In this issue

Research and Best Practice

P. 3 Editorial: Smoking is still a major problem and challenge worldwide
P. 5 Contrasting university-based and older-age samples on weight-loss effects and their behavioral and psychological predictors associated with the Weight Loss For Life protocol
P. 12 Japanese dietary habits: Results from a questionnaire survey on 305 health check-up participants
P. 18 Patient insight - perioperative smoking and alcohol cessation intervention
P. 22 Abstracts selected for publication

News from the HPH Network

P. 28 HPH News & Update
P. 30 Cerebrospinal Menigitis Outbreak in Nigeria
P. 32 Hong Kong Network - a small but active network
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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Smoking is still a major problem and challenge worldwide

Hanne Tønnesen

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Smoke-free future is the goal
In this autumn, the new analyses on the global burden of diseases (GBD) was published. They showed that smoking is still the number one risk factor high income countries for years of lost life and years with disability. In lower income countries, smoking is also an important risk factor – but even higher risks originate from child/maternal malnutrition and general dietary risks as well as environmental risks such as air pollution and unsafe water (1).

Good news
The good news is that prevalence of smoking has been reduced globally; thus, the related risk of lost years has also been reduced significantly over the last 25 years; i.e. since the present GBD collaboration began. The age-adjusted prevalence of daily smoking is 25% for men and 5% for women. Those results are based on data from 2015. When compared to 1990 the new analyses identified a clear smoking reduction of 28% for men and 34% in women. However, this total reduction is based on a large variety, including even increase in a few countries (2).

The plan for smoking reduction in 2025
In 2010 the 194 member states in WHO had a daily smoking prevalence of 22% (37% for men and 7% for women). With a plan for an overall reduction of 30% for smokers at the year of 2025, the prevalence was projected to around 15% in total; 26% and 5%, respectively (3).

Those numbers are not far away from the good news above; never-the-less, as the data originates from different collections and methods the prevalences are not directly comparable and should be interpreted with cautions. Anyway, we seem to on the track.

The WHO FCTC and MPOWER
In 2015, altogether 180 parties have ratified the WHO Framework Convention on Tobacco Control (FCTC), that covers about 90% of the global population. FCTC was initiated back in 2003 to fight the global smoking and went into force in 2005. The parties signed up to regulate tobacco industry marketing and sales, reduce the demand for tobacco, and provide agricultural alternatives for the farmers. WHO launched an important tool to support the implementation of FCTC. That was the MPOWER, which is an acronym for Monitoring tobacco use and prevention policies, Protecting people from tobacco smoke, Offering help to quit tobacco use, Warning about the dangers of tobacco, Enforcing bans on tobacco advertising, promotion and sponsorship, and Raising taxes on tobacco (4).

New goal: Tobacco Endgame (TE)
TE is an international strategy aiming at phasing out smoking on long term. The ambitious goal of TE means a change of perspectives – going from reducing smoking to becoming smoke-free. TE is often defined by a smoking prevalence below 5% (5). It requires both political decisions and full implementation of FCTC.

Around the world, many parties, especially counties, municipalities and organizations are targeting the smoke-free future by deciding and implementing smoking ban in specific areas and raising smoke-free new generations.
Some brave member states of WHO have taken the strong political decision of implementing TE and phase out smoking within the next decade or two. For now, they are New Zealand and Ireland (2025), Finland (2030) and Scotland (2034) - and countries are underway.

References
Contrasting university-based and older-age samples on weight-loss effects and their behavioral and psychosocial predictors associated with the Weight Loss For Life protocol

James J. Annesi1,2, Ping Hu Johnson2

Abstract
Background Behavioral weight-loss treatments have generally been unsuccessful, and young-adult participants have been underrepresented in related research. This investigation assessed effects of the new Weight Loss For Life protocol in a university sample of young women through contrasts with older-age women.

Methods Women with class 1 and 2 obesity from either a university (n = 37, M_age = 20.4 years) or a community wellness setting (n = 37, M_age = 45.0 years) were volunteer participants. The same cognitive-behavioral weight-loss protocol was administered to both groups. One-on-one physical activity-support sessions supported self-regulatory skills, self-efficacy, and mood improvements so they would carry-over to controlled eating during bi-weekly group nutrition sessions.

Results The university group consumed fewer fruits/vegetables and completed more physical activity at baseline than the older group. However, significant improvements over 6 months in those variables, sweets intake, and weight (-4.5% and -6.1%, respectively) did not significantly differ. Age group also did not affect the significant prediction of 6-month changes in physical activity and fruit/vegetable intake, by 3-month changes in self-regulation, self-efficacy, and mood (R2-values = .26 and .35, respectively).

Conclusion Tenets of social cognitive theory that formed the basis of the Weight Loss For Life curriculum were supported for both age groups, and were associated with similar positive effects over 6 months. Extensions of the research require testing over longer periods.

