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Research & Best Practice for patients, staff and community

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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

Health Promotion for mentally ill patients - start now!

Hanne Tønnesen

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Mentally ill patients in Scandinavia have a shorter life expectancy than the background population by approximately 15 years. Their high pre-mortality is predominantly caused by life-style related non-communicable diseases (1). This is probably a general issue for mentally ill patients all over the world. Nevertheless most of this pre-mortality is preventable by health promotion interventions.

The patients

Smoking is wide-spread among mentally ill patients, and high-quality smoking cessation intervention programs as well as smoke-free wards are seldom in psychiatric settings. A Swedish study has shown that about 70% of adult alcohol or drug dependent patients are daily smokers (2), which stands in contrast to the overall 13% smokers among people over 15 years old in Sweden (3). The heavy smoking alone can explain between 5-10 years of the reduced life expectancy. Thus, there seems to be a large and unused potential for health promotion in mental illness.

The staff

Experience from the wards and clinics shows that not only do the mentally ill patients often smoke, the staff, expected to help the patients giving up smoking, also have a high smoking rate them-selves and have reservations about the importance of smoke-free policies (4). In general, the staff members' lack of competence on smoking cessation intervention and their own smoking are important explanations of their neglect of recognising smoking as a risk factor. As a further result of their smoking, the staff also tend to overlook other lifestyle-related risk factors; such as overweight and high alcohol consumption (5). Therefore, in order to reach out to the mentally ill patients and their relatives, it is important to meet the staff's need for training to improve their competences and health promotion intervention to improve their health.

The culture

Along with the well-developed and evidence-based mental care in Scandinavia, a parallel culture for smoking and other unhealthy life-styles co-exist in many psychiatric hospitals and clinics of mental illness. Earlier, in this unhealthy culture, cigarettes were handed out as a reward or a payoff to different behaviors, such as taking the medicine or keeping calm for a period. Another example of previous practice was the joined smoking between therapist and patient in order to create a positive atmosphere for intervention.

Today, these actions are no longer acceptable, but interesting myths still exist in relation to changing lifestyles for mentally ill patients. The myths claim that 'changing has no effect', 'it is not possible for mentally ill patients to change lifestyle', and 'it is very dangerous for them to stop smoking and drinking, and to start exercising and eating healthy'. Thus, the myths support the survival of the unhealthy culture.

Inspiration for tackling the serious myths could be obtained from the Swedish surgeons, who began the movement of 'Smoke-free Operations' a few years ago. They discussed similar myths in scientific and public forums. Now they have carefully replaced the myths by evidence, new staff competences and patient preferences. All important elements, when you start a change of approach and actions in your setting (6).

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Consequences

Overall, the major actions taken against tobacco during the last decades have not been offered to the large group of mentally ill patients; this in spite of their high prevalence of smoking and other unhealthy life-styles. Similar to the neglect of the need for smoking cessation intervention, other health promotion activities are also rarely offered to patients with a mental illness. Thus, hazardous alcohol drinking, overweight, malnutrition and physical activity are seldom addressed, in spite of the fact that they all add seriously to the disease burden most often responsible for shortened life expectancy (7). Continuous neglect of need for better health gain for mentally ill patients has tremendous consequences, as it causes development and aggravation of co-morbidity, especially from non-communicable diseases and high pre-mortality.

Evidence leaves no room for questioning the fact, that giving up smoking and other unhealthy life-styles improves health, delays the development and progression of non-communicable diseases and reduces pre-mortality. There are no valid arguments for stating that mentally ill patients should not be offered the same effective health promotion programmes as somatic patients. They have the same rights, and not surprisingly, they care for their health in the same way as any other patient (2). Because of their major health issues, mentally ill patients should have even better access to health promotion activities than other patient groups with minor health challenges, but unfortunately this is not the case today.

Get started

Much evidence has been collected on health promotion among mentally ill patients, and the results call for immediate implementation. In addition, clinical guidelines and several good examples exist on best practice for integrating smoking cessation and other health promotion activities in real life. More research is on its way in the nearest future from several research groups, evaluating the effect of new programs in high-quality randomized designs, often including qualitative interviews of patients and staff.

It will be a challenge to change the heavy smoking culture and unhealthy lifestyle tradition – however, it is possible and worth doing, to improve the health gain for these patients. Changing this culture and replacing it with health promotion interventions aimed at patients, relatives and staff, necessitates good leadership and a comprehensive health promotion policy. When formulating the policy, special focus on teaching and training of staff and careful information of patients and relatives is required (8).

It is important to carefully follow-up the effect of the implementation among the patients and the staff – and thereby secure the quality and the effect of health promotion interventions for the mentally ill patients.

In conclusion

Mentally ill patients are in great need for health promotion and should be offered the same activities and interventions as any other patient group. So please, start now!

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Research and Best Practice

Reciprocal effects of changes in mood and self-regulation for controlled eating associated with differing nutritional treatments in severely obese women

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Abstract

Background Weight-loss interventions have had disappointing outcomes, partly because of a minimal understanding of associated psychological factors. Theory-based treatments often seek to build self-regulation for controlling eating – a strong predictor of weight loss. Mood changes associated with treatment may, however, affect self-regulatory changes in obese women. Self-regulatory changes may, reciprocally, impact mood. Consequently, the aim of this study was to (a) assess treatment-associated effects on depression, total negative mood, and self-regulatory skills usage, and (b) determine whether changes in mood mediate self-regulatory skill changes, and vice-versa.

Methods Women with severe obesity were randomly assigned to groups of exercise support plus either nutrition education (n = 134) or cognitive behavioral methods emphasizing the building of self-regulation skills for eating (n = 135). In addition to exercise support, the nutrition groups met every 2 weeks for 3 months, with follow-up after 6 months.

Results Significant overall improvements in self-regulation, depression, and total mood disturbance were found over 6 months, with changes in total mood disturbance and self-regulation significantly greater in the cognitive-behavioral treatment group. Because the mediating effects of mood changes on the relationship of treatment type and changes in self-regulation were significant, as was the mediation of self-regulation change in the treatment-mood change relationships, the criteria for reciprocal effects was met. For participants with high total mood disturbance scores, changes in total mood disturbance and self-regulation completely mediated the treatment-self-regulation and treatment-mood relationships, respectively. Post hoc testing indicated significant associations between participants' exercise volume and improvements in their mood scores.

Conclusion Because treatment-induced changes in mood and self-regulation for eating may have reciprocal effects, methods for improving both should be incorporated in weight-loss treatments for obese women. Moderate physical activity may be a method for improving mood.

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Introduction

Results from behavioral weight management treatments have been disappointing (1). It is thought that after initially reinforcing effects (e.g., complements from peers, ongoing progress viewed on one's scale), individuals become less able to self-regulate their eating through the many barriers typically encountered (e.g., social pressure to eat, boredom, easily available "fast foods") (2). Additionally, the physiological response of their reduced weight plateauing can be discouraging, and trigger relapses into old eating patterns (and weight regain). Although typical weight-loss treatments continue to focus on educating individuals on healthy eating practice, both theory and research have not supported the efficacy of that approach (1). Cognitive-behavioral methods that emphasise specific self-regulatory skills (e.g., attending to cues to eating, cognitive restructuring) have emerged from social cognitive and self-efficacy theories (3;4), and are performing better than educational approaches (5;6). However, results are still minimal and inconsistent, and reasons for any positive behavioral effects have been both unclear and understudied.

Another psychological factor that may affect overeating, especially in women, is mood (7). Emotions may not only trigger inappropriate eating, they may undermine all important self-regulatory abilities (that are already challenged for most individuals). For example, research suggests that improvements in "... variables such as depression and anxiety could

lead to a healthier psychological climate in which individuals have more cognitive and emotional resources [to continue to self-regulate through barriers]…" (7, p 320). This suggested a need for a better understanding of how such psychosocial factors, previously indicated to be associated with eating, may interact with one another (9).

The use of physical activity in weight management has been an area of increased interest (1). Although commonly used as an adjunct to nutritional weight-loss treatments because of its obvious effect on caloric expenditure, researchers have recently suggested its additional (possibly greater) improvements in self-regulation to eating behaviors (2;10;11). For example, self-regulatory skills nurtured within a context of adherence to exercise might then "carry over" to help control eating. Physical activity, even in volumes of as little as 2 moderate sessions per week (2;12), have been associated with improvements in depression, anxiety, and overall mood in individuals both with and without initially low mood (13), and may positively affect emotional eating (2). Although understanding whether emotional eating is actually induced by decrements in mood "breaking down" self-regulatory skills, and/or if change in self-regulation impacts mood (and the possible role of physical activity affecting each of those relationships) is of critical importance for effective treatment, surprisingly, little corresponding research is available.

Because researchers acknowledge a minimal understanding of psychosocial factors' role in nutritional weight-loss treatments (8) – sometimes even questioning the viability of continuing behavioral obesity treatment research at all (because of such poor results persisting for so long) (14) – this study was conducted. Specifically, we tested a sample of severely obese, sedentary women initiating physical activity and enrolled in either a nutrition education treatment, or a treatment emphasising self-regulation for controlled eating, to (a) assess associated effects on depression, total negative mood, and self-regulatory skills usage, and (b) determine whether treatment-induced changes in mood mediate self-regulatory skill changes, and vice-versa. We hypothesized that we would find significant improvements in each psychological variable studied; and that changes in self-regulation would be mediated by mood changes, and changes in mood would mediate self-regulatory skill change (i.e., a reciprocal relationships). It was thought that a better understanding of how treatment-induced changes in self-regulation and mood interact could provide useful data for much-needed improvements in weight-loss treatments.

Methods

Participants

Women responded to advertisements in the local print media for an investigation into exercise and nutrition methods for weight management at a local YMCA. Inclusion criteria were: age ≥ 21 years, BMI between 35 and 55 kg/m², and no regular exercise (less than 20 minutes/week average) in the past year. Exclusion criteria were: present or planned pregnancy and/or current use of medications for weight loss or a psychological condition. A physician-endorsed statement of adequate physical health for participation was required. Institutional review board approval and written consent from all participants was obtained. After minimal attrition due to self-reported problems with transportation (n = 2), illness (n = 2), and not returning phone calls or emails (n = 3), there was no significant difference in age (overall M = 42.9 years, SD = 9.9), BMI (overall M = 41.2 kg/m², SD = 5.1), and racial make-up (overall 44% white, 51% african American, and 5% of other racial/ethnic groups) between participants randomly assigned to a treatment of supported exercise plus either standard nutrition education (n = 134) or cognitive-behavioral nutrition methods emphasising self-regulation (n = 135). Most participants (94%) were classified as middle-class.

Measures

A previously validated scale (15) was adapted to measure self-regulatory skill usage for controlled eating. As suggested by its developers, the revision was based on the self-regulation skills addressed within this study. Possible responses to its 10 items (e.g., "I say positive things to myself about eating well.") ranged from 1 (never) to 5 (often). Internal consistency was α = .81, and test-retest reliability over 2 weeks was .74 (11).

Two scales from the Profile of Mood States Short Form (16) were used. Total mood disturbance is an aggregate measure of tension, depression, fatigue, confusion, anger, and vigor (30 items total). Depression was also measured separately (5 items; e.g., "sad", "dejected"). Possible responses to items ranged from 0 (not at all) to 4 (extremely). Internal consistencies ranged from α = .84-.95 (.95 for depression), and test-retest reliability at 3 weeks averaged .69 (.74 for depression) (16). Concurrent validity was suggested through contrasts with well-accepted measures such as the Beck Depression Inventory, Manifest Anxiety Scale, and Minnesota Multiphasic Personality Inventory (16).

The Godin Leisure-Time Exercise Questionnaire (17) measured volume of physical activity over the last week. Frequencies of strenuous ("heart beats rapidly"; e.g., running), moderate ("not exhausting"; e.g., fast walk-

ing), and light ("minimal effort;" e.g., easy walking) physical activities occurring for at least 15 minutes per session are entered, multiplied by 9, 5, and 3 standard metabolic equivalents (METs) (18), respectively, and then summed. Test-retest reliability over 2 weeks was .74 (17). Construct validity was supported by significant correlations of questionnaire scores with other measures of exercise output (i.e., accelerometer and maximum volume of oxygen consumption scores) (19;20).

Procedure

Each participant reported to an assigned YMCA center and received a group orientation to study processes. The physical activity support component was identical for each of the 2 treatment groups. It consisted of a standard protocol of six 1-hour meetings (approximately monthly) with a trained wellness specialist over 6 months (11). These one-on-one sessions included an orientation to exercise apparatus, goal setting, and review of self-management methods intended to support adherence. Physical activity plans were based on each participant's preference. Standard recommendations of 150 minutes/week of moderate cardiovascular activity (21) were described; however, the benefit from any increase in physical activity was also indicated.

The nutrition treatment components differed by group. The nutrition education treatment emphasized education in healthy eating practices. The cognitive-behavioral nutrition treatment emphasised the use of self-regulation skills to control eating. Each had six 1-hour sessions administered by a certified wellness specialist in group format of 10 to 15 participants over approximately 3 months. In the nutrition education treatment, the standardised protocol used included: (a) understanding macronutrients and calories, (b) healthy recipes, (c) menu planning, (d) low-fat snacking, and (e) stocking a healthy kitchen (22). In the cognitive-behavioral nutrition treatment group, the protocol administered included: (a) establishing daily caloric goals and logging foods along with their associated calories, (b) thought stopping, (c) cognitive restructuring, (d) relapse prevention training, (e) attending to cues to overeating, (f) barrier identification, and (g) behavioral contracting. Wellness specialists who were trained to administer the treatments had YMCA and other national health and fitness certifications, and were blind to the purposes of the study. Treatment fidelity was assessed by senior wellness staff members under the direction of the study staff. Assessments were administered at baseline and month 6.

Data analysis

The intention-to-treat design incorporated in the expectation-maximisation algorithm (23) to impute data for the 15% of missing scores. Statistical significance was set at $\alpha = .05$ (2-tailed). To detect a small effect ($f^2 = .05$) at the statistical power of .80 ($\alpha = .05$), a minimum of 193 participants was needed. Mixed model repeated measure ANOVAs (time × treatment type) simultaneously assessed whether score changes were significant over 6 months, and whether those changes differed by treatment type. Based on previous suggestions (24), unadjusted score changes were calculated. Effect sizes were expressed as either Cohen's d or partial eta-squared (η^2_p) where .20, .50, and .80; and .01, .06, and .14 represent small, moderate, and large effects, respectively. Collinearity was tested through multiple regression analyses predicting self-regulation changes. The associated variance inflation factors (1.01-1.03) and tolerances (.97-.99) were well within acceptable limits.

