / Region with individual Hospital or Health Service HPH Member(s)

News from SEEHN

The control of chronic non-communicable diseases is a success in the sustainable development of society

The SEEHN is entering its second decade, with a clear commitment of Member States to take responsibility for the further development of partnership and institution networks.

About SEEHN

The South-eastern European Health Network (SEEHN) is a governmental sub-regional cooperation established in 2001. SEEHN consists of ten countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Israel, Macedonia, Moldova, Montenegro, Romania, and Serbia

WHO, Regional Office for Europe is one of SEEHN's founders and has supported the SEEHN from its establishment.

For more information: www.moh.gov.mk

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The 32nd plenary meeting of the SEEHN took place in Podgorica, Montenegro from 27 to 28 November 2013. It took stock of the activities during the Montenegrin Presidency and fostered consensus of the Network for activities to take place during the upcoming Presidency of Romania. During the Montenegrin Presidency of the SEEHN, the Network actively participated in the process of developing the SEE 2020 Growth Strategy (www.rcc.int). The South East Europe (SEE) 2020 Strategy, developed under the auspices of the Regional Cooperation Council (RCC), was adopted in Sarajevo on 21st November 2013, at the Ministerial Conference of the South East Europe Investment Committee. Creation of one million new jobs in SEE until 2020 is the most important aim of the strategy "Jobs and Prosperity in a European Perspective (www.rcc.int).

Delegates at the 32nd plenary meeting of the SEEHN

Key strategy actions in Dimension M 'Health'

A set of key actions have been identified to address the Dimension M Health in the inclusive growth strategy (www.rcc.int). They include:

- Introduce policy measures for improving the health gain of the populations, with a focus on low-income and disadvantaged groups, by strengthening the delivery of universal and high-quality health-promoting services
- Strengthen the institutions and improve inter-sectoral governance of the health sector at all levels, including health information infrastructure and regional cross border information exchange
- Harmonise cross-border public health and public health services legislation, standards and procedures; develop mutual recognition and trust to enable the creation of a Free Trade Area from a public health perspective
- Strengthen human resources in the health sector, harmonise the qualifications of health professionals in the SEE region, monitor Human Resources for Health (HRH) mobility.

The 32nd Plenary Meeting of the SEEHN adopted a decision to reinforce the health chapter of the SEE 2020 Strategy with the prospect to formulate specific implementation activities in future.

Chronic non-communicable diseases represent a major challenge for the countries of South Eastern Europe , not only as a health issue, but as a serious threat to the development of society. The Health in All Policies is a means to achieve general social understanding that health, a state of physical, mental and social well-being should be a whole-of-society task. In this sense, any economic development program is inadequate if it has no health and social dimension. There is a wealth of evidence that investment in health is an investment in the sustainable development of societies. Health, being dependent on multiple

and complex determinants, lifestyle, environmental, societal, economic and political, was a responsibility not only of the health sector but of the whole society. Development Strategy 2020 in South-Eastern Europe, which defines the creation of new jobs and innovative economic development, can not avoid the health and fighting against the preventable chronic non-communicable diseases. Therefore, it is a great achievement that a Health Chapter in the document is one of the important pillars of the strategy of development until 2020.

Strategies are serious documents, but without real implementation it may remain as a set of desires and good intentions without result at the level of the citizens and the population at large. The main challenge is precisely to define realistic action plans, as well as the realization of these plans. The SEEHN is preparing itself during the Romanian Presidency not only to develop its Health Action Plan but to launch implementation of concerted actions at regional and national levels supported by its main partners and the RCC.

The 32nd plenary meeting of the SEEHN in Podgorica, Montenegro, 27-28 November 2013.

A SEE health regional workshop on preventive actions for reducing the excessive salt intake for NCD prevention, Podgorica, Montenegro, 25-26 December 2013

A very rich and informative meeting, organized by the EC TAIEX Instrument, with active participation of experts from the EU (Croatia, Latvia, Slovenia, Romania, and Denmark), WHO Europe, and more than 50 participants from the 10 SEEHN countries, dealt with the important issue of salt intake that directly affects health and could result in hypertension and brain stroke if consumed in excessive levels (recommended daily intake of 5 g). Currently it is assessed that the average salt intake varies between 8 and 13-15 grams daily in the region.

The Workshop reviewed in depth the EU Regulation EU/169/2011, European Parliament and Council, the food information to consumers and the WHO Europe recommended "best-buys" interventions of its Action Plan for Preventing and control of Non-communicable Diseases.

SEE countries show a large variety of approaches used to tackle the problem, both from the political (administrative) and practical points of view. In all cases, the Ministries of Health and Agriculture are the main actors along with the food industry and very often the consumer organizations.

As a result, a huge SEE initiative of concerted regional and national actions will be launched in 2014 and onwards, based on a formal signed Decision by the SEE Health Network Presidency. The actions will focus on: (I) Data collection, monitoring and research; (II) Implementing national action plans; (III) Minimum benchmarks for salt content in major food categories; (IV) Labeling; (V) Effective public awareness campaigns; (VI) Industry involvement, and (VII) Vigilant and transparent monitoring, evaluation and reformulation of the regional, national and sub-national policies and interventions.

The implementation of the initiative will be coordinated by the SEE Regional Health Development Centre in Podgorica, Montenegro.

CLINICAL HEALTH PROMOTION

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During 2013 we have been so fortunate to have all submitted papers peer reviewed by our honoured panel of international scholars.

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