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Introduction
The health risk of obesity is prevalent in United States women at 37% for ages 20–39 years, and 45% for ages 40–59 years (1). Behavioral weight-loss treatments have overwhelmingly been unsuccessful beyond their initial several weeks or months (2;3). In fact, some behavioral scientists recently suggested that corresponding research should be terminated due the consistency of unfavorable results for decades (4). However, 2 trials of an experimental cognitive-behavioral protocol entitled Weight Loss For Life demonstrated atypical success by maintaining a 6.1–6.3% mean loss in body weight over 2 years in mostly middle-age women with obesity (5). Weight Loss For Life is a low-cost, community-based treatment grounded in tenets of social cognitive theory (6). Social cognitive theory assumes that individuals can gain control over their behaviors through purposeful use of self-management, feelings of ability (i.e., self-efficacy), and positive psychological states (6).

A major departure of Weight Loss For Life from other behavioral weight-management treatments is that its first aim is to increase physical activity – the most salient predictor of long-term weight loss (7;8) – to improve self-regulation, self-efficacy, and mood. Those psycho-
social improvements are then carried over to facilitate controlled eating (e.g., increased fruit and vegetable intake, reduced sweets). Conversely, almost all other behaviorally based weight-loss programs have dealt with physical activity as an (often optional) adjunct to a near-singular focus on energy-intake restriction (2;4). Within Weight Loss For Life, the considerable challenge of adherence to physical activity (9) has been addressed through incorporation of the validated Coach Approach curriculum (10) for 8 weeks prior to any change in the diet. Emotional eating was also focused upon through physical activity-induced improvements in mood (11). Emotion-based eating has been associated with an overconsumption of sweets, fats, and mostly unhealthy foods (11). Even modest amounts of physical activity (e.g., 3 moderate sessions/week) might be as useful as greater volumes for improving psychosocial factors (10).

Consistent with most weight-loss treatment trials, however, younger adults were minimally represented in the initial research on Weight Loss For Life (12). Little was known of its effects on younger-age women, and/or specific sample types (e.g., enrollees of a university) that might pose yet-unknown challenges. Thus, within this short-term (6 month) research, findings from college-age women with obesity were contrasted with results from older-age (but still below the “old age” category) women – each participating in the Weight Loss For Life treatment (5). Results could clarify the salience of the proposed treatment model, determine age-related effects, and assess whether longer-term studies (which are difficult to conduct in transient university samples) are warranted. Ultimately, findings could inform administrators and practitioners concerned with reducing health risks in young adults and other individuals across age ranges (13).

Hypotheses were as follows:

- There will be significant overall improvements in weight, physical activity, nutrition, and each of the psychosocial measures tested. No hypothesis was given, however, regarding whether these changes would differ by age group.
- Changes in physical activity and fruit/vegetable intake will predict weight change.
- 3-month changes in physical activity- and eating-related self-regulation, self-efficacy, and mood will significantly predict 6-month changes in physical activity and fruit/vegetable intake, respectively.
- Emotional eating change will significantly mediate the relationship between changes in mood and consumption of sweets.

It was also of interest to determine if weight reduction would be better-predicted by attaining a mean of 3 moderate physical activity sessions/week, or by absolute volume of physical activity/week (i.e., more physical activity-more weight loss).

Methods
Participants
Women volunteered to participate in a weight-loss trial that incorporated physical activity. Enrollment was conducted separately within a large university (UNIV; age range 18–25, M̅ = 20.4 years, SD = 2.0, n = 37) and a community (COMM; age range 26–55, M̅ = 45.0 years, SD = 7.9, n = 37) in the southeast United States. Inclusion criteria were: (1) body mass index (BMI) 30–40 kg/m² (class 1 and 2 obesity), (2) not presently participating in any weight-loss program, and (3) no known health-related contraindications for participation. Institutional review board approval, and written informed consent from all participants, was obtained. Principles of the Declaration of Helsinki were followed throughout.

Measures
Weight
Body weight (kg) was measured by a recently calibrated digital scale using the mean of 2 consecutive measurements.

Behavioral measures
Measures of self-reported daily servings of fruits/vegetables and sweets (11), and weekly physical activity (converted to metabolic equivalents [1 MET = 3.5 ml of O2/kg/minute] using the Leisure-Time Physical Activity Questionnaire) (14), previously demonstrated acceptable–strong reliability and validity across the age ranges within this research (14;15). Within those validated behavior recall surveys, previously used in related research (16), examples of fruit/vegetable servings (e.g., 1 small apple; 118 mL fruit juice; 118 mL carrots) and physical activity intensities (3 METs [mild activity; e.g., easy walking] to 9 METS [vigorous activity; e.g., running]) were given.