Mediation models (Figure 1) were derived using a bias-corrected bootstrapping procedure incorporating 10,000 re-samples (25). Thus, normally distributed data were not required. Because of their significant bivariate correlations with change scores, baseline scores were entered as covariates. If the relationship of the predictor and outcome variable (path c) changed from statistically significant to non-significant after entry of the mediator (path c′), then complete mediation was considered to be present. Utilising the above mediation analysis procedure, and based on recent research (26), a series of reciprocal effects analyses were computed that assessed the presence/non-presence of reciprocal effects of changes in depression or total mood disturbance, with self-regulation for eating changes, resulting from the 2 treatment conditions. A reciprocal effect is considered present if significant mediation is concurrently found in each of 2 complementary equations; the first equation where a psychosocial variable is entered as the outcome (i.e., dependent variable), and the second where that same variable is entered as the mediator (26). For example, in the first reciprocal effects analysis, the first equation had self-regulation change entered as the outcome variable, and change in depression score entered as the mediator. In the second equation of the same analysis, change in depression was the outcome variable and self-regulation change was the mediator. The same procedure was then followed in the second reciprocal effects analysis where change in total mood disturbance was, instead, the mood measure of interest. Finally, the same mediation and reciprocal effects analyses were completed, separately, for participants with high depression and high total mood disturbance scores. Based on previous research (27;28), high depression and high total mood disturbance was defined as a baseline score of at least 1.5 SD above the normative mean for the corresponding measure (16;29).

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Post hoc testing was conducted to determine if (a) change in weekly volume of physical activity, (b) mean volume of physical activity, and (c) presence/absence of a volume of physical activity equivalent to at least 2 sessions per week (i.e., ≥ 10 METs/week average over the duration of the investigation) was significantly related to change in depression and/or total mood disturbance score (see Table 1 for data on physical activity volumes at baseline and month 6).

Results

Descriptive statistics of scores of self-regulation for controlled eating, depression, and total mood disturbance at baseline and month 6, their mean change scores, and corresponding effect sizes are given in Table 1. There were no significant differences between the treatment types at baseline in any of the measures (p-values > .14). Significant effects for time were found for each measure

Figure 1 Mediation models

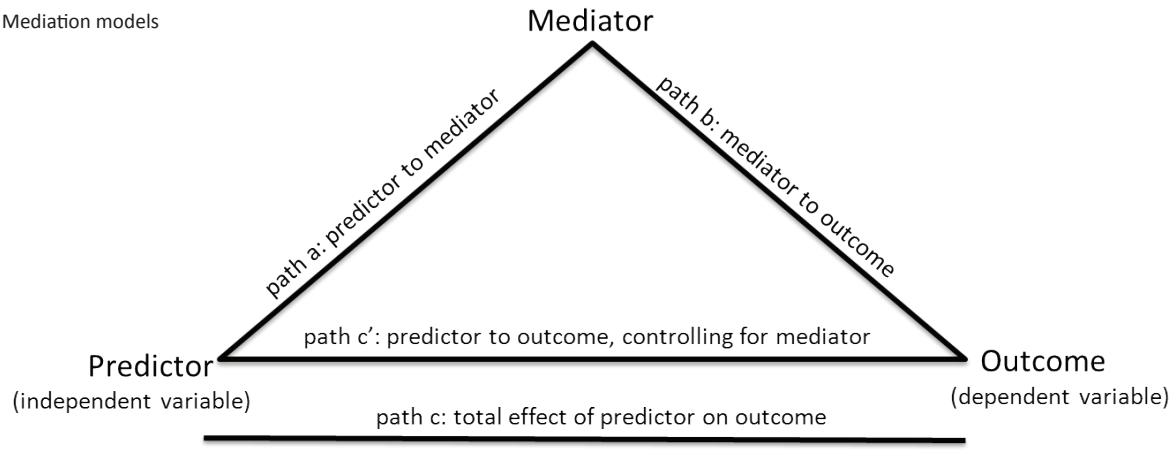

Table 1 Changes in study measures over 6 months

	Baseline		Month 6		Change		
	M	SD	M	SD	d	M	SD
Self-regulation for controlled eating							
Nutrition education group	21.76	5.84	25.16	6.76	.58	3.40	5.44
Cognitive-behavioral nutrition group	22.27	5.46	29.07	6.85	1.25	6.80	6.60
Aggregated data	22.01	5.65	27.12	7.07	.90	5.10	6.28
Depression							
Nutrition education group	4.71	4.31	3.77	3.95	.22	-0.94	2.84
Cognitive-behavioral nutrition group	3.99	3.62	2.56	3.05	.39	-1.42	2.98
Aggregated data	4.35	3.99	3.16	3.57	.30	-1.18	2.91
Total mood disturbance							
Nutrition education group	24.00	16.96	15.72	18.93	.49	-8.28	14.60
Cognitive-behavioral nutrition group	22.12	16.97	8.43	17.12	.81	-13.69	16.47
Aggregated data	23.05	16.96	12.06	18.38	.65	-10.99	15.77
Physical activity (METs)							
Nutrition education group	8.94	9.57	20.88	18.22	1.25	11.94	16.00
Cognitive-behavioral nutrition group	9.20	9.21	28.40	17.80	2.08	19.20	17.63
Aggregated data	9.07	9.38	24.65	18.37	1.66	15.58	17.20

Abbr.: M = mean; SD = standard deviation; d = Cohen's effect size for within-group changes: $M_{month\ 6} - M_{baseline} / SD_{baseline}$
Nutrition education group n = 134; Cognitive-behavioral nutrition group n = 135

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(p-values < .001), indicating overall significant improvements. There was a significant time × treatment interaction found for self-regulation (F1, 267 = 21.28, p < .001, η^2_p = .07) and total mood disturbance (F1, 267 = 8.14, p = .01, η^2_p = .03), indicating greater improvements associated with the cognitive-behavioral nutrition treatment. That interaction term did not reach statistical significance for depression (F1, 267 = 1.82, p = .18, η^2_p = .01).

Table 2 displays results from the reciprocal effects analyses (see Figure 1). In the first reciprocal effects analysis, change in depression significantly mediated the relationship between treatment type and change in self-regulation for controlled eating; and change in self-regulation significantly mediated the relationship between treatment type and change in depression (complete mediation). Thus, results were consistent with the presence of a reciprocal effect between changes in depression and self-regulation (emanating from treatment type). In the second reciprocal effects analysis, change in total mood disturbance significantly mediated the relationship between treatment type and change in self-regulation; and change in self-regulation significantly mediated the relationship between treatment type and change in total mood disturbance (complete mediation). Therefore, results indicated a reciprocal effect between changes in total mood disturbance and self-regulation (resulting from treatment type).

For participants with a high depression score (n = 34), although change in self-regulation significantly mediated the relationship between treatment type and depression change (noting that a significant relationship between treatment and change in depression was not found; path c, p = .14), depression change did not significantly mediate the treatment-self-regulation change relationship. Thus, a reciprocal effect between changes in depression and self-regulation (derived from treatment type) was not detected. For participants with a high mood disturbance score (n = 34), change in total mood disturbance was a significant mediator of the treatment-self-regulation change relationship; and change in self-regulation

Table 2 Results from mediation and reciprocal effects analyses

Predictor	Mediator	Outcome	*Path a Coef*		*Path b Coef*		*Path c Coef*		*Path c' Coef*		*Indirect effect Coef*		*Model R^2*
			(SE)	p	(SE)	p	(SE)	p	(SE)	p	(SE)	95% CI	p
All participants (N = 269)													
Treatment	ΔDepression	ΔSelf-regulation	*-.75* (.31)	.01	*-.87* (.13)	<.001	*3.58* (.70)	<.001	*2.93* (.66)	<.001	*.65* (.30)	.12, 1.28	*.29* <.001
Treatment	ΔSelf-regulation	ΔDepression	*3.58* (.70)	<.001	*-.17* (.02)	<.001	*-.75* (.31)	.01	*-.16* (.30)	.59	*.59* (.14)	-.92, -.35	*.37* <.001
Treatment	ΔTotal mood disturbance	ΔSelf-regulation	*-6.07* (1.76)	.01	*-.23* (.02)	<.001	*3.58* (.70)	<.001	*2.21* (.59)	<.001	*1.37* (.43)	.55, 2.24	*.44* <.001
Treatment	ΔSelf-regulation	ΔTotal mood disturbance	*3.58* (.70)	<.001	*-1.42* (.13)	<.001	*-6.07* (1.76)	.001	*-1.01* (1.52)	.51	*-5.07* (1.06)	-7.30, -3.10	*.44* <.001
High depression scores (n = 34)													
Treatment	ΔDepression	ΔSelf-regulation	*-2.38* (1.58)	.14	*-.84* (.15)	<.001	*4.52* (1.86)	.02	*2.51* (1.36)	.08	*2.01* (1.44)	-.88, 4.78	*.62* <.001
Treatment	ΔSelf-regulation	ΔDepression	*4.52* (1.86)	.02	*-.61* (.11)	<.001	*-2.38* (1.58)	.14	*-.37* (1.22)	.77	*-2.75* (1.23)	-5.18, -.29	*.55* <.001
High total mood disturbance scores (n = 34)													
Treatment	ΔTotal mood disturbance	ΔSelf-regulation	*-18.62* (6.95)	.01	*-.27* (.03)	<.001	*5.55* (2.17)	.02	*.52* (1.24)	.68	*5.03* (1.99)	.91, 8.90	*.79* <.001
Treatment	ΔSelf-regulation	ΔTotal mood disturbance	*5.55* (2.17)	.02	*-2.76* (.29)	<.001	*-18.62* (6.94)	.01	*-3.32* (3.92)	.40	*-15.30* (5.99)	-27.44, -3.45	*.79* <.001

Abbr.: Coef = coefficient; 95% CI = 95% confidence interval; the Delta symbol (Δ) denotes score change from baseline to month 6
Path a = predictor → mediator; Path b = mediator → outcome; Path c = predictor → outcome;
Path c' = predictor → outcome, controlling for the mediator

was a significant mediator of the relationship between treatment and total mood disturbance change (with both equations demonstrating complete mediation). Thus, findings suggested a reciprocal effect between changes in total mood disturbance and self-regulation (resulting from treatment type).

Linear bivariate correlations of each measure of physical activity volume with depression change were significant (r-values = -.27, -.25, and -.26, respectively, p-values < .001). Relationships of physical activity volumes with change in total mood disturbance were, similarly, each significant (r-values = -.49, -.35, and -.35, respectively, p-values < .001). For participants with a high depression score, corresponding r-values were -.60 (p < .001), -.32 (p = .06), and -.58 (p < .001). For participants with a high mood disturbance score, corresponding r-values were -.69, -.58, and -.62, respectively (p-values < .001).

Discussion

Results provided an increased understanding of behavioral treatment-associated effects on self-regulation for controlled eating, and mood; and how such changes might affect each other. Consistent with previous research (27;28), changes in physical activity, even at a volume equivalent to only 2 moderate sessions per week, was associated with significantly reduced depression and total mood disturbance scores over this 6-month trial with severely obese women. The addition of cognitive-behavioral methods that emphasised self-regulatory skills for eating was, predictably, associated with more improvement in self-regulation than a treatment based on education in appropriate nutritional practices. It should, however, be noted that moderate effects were found for self-regulation changes in the nutrition education group also. Thus, because self-regulation is such a key component of eating behavior change (2), research focusing upon it spontaneously benefiting from establishment of a program of physical activity requires extension (10).

As expected, changes in self-regulation were significantly mediated by depression and total mood disturbance changes. This is in agreement with research suggesting both the empowering (for improvements in mood) and destructive (for decrements in mood) effects of mood on self-regulation (8). Reciprocal effects were identified through, additionally, establishing the mediating effects of changes in self-regulation on depression changes. Although the mediation models corresponding to these findings explained a significant portion of the overall variances, they were especially strong when only participants with high depression and high total mood disturbance were considered. For these participants, however, analyses incorporating total mood disturbance, but not depression, demonstrated reciprocal effects.

Treatment implications emerging from these findings are considerable. For example, the importance of mood change on self-regulation appeared to be quite clear. Because physical activity is a behavior consistent with weight management, and positively affects mood, it should be emphasised within treatments. Because adherence rates for exercise are problematic, and obese individuals may be especially uncomfortable partaking in it (2), volumes may be limited so that adherence and mood change, rather than high energy expenditures, are primary goals. Instruction and rehearsal in self-regulation for controlled eating also seems essential for inclusion in treatments. Possibly, these may be specifically nurtured through teaching similar behavioral skills applied to physical activity (to promote carry-over of these skills to better control eating behaviors). To impact mood, possibly self-regulation skills may also seek to identify, and act on, low mood (e.g., within cognitive restructuring).

Limitations of this investigation should, however, be noted. The use of change (gain) scores inflated the measurement error of the scales by combining error from measurements at both baseline and month 6. Accounting for the dynamic process of changes in the psychosocial factors of mood and self-regulation over the course of the study was, however, an important aspect of this research. Although both mood scales used were deemed to be important, it should be noted that the depression scale was embedded within the measure of total mood disturbance; thus there was, undoubtedly, conceptual overlap between them. Replication with different sample types (males, across degrees of overweight, cancer survivors, individuals with diabetes) are needed to increase confidence in findings, or help to determine if separate predictive models are required (e.g., between men and women). While expectation and social support effects can bias findings within any field-based investigation, the ability to readily generalise findings to applied settings might, overall, be considered an advantage (30).

In summary, addressing previously suggested analytic goals (9) served to extend theory on the relationship of psychosocial factors in weight-loss treatment. Specifically, the use of recently suggested methods of reciprocal effects analysis (26) indicated interrelationships of changes in measures of mood and self-regulation for eating, resulting from treatments with distinctly different emphases. As this area of research advances, psychosocial variables found to be predictive of improved

weight management may facilitate more effective behavioral treatments.

Contribution Details

All authors read and met the ICMJE criteria for authorship and agree with the results and conclusions. JJA designed the study and analysed the data. JJA and KJP contributed to the interpretation of the data and wrote the report.

Competing interests

None declared.

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Research and Best Practice

Preliminary inquiry: Adherence to universal precaution methods among healthcare providers in a government hospital in Odisha, India

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Abstract

Background Risk of infections associated with health care facilities have long been known. However, occupationally-acquired infections are still a significant problem for health care personnel (HCP). The aim of this study was to make a situational assessment of universal precaution (UP) adoption and to identify factors influencing compliance.

Methods A hospital based cross-sectional study was conducted among 32 of 39 HCPs working in a sub-district hospital (SDH) at Nilgiri, Balasore Odisha. A validated questionnaire was used to collect data on knowledge and practice, while a check list was used for observation of factors influencing compliance.

Results Over 90% of the study participants answered correctly on 12 of the 19 questions concerning knowledge and understanding of UPs, while questions regarding practice scored significant lower with 5 of 19 (p = 0.049). Prevalence of practices such as the use of protective glasses, surgical masks and use of gloves was found to be 38%, 31% and 50% respectively. Facility assessment and observations identified a lack of protective measures such as gloves in the laboratory and dressing rooms, chlorine or any other chemical disinfectants and a proper place for waste disposal as well as a lack of training in safety precautions.

Conclusion The knowledge, practice and attitudes of using UP were very low in this study, thus indicating a major need of interventions to improve UP compliance.

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Introduction

Despite advancements in technology and health care safety, occupationally acquired infections remain a challenge for health care workers. According to the World Health Organization estimates, nearly three million people worldwide are exposed to percutaneous and mucocutaneous accidents every year, which could result in diseases such as Hepatitis B, C and HIV. 90% of reported cases occur in developing countries (1). The risk of occupational exposure to blood borne diseases is an alarming and real threat for all HCP. As the number of people infected with blood borne diseases increases, it has become critical that all HCP exhibits unfailing compliance with a strategy for isolation precautions, known as UPs (2). The obligatory behaviours incorporated with the practice of UPs must be used by all HCP, whose work practices involve contact with patients' body fluids (2). Few studies have documented the compliance of HCP to UPs in public hospital settings in India (3-5). The aim of this study was, for the first time, to make a situational assessment of universal precaution adoption in a SDH of Odisha State in India and to identify factors influencing compliance. SDHs are concerned with secondary care provision, which necessitates adherence to prescribed infection control measures both for patients as well as health care providers.

Methods

This hospital-based cross-sectional study is a preliminary inquiry, carried out in a SDH at Nilgiri, Odisha between April and June 2012.

The study was conducted among 32 of 39 HCP. A validated questionnaire was used to collect data on knowledge and practice, while a check list was used for observation of factors influencing compliance.

Setting

SDHs are organised below the district level and above the community health centres (block level hospitals). They act

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as first referral units for the population in their geographical areas and offer secondary care services. They also provide specialist services in emergency obstetrics and neonatal care, general surgery, general medicine and pediatrics, with one major and one minor operation theatre as well as one laboratory. SDHs receive referred cases from neighbouring community health centres, primary health centres and sub-centres. A SDH caters to about 500,000-600,000 people. The study was carried out in the only SDH in the Balasore district, catering to the tribal blocks of Balasore and the adjacent Mayurbhanj district.

Participants

In total, there were 39 HCPs in the SDH, comprising 10 doctors, 14 nurses, 2 pharmacists, 3 laboratory technicians and 10 attendants. For the study, it was decided to include all of the HCPs, as all of them were involved in in-patient care and delivered different types of healthcare encompassing emergency, indoor and out-patient services. Informed consent was obtained before the interviews; all the participations were voluntary and confidential in nature.

Data collection

Information on UP was collected through a semi-structured questionnaire on knowledge, attitude, practice and barriers; an infrastructure- and a direct observation of procedures was registered by using a check list.

The semi-structured questionnaire for interviewing of HCPs was developed by adopting the theme questionnaire of study conducted by Michelle Kermode et al (4). The questionnaire was validated through a pilot study. It included 19 questions on knowledge about UPs (Table 1), such as whether cut with a used scalpel spreads infection and if needle stick injuries can spread blood borne viruses (such as HIV/AIDS and hepatitis)? Additional 19 questions on practices were addressed to identify the participants' practice behaviours (Table 2), such as whether the participants take extra care when using scalpels, needles, razors or other sharp objects and if they dispose of all blood-contaminated items by using the designated bag or bucket for disposal?

Facility assessment was made with the help of a checklist adopted from Universal Precautions Guidelines for Primary Health Care Centers in Indonesia (6).

This study was approved by Institutional Ethical Committee of Indian Institute of Public Health, Bhubaneswar.

Table 1 Knowledge and Understanding of Universal Precaution

Items	Respondents answered "Yes" (n=32)	
	%	(95% CI)
Re-using needles and syringes in hospitals can spread blood borne viruses	100.0	(91.06-100)
A cut with a used scalpel blade can spread blood borne viruses	100.0	(91.06-100)
Hands should be washed every time after and before examining the patient/ any procedure	100.0	(91.06-100)
A single pair of gloves should be used to examine multiple peoples	100.0	(91.06-100)
Gloves should be worn for all procedures that may involve contact with blood or body fluids	100.0	(91.06-100)
UPs are an effective way to protect doctors, nurses and other health workers from infection with blood borne viruses such as HIV/AIDS	100.0	(91.06-100)
Blood and body fluids of all patients should be treated as infectious, as per UPs	96.9	(85.54-99.84)
Re-using razors can spread blood borne viruses	96.9	(85.54-99.84)
A mask should be worn for all procedures where blood and body fluids may splash	93.8	(80.85-98.94)
Needle stick injuries can spread blood borne viruses (such as HIV/AIDS and hepatitis)	93.8	(80.85-98.94)
Blood /body fluids that has spilled on the ground (eg. in labour room, OT) should be cleaned up immediately	93.8	(80.85-98.94)
Eye protection should be worn for all procedures where blood and body fluids may splash	90.6	(76.57-97.56)
I have a good understanding of how to apply UPs in my work	78.1	(61.45-89.9)
Amniotic fluid (liquor) splashing in the eyes or mouth can spread blood borne viruses	68.8	(51.33-82.91)
Blood splashing in the eyes or mouth can spread blood borne viruses	62.5	(44.97-77.85)
Used needles should not be recapped	59.4	(41.9-75.22)
Blood on unbroken skin can spread blood borne viruses	40.6	(24.78-58.1)
Knowledge about protecting from blood borne infections (such as HIV/ AIDS and hepatitis B) at work	75.0	(58-87.66)
There is need of precaution against exposure to blood only if the patient has an infectious diseases such as HIV/ AIDS	28.1	(14.67-45.38)

Analyses

The responses were presented as % yes answers of participating HCPs, including the 95% Confidence Interval (CI). The response was considered correct for the whole group of HCPs if more than 90% had answered correctly. The difference between the number of correct answers were compared for knowledge/understanding and practice by Fisher's exact test. A p-value below 0.05 was considered significant.

Results

In total, 39 health workers were approached, out of which seven refused to participate due to time constraints thus resulting in 32 study participants and a response rate of 82%.

Over 90% of the study participants answered correctly on 12 of the 19 questions concerning knowledge and understanding of UP (Table 1), while practice was significantly lower; 5 of 19, p = 0.049 (Table 2).

Very low knowledge and understanding was observed among HCPs, who believed that precaution measures should be taken only when treating patients diagnosed with HIV/AIDS (28%). Another area of little knowledge and understanding included the risks of spreading blood borne diseases on unbroken skin (41%) (Table 1).

Prevalence of practices such as use of protective glasses, surgical masks and use of gloves was found to be low; 38%, 31% and 50% respectively (Table 2). Most of the participants expressed difficulties in adopting precautions because they felt that they were too busy, lacked adequate training or experienced discomfort using personal protective equipment (Table 2). Interestingly, there seemed to be an internal discrepancy among the responses on the different practice questions, since 91% answered that they used protection against blood and body fluids, regardless of the patient's diagnosis, but at the same time 72% answered that they were too busy to follow the recommended precautionary steps against contact with patients' blood and body fluids. However, the number of participants was too small to allow more detailed analyses on this.

Furthermore, the facility assessment and observations identified lack of gloves in the laboratory as well as in the dressing rooms; clean towels, chlorine, ethanol and other chemical disinfectants; a proper place for waste disposal and training on safety precautions. An interesting observation was that infected material was not made unavailable, even in areas with access for all hospital staff and therefore constituted a potential risk of exposure to staff members.

Table 2: Practice of precautionary measures

Item	Respondents answered "Yes" (n=32)	
	%	(95% CI)
Taking extra care when using scalpels, needles, razors or other sharps objects	100.0	(91.06-100)
Disposing of all blood-contaminated items into the designated bag or bucket for disposal	96.9	(85.54-99.84)
Washing my hands after removing disposable gloves	93.8	(80.85-98.94)
Putting used needles and other sharp objects into the designated sharps container	93.8	(80.85-98.94)
Protecting against the blood and body fluids of all patients, regardless of their diagnosis	90.6	(76.57-97.56)
Covering any broken skin before coming to work	81.3	(65.02-92.03)
Wiping up all spills of blood and other body fluids promptly	75.0	(57.99-87.66)
Too busy to follow the recommended precautionary steps to protect against contact with patients' blood/body fluid	72.0	(54.62-83.33)
In emergency situations it is not possible to follow the protective guidelines against contact with patients' blood/body fluid because the patients' needs come first	59.4	(41.9-75.22)
Recapping needles that have been contaminated with blood	56.25	(38.89-72.52)
Using recommended precautionary steps to protect against contact with patients' blood, may offend /emotionally hit the patient.	53.1	(35.95-69.76)
Wearing gloves whenever there is a possibility of exposure to blood or other body fluids	50.0	(33.06-66.94)
Wearing a waterproof apron whenever there is a possibility of blood or other body fluids splashing on clothes	46.9	(30.24-64.05)
Wearing eye protection (glasses) whenever there is a possibility of blood or other body fluids splashing on face	37.5	(22.15-55.08)
Training status for correct use of protective equipment (eye wear, gloves, masks)	37.5	(22.15-55.08)
Wearing of protective equipment (eye wear, gloves, masks) is very uncomfortable in this working condition	37.5	(22.15-55.08)
Wearing protective equipment (eye wear, gloves, masks) makes it difficult to do the job properly	34.4	(19.58-51.88)
In this hospital it is not essential for staff to protect themselves against contact with patients' blood because the patients are from tribal area , so risk of infection with blood borne viruses such as HIV/AIDS is minor	3.1	(0.15-14.46)
Wearing a surgical mask whenever there is a possibility of blood or other body fluids splashing in my face	31.3	(17.09-48.67)

Discussion

Overall, the high prevalence of shortcomings in knowledge, practice and attitudes towards precaution measurement assessed in this study revealed that most of the HCPs put themselves (and as a result, their patients) at risk of getting infected with blood-borne diseases. Due to the fact that all blood and body fluids are potentially contaminated with infectious diseases, it is presumed that all hospital patients, regardless of their blood-borne infection status, represent a potential source of infection.

The lack of appropriate knowledge, practice and facilities has been documented in other studies from developing countries, including India (3, 4, 7). These problems can be explained by the absence of training and follow-up procedures as well as traditions and cultures unintentionally promoting infections instead of preventing and controlling them. Perceived barriers to compliance with UPs clearly influence HCPs' ability and willingness to comply with them in practice. Only about half of the study participants reported to use protective measures such as gloves and water proof aprons. "Improper training", "uncomfortable" and "difficulty in working" were cited to be reasons behind it. Similar factors have also been reported in other studies (8, 9). This could be due to low level of training received by the HCPs and the low availability of equipment, as shown in some studies (10). One of the weaknesses of this study is the low number of participants along with time and resource constraints. However, the results were relatively clear, and it is not probable that the outcomes of a larger study population would have been different. Nonetheless, a larger study population would have allowed an evaluation of the internal discrepancy in the answers. Another weakness is that this work was confined to a single health care facility, which means that the results may not be extrapolated to other settings.

Absence of equipment for sterilization and lack of a sterilization area, as observed during the study, aggravates the compliance of UPs. In order to improve the practice, it seems to be important to have a comprehensive policy and strategy. An integrated approach for promoting positive perception of UP compliance should consider training for all staff including the managers as well as monitoring the follow-up results over time, adequate supply of personal protective equipment, securing facilities for sterilisation and encouraging HCPs to avail the services as well as working towards improving the traditions and culture.

To conclude, the knowledge, practice and attitudes of using UP were very low in this study, thus indicating a major need of interventions to improve UP compliance.

Contribution details

Dr S. Pati carried out the design and coordinated the study. Dr S. Parida provided assistance in the design of the study, coordinated and carried out all the experiments and participated in manuscript preparation. Dr Akhtar and Mr Swain provided assistance for all experiments in analysis and drafting the paper. All authors have read and approved the content of the manuscript.

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Competing interests:

None declared.

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Research and Best Practice

Review: Experiences and preferences of counselling about living habits in healthcare – a systematic review of studies on the patient perspective

Sebastian Eriksson[1], Hanne Tønnesen[2]

Abstract

Background Recent policy in Sweden states that patients in every part of health care are to be presented with health counselling concerning living habits: tobacco, alcohol, an inactive lifestyle and eating habits. This review aims to investigate experiences and preferences of counselling about living habits from the patient's perspective.

Method A literature review of six major databases using a wide approach to detect studies of different methodologies, patient categories, health care settings and intervention types. Inclusion criteria were studies in any setting/category concerning patients' experience of discussing living habits with a health care practitioner (HCP). Results came to merit synthesis and quality appraisal using only instruments for qualitative studies.

Results 21 studies are presented. With one exception all originate from primary care. Themes are presented under headlines: encouragement, empowerment & support; doctor-patient relationship; individualization & involvement; stigma; time and ongoing support; empathy; and attitudes not favoured by patients. Most studies are of good quality with the most common remark of not having discussed chosen methodology or not having discussed the researcher's role in outcome.

Results are discussed in relation to Motivational Interviewing, Self-Determination Theory and Social Cognitive Theory. A review of qualitative studies had to take special emphasis to search strategy, quality appraisal and synthesis.

Conclusion/implication This review provides an overview of published studies in the field of patient experience. Further study is needed to widen the scope beyond Primary care and to secure findings in more controlled settings.

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Introduction

According to a recent investigation and policy document from the Swedish National Board of Health and Welfare every person in contact with Swedish healthcare should be provided with health counselling about living habits such ass tobacco, alcohol, an inactive lifestyle and unhealthy eating habits (1). The foundations of such a policy is hardly disputed with an estimated one third of the total burden of disease in the industrialised countries derive from tobacco, alcohol, blood-pressure, cholesterol and obesity according to the World Health Organisation (WHO) (2). Growing attention is being directed towards lower income countries with an increase of lifestyle related disease making lifestyle related disease a global dilemma, and even in these countries more persons die from lifestyle-related illnesses than infections (3). In Sweden, tobacco, excessive use of alcohol, insufficient physical activity and unhealthy eating habits together constitutes the greatest contribution among living habits to the total burden of disease (4).

Health promotion (HP) was conceptualised in the Ottawa charter from 1986 as "the process of enabling people to increase control over, and to improve, their health" and is since then seen as a process of empowerment towards health (5). This concept of health dates back to the original WHO definition from 1948 where health was seen as "a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity" (6). Since 2000 the WHO has focused on securing HP on an evidenced based platform, hence the WHO general secretary statement: "Health promotion should be based on evidence rather than ideology", and evidence based HP is recently acknowledged and conceptualised

in a WHO document emphasising the importance of empowerment concerning lifestyle, behaviour and readiness for change as an entrance to lifestyle intervention programs (7).

From a theoretical perspective patient centred medicine is a topic receiving a lot of attention in the field of doctor-patient relationships today (8). Although multiple theories and frameworks coexist, Mead and Bower provide five dimensions of patient centred care: a bio-psychosocial approach, understanding the meaning of health from the patient's personal perspective, using shared decision making and sensitivity for patient preference, creating a therapeutic alliance and understanding the meaning of personal quality and preference in the practice as a doctor (9). One way of increasing patient centeredness is by conducting a Motivational Interviewing (MI) approach to the health encounter as proposed by Miller & Rollnick (10).This includes the four major techniques: showing empathy, developing discrepancy, avoiding resistance and increasing autonomy. Another way, Self-Determination theory by Deci and Ryan (11), is based on autonomy, competence and relatedness, and yet another stems from the concept of self-efficacy of social cognitive theory by Bandura (12), both of which link to the influence of behaviour.