Psychosocial measures
Each self-report measure had acceptable–strong internal consistency (Cronbach’s α ≥ .70) and test-retest reliability (≥ .70 over 1–2 weeks).
The self-regulation for physical activity and self-regulation for eating scales each had 10 items that assessed use of specific self-regulatory skills (e.g., “I make formal agreements with myself to be physically active”; “I keep a record of my eating”) using a scale of: 1 = never to 5 = often (16). Self-efficacy for physical activity was measured by the 5-item Exercise Self-Efficacy Scale (e.g., “I can persist with exercising when I have more enjoyable things to do”) using a scale of: 1 = not at all confident to 11 = very confident (17). Self-efficacy for controlled eating was measured by the 20-item Weight Efficacy Lifestyle Scale (e.g., “I can resist eating when I am depressed or feeling down”) using a scale of: 0 = not confident to 9 = very confident (18). Both self-efficacy measures assessed confidence for overcoming specific behavioral barriers. Overall negative mood was measured by the Profile of Mood States Short Form (19). Reflecting on the past 2 weeks, its 30 items asked the respondent to evaluate the presence of affective states (e.g., “sad”; “tense”; “annoyed”) using a scale of: 0 = not at all to 4 = extremely. Emotional eating was measured by 15 items of the Emotional Eating Scale (20). It addressed feelings that might prompt emotion-based eating (e.g., “irritated”; “on edge”; “blue”) using a scale of: 0 = no desire to eat to 4 = an overwhelming urge to eat.

Procedure
All Weight Loss For Life treatment components were administered by wellness professionals with national certification(s) and/or an advanced degree(s) related to health promotion, and 16 hours of training specific to the present treatment protocols.

Physical activity support consisted of 6, 45–60-minute one-on-one sessions over 6 months using The Coach Approach curriculum of instruction in self-regulatory skills (e.g., goal-setting, relapse prevention, cognitive restructuring) to counter barriers to physical activity (e.g., slow progress), leveraging social supports, and minimizing impediments (e.g., exercise-induced discomfort) (10). Although the internationally recommended volume of physical activity for health promotion (i.e., 150 minutes/week of moderate-intensity activity) was indicated to participants, exercise plans were mostly based on their individual preferences and tolerances.

After 8 weeks, participants were instructed in recording daily energy intake, and provided a daily kilocalorie (kcal) limit based on present weight (e.g., 1500 kcal/day limit for 79–99 kg). Beginning at week 10 of the 6-month trial, 60-minute group nutrition sessions were held every 2 weeks that adapted the learned physical activity-related self-regulation skills for use in controlling eating – especially focusing upon increasing fruit/vegetable intake and minimizing sweets. Figure 1 displays a timeline of treatment processes.

**Figure 1 Treatment Timeline**

<table>
<thead>
<tr>
<th>Month</th>
<th>The Coach Approach physical activity support</th>
<th>Initiate food tracking</th>
<th>Self-regulation for weight loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><img src="image" alt="timeline" /></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Advancement of self-efficacy through overcoming barriers, and leveraging exercise-induced mood improvements to counter emotional eating, were additional foci. Participants were instructed to weigh themselves at home at least once per week. Fidelity checks on approximately 15% of treatment sessions indicated few protocol violations that were easily rectified by study staff.

Data analyses
To avoid inflation of treatment effect sizes found in weight-loss studies that inappropriately retained data from only treatment “completers” (21), the conservative intention-to-treat approach was instead used. Thus, data from all individuals who initiated the treatment components were included. Statistical significance was set at $\alpha \leq .05$, 2-tailed, unless otherwise noted. Analyses were conducted using SPSS version 22.0 (IBM, Armonk, NY).

Data preparation
Based on suggested criteria (22), missing data were found to be missing-at-random (i.e., absent of systematic bias) so imputation of the 9% of overall missing scores, and scores deleted because they met suggested criteria for being an outlier (23), was conducted using the expectation maximization algorithm (24). Under the present research conditions, application of the expectation maximization algorithm is considered, “… the most accurate estimate of means or co-variances…” (25, p 41). To normalize distributions where needed, the Box-Cox transformation (26) was applied.

For the primary analysis of multiple regression models with 5 predictors, the anticipated effect size of $f^2 = .25$ (estimated from pilot research) at the statisti-
cal power level of .80 (α = .05) required a minimum overall sample size of 57 (27). Variance inflation factors of 1.08–1.54 indicated a low and acceptable degree of multicollinearity in the data. The 2 variables that at baseline demonstrated a significant group difference (physical activity and fruits/vegetables) were controlled for throughout the analyses.