To fully carry out evidence based medicine one must acknowledge evidence, competence within staff and the preference of patient, where the patient's perspective is to be just as acknowledged as evidence and skill (13) and should be used to educate policy makers (14). It is known that patients accept questions and advice from healthcare practitioners (HCP). This has been recognised in the first studies of the subject (15) as well as in a recent Scandinavian context by Johansson et al. where advice about exercise was the most common and advice about alcohol the least common (16). They also found that patients receiving advice were more satisfied with their visit than patients who did not receive advice. Nilsen investigated feelings toward brief alcohol advice finding that conversations rarely generated unease and that conversations were more likely to result in changed living habits if they lasted ten instead of five minutes (17). These studies mainly use questionnaires to investigate the views of the public and it, with the words of Stott and Pill, "with its reliance on self -administered postal questionnaire and forced choice format answers, inevitably means that little is known about those who reject or have reservations about the concept of lifestyle counselling or why they hold such views" (18). Whether or not the public opinion is in line with healthcare causal relationships between living habits and disease is to some part questioned though (19). This merits the use of qualitative studies as well as quantitative. Furthermore, many qualitative studies have been performed on patient preferences, but only recently international consensus has been gathered for the methods of reviewing qualitative research (20).

The aim of this review was thus to gather the experiences and preferences of patients in relation to receiving health counselling concerning the four major lifestyle habits responsible for most disease, hence answering the following research question: What are the experiences and preferences of patients having undertaken various ways of health counselling directed towards living habits?

Methods

Search methods

In the period March 6 to April 4 2012, Medline, Embase, CINAHL, Web of Science, The Cochrane Library and PsycInfo were searched for scientific publications using the search strategy given in appendix 1, supplemented by manual search. Although changes were made to comply with respective database index system, such as the Medline MeSH, the basic concepts of each search strategy were similar to the one provided.

Inclusion/ exclusion

Studies included in this review investigated patients' experiences and preferences about health, personal behaviour and treatment during health promoting interviews. Studies were accepted for review independently of qualitative or quantitative methodology. Included studies concerned adult patients of any kind, who had undergone health counselling of health promotive, preventive and rehabilitative nature. Living habits included by this review concerned the four major ones: tobacco, alcohol, insufficient physical activity and eating habits as related to recent guidelines (1). The studies should evaluate the experiences of HP counselling that had taken place and if possible also the preferences, but not for example only evaluate the effect, compliance, satisfaction and frequency of HP counselling, or deal with wishes, barriers, visions, facilitators and expectations without having undertaken the HP counselling. Most importantly it should explicitly be mentioned in the aim of the studies to measure patient preference and expectation of the review topic.

Exclusion criteria were studies of children, partners or families as well as studies of health professionals alone or together with patients. In addition other health talks and specific health concerns were not included. There were no exclusion criteria for publication year, language or gender.

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Design

Although we had no preconception of certain methodological preferences such as RCT studies, qualitative studies or studies using survey methodology, we acknowledged that patient preference could often be investigated using qualitative methodology such as individual interview or focus group interview. Although this acknowledgment did not affect our search strategy, the studies retrieved by the search warranted synthesis of qualitative material and quality appraisal related to qualitative research. For such a synthesis we have chosen the thematic analysis as described by Dixon-Woods (21), and the criteria for good and poor quality was chosen from the Cochrane Collaboration (20). According to this a quality assessment tool should comprise of the following four core themes: credibility, transferability, dependability and confirmability corresponding to quantitative terminology: internal validity, generalisability, reliability and objectivity. For the critical appraisal of studies in this review we use the Critical Appraisal Skills Programme (22) as it is recommended for first time users by the Cochrane collaboration. The results of this evaluation are found as table 1 in this review.

According to thematic analysis we have read manuscripts repeatedly to look for common themes and patterns. Although no attempt has been made to alter or conjoin themes they are presented under common headlines for clarity.

Results

Search outcome

The search strategy resulted in 30,274 articles. These were sorted according to relevancy of title, which rendered 4,849 articles of relevant topic. After controlling for duplicates these amounted 4,175 (see figure 1). Inclusion procedures included reading abstracts, examining inclusion criteria and performing a team conference after which a total of 21 qualitative studies were accepted for review (18;23-42) (see appendix 2 for details of the studies).

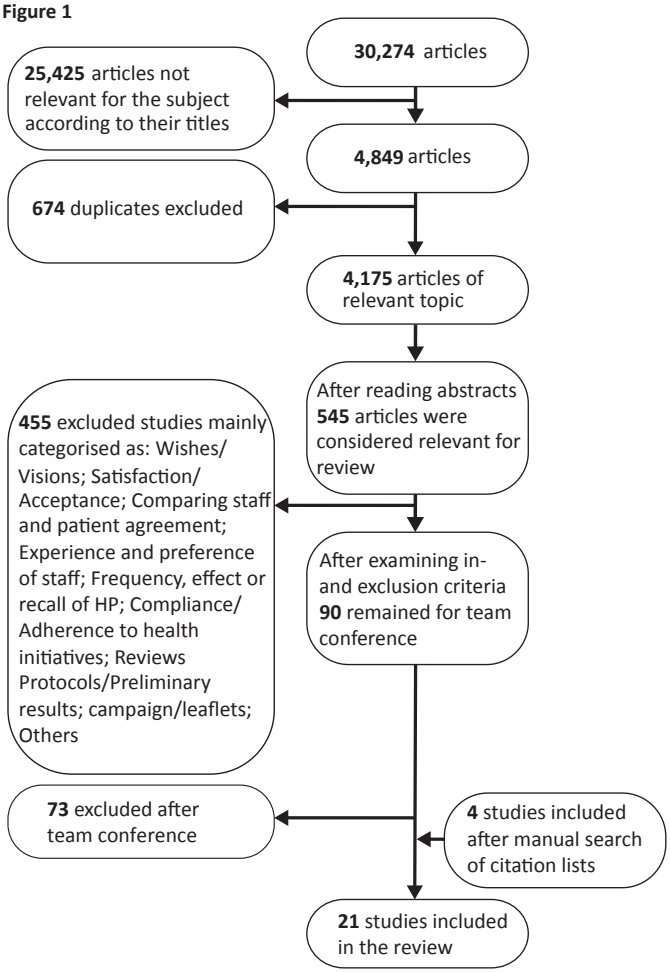
Settings

The presented studies used the primary care setting only or in part but Arborelius et al. (ante-natal clinic) (40). Other settings included a hospital setting (23;24), a diabetes learning centre (27) and an ante-natal clinic (41) in addition to primary care.

Health determinants

Seven studies focused on tobacco specifically (18;24;38-42). Stott & Pill and Lock put particular emphasis on alcohol (18;36). Insufficient physical activity was considered in five studies (18;25;28;30;32). Only Hardcastle et al. and Cable et al. investigated diet expressly (25;38) and weight reduction was considered by Malterud et al., Brown et al. and Stott & Pill (18;26;34). Five studies explored lifestyle counselling within DM-2 treatment (27;31;33;35;37). Dellasega et al. and Walseth et al. had no certain living habit in focus but general lifestyle counselling (23;29).

Figure 1



Themes elicited

Major themes from thematic analysis of chosen studies are presented in detail in table 1 and are described under the following headlines: encouragement empowerment & support; doctor-patient relationship; individualisation & involvement; stigma; time and ongoing support; empathy and attitudes not favoured by patients.

Encouragement, empowerment and support

Participants in 13 studies stressed the importance of receiving encouragement, being empowered or getting support from their HCP during discussion of living habits (23-25;28-31;34-36;38;40;42). Studies by Dellasega

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Table 1 Critical Appraisal Skills Programme

Article	Was there a clear statement of aims?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the study?	Was the recruitment strategy appropriate to the aims of the research?	Were the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis suficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Score:
Dellasega, 2011 (23)	+	+	-	+	+	-	+	+	+	-	7/10
Hansen, 2011 (24)	+	+	-	+	+	-	-	+	+	+	7/10
Hardcastle, 2011 (25)	+	+	-	+	+	+	-	+	+	+	8/10
Malterud, 2010 (26)	+	+	-	+	-	-	+	+	+	+	7/10
Oftedal, 2010 (27)	+	+	-	+	+	-	+	+	+	+	8/10
O'sullivan, 2010 (28)	+	+	-	+	-	-	+	+	+	+	7/10
Walseth, 2010 (29)	+	+	-	-	+	+	-	+	+	+	7/10
Horne, 2009 (30)	+	+	-	-	+	-	+	-	+	+	6/10
Adolfsson, 2008 (31)	+	+	-	+	+	-	+	+	+	+	8/10
Elley, 2007 (32)	+	+	-	+	-	-	+	-	+	+	6/10
Kokanovic, 2007 (33)	+	+	-	+	-	-	+	+	+	+	7/10
Brown, 2006 (34)	+	+	-	+	+	-	+	+	+	+	8/10
Hornsten, 2005 (35)	+	+	-	+	+	-	+	+	+	+	8/10
Lock, 2004 (36)	+	+	-	+	+	-	+	+	+	+	8/10
Pooley, 2001 (37)	+	+	-	+	-	-	-	+	+	+	6/10
Cable, 1999 (38)	+	+	+	+	+	-	-	+	+	+	8/10
Butler, 1998 (39)	+	+	-	+	+	+	+	+	+	+	9/10
Arborelius, 1997 (40)	+	+	-	+	+	+	+	+	+	+	9/10
Haugland, 1996 (41)	+	+	-	+	+	-	-	+	-	+	6/10
Willms, 1991 (42)	+	+	+	+	+	-	-	+	+	+	8/10
Stott, 1990 (18)	+	+	+	+	+	-	-	-	+	+	7/10

et al., O'sullivan et al. and Hornsten et al. put emphasis on autonomy supportive consultation styles (23;28;35). In the study by Hardcastle & Hagger to provide physical exercise and diabetic counselling support and encouragement was considered more important than advice and information (25).

O'sullivan et al. report a strong satisfaction from participants in being supported with aspect to autonomy and letting the patient be in control of the decision making process and simultaneously in conveying a sense of responsibility into these decisions (28). Participants do not like being told what to do but to acknowledge what is needed together with their counsellor and thereby feeling responsible. Autonomy is delivered from having an ability to choose among different alternatives and getting to set the agenda for exercise for themselves. (28).

The Doctor-Patient relationship

Twelve out of 21 studies emphasised the importance of a good doctor-patient relationship (18;23-25;29;31;33;35-38;42). According to Hansen et al. and Walseth et al. this facilitated a good reception and tolerance of advice within the patient and impeded feelings of aversion or submission. Patients, who empathised with their practitioner, accepted and welcomed advice (18;24;27-30;34;36;39). Apart from increased tolerance, a good relationship could create a sense of responsibility towards the healthcare practitioner (23;25;26;29;31;42) and could determine whether advice were acted upon or not (18). A successful relationship was described more as a partnership and contrasted with images of a more paternalistic approach (23;35). Adolfsson and colleagues described, in their setting of an empowerment group, relationships of horizontal nature where changing and learning came through active involvement rather than by receiving knowledge and complying (31). A more hierarchical relationship could in turn make patients lie to HCPs (24) or withhold information and questions (33;37). Patients across the sample of studies appreciated when the HCPs were familiar with their personal circumstances and when patients were regarded as experts of their life (29;33). In the study by Dellasega et al. the patients reported enjoying talking to MI trained nurses instead of standard condition doctors because of "being heard and responded to as a person" (23).

Individualisation & involvement

Six studies stressed the need for patient involvement during consultation (23;26;27;31;35;42). The Dellasega et al. participants reported agreement with a partnership in planning and goal setting together with MI-trained nurses. Nurses way of informing patients, letting them decide among alternatives, acted as empowerment to make own decisions using nurses as a resource. A tailored approach, fit to the unique patient, was centred by nine out of the 21 studies reviewed (27-29;32;33;37;39-41). According to Dellasega et al. one way of facilitating the relationship to patients was by using patient centred communication (23) which was described by Butler et al. as respectful, responsive and understanding. Being heard and listened to in an interested way as a way of performing a patient centred approach were emphasised by several studies (18;23;25;35;37;40).

Stigma

Seven studies concerned the topic of stigma within the patient and concerned mostly smoking or weight related living habits (24;26;30;34-36;39). In the Hansen et al. study perceptions of stigma was a prevalent finding. This included the feeling of smoking being the only thing on the doctor's mind and, to the patients, an unrealistic causality with smoking being blamed by health professionals for every sign of disease. Strategies to avoid this included lying to doctors about smoking status.

Time and ongoing interventions

To participate in lifestyle discussion the patients wanted sufficient time during the consultation (29;33;34;37;41), and ongoing support (25;27;28;32). Oftedal pointed out the importance of receiving supportive feedback from HCPs to motivate ongoing life style remodelling and in the same time emphasising its constant presence (27). Ongoing guidance and support were further acknowledged by O'sullivan et al., with participants emphasising the meaning of ongoing support from a physical activity counsellor in addition to physical activity counselling from their ordinary HCP.

Empathy

Participants from four studies included empathy (23;27;29;33). Dellasega et al., Oftedal et al. and Kokanovic et al. all emphasised the need to receive empathy during consultations (23;27;33). Oftedal et al., in their study of support and education to self-manage DM-2, underscored the importance and breadth of empathy in consultations, reporting empathy as the main ingredient in support. Empathy, being defined by participants as "an understanding, listening and holistic approach", impede participants to be honest to their practitioners, being willing to engage in conversations, whereas lack of empathy gave the most opposite effect. Participants underscore the listening aspect of empathy, waving of text book solutions to lifestyle and making it more about the patient where empathy is seen as a way to gain a holistic approach to the individual's needs. Another kind of empathy was wished for by participants in the Walseth et al. study (29). They see empathy as a way of support, such

as appreciation when things go well, but also seek for encouragement, consolation and support when things don't. This also emphasises that patients in the Walseth condition see the practice of lifestyle intervention as an ongoing process in partnership with HCP.

Attitudes not favoured by patients

In addition, eight studies described attitudes that were not favoured by patients. Six studies rejected attitudes described as vertical, paternalistic or preaching (23;24;31;33;35;40). Although, some of the participants in the Hansen condition did not reject to a lecturing consultation style about smoking (24). Two articles mention lack of interest for discussion among staff (35;41). Patients strongly strived for non-judgmental treatment from HCPs (23;26;34).

Quality of studies

On a scale from zero to ten the assessment of the study quality ranged from six to nine with a median value of seven (see table 1) with regard to the CASP assessment tool. Most commonly studies did not discuss choice of design within the qualitative field (such as why a focus group is chosen instead of individual interview etc). Another common shortage was a discussion of the researchers' own role in formulating research questions or possible part in the outcome narratives.

Discussion

This review included twenty-one qualitative studies involving 760 (498 women/ 262 men) patients participating in HP counselling. The main experiences and preferences of patients undergoing HP counselling showed in the doctor-patient relationship; individualisation & involvement; encouragement, empowerment & support; and stigma. Further, but less frequent themes, were time & ongoing interventions; empathy; and attitudes not favoured by patients.

The doctor-patient relationship was further examined in a review by Di Blasi et al. (44), which showed that friendly appearance supports the patient's health outcome, but also that studies in this field are methodologically complex to conduct. This is further supported in a study by Moller Hansen et al. (45). In their work-shop based study about patient education, one major theme from participants was ensuring 'Entirety' in the meeting with the doctor. Entirety is about connecting what has happened in the past with what is present today, which put special focus on the doctor-patient relationship. Entirety is also about taking a patient centred viewpoint, to see the person instead of the disease. This is an aspect of individualisation which therefore could be seen as an outcome of a good doctor-patient relationship and as the ability to provide individualised care.

Another recurrent theme is that of support, which in terms of Bandura's social cognitive theory is about increasing clients concept of self-efficacy through encouragement and being positive (12). Supporting self-efficacy strengthens the individual's confidence about capability to perform certain activities, possibly lifestyle modification. To support self-efficacy is also to consider lasting behaviour change, and is associated with positive feedback, which was also mentioned as desirable, by several of the studies. Hardcastle interprets this as to use individualised feedback and to set personalised goals (25). A way of increasing autonomy, competence, as well as self-efficacy is by using an MI approach. This was done in the study by Dellasega et al. (23). Although here used in a longer term intervention, the essence of the approach can be used in every day consultations by using open-ended questions, affirm and support patients' self-confidence by using reflective listening and by summarising discussion (23).

Also mentioned, the presence of stigma put forth by several studies pose special consideration by HCPs, and patients in these studies wish for a sensitive approach (24;26;30;34-36;39). The opinions of the overweight or obese have furthermore been investigated by Gray et al. who found a wide spread of opinions, but propose avoiding terms as 'Fat', while 'obese' although also negative to patients were considered effective within the frame of health discussions (46). Equally important is the subjectivity of experience mentioned by Malterud et al. (26). This is important in the case of perceived paternalistic, hierarchal or preaching communication styles perceived from the aspect of patients where, as Malterud et al. puts it "exploring encounters between doctor and patient from the perspective of one of them – the patient – will not provide access to the motives or attitudes of the other" (p 208). That is to say, what have been perceived as stigmatising or humiliating may have been with the best of intentions.

The hierarchical communication patterns were among the most prevalent of unfavoured behaviours in this review (23;31;33;35;40). Although, the results of Hornsten also provide an alternative possible conclusion that unfavoured behaviours were the mere failures of delivering the wanted ones such as empathy, autonomy or equality (35).

The need for time in form of constant or prolonged surveillance and control was apparent in many of the studies. This is in line with the second and less successful

means of behaviour motivation postulated by Deci and Ryan in Self-determination theory. This theory suggests that motivation can either be autonomous or controlled, where autonomous means of motivation is strived for as this extends behaviour change beyond intervention time frames (11). This theory suggest three psychological needs for behavioural activation; autonomy, competence and relatedness. All three are suggested by independent studies in this review, where a lack of choice produce resistance and acknowledgment of feelings, and perspectives produces incentives to change. MI has previously been associated with all three concepts of psychological need for behaviour change postulated by self-determination theory. Although MI in the studies reviewed was used more as a controlled intervention it is, as postulated by Hardcastle, also possible to use this as an approach in regular counselling and conversation. Another of the main ingredients to MI-inspired communication is empathy, which is emphasised as important in four of the reviewed studies (23;27;29;33). Pollak et al. provide further support to the importance of empathy, which, as delivered by doctors during weight-loss discussions can increase patients' attempts to lose weight by providing empathy in the consultation (47).

The present review shows that primary care and diabetes constitute the load of attention from researchers. Eggleston et al. show that GPs and practice nurses are the most appropriate professional category to deliver professional advice according to patients (48), and most studies concerned in this review focused GPs and practice nurses. Although, since the health promotive paradigm is to be spread everywhere in healthcare (1), more research is necessary to investigate the roles of professionals other than the GP and Nurse Practitioner, and to healthcare settings other than primary care. Also the perceptions of hospitalised patients and special populations merit more focus since none of the studies rendered by this review mention these.

This review has several strengths and limitations. The comprehensiveness and the broad searching for literature are strengths. However, still many papers may have been overlooked according to the tradition of grey literature in qualitative studies. Other publication bias would be similar to those known from quantitative studies, i.e. positive or unique results and English language skills (49).

Although this review did not search for qualitative material only, it was expected from the start that the majority of material would be of such type. Several authors have emphasised the limitations of carrying out a systematic literature search of qualitative studies (50-52). Evans et al. described the difficulties of using title searches for qualitative studies, which in qualitative standards are more descriptive than informative. Further, abstracts of qualitative studies have been under less evaluation and may lack the type of structure and standard known to RCTs (51). Both Evans et al. and Mays et al. suggest differences and deficiencies in indexing of qualitative material in scientific databases (51;52). This might be because of less interest in qualitative studies during early development of evidence based medicine. In all, difficulties as such may make the search process less efficient in finding everything written on a subject and authors may expect a lot more material from the hand search not covered by the systematic literature search (50;52), for example as much as half of included studies in a study by Casteel et al. (53). For the reviewer this might mean, as for Harden et al. who report difficulties finding qualitative material for their review, a need to use a wider scope returning a large number of citations to include relevant qualitative material (50).

The concept of quality is another limitation of debate concerning qualitative studies as for how much emphasis, and in what way, quality is to be measured (54). For quality selection and criteria this review acknowledged the need for a quality assessment, but in agreement with Dixon-Woods et al. (54) faced the difficulties in choosing such criteria for such a diverse field as qualitative research and that quality does not necessarily have much to say about individual narratives in an otherwise flawed study as concluded by Hannes (20). Thus, in agreement with Harden et al. (50), quality assessment was not used as an exclusion criteria but instead to inform the reader, to make sure studies do in fact assess intervention and outcome in the subject of review (20) and as a way of the exploration and interpretation process (55). It is, as according to Hannes, about detecting methodological flaw, yet maintaining the importance of the narrative (20).

In congruence with Dixon-Woods et al. (21) there are numerous ways to conduct a meta approach to qualitative research. Two main categories of synthesis can be identified; the integrative and the interpretive. Integrative synthesis will allow for causal generalisations but demand secure parameters and well defined concepts. The interpretive will avoid specifications beforehand and aim to develop these along analysis. Although theories of meta-analysis seldom consist exclusively of one or the other, proportions of these two main directions exist within every technique. For this review we chose the thematic analysis as described by Dixon-Woods et al. (21) similar to the narrative review (56), because of its suitability with reoccurring themes. According to Dixon-Woods et al. the thematic analysis "involves the

identification of prominent and recurrent themes in the literature and summarising findings of different studies under thematic headings" (p 47) (21). As most studies in this review used a thematic approach conceptualising participants' narratives into common themes, the narrative approach was fitting since strategies like thematic analysis and narrative reviews "seeks to identify and bring together the main, recurrent or most important issues or themes arising from a body of literature" (p 12) (52). Such an approach demands that data and themes are well defined such to avoid forming new themes or concepts (21).

From a clinical perspective it is important to realise that patients have important experiences and clear preferences to use for future HP counselling. However, it is unknown to which degree the results of this qualitative review will have an effect, if they are generalised and implemented, or if the value lies in the further generation of new hypotheses or qualification of existing hypotheses to become evaluated in for instance a randomised design to create evidence at a higher level. In case of direct implementation it would be relevant to carefully monitor the results and outcomes. It is also important to evaluate the possibilities of generalisibility of the results beyond those specific settings and realities of the individual studies (57).

From a research point of view, this review has given a collated overview of the existing papers, their quality and results. Interestingly the quality of the studies included was relatively good. The review process has shown the need for better structured abstracts and articles.

To our knowledge this was the first review to gather and present what is known on the patient's perspective of lifestyle counselling within healthcare. In conclusion this review identified the importance of encouragement, empowerment & support, a good doctor-patient relationship; individualisation & involvement; the significance of stigma, distributing sufficient time for discussion and the advantages of showing empathy while discussing healthy lifestyle change with patients.

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Appendix 1 Search strategy, Medline

1	MH "primary health care+"
2	MH "general practice+"
3	MH "inpatients+"
4	MH "outpatient clinics, hospital+"
5	MH "pregnant women+"
6	MH "alcoholics+"
7	MH "alcohol drinking+"
8	MH "drug users+"
9	MH "mental disorders+"
10	MH "psychiatric nursing+"
11	MH "smoking+"
12	MH "diabetes mellitus+"
13	MH "cardiovascular diseases+"
14	MH "lung diseases+"
15	MH "vulnerable populations+"
16	MH "overweight+"
17	MH "sedentary lifestyle+"
18	(TI maternal N2 care) OR (AB maternal N2 care)
19	(TI maternal N2 care) OR (AB maternal N2 care)
20	(TI maternal N2 "health care") OR (AB maternal N2 "health care")
21	(TI maternal N2 "health care") OR (AB maternal N2 "health care")
22	(TI "maternal health" N2 service*) OR (AB "maternal health" N2 service*)
23	(TI alcohol N2 use*) OR (AB alcohol N2 use*)
24	(TI drug N2 use*) OR (AB drug N2 use*)
25	(TI psychiatric N2 patient*) OR (AB psychiatric N2 patient*)
26	(TI diabetes) OR (AB diabetes)
27	(TI surgical N2 patient*) OR (AB surgical N2 patient*)
28	(TI special N2 population*) OR (AB special N2 population*)
29	(TI inactive N2 lifestyle*) OR (AB inactive N2 lifestyle*)
30	(TI obes*) OR (AB obes*)
31	(TI sedentary) OR (AB sedentary)
32	(TI smoker*) OR (AB smoker*)
33	(TI hospitalized N2 patient*) OR (AB hospitalized N2 patient*)
34	OR/1-33
35	MH "data collection+"
36	MH "questionnaires+"
37	MH "qualitative research+"
38	MH "focus groups+"
39	(TI qualitative) OR (AB qualitative)
40	(TI survey*) OR (AB survey*)
41	OR/35-40
42	MH "health promotion+"
43	MH "patient education as topic+"
44	MH "counseling+"
45	MH "health education+"
46	MH "early intervention+"
47	MH "early intervention+"
48	MM "Early Intervention (Education)"
49	TI counsel#ing) OR (AB counsel#ing
50	(TI health N2 advice*) OR (AB health N2 advice*)
51	(TI lifestyle N2 advice*) OR (AB lifestyle N2 advice*)
52	(TI health N2 counsel#ing) OR (AB health N2 counsel#ing)
53	(TI health N2 education) OR (AB health N2 education)
54	(TI simple N2 advice*) OR (AB simple N2 advice*)
55	(TI advice*) OR (AB advice*)
56	(TI minimal N2 intervention*) OR (AB minimal N2 intervention*)
57	(TI brief N2 intervention*) OR (AB brief N2 intervention*)
58	(TI motivational N2 enhancement*) OR (AB motivational N2 enhancement*)
59	(TI motivational N2 interviewing) OR (AB motivational N2 interviewing)
60	(TI behavio#ral N2 counsel#ing) OR (AB behavio#ral N2 counsel#ing)
61	(TI extended N2 intervention*) OR (AB extended N2 intervention*)
62	(TI stage* N2 change) OR (AB stage* N2 change)
63	(TI goal N2 setting*) OR (AB goal N2 setting*)
64	(TI negotiation N2 method*) OR (AB negotiation N2 method*)
65	(TI self N2 efficacy) OR (AB self N2 efficacy)
66	(TI reasoned N2 action*) OR (AB reasoned N2 action*)
67	(TI social N3 learning N3 theor*) OR (AB social N3 learning N3 theor*)
68	(TI patient N3 cent#red N3 counsel#ing) OR (AB patient N3 cent#red N3 counsel#ing)
69	(TI planned N2 behavio#r*) OR (AB planned N2 behavio#r*)
70	(TI health N4 action N4 process N4 approach) OR (AB health N4 action N4 process N4 approach)
71	(TI FRAMES) OR (AB FRAMES)
72	(TI 5A) OR (AB 5A)
73	OR/42-72
74	MH "patient satisfaction+"
75	MH "patient preference+"
76	MH "attitude to health+"
77	MH "professional-patient relations+"
78	MH "patient acceptance of health care+"
79	(TI patient N2 opinion*) OR (AB patient N2 opinion*)
80	(TI patient N2 perspective*) OR (AB patient N2 perspective*)
81	(TI patient N2 perspective*) OR (AB patient N2 perspective*)
82	OR/74-81
83	34 AND 41 AND 73 AND 82

Appendix 2 *(1/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Dellasega 2011	19 (9w/10m) DM-2I from an RCTII (intervention group). Gen med clinics and primary care.	Adult, > 1 yr in RCT study, diverse sample, underserved neigh-bourhood.	Nurses with 4 months MI[III]-training.	Patients' preferences after MI.	Focus group, exp facilitator, PhD.	Min. 4 MI sessions over 1 yr.	"All areas of lifestyle change".	Interpretative Pheno-meno-logical analysis (IPA).	MI, patient centred communication.	5 themes: Non-judgmental account-ability, being heard and listened to as a person, encourage¬ment and empower¬ment through em¬pathy, collaborative action planning and goal setting and coaching rather than critique.	DM-2 patients receptive to MI counselling technique. The MI approach applicable to everyday consultation.	7/10
Hansen 2011	32 (9w/23m), Smokers at time of first time ACSIV. Public hospital and primary care.	Adult (40-74). Ongoing smokers + abstainers, minimum 1 yr.	Doctors, primarily General practioners (GPVs).	Patient's view of doctor's role in smoking cessation talks.	Semi-structured interviews by research assistant.	Smoking cessation counselling by doctors of different speciality.	Smoking.	Grounded theory and Constant Comparison Method.	None specified.	Major themes: Advice, stigma and support. Unsolicited advice unwanted, personal experience of doctors preferred, GPs positively viewed and were less likely to lecture. Feeling stigmatized by doctors.	Doctors should avoid lecturing, engage in dialogue and inform patients of cessation possibilities.	7/10
Hardcastle 2011	14 (9w/5m) overweight from an RCT (intervention group). Primary care.	18-65 yrs. > 1 CHD[VI] RF[VII] Both un- + successful participants.	PA specialists + dieticians trained in MI.	Patients' perceptions + experiences of counselling.	Semi-structured interviews performed by nurse.	5 MI-sessions over 6 m.	PA[VIII], Diet CHD RF.	Inductive thematic content analysis.	MI self determination theory, self-efficacy theory.	4 themes: Monitoring and support; Listening support; Motivation and selfregulation; Barriers.	Extended contact and support were deemed necessary for these patients.	8/10
Malterud 2010	13 (8w/5m), obese patients. Primary care.	Adult (30-55). BMI[IX] > 40 or > 35 + additional related problem.	GPs.	Patients' experiences with weight management by GP.	Gender separate focus group by first author. Introduced with an openended question.	Lifestyle consultation towards weight reduction and referral.	Weight management.	Systematic text condensation.	Stigma.	Patients want their GP to discuss weight problems non-judgmentally, although not loosing focus other aspects of the consultation. Patients want information of choices available.	Doctors are to discuss weight in an individual-ized/ EBM[X] -manner, while preserving patient dignity.	7/10
Oftedal 2010	19 (7w/12m) DM-2. Diabetes coping and learning centre, primary care, diabetes association.	Adult (30-65). ≥ 1 yr from Diagnosis.	GPs in primary care condition.	Patient's descriptions of support by HCP[XI].	Semi-structured Focus group × 2, by first author.	Structured educational diabetes programme, or standard GP care.	DM-2 self management.	Qualitative content analysis.	The expectancy-value model of achievement motivation and social support theory.	Five main themes of support from health care practitioners: An empathetic approach, practical advice and information, involvement in decision-making, accurate and individualized information and ongoing group based support.	Empathic, individualized, practical and ongoing support can be used to empower DM-2 patients to self manage disease.	8/10
O'sullivan 2010	15 (11w/4m) from PA-Coun-seling RCT (intervention group). Primary care.	Adult (32-65). Diverse sample, intensive counselling arm of intervention.	Not specified for learning centre condition.	Patients' perceptions + patient attributions of successful intervention.	Semi-structured interviews × 3 by exp qualitative researchers.	Brief PA counselling + 6 sessions (3 mths) in congruence with SDT[XI].	PA.	"Variant of Grounded theory".	SDT [XII].	9 themes: Satisfaction with intervention, intensive counselling, the tailored approach, autonomy support, competence through encouragement, information and strategies, relatedness, further recommendations.	Satisfaction and feasibility of PA-counsellor in primary health team. A tailored approach and autonomy-supportive counselling.	7/10