**Assessing changes over time**

One-way analysis of variance (ANOVA) was used to assess differences between the UNIV and COMM groups at baseline. Mixed-model repeated measures ANOVAs then assessed overall changes over time, and whether those changes differed between the UNIV and COMM groups. These were followed-up by paired t tests to contrast within-group effects. Effect sizes for repeated measures ANOVAs were calculated as partial eta-squared (ηp² = SS effect/[SS effect + SS error]), and for paired t tests as Cohen’s d (Mpost - Mpre)/SDpost), where .02, .13, .26, and .20, .50, .80 are, by convention, small, moderate, and large effects, respectively.

**Predicting behavioral changes from psychosocial changes**

Because the planned multiple regression analyses inferred directionality (i.e., changes in the psychosocial variables predicting changes in the behavioral variables), 2 separate theory-based models were specified that entered 3-month changes in physical activity- and eating-related self-regulation, self-efficacy, and mood as predictors of 6-month changes in physical activity and fruit/vegetable intake. Group was then entered in step 2 of those models. Considering previous research and suggestions (16), and an absence of floor and ceiling effects, unadjusted change scores were used rather than residualized change values or analysis of covariance. Using a bootstrap procedure with 20,000 resamples (28), additional regression models were specified that separately assessed the mediation of relationships between mood change and changes in consumption of sweets and fruits/vegetables, by change in emotional eating. Mediation is significant if a 95% confidence interval (95% CI) does not include 0.

**Assessing the effect of physical activity on weight change**

The predictive value of weight change over 6 months by either the continuous variable of participants’ change in physical activity/week, or the dichotomous variable of completion of at least (the equivalent of) 3 moderate–vigorous sessions of physical activity/week (M ≥ 21 METs/week on the Leisure-Time Physical Activity Questionnaire (11); coded no = 0, yes = 1), was contrasted using 1-tailed bivariate analyses.

**Results**

**Assessing changes in weight, weight-loss behaviors, and psychosocial factors**

Baseline score on fruit/vegetable intake was significantly greater in the COMM group, and consumption of sweets was significantly greater in the UNIV group. No other significant baseline difference was found (Table 1). There were significant changes in the favorable direction on all measures, but they did not significantly differ by group (Table 1). Within-group effect sizes were larger on weight reduction from baseline in the COMM group (-6.1%) vs. the UNIV group (-4.5%). That was also the case for increase in physical activity. Effect sizes on changes in psychosocial variables were similar between groups (Table 1).

**Predicting changes in weight, physical activity, and eating behaviors**

Changes in physical activity and fruit/vegetable intake, together, significantly predicted weight change, R² = .19, p = .001. Change in fruit/vegetable intake, beta (β) (standard error [SE]) = -.32 (.49), p = .009, but not physical activity volume, β = -.19 (.07), p = .116, independently contributed to the variance explained. Subsequent entry of group into the multiple regression equation did not significantly improve its explanatory power, ΔR² = .01, p = .353.

Changes in physical activity-related self-regulation, self-efficacy, and mood significantly predicted change in physical activity, R² = .26, p < .001. β-values were .11 (.32), .19 (.19), -.21 (.12), respectively, p-values > .08. Changes in eating-related self-regulation, self-efficacy, and mood significantly predicted change in fruit/vegetable intake, R² = .35, p < .001. β-values were .20 (.04), .12 (.01), -.17 (.01), respectively, p-values ≥ .08. Entry of group did not significantly improve the above equations’ explanatory power, ΔR²-values ≤ .03, p-values > .06.

Change in emotional eating significantly mediated the total effect, β = -.04 (.01), p = .008, of mood change on change in the intake of sweets, β=.01 (.01), 95% CI = .002, .023. The effect of group was not significant, β = .06 (.43), p = .882, however the overall model was significant, R² = .14, p = .014. Change in emotional eating did not significantly mediate the total effect, β = -.03 (.01), p = .012, of mood change on change in the intake of fruits/vegetables, β = -.0002 (.01), 95% CI = -.011, .013. The effect of group was, however, significant, β = .94 (.47), p = .049, suggesting a greater degree of mediation in the COMM group. The overall model was significant, R² = .32, p < .001.
The bivariate inverse relationship between changes in physical activity/week and weight did not reach statistical significance, $\beta = -0.12$ (1.10), $p = .148$; whereas the inverse relationship between completion/non-completion of the equivalent of 3 moderate-vigorous sessions of physical activity/week and weight change was significant, $\beta = -0.21$ (2.19), $p = .039$.

**Discussion**

Findings suggest that the Weight Loss For Life protocol administered to university women with obesity was associated with significant improvements in weight, physical activity and eating behaviors, and their psychosocial correlates over 6 months, as they were with older women. This occurred even though the university sample completed more physical activity and consumed less fruits and vegetables at baseline, which was consistent with previous research (29;30). Participants’ age group also had little effect on the prediction of physical activity and fruit/vegetable changes by changes in self-regulatory skill use, self-efficacy, and mood. The relationships of psychosocial and behavioral changes supported propositions extrapolated from social cognitive theory (6) and previous research with...
older women (5;16). The finding of the modest-volume threshold of physical activity (i.e., 3 moderate sessions/week) being associated with weight loss might be beneficial for adherence by not over-burdening participants (29).