Appendix 2, *continued (2/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Walseth 2010	12 (5w/7m), life style related disease. Primary care.	Adult, 1 teenager, Pt's provided by GPs as suitable. Ag-enda to dis-cuss lifestyle.	Experienced GPs.	Habermas' communication theory + important topics to pt in lifestyle con-sultation.	Observation, semi-structured interviews × 2 (3 months apart) by experienced GP.	1 session, standard lifestyle consultation in primary care.	General life style consultation. Not specified.	Systematic text condensation.	Patient-centred medicine (PCM), shared decision-making and Haberma´s communication theory.	A good doctor-patient relationship and Patient-Centred Medicine creates common ground and facilitates responsibility, motivation and facilitates responsiveness to advice. Support/encouragement.	Pt's want time for dialogue. Long term effects of good relations and personalized care.	7/10
Horne 2009	127 (81w/46m), regularly activesedentary older adults. Primary care.	Adult (60-70). Diverse sample regarding, ethnicity, health, PA-experience.	Primary health care practitioners (PHCP).	Patient's experiences + pre-ferences of talking to PHCPs about PA.	Etnographic approach, semi-structured focus group or interview by author. Real-timetranslation when needed.	PHCP PA-counselling.	PA.	Frame-work approach.	None specified.	Use of encouraging and positive information, avoidance of ageist remarks.	PHCP advice is welcome as primary pre-ventive measure rather than secondary prevention.	6/10
Adolfsson 2008	28 (14w/14m), DM-2, from RCT, (intervention + control group). Primary care.	Adult. Usual diabetes care (individual) or and also empowerment group (control).	GPs and Diabetes specialist nurses.	Patients experiences of empowerment group or individual counselling.	Semi-structured interviews.	DM-2 education, 2 approaches.	DM-2 self management.	Qualitative content analysis.	None specified.	Horizontal communication appeared in empowerment group making learning participatory. Vertical, one-way communicative in counselling, making learning compliant reducing sense of responsibility.	Individual counselling need to involve patients actively and use horizontal relationships.	8/10
Elley 2007	15 (9w/6m), sedentary adults from RCT (intervention group). Primary care.	Adult (43-78). Both un - + successful participants.	GPs or Practice Nurses.	Patients' attitudes and experiences of RCT intervention.	Semi-structured telephone interviews.	Tailored physical activity + written advice on PA-prescription + telephone support 3m.	PA.	Content analysis.	Transtheoretical model of change.	Four themes: Tailored advice (personalised, advise characterised as physically, psychologically and socially acceptable), Barriers, Internal motivators and Significant others.	Continuous support may be expensive to incorporate but effective. HCPs need to address themes put fourth by patients.	6/10
Kokanovic 2007	30(15w/15m), DM-2 Primary care.	Adult (mean 66.43). DM-2 diagnose > 5 yr, oral medication or insulin, no complications Immigrants.	GPs.	Perceptions of interaction with GP about DM-2.	Semi-structured interviews by author or interpreter.	DM-2 consultation by GP.	DM-2 self management.	May's and Pope's framework of qualitative research.	Shared decision making.	Patients appreciated additional time, understanding of personal circumstance and empathy. Success is put in partner¬ship terms, though relationships most often considered hierarchical.	Communication and relationships are crucial to patients chronic disease or preventive care.	7/10
Brown 2006	28 (18w/10m), obese. Primary care.	Adult (19-77). BMI > 30 + aware of diagnosis and suitable for interview.	GPs.	Patients' perceptions and experiences of support in primary care.	Semi-structured interviews.	Lifestyle consultation towards weight reduction.	Weight management.	Grounded theory.	Stigma.	Elements of longer intervention and non-judgmental practical support as well as longer term support groups being non-judgmental, sensitive and clear gained most approval.	Clear, non-judgmental communication with recognition of stigma associated with obesity.	8/10

Appendix 2, *continued (3/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Hornsten 2005	28 (18w/10m), obese. Primary care.	Adult (19-77). BMI > 30 + aware of diagnosis and suitable for interview.	GPs.	Patients' perceptions and experiences of support in primary care.	Semi-structured interviews.	Lifestyle consultation towards weight reduction.	Weight management.	Grounded theory.	PCM.	Agreement/disagreement about goals, autonomy and equal/ adaptation and submission, worthy/ worthless, attended and welcomed/ignored, safe and confident/unsafe and lacking confidence.	What satisfies patients simulate PCM. Focusing on what's good and what's less good can improve consultations.	8/10
Lock 2004	44 (21w/23m), DM-2. Primary care.	Adult (40-80). DM-2 > 2 yr, from 4 Health care centres.	PHCP.	Reflections and experiences on clinical encounters.	Interviews with set initial question.	DM-2 consultation in primary care.	DM-2 self management.	Qualitative content analysis.	None specified.	Positive to advice in an appropriate context. Unwarranted advice instead of acknowledgment gave humiliation. Doctor-patient relationship facilitated permitting climate.	PHCP should indulge in positive lasting relationships to create a positive climate for lifestyle discussion.	8/10
Pooley 2001	47 (gender not specified), DM-2. Primary care.	Adult (50-76). DM-2, > 50 yr of age, living at home.	Primary care diabetes teams. Mainly GP setting, but significant spread in care regimes.	Central issues in diabetes management with emphasis on doctor-patient relationship.	Semi-structured interviews.	By diabetes team.	DM-2 self management.	None specified.	PCM.	Five themes: Time, continuity, questioning, listening, individuality.	For efficient diabetes care there is an increased need of staff and time to make sufficient relational investment.	6/10
Cable 1999	25 (0w/25m), patients with increased risk of CHD, from OSDAT study 1972-1980 (intervention group of 1975). Primary care.	Adult (62-71). s-cholesterol ≥ 6.9 mmol/l syst. BP < 150mm Hg. Both un- + successful participants. 80 % smokers.	GP and dietician.	Patient perceived factors of long term, behavioural change.	Semi-structured focus groups by fourth author.	Smoking cessation advice and dietary education.	Diet and smoking.	Method according to "long interview" by Crabtree and Miller(43).	Locus of control theory, transtheoretical model, health belief model, social learning theory.	Five themes identified: Doctor-patient relationship, significant others, motivators, barriers and empowerment.	Great importance of doctor-patient relationship supporting long term behaviour change. Should be emphasized in medical.	8/10
Butler 1998	42 (24w/18m), smokers, from RCT (intervention group). Primary care.	Adult. Opportunistic recruitment. Quitters + ongoing smokers.	GPs.	Patient' experiences of oppor-tunistic anti-smoking intervention.	Semi-structured interviews by social scientist and general practitioner.	Opportunistic smoking intervention talk.	Smoking.	None specified.	None specified.	Patient centred approach (respectful, sensitive, understanding, not preaching). Patients sceptical about persuasiveness of doctors and some found it irritating.	Doctors should engage in a caring and respectful way but not all may benefit from repeated advice.	9/10
Arborelius 1997	13 (13w/0m), birth giving mothers. Antenatal clinic.	Adult (20-38). Birth givers + smokers during antenatal visits.	Midwives.	Perceptions + experiences of smoking in pregnancy.	Structured inter-views by midwives during home visits.	Smoking related information or advice by midwives.	Smoking.	None specified.	PCM.	Most women agree, authoritarian advice or lecturing style is inefficient counter productive. Friendly, positive and asking attitude preferred.	Midwives should act in a patientcentred way and support mothers self image.	9/10

Appendix 2, *continued (4/4)*

Study	Patients and setting	Incl. criteria	Counselling staff	Aim	Method	Intervention	HDS	Analysis	Frame of reference	Outcomes	Conclusion/ implication	Quality of study
Haugland 1996	33 (33w/0m), Pregnant smokers. Ante-natal clinic + primary care	Adult (>20). Pregnant, daily smokers pre con¬caption + on¬going at first ultrasound.	GPs and midwives.	Patients' experience of info at antenatal clinic + smoking cessation assistance	In depth, semi-structured interview, by first author in week 27-35 of pregnancy.	Smoking cessation counselling from midwives and GPs.	Smoking.	Hermeneutic, phenomenological. Case analysis and Cross case analysis.	Self efficacy.	Patients experienced lack of interest and supporting smoking conversations. Often the topic wasn't mentioned or to discrete. Patients wanted repeated updating.	Midwives and GPs are responsible to raise smoking subject.	6/10
Willms 1991	43 (23w/20m), from a clinical trial, smokers. Primary care.	Adult. Patients offered participation in trial during regular office visit.	GPs.	Patients perspectives of efficient "personalistic" components of intervention.	Ethnographic method, open-ended questions, "relatively unstructured". Several interviews/ patient, spanning over one year.	Highly structured smoking cessation intervention.	Smoking.	Etnographic analysis.	None specified	Degree and nature of support mostly valued by participants. Patients value "positive imagry", good doctor-patient relations generating sense responsibility. Less of actual intervention.	More should be done to create clinically based support groups.	8/10
Stott 1990	130 (130w/0m), Mothers, Primary care.	Adult (25-40). Participants of earlier study, General practice population + "Mothers of lower social class".	GPs.	Contrast quantitative survey material on perception of HP in primary care to qualitative follow up.	Survey material and semi-structured interview by second author and research assistant.	Lifestyle advice by GP.	Weight problem, smoking problem, drinking problem and/or fitness problem.	None specified.	PCM.	Respondent accepted advice but expected them to be relevant to their situation. Responsibility of the individual emphasized. Doctor-patient relationship determines how advice is perceived and acted upon.	Qualitative methods explain and strengthen quantitative data. Doctors should precede advice by investigating beliefs, investing in the relationship.	7/10

Abbreviations
I = Diabetes Mellitus Type 2, II = Randomized Control Trial, III = Motivational Interviewing, IV = Acute Coronary Syndrome, V = General Practitioner, VI = Coronary Heart Disease, VII = Risk Factor, VIII = Physical Activity, IX = Body Mass Index, X = Evidence Based Medicine, XI = Health Care Practitioner, XII = Determination Theory.

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

Research and Best Practice

Abstracts selected for publication

This year we continue the feature introduced last year at the 20th International HPH Conference, where a collection of scientific abstracts are selected for publication in Clinical Health Promotion. The abstracts represent posters presented at the 21st International HPH Conference in Gothenburg in May 2013. The selection of the abstracts was conducted by our Journal Editors, and the selection illustrates the methodological and international breadth of the research performed within the area of Clinical Health Promotion.

Two schools of thought: barriers and incentives to cycling among staff in a Dublin academic hospital

Kirsten Doherty, Irene Gilroy, Nicole Donnelly, Wayne Matthews, Greg Conlon, Patricia Fitzpatrick, Anna Clarke, Daly Leslie, Cecily Kelleher

Introduction

Recent medical journal articles have highlighted the contribution of active commuting, such as cycling, to exercise levels (1), and have recommended that health services do more to promote such exercise among their staff (2). Country comparisons have shown that those with the highest levels of active transport generally have the lowest obesity prevalence (3). Since 2006, this hospital has promoted cycling in staff through improved facilities and cycling events, while since 2009, national and local incentives have been introduced.

Purpose/Methods

A staff survey of cycling was carried out at a tertiary referral hospital during Bike Week 2011. Questionnaires were sent electronically to staff with computer access, while paper copies were placed in the canteen. The survey was completed by 192 staff members. Analysis with SPSS established the proportion of staff who cycled to work, and as well as perceived barriers and incentives to cycling.

Results

40.6% (n=78) cycled frequently/always, while 8.9% (n=17) cycled occasionally. From 2007–2010 there was a 37.9% increase in the numbers that started cycling. Intending cyclists were more interested in safety classes than those already cycling (21.6% versus 5.3%; p=0.001), while cyclists placed more importance on facilities (34.7% versus 12.4%; p<0.001) and bike maintenance classes (25.3% versus 2.1%; p<0.001). Among those that never cycled there was a trend for more men (40%; n=4) than women (16%; n=14) to be concerned about weather (p=0.066).

Conclusions

These results are of international relevance. While this is a self-selected sample, it does identify two distinct groups of cyclists – seasoned and potential – with diverse priorities. The needs of each group should be catered for to increase the rate of cycling in those who live relatively close to work. Health service employers should lead by example and use best practice methods of increasing active transport among their own staff.

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Research and Best Practice

Standing Up for the Health of our Workforce

Kirstan Corben, Andrew Way

Introduction
Alfred Health has demonstrated leadership and innovation in responce to emerging evidence regarding the health risk of occupational sedentariness, specifically prolonged sitting. Through a research trial among its workforce, Alfred Health has identified high levels of user acceptance of sit-stand workstations. Such a workstation retrofits to an existing workspace and enables a computer to be used in either sitting or standing position. This research contributes new knowledge highly applicable to other health services committed to achieving a healthy workplace.

Purpose/Methods
The overall aim of the research was to determine the level of user acceptance of sit-stand workstations over a three month period. More than 100 Alfred Health employees were engaged as participants in this research trial. Priority was given to those with high levels of exposure to prolonged sitting and therefore included strong representation from areas such as finance, health information services, human resources and payroll, information technology services as well as those in executive and administration roles.

Results
Based on self-reporting from the first 42 users to complete the three month trial period: (*) >90% retained the sit-stand workstation for ongoing use (*) Average sitting reduced from 90% to 56% of working time (*) 83% agreed the sit-stand workstation benefited them, particularly via: Improved sense of wellbeing (65%) Ability to concentrate or focus (48%) Sense of productivity (47%) 98% would recommend a sit-stand workstation to their colleagues working in desk based roles.

Conclusions
Alfred Health has identified a high degree of user acceptance of sit-stand workstations, matched by substantial replacement of sitting with standing. Such a result shows great promise for organisations to act to reverse the negative impacts associated with occupational sedentariness, particularly from prolonged sitting. Further consideration will be given to the broader implementation of such workstations throughout the organisation, together with other opportunities to reduce sitting in meetings and other settings away from the individual workstation.

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Health promotion for all communities through "Health Challenge"

Zenjirou Kikuchi, Fumihiro Saitoh, Kyota Negish

Introduction
Japanese Health and Welfare Co-operative Federation (HeW CO-OP JAPAN) is a co-operative that operates medical and long term care facilities. The aim is always working on a community plan that is continuous to living in peace in our familiar region through mutual aid and health promotion. The Tokyo Health Co-op is a member of HeW CO-OP JAPAN and consists of 50,000 members, including medical staff and community. The Tokyo Health Co-op is managed in the center of Tokyo, Japan.

Purpose/Methods
We conducted nine health promotion courses to improve individual health and lifestyle, under the name "Health Challenge". Each course continued for two months. There were 105 participants (15% of all 700 members in branch-community) in the area of Doshida-Oizumi, which is a branch of our co-op. Data was recorded daily, and after two months questionnaires were handed out and data analysed.

Results
The analysis of the data from the questionnaires showed that 90% of the participants completed their "Health Challenge"-course. They were able to reevaluate their behaviors and lifestyles: nutritional balance, exercise and tooth brushing after every meal. The 10% of participants who stopped had future plans for health promotion. The incentive and recognition of health promotion seem to have rooted in all community members. Moreover, opportunities to interact with the participants have increased through the personal contact when the questionnaires were handed out.

Conclusions
From our study we made three conclusions: 1) The participants were able to objectively reconsider their own health, which led to reviewing their lifestyle. 2) Recognition of health promotion was widespread in our community as a result of more than 100 participants. 3) Apart from health care, we have been cooperating on life style changes, which have contributed to developing a trustful dialogue concerning health in our community.

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Research and Best Practice

Västerbotten the Healthiest County 2020

Lena Sjöquist Andersson, Lina Tjärnström

Introduction
The vision for Västerbotten County Council is to have "The world's highest quality of health and healthiest population by 2020". The county council has, since the 1980's, worked close together with the local communities in Västerbotten to achieve a healthier population and has also a variety of activities related to health promotion in health care. Metrics for the vision have been developed and are used to follow up on the efforts that have been made.

Purpose/Methods
Västerbotten Intervention Program (VIP) is aimed at members of the community aged 40, 50 and 60 years. Factors related to cardiovascular disease are in focus in a health dialogue about lifestyle. The Salute program supports parents and children to a healthy lifestyle. It includes maternity-, child- and public dental care, school and social services. A programme called Tobacco-Free Duo reaches young people and prevents tobacco use. The employees of the County Council are reached through the initiative "Healthy Workplace". Actions to support and create a healthy climate have been developed.

Results
Research shows that VIP can contribute to reduce differences in health, related to socioeconomic factors. Studies show that the Salute-program can increase collaboration to support healthier children. All communities in Västerbotten are engaged in the Tobacco-Free Duo programme and a reduced use of tobacco is observed. To reach the population, the website halsa2020.se has been created. The website offers a blog, chat, pedometer registration and a platform for exchanging experiences. During 2012 nearly 35 000 people visited the website.

Conclusions
The County Council of Västerbotten has a long tradition of public health work and health orientation of the health care system. The vision of being the healthiest county is an initiative that comes from brave politicians. Increasing efforts has been done during the last five years to reach the vision. The health development is constantly being monitored with research and it indicates that the health development is going in the right direction.

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The effect of free NRT on motivation to quit smoking

Ellen Excelmans

Introduction
The high cost of NRT is a major obstacle in taking the first step toward smoking cessation. In this pilot project, nicotine replacement products were given to psychiatric patients who wished to stop smoking. This had a positive effect on the willingness to make an extra effort in the attempt to quit smoking.

Purpose/Methods
The motivation to quit smoking was assessed by a questionnaire at two times: before the free NRT was embedded in the treatment and after 6 months.

Results
Providing free NRT for patients, who want to quit smoking, enhances the importance of the quit attempt and the willingness to make a bigger effort in their attempt to quit smoking. Self-efficacy and readiness are not influenced by giving NRT to the patients for free.

Conclusions
We use these findings as an argument to provide a financial contribution to NRT for psychiatric patients who want to quit smoking. Quit rates are lower among psychiatric patients. If their willingness to make an effort enhances, quit rates could perhaps rise. The study showed that providing free NRT has a positive effect on the willingness of putting in a bigger effort in the attempt to quit smoking.

Comments
In Belgium there is no refund for NRT. This is a serious obstacle in attempting smoking cessation. With this study we wanted to prove that giving a repayment of NRT will increase the motivation to quit smoking.

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Research and Best Practice

The status of HPH activities in Korea and initiatives toward advancement

Eunwoo Nam, Donwon Lee, Yunhee Jang

Introduction
The National HPH network of the Republic of Korea has 33 members and many of them are Regional Public Hospitals. They are important factors for the success of national health promotion projects as well as the community-based health care facilities. There should therefore be active support and cooperation from local and provincial governments. To help raise awareness about HPH activities among hospital executives and policymakers, further studies on Health Promoting Hospitals are necessary.

Purpose/Methods
This study aims to propose future directions for HPH activities in Korea, based on the result of a survey regarding current HPH activities, major obstacles etc. A questionnaire of 70 questions within 12 areas reflecting the reality of HPH in Korea, was developed. 5 HPH experts examined the validity of the questionnaire, after which the questionnaires were distributed to 34 people in charge of HPH projects. General frequency analysis and Radar Chart analysis were conducted to analyse the results by using SPSS 12.0.

Results
T56.7% of HPH activities were handled by existing departments and 80% of HPH personnel were put in charge of both existing tasks and HPH projects. ”A lack of governmental financial support” and ”inadequate linkage between hospital’s overall development direction and HPH activities”, were identified as major obstacles. ”CEO’s active support” and ”the opportunity for employees to participate in HPH projects” were identified as major facilitators with ”developing specific action plans”, ”applying standardized management index” as necessary conditions.

Conclusions
Along with the development of HPH, hospitals are expected to become major players in national health promotion projects in Korea. This will be followed by a need to establish an independent department focusing on HPH activities and governmental financial support. To increase the support from CEOs, we propose HPH education and field trips to hospitals overseas, which will increase the managements awareness about HPH activities. It is also imperative to utilize an HPH manual tailored to the situation in Korea.

Comments
We hope that HPH activities will become more effective, be continuously pursued, and managed at a local level through the establishment HPH infrastructure around the HPH members of Regional Public Hospitals.

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Paediatrician-lead motivational counselling is effective for BMI control in 4-7 overweight children: a individually randomized controlled trial

Anna Maria D Avoli, Elena Ferrari, Gino Montagna, Laura Bonvicini , Serena Broccoli, Paolo Giorgi Rossi, Gabriele Romani, Annarita Di Buono, Costantino Panza, Cinzia Cucchi, Alessandra Fabbri, Simone Storani, Marco Tamelli, Mirco Pinotti, Antonio Chiarenza

Introduction
Obesity is one of the leading causes of morbidity and mortality in the industrialised world. One of the risk factors for lifetime obesity is overweight and obesity in pre-puberty and adolescence. Healthcare services, particularly paediatricians, can be a point of contact for early prevention. Patient-centred and motivational counselling is recommended to change behaviours in children. However, the efficacy of a family paediatrician-lead counselling intervention in young overweight children is not clear.

Purpose/Methods
We conducted a randomised controlled trial to evaluate the efficacy of a family paediatrician-lead counselling in reducing the BMI of overweight (85th≤BMIpercentile<95th, CDC) children aged 4-7. The study was conducted in 2011-2012 and involved 75 out of 81 family paediatricians in Reggio Emilia Province, Italy. The children who were enrolled in the study attended a baseline and a 12-months visit, where BMI and lifestyle behaviour were assessed. The control group received the usual care and information leaflet. The intervention group received five counselling sessions, for which the paediatricians had been trained.

Results
187 children were randomly allocated to counselling and 185 to control; 95% of the children attended the 12-months visit. There were significant differences in variation of BMI score from baseline to 12 months between intervention (+0.49, 95%CI 0.31-0.67) and control group (+0.81, 95%CI 0.63–0.99). Counselling was particularly effective among females and among children with highly educated mothers. There were also an increased number of positive changes in dietary behaviours and physical activity in the intervention group than in the control group.

Conclusions
The compliance was excellent. The family (children and parents) paediatrician-lead motivational counselling studied in this trial was concluded to be effective for BMI control compared to usual care, in overweight children aged 4-7. Lifestyle behaviours were also affected positively by the intervention.

Comments
Our pragmatic trial, involving virtually all the Reggio Emilia family-paediatricians and a vast majority of eligible children, proved at the same time efficacy and effectiveness of the intervention. Paediatricians' satisfaction, assessed with an interview, was very high. Our results encourage the use of BMI measurement and motivational counselling in primary care practice for early intervention in overweight children.

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Health Promotion in the Hospital: A Health Promotion Needs Assessment Survey of Nurses at Changi General Hospital, Singapore

Jia Min Foo, Li Jiuen Ong, Magdalin Cheong

Introduction
In the hospital setting, encouraging workplace health promotion can positively influence the physical, mental and social well-being of healthcare staff as well as the health of their families, communities and society. Nurses play an important role in health promotion; hence, a health promotion needs assessment survey for nurses was conducted in December 2012. This will help in the future development of a comprehensive health promotion program to empower healthcare professionals at Changi General Hospital (CGH) to lead and promote healthier lifestyle.

Purpose/Methods
The purpose of conducting the health promotion needs assessment survey for nurses was to explore the nurses' perceptions of health promotion, gain awareness of nurses' concerns about health promotion issues and determine the priority areas of health promotion in CGH. Survey forms were distributed to nurses in all outpatient clinics and inpatient wards. The survey questionnaires were designed to include different multiple choice and open-ended questions related to health to collect qualitative information from responses of nurses towards health promotion.

Results
A total of 447 (11M: 436F) nurses participated in the survey. 76% of nurses had participated in past health promotion activities in the hospital. 55 % of those who had participated in previous health promotion activities reported these activities as "Beneficial". 34% of nurses responded that it was "Very Important" to support health promotion in the hospital. 92% of nurses indicated an interest to participate in future health promotion activities. 33% of nurses felt that all staff members were responsible for health promotion.

Conclusions
It is encouraging to know that nurses are supportive and aware of the importance of health promotion in the hospital. At least three-quarters of nurses surveyed had participated in past health promotion activities in the hospital and more than 90% of nurses had indicated their interest and willingness to participate in future health promotion activities. For future health promotion and advocacy initiatives in the hospital, nurses can be nominated as health champions to promote a healthy lifestyle among healthcare staff.

Comments
Special thanks to the Nurses at Changi General Hospital for their participation in the survey.

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Research and Best Practice

Full participation of disabled people in society

Vilma Levinger, Snieguole Zadeikyte

Introduction

Around 10 percent of Lithuanians live with a disability. Disability or diseases caused by traumas and the associated psychological and social changes, significantly affect these people and their families. Such people need time to integrate into society. It is a serious problem from both a social and economic perspective, which has led to increased attention to the rehabilitation of sick and disabled people.

Purpose/Methods

The purpose of this study is to analyse the 20 years of experience, which Palanga Rehabilitation Hospital has in organizing integrated rehabilitation for people with disabilities. We also review the rehabilitation projects for disabled, which are carried out in Palanga Rehabilitation Hospital.

Results

Medical rehabilitation is an integrated application of medical rehabilitation measures with the purpose of restoring lost functions, or to compensate for permanent disabilities. Timely vocational rehabilitation and proper motivation can turn a person with a disability, from passive user and a dependent, into an active member of society. In PRL, patients can acquire 22 professions. The aim of active rehabilitation is to identify the problems and to show the patients the possible solutions, which is acquired by personal examples given by an instructor, who has experienced the same himself.

Conclusions

1. Rehabilitation – both medical and social – must be started as quickly as possible to ensure its full integration. Otherwise, termination of work activity and social support may lower disabled people's motivation to restore independence, and as a result, turn people into dependents of the society.

2. We believe that this, and all the subsequent projects, will help to increase employment among people with disabilities, improve their skills of finding a job, encourage their social integration, and help to change society's attitude towards people with disabilities

Comments

Palanga Rehabilitation Hospital is located in the resort of Palanga, 900 meters from the Baltic Sea. The hospital has 220 beds, and 256 employees. It is a specialized third-level hospital providing rehabilitation services to patients. It offers complex medical, professional and active rehabilitation services for patients who have suffered severe head or spinal cord injuries, various traumas, surgeries, or who are suffering from nervous and pulmonary disorders. The hospital is fully adapted for disabled people: equipped with lifts, ramps, adjustable furniture, sinks and handrails.

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WHO Follow-up Meeting on the 2008 Tallinn Charter, October 17-18, 2013

Five years after the Tallinn Charter was signed, WHO Regional Office for Europe and Estonia hosted a meeting to follow-up on the Member States' effort to strengthen their health systems in response to the Tallinn Charter.

About the TALLINN CHARTER

The Tallinn Charter: Health Systems for Health and Wealth.

The Charter provides guidance and a strategic framework for strengthening health systems in the WHO European Region. It was endorsed by all European Member States at the WHO Regional Committee for Europe's session in Tbilisi in September 2008 (resolution EUR/RC58/R4)

(Source: WHO Regional Office for Europe)

The International HPH Network was invited to present the important role of hospitals to promote public health and address inequalities. The main messages were:

- The large majority of the patients are in major need for health promotion when entering the hospitals
- Evidence-based programs should be offered in a systematic way to reach otherwise unreachable and vulnerable patients
- Staff require both health promotion skills and programs to improve own health
- Health promotion inside hospitals improves the immediate treatment results significantly and the health on longer term

Many improvements have been achieved, but the Tallinn Charter is as needed as ever. The Tallinn Charter focuses on 'Health systems for wealth and health'. The aim is to move from values to action by investment in health systems and to foster investments across sectors that influence health. This has now been reinforced through the 'Health 2020'.

Naturally, the main part of health promotion takes place outside hospitals – and the follow-up meeting revealed that there is a major room for improvement, and that giant steps are required in the years to come. However, as long as the majority of patients entering the hospitals are in heavy need for health promotion, the HPH Network plays a very important role in promoting health and address inequalities for the benefit of the patients, staff and communities.

Congress on ageing population and the impact on hospitals

In Sao Paolo Brazil, the 2nd CONAHP Congress took place October 2nd to 4th, 2013. The theme of the Congress was: "The Aging Population and the Impact on Hospital Activity and Assistance Management".

The Congress was organised by the Brazilian National Association of Private Hospitals, a national Brazilian division under the International Hospital Federation (IHF). As a result of the newly signed Memorandum of Understanding between IHF and the HPH Network, CEO of the International HPH Secretariat, Professor Hanne Tønnesen was invited to present the experience and results of the work from the HPH Network on the topic of the congress.

Source: http://conahp.org.br

The focus on the aging population falls within the newly founded Task Force on HPH and Age-Friendly Health Care. The Task Force with members from 13 countries was established as a Working Group in Taipei 2012, and the transition to a Task Force was approved by the HPH General Assembly in Gothenburg 2013.

News from the International HPH Network

HPH General Assembly

On May 22, 2013, the annual HPH General Assembly took place in Gothenburg, Sweden. This year's General Assembly was the 19th Meeting of the National/Regional Network Co-ordinators and Task Force Leaders of the International Network of Health Promoting Hospitals and Health Services.

About the GENERAL ASSEMBLY

The HPH General Assembly is the supreme governing body of the International Network of Health Promoting Hospitals & Health Services.

The full Meeting Report of the HPH General Assembly can be downloaded at the HPH website: www.hphnet.org/about/about-hph/general-assembly

Present at the General Assembly was 24 National/Regional HPH Coordinators (N/R Coord.), Leaders from six HPH Task Forces, observers from up-coming HPH Networks, WHO Regional Office for Europe and other partner organizations. Also present were the WHO-CC for Health Promotion in Hospitals and Health Care and the WHO-CC for Evidence-Based Health Promotion in Hospitals & Health Services.