A limitation of this research, however, was the 6-month duration of this investigation that did not allow analyses of longer-term maintenance of lost weight. Based on the present findings, this warrants attention in extensions of this research, even given the difficulties with college students residing in multiple locations throughout the year. Also, because psychological factors such as body image, social physique anxiety, and expectations might particularly affect young women, future research should better-account for them and their possible interactions with emotional eating and weight. Generalization of findings to men, and those who are overweight or with class 3 obesity, also require testing. Consistent with most weight-loss treatment research, the motivation to participate might have yielded self-selected samples that affected both the psychological and behavioral changes. Although this is difficult to address in studies requiring volunteers, replications might seek to incorporate individuals who were assertively “prescribed” enrollment in a behavioral weight-loss program by a medical professional. Finally, although physical activity was a key aspect of the tested treatment, physical activity plans were largely left up to the individual participant. Effects of professionally prescribed physical activity regimens, and/or ones that include resistance training (which might have different effects on body composition than aerobic activity (31)), should also be tested.

Conclusion
Based on these and earlier findings, and after replications over longer periods, health promotion professionals and administrators should consider offering the Weight Loss For Life protocol within the college/university and other settings with young adults. Its theoretical foundation for behavioral changes remained sound across the present samples, and its administration could have low costs by incorporating graduate students and faculty members, as well as practitioners such as community health workers, nurses, and fitness facility staff members to administer the standardized methods to large numbers of individuals in need. Although continued evaluation is warranted, effective use of this and other treatments with similar theoretical bases and uses of physical activity might finally help to reliably reduce obesity-related health risks across age ranges.

Contribution details
All authors read and met the ICMJE criteria for authorship and agree with the results and conclusions. JJA designed the study, analyzed the data, and wrote the report. PHJ contributed to the design and interpretation of the report.

Competing interests
None declared.

References
(20) Arnow B, Kenardy J, Agran W. The Emotional Eating Scale: the de-
Japanese dietary habits: Results from a questionnaire survey on 305 health check-up participants

Toh Yoon Ezekiel Wong, Hirohiko Murata

Abstract

Introduction The Japanese diet has been associated with a healthier lifestyle and lower obesity rates. However, dietary habits may also be important. To investigate the dietary habits of Japanese people, we conducted a survey at the health check-up center of Hiroshima Kyoritsu Hospital.

Methods 305 Japanese adults who received health check-ups and participated in the questionnaire survey (conducted from January to February 2015) were enrolled. Basic information such as age, gender, body mass index (BMI) and mean arterial pressure (MAP) were recorded along with answers and analysed.

Results Participant’s age ranged from 22 to 77 years old, BMI ranged from 15.4 to 35.0 kg/m² and the average MAP was 90.7 ± 14.3 mmHg. 58% of the respondents started their meals with a vegetable dish. 74% of the participants ate between 10 to 29 minutes on average. Those who skipped breakfast (19%) had significantly higher BMI than those who ate breakfast. Those who stopped eating at 80% satiety had lower BMI as well as MAP levels compared to those who ate until 100% satiety.

Conclusions The survey showed that simple practices like starting meals with vegetables, eating regular breakfast and stopping at 80% satiety were all part of the Japanese dietary habit. These dietary habits are relatively easy to follow and may contribute to a healthier lifestyle.

Introduction

According to the World Report on Ageing and Health 2015, Japanese people have the highest life expectancy at birth (1). Two key behaviours that may influence healthy ageing are physical activity and nutrition. The Japanese diet (Washoku) is not only considered healthy but is also recognized as a cultural treasure by UNESCO since 2013. Short-term intake of Japanese diet have been shown to prevent and improve metabolic syndrome (2). Closer adherence to Japanese dietary guidelines was also found to be associated with a lower risk of total mortality in Japanese adults (3). Although the Japanese diet has been associated with a healthier lifestyle and lower obesity rates, each country differs in their access to various food sources and therefore not everyone can benefit by simply reproducing such a diet over the long term.

Dietary habits may also contribute to a healthier lifestyle and the emulation of these habits may be a more practical approach in the search for a health promoting lifestyle. To investigate the dietary habits of healthy Japanese people, we conducted a questionnaire survey at the health check-up center of Hiroshima Kyoritsu Hospital and report the results in this article.