The Assembly was updated on the work of the various organizational bodies of the International HPH Network.

The Governance Board reported on the progres of the Global HPH Strategy 2011-2013 and the HPH Action Plan 2012-2013.

The TFU and Alcohol & Alcohol Intervention gave their final Task Force reports. The existing TFs gave their progress reports, and HPH & Age-Friendly Health Care was approved as a new Task Force.

The Scientific projects (HPH PRICES; The VIP Project, and WHO-HPH Recognition Project) all presented their progress, publications, and future steps.

In the progress report of the Secretariat, the Assembly were updated on the challenges brought about by long overdue payments from existing members.

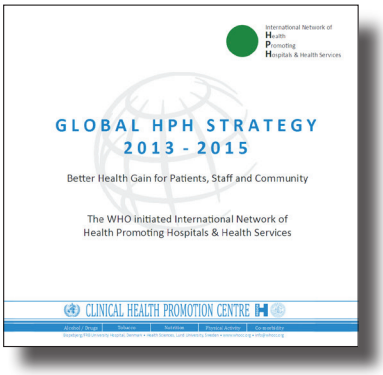
This year, the General Assembly also included a workshop on implementation of the new 2013-2015 Global HPH Strategy (See more on the strategy below).

The Global HPH Strategy 2013-2015

Every second year, a Global HPH Strategy is developed in order to align the work and efforts of the different bodies of the International HPH Network. The Global HPH Strategy 2013-2015 has been developed through discussions in the Governance Board, a workshop at the annually HPH General Assembly in Gothenburg and with assistance from strategic consultant Tune Hein.

The Strategy is designed to guarantee the fulfilment of goals and aims outlined in the agreement between WHO Regional Office for Europe and the International HPH Network. The strategy is closely related to WHO Health 2020 and the WHO/UN Declaration on Preventing and Controlling Non-communicaple diseases. It is build on 4 priority areas: WHO-HPH Standards & Indicators; Teaching & Training; Communication & Advocacy; Advancement of Clinical Health Promotion Research.

The layout of the Global HPH Strategy 2013-2015 is similar to previous strategies, which should ease use and understanding. The strategy lists activities and goals for National/Regional Networks, Task Forces and the Governance Board respectively. This align actions and result in synergy across the International HPH Network.



The Global HPH Strategy has been distributed to all National/Regional HPH Coordinators, to individual and affiliated members as well as to partners and other interested. The Strategy can be downloaded from the Toolbox at the HPH website.

News from the International HPH Network

The 22nd International HPH Conference: Abstract submission is now open

About the INT. HPH CONFERENCE

The annual International Conference on Health Promoting Hospitals and Health Services is the main event of the International HPH Network's calendar. It is a forum for learning and exchanging knowledge and experience on health promotion in and by hospitals and health services.

The annual HPH Conference usually attracts a very wide range of professionals - from health practitioners to consultants, scientists and politicians.

Contact:

For any questions about the conference, please contact:

vienna.who-cc
@hphconferences.org.

The 22nd International HPH Conference takes place in Barcelona from April 23-25, 2014 and it is hosted by the Regional HPH Network of Catalonia, Spain.

HPH Catalunya
Health Promoting Hospitals

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

This year the title of the Conference is:

"Changing hospital & health service culture to better promote health," with three sub-titles:

- Health literacy - an emerging concept for more patient-oriented healthcare
- Developing a more salutogenic culture for and by healthcare staff
- Better health care responses to community needs through a culture of cooperation

La Sagrada Familia in Barcelona, Spain.
Photo: Pixabay.com

Submission of abstracts is now possible. Deadline for submission is December 20, 2013.

Topics applicable for abstract submission include:

- Health literacy – an emerging concept for more patient-oriented healthcare.
- Developing healthcare organizations into salutogenic workplaces.
- Better responding to community health needs through a culture of collaboration.
- Child and maternal health.
- Older patients.
- Migrants and minorities.
- Psychiatric patients and mental health.
- Alcohol consciousness.
- Tobacco cessation.
- Physical activity.
- Environment-friendly management.
- Cooperation between HPH and self-help/patient groups – approaches and experiences.
- Health promoting integrated care.
- Sustainable and health promoting health services.
- Cooperation between HPH and Pain-free hospitals.

To submit your abstract, please go to the link below and click on Abstract submission.

www.hphconferences.org/barcelona2014/

If you do not already have a username (from the previous submission), please follow the instructions on the website and create one.

Clinical Health Promotion Society

A new scientific society for researches and people with interest in research with in Clinical Health Promotion

Naming the new scientific society
At the 21st International HPH Conference in Gothenburg, Sweden, May 2013, a naming competition was arranged to name the newly established scientific society covering the realm of Clinical Health Promotion. The competition drew many competent suggestions for names to the society, but the naming commitee found one name particularly suiting for the scientific society, namely:

"Clinical Health Promotion Society"

The winner was granted a free membership for one year.

Join!
Join Clinical Health Promotion Society to strengthen your knowledge within the field of clinical health promotion, build a stronger network with like-minded colleagues and take advantage of the many other membership benefits.

Attention young researchers: If you are a researcher under the age of 35 you are eligible for a discount on your membership as well as special offers relevant to young researchers.

To learn more and sign up visit:
www.clinhpsociety.org

Associated events at the 22nd International HPH Conference

Each year, the International HPH Conference has a string of satellite events, including HPH Schools and workshops. With the inclusion of these associated events, the participation at HPH Conference in Barcelona can be a full week event.

In association to the 22nd International HPH Conference, the following teaching activities will held in Barcelona in the week of the conference:

- **The HPH School**: Continuity and Cooperation – WHO HPH Standard 5 (April 21-22).
- **The HPH Coordinators Workshop**: Closed event for National and Regional HPH Coordinators (April 22).
- **The HPH Newcomers Workshop**: Half-day-workshop on the International HPH Network, and the different task and possibilities a HPH membership offers (April 26).

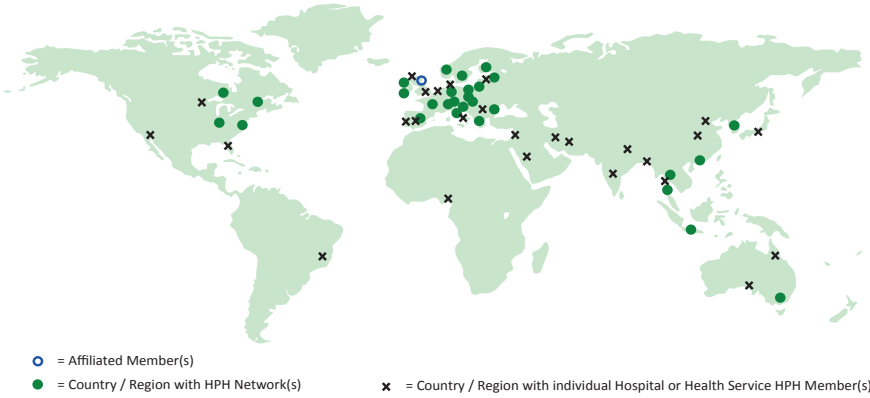
For more information on the teaching activities visit http://www.hphnet.org

New HPH members

The international HPH Network would like to welcome five new members from hospitals and health services in countries or regions without an N/R HPH Network:

- Zhengzhou Aixin Hospital (China)
- Bejing Yanqing County Hospital (China)
- Poole Hospital NHS Foundation Trust (England)
- Yoshida Hospital (Japan)
- Maastricht University Medical Centre (The Netherlands)

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



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.

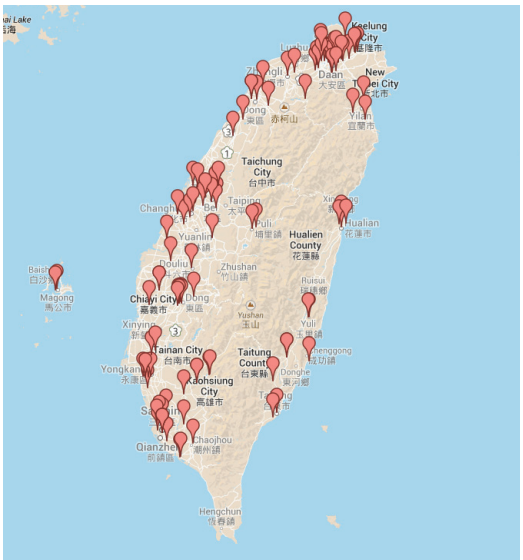
In the 'Members' section at the website you will find all information required for membership. This also includes information on the new affiliated membership, which applies for entities wishing to support the HPH Network without being eligible for normal hospital or health service membership.

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

The HPH Network in Taiwan is now the largest network in the International HPH Network

The Taiwanese HPH Network has since its establishment in December 2006 experienced an impressive progress with a continued increase in members. This year alone, 35 new hospitals and health services have signed up for membership in the Taiwanese HPH Network, which now have a total of remarkable 126 member hospitals and health services.

Dr. Shu-Ti Chiou was one of the pioners of HPH in Taiwan, and since the establishment of the Taiwanese HPH Network she has been acting as the HPH Coordinator. Dr. Chiou is heavily involved in the International HPH Network and was elected to the Governance Board in 2010, first as Vice-chair and currently as Chair. Furthermore, Dr Chiou acts as Leader of the two Task Forces: HPH & Age-Friendly Health Care and HPH & Environment.



The 126 Taiwanese member hospitals and health services.

News from SEEHN

The South-eastern Europe Health Network increases the focus on non-communicable diseases

The South-eastern Europe Health Network (SEEHN) is recognising health as an integral determinant of social cohesion. By adopting Health 2020 to local conditions and emphasising the need for a stronger focus on noncommunicable diseases, SEEHN has taken the first steps in meeting the challenges

By Snezhana Chichevalieva, Head WHO Europe Country Office in the Former Yugoslav Republic of Macedonia

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 South-eastern European Health Network (SEEHN) put the issue of health and economic development high on its agenda in 2005, discussing it with the ministers of finance of its member states, at the Second Ministerial Forum in Skopje, The Former Yugoslav Republic of Macedonia. Ministers of Health have pledged to demonstrate the economic potential of health as a means to increase productivity and decrease public expenditure on illness, acknowledging that "a healthy population works better and produces more".

The SEEHN has continued to contribute to the SEE and European policies in health and economic growth development and implementation. It supported development of the WHO strategy "Health 2020: a European policy framework supporting action across government and society for health and well-being", as well as of the "European Action Plan for Strengthening Public Health Capacities and Services" and their adoption at the 62nd WHO Regional Committee (September, 2012). Both documents prove the case of health as an investment in growth. SEEHN works today on the SEEHN 2020 strategy to implement those documents. Important part of this strategy is the SEEHN contribution to the development and implementation of the SEE2020 regional growth strategy.

Most recently, senior government officials reached broad agreement on the policy responses needed to address the health impact of the economic crisis, during discussions at Oslo conference on health systems and the economic crisis, held on 17–18 April 2013 where the current President of the SEEHN, Dr. Andrei USATII Minister of Health of the Republic of Moldova, on behalf of the SEEHN Member States, stated: 'There is a growing body of economic evidence of the cost-effectiveness of public health interventions to reduce the burden of noncommunicable diseases. Investing in public health interventions will show a significant return in the future and bring far-reaching and life-changing results.'

31ST Meeting of SEEHN in Chisnau, Republic of Moldova, 20-21 June 2013

The SEEHN continues to enhance sub-regional cooperation in health in the SEE through support of national public health investments in the areas where they can show an impact on overall health status and are associated with improved investment opportunities that contribute to growth.

News from SEEHN

Sector perspective on South-eastern Europe 2020: Public Health

Newsletter from Regional Cooperation Council

By Maria Ruseva

About The Regional Cooperation Council

The Regional Cooperation Council (RCC) was officially launched at the meeting of the Ministers of Foreign Affairs of the South-East European Cooperation Process (SEECP) in Sofia, on 27 February 2008, as the successor of the Stability Pact for South Eastern Europe.

The RCC functions as a focal point for regional cooperation in South-eastern Europe and its key role is to generate and coordinate developmental projects of a wider, regional character.

SEEHN is one of five pillars of the Regional Cooperation Council.

The RCC and the SEEHN have signed an MoU on their future cooperation. RCC will continue providing political support and representation to the SEE Health Network and its regional activities and assist the Network in coordinating its activities with other initiatives relevant to regional cooperation in the area of public health.

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Health and well-being are human rights. Health is a public good that is a determinant and contributor to peace, economic development and growth. Health is one of the 2 pillars of human capitol and as such a perquisite to growth and development. Cross-country studies using worldwide samples show that a 1 year increase in life expectancy corresponds to 4% GDP growth. Evidence shows how in families and communities where levels of health are poor, labour market supply and productivity suffers and participation in education and in lifelong learning & active labour market programs is lower than average / suboptimal. Further good health has also been indicated to support inclusion in other areas of life such as civic activity, social economy and decision making processes. The strong association between average per capita income and mortality levels is well recognized and evident in the European Region. For example mortality rates for diseases of the circulatory system exceed the European average in countries with per capita income levels below US$ 20 000, and these tend to increase rapidly with lower income (source: European Health for All Database, online database, Copenhagen, WHO Regional Office for Europe, 2012).

The gain of the highest level of health and well-being is in the hands not only of the health sector per se. Health is dependent on multiple and complex determinants, both genetic, lifestyle, environmental, societal, economic and political. It, therefore, needs to be dealt with, the actions and the care of all sectors and stakeholders, and the whole of governments and societies, if better health gains are goals of each and every state and society. Health is a responsibility not only of the health sector but of the whole of society. For example, the agricultural and food industries' policies and actions will have to secure the production and trade of safe food products with high nutritional value, low salt content at prices that can be affordable for healthy nutrition and prevention of spread of food-borne infectious diseases and of obesity, high blood pressure, diabetes and cardio-vascular diseases. Trade, particularly in view of the main goal of the SEE 2020 Strategy to create a Trade Free Area in the region, will require creating of conditions for free movement of people and goods which is related to the full implementation of the WHO International Health Regulations, and harmonization of legislation, standards and practices if cross-border spread of diseases and major threats of biological, chemical, radiological and other nature are to be prevented. In both cases, a huge part of this work is in the hands of several sectors, the health one being a major actor.

It is for the above mentioned reasons, that Health is an important dimension of SEE 2020 Inclusive Growth pillar. The SEE Health Network, one of the RCC Initiatives since 2001, with its clear legally binding documents, and institutions (SEE Health Network Secretariat inaugurated on 07 March 2013 in Skopje, 10 Regional Health Development Centers in each one of the 10 Member States, and a network of over 300 experts) is developing the Health chapter for the SEE 2020 Strategy. The Network is also developing its own SEEHN 2020 Strategy and Action Plan. In both documents, the links between health and all other sectoral policies, such as trade, economic growth, agriculture, food industries, labour, social policies, education, environment, urban and rural development, governance, anticorruption, etc. are direct. This calls for improved governance and implementation of the EU Health in All Policies approach developed further by WHO Regional Office for Europe' Policy Health 2020.