Methods

305 Japanese adults who received health check-ups at the health check-up center of Hiroshima Kyoritsu Hospital and who were willing to participate in the questionnaire survey were enrolled in this study. The health check-up center is located at the hospital’s outpatient floor and is open to those who wish to undergo screening for various underlying conditions. The survey was conducted during a two week period from January to February 2015. Those who were not willing to participate in the survey during the given period and those who did not complete the questionnaire forms were
excluded from the analysis. A questionnaire regarding eating habits and dietary patterns (listed in Table 2) was included along with a routine questionnaire that our health check-ups recipients are usually required to answer. In total, 10 questions with multiple choices were asked. Demographic data and basic information such as age, gender, body mass index (BMI) and mean arterial pressure (MAP) were also recorded along with the answers and these were analyzed for the study (cross-sectional). MAP was estimated with the measured systolic (SP) and diastolic (DP) pressures using the equation \( \text{MAP} = \frac{\text{SP} + (2 \times \text{DP})}{3} \) with the measurements taken during normal resting heart rates.

Continuous variables are expressed as mean (standard deviation, with or without range). Categorical (qualitative) variables are expressed as numbers (percentage). Comparisons for continuous variables were made using the Student t-test for normal data and the Mann-Whitney U test for non-parametric data. Statistical significance was defined as \( p < 0.05 \) and analysis was performed using XLSTAT2014 for Windows (Addinsoft Ltd., Paris, France). This study protocol was reviewed and approved by the ethics review committee of Hiroshima Kyoritsu Hospital.

Table 1 Characteristics of survey participants (n=305)

<table>
<thead>
<tr>
<th>Age, years, mean (SD, range)</th>
<th>51.1 (10.7, 22 - 77)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (male/female)</td>
<td>105/200</td>
</tr>
<tr>
<td>BMI, kg/m², mean (SD, range)</td>
<td>22.7 (3.6, 15.4 - 35.0)</td>
</tr>
<tr>
<td>MAP, mmHg, mean (SD, range)</td>
<td>90.7 (14.3, 56.7 - 139.0)</td>
</tr>
</tbody>
</table>

SD: Standard deviation; BMI: Body mass index; MAP: Mean arterial pressure.

Results

The basic characteristics of participants in the survey are summarized in Table 1. Participant’s age ranged from 22 to 77 years old, the average being 51.1 ± 10.7 (SD) years old. 105 men and 200 women participated in the survey. BMI of participants ranged from 15.4 to 35.0 kg/m² (mean 22.7 ± 3.6 kg/m²) and the mean MAP was 90.7 ± 14.3 mmHg. Questions (along with participant’s answers) regarding eating habits and dietary pattern are summarized in Table 2. 58% started their meals with a vegetable or salad dish and 23% started their meals with liquid (soup or drink). 13% of respondents started their meals with the meat or fish dish and only 6% started with rice or noodles (Figure 1).

Table 2 Results from a questionnaire survey on 305 health check-up participants

<table>
<thead>
<tr>
<th>Questions and answers</th>
<th>n</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1: Which food item do you start with at meals?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Vegetable dish (Salad included)</td>
<td>178</td>
<td>58</td>
</tr>
<tr>
<td>• Meat dish (Fish included)</td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>• Soup or drink (or Water)</td>
<td>69</td>
<td>23</td>
</tr>
<tr>
<td>• Rice (or Noodles/Pasta)</td>
<td>19</td>
<td>6</td>
</tr>
<tr>
<td>Question 2: How long does each meal last on average?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less than 10 minutes</td>
<td>21</td>
<td>7</td>
</tr>
<tr>
<td>• 10 to 29 minutes</td>
<td>227</td>
<td>74</td>
</tr>
<tr>
<td>• 30 to 59 minutes</td>
<td>51</td>
<td>17</td>
</tr>
<tr>
<td>• 60 minutes or more</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Question 3: How many times do you chew before swallowing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Less than 10 times</td>
<td>92</td>
<td>30</td>
</tr>
<tr>
<td>• 10 to 19 times</td>
<td>178</td>
<td>58</td>
</tr>
<tr>
<td>• 20 to 29 times</td>
<td>31</td>
<td>10</td>
</tr>
<tr>
<td>• 30 times or more</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Question 4: How often do you skip breakfast?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 3 times or more per week</td>
<td>57</td>
<td>19</td>
</tr>
<tr>
<td>• Less than 3 times per week</td>
<td>248</td>
<td>81</td>
</tr>
<tr>
<td>Question 5: When do you have the last meal of the day?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• More than 2 hours before sleeping</td>
<td>85</td>
<td>28</td>
</tr>
<tr>
<td>• Less than 2 hours before sleeping</td>
<td>220</td>
<td>72</td>
</tr>
<tr>
<td>Question 6: When do you stop eating?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Stop at 80% satiety (80% full)</td>
<td>157</td>
<td>51</td>
</tr>
<tr>
<td>• Stop at 100% satiety (Until I am full)</td>
<td>148</td>
<td>49</td>
</tr>
<tr>
<td>Question 7: What will you choose when you want to drink something other than water?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Black tea (or other kinds of tea)</td>
<td>61</td>
<td>20</td>
</tr>
<tr>
<td>• Coffee (with sugar)</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>• Juice (or Non-carbonated drinks)</td>
<td>18</td>
<td>6</td>
</tr>
<tr>
<td>• Green tea</td>
<td>113</td>
<td>37</td>
</tr>
<tr>
<td>• Carbonated drinks (Zero-calorie drinks included)</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Question 8: What do you use to sweeten your drink or food?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sugar</td>
<td>232</td>
<td>76</td>
</tr>
<tr>
<td>• Other sweeteners</td>
<td>73</td>
<td>24</td>
</tr>
<tr>
<td>Question 9: How often do you snack after dinner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 3 times or more per week</td>
<td>66</td>
<td>22</td>
</tr>
<tr>
<td>• Less than 3 times per week</td>
<td>239</td>
<td>78</td>
</tr>
<tr>
<td>Question 10: Do you want to lose weight?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Yes</td>
<td>204</td>
<td>67</td>
</tr>
<tr>
<td>• Not really</td>
<td>101</td>
<td>33</td>
</tr>
</tbody>
</table>
For 74% of participants, an average meal lasts between 10 to 29 minutes (Question 2). 17% reported their average meal lasting between 30 to 59 minutes. 58% of those surveyed chewed their food 10 to 19 times before swallowing (Question 3) while 30% chewed less than 10 times before swallowing. Only 19% of survey participants skipped breakfast more than 3 times a week (Question 4) and only 28% had their last meal of the day less than 2 hours before going to bed (Question 5). 51% of respondents stopped eating when they were 80% full while the remaining 49% reported eating until they had reached 100% satiety (Question 6).

Regarding the choice of drink, 37% of respondents chose green tea, 25% chose coffee without sugar and 20% chose black tea (or other kinds of tea). Juice and carbonated drinks were low on their list (Question 7). Only 24% of those surveyed used non-sugar or non-caloric sweeteners as an alternative (Question 8). Snacking after dinner 3 times or more per week was reported in only 22% of respondents (Question 9). As for whether the participants wanted to lose weight (Question 10), 204 (67%) replied “Yes” while the remaining 101 (33%) replied “Not really”.

Table 3 shows the differences in BMI between answer groups for Questions 4, 5, 6, 8, 9 and 10. Those who skipped breakfast, those who had their last meal of the day less than 2 hours before going to bed and those who ate until they reach 100% satiety had significantly higher BMI levels than those who did not. Table 4 summarizes the differences in MAP between answer groups for the same questions (Questions 4, 5, 6, 8, 9 and 10). Quite similarly, those who had their last meal of the day less than two hours before going to bed and those who ate until they reached 100% satiety had significantly higher MAP levels than participants who did not.
As for Question 10, respondents who wanted to lose weight had significantly higher BMI as well as MAP levels compared to those who did not really want to lose weight. BMI and MAP of survey participants were found to be significantly correlated (Figure 2).

**Figure 2** The correlation between body mass index (BMI) and mean arterial pressure (MAP) of participants in the survey

![Graph showing the correlation between BMI and MAP](image)

**Discussion**

Some studies have demonstrated a positive effect of the Japanese diet on obesity, metabolic syndrome and mortality (2-4). However, few studies have investigated the dietary habits of Japanese adults and its relation to health (5). Although the Japanese Ministry of Health Labour and Welfare provide standardize questionnaires to health check-up centers that covers some behavioural aspects including eating habits such as breakfast skipping and eating out (6), the self-developed questionnaire used in this study is unique and comprises questions that are not commonly asked or explored.

One interesting finding was that the majority of those surveyed started their meals with either vegetables or liquid food (soup) has also been shown to enhance satiety and reduce energy intake (9). This way of starting a meal is very practical and may be emulated in almost every country, regardless of the differences in access to food sources.

Eating at a fast rate has also been demonstrated to increase the risk of Type 2 Diabetes mellitus and obesity (10;11). This survey showed that only 7% of the participants finished their meals within 10 minutes while the majority (74%) of meals were finished between 10 to 29 minutes. 17% reported taking 30 to 59 minutes to finish an average meal. Along with slower eating rates, increase in mastication and chewing are also shown to have a protective effect towards obesity and the risk for diabetes (12;13). The results of this survey showed that almost 60% of respondents chewed at least 10 to 19 times before swallowing. Eating speed and chewing rate are both modifiable eating habits that can also be applied with relative ease no matter your setting.

Although the causative effect is still controversial, skipping breakfast has long been associated with increase in obesity levels (14;15). Incidentally, in agreement with these earlier studies, the BMI of those who skipped breakfast in this survey were significantly higher compared to those who did not. Just like skipping breakfast, late meals or snacking is also associated with obesity and metabolic syndrome (16-18). In this study, participants who had late meals (less than two hours before going to bed) also had significantly higher BMI and MAP when compared to those who did not (Question 5). However, there were no differences in BMI or MAP levels between respondents who had a snack after dinner three times or more per week when compared to those who did not (Question 9).

There is a Japanese saying that when eating, eat only until you are 80% full (hara hachi bunme). In our survey, 51% of the respondents managed to practice this restraint during meals and their BMI as well as MAP levels were significantly lower compared to those who ate until 100% satiety. Discipline is required but these habits are also replicable to some extent.

When offered something to drink other than water, the most popular choice (37% of the respondents) in this survey was green tea. Drinking green tea is not only associated with lower obesity levels and cancer rates but also has been demonstrated in large studies to have a positive effect on overall mortality (19;20). Green tea may also protect against functional disability in the elderly (21). Coffee (25%) and black tea (20%) which were the second and third most popular choice re-
spectively, is also associated with lower risk of mortality, particularly mortality from cardiovascular disease (22:23). Although access to green tea may be difficult for some, coffee is a widely available commodity which can be taken with moderation on a regular basis. Regarding the use of artificial sweeteners, which is also an increasing trend in Japan, it remains unclear whether low-calorie sweeteners are beneficial for weight loss and if sugar alone is responsible for obesity or diabetes (24;25). The results of this survey showed that the majority of Japanese adults prefer sugar when they want to sweeten their food or drink. There were no differences in BMI or MAP for those who used sugar compared to those who used other sweeteners.

Recently, the issue of distorted body image and abnormal weight control among Japanese adults (particularly younger women) has been brought out in both media and literature (26). A question was added to check whether the survey participants had such issues (Question 10). Since those who wanted to lose weight had significantly higher BMI and MAP than those who did not, it may be safe to assume that body image distortion was not prominent among our respondents.

Although the survey gives new insight into Japanese dietary habits of healthy adults, there were notable limitations. Firstly, all participants were adults receiving health check-ups at our institution, either voluntary (presumably health conscious) or mandatory (due to employment regulation etc.). Therefore, the participants are not representative of the typical Japanese population. Secondly, the data collection did not include socio-economic factors like education and income. The statistical analysis in this study only involved simple comparison between groups and did not adjust for possible confounders. Future studies should aim to evaluate the association between socio-economic background and dietary habits.

Conclusions

The results of this survey showed that dietary habits themselves seem to be contributing to a healthy lifestyle. Simple practices like starting each meal with vegetables, eating slowly, chewing adequately, not skipping breakfast, not eating late at night (meals or snacks) and stopping at 80% satiety form part of the Japanese dietary habit. These dietary habits are relatively easy to follow and the results of this survey showed them to be associated with lower BMI and MAP levels. Focussing on such practical habits in addition to the diet itself may contribute to a healthier lifestyle, lower obesity rates and healthy aging.

Author Contributions

EWTY designed and performed the study, analyzed the data, and drafted the manuscript. HM overviewed the project/study. All authors read and approved the final manuscript.

Conflicts of Interest

None declared

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Patient insight - perioperative smoking and alcohol cessation intervention?

Hanne Tønnesen1,2, Susanne Vahr Lauridsen2,3

Abstract

Background The involvement of patient preferences is sometimes forgotten in the evidence-based medicine and the development of clinical guidelines. Many preunderstandings among clinical staff exist on patients’ preferences towards smoking and alcohol cessation programs.

The aim of this project was therefore to get insight of the patients’ preferences regarding undertaking smoking and risky alcohol cessation intervention to reduce postoperative complications.

Method Six Scandinavian interview studies on adult surgical patients were identified and the focus of the analyses was on preference and motivation of the patients in relation to cessation programs taking place in the perioperative period.

Results Five intensive programs and one brief program were offered for smoking and alcohol cessation. All participants welcomed being offered the hospital’s support to quit smoking and risky drinking in relation to surgery. Most of them felt especially motivated by the possible health gain following the coming surgery itself.

Conclusion The patients seem to have a high preference for smoking- and alcohol cessation intervention in relation to surgery, especially towards the intensive programs.

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Introduction

Patient preferences are an important part of the evidence-based medicine in addition to the evidence itself and the necessary clinical competences (1). Daily smoking and risk drinking are important risk factors for development of postoperative complications. To date twelve randomised studies have evaluated the effect of perioperative smoking and alcohol cessation intervention (2-13) and more are coming soon (14;15).

In these studies, the inclusion rate varies from 50% to 82% in the different studies, but overall the compliance to the program is relatively good, ranging from 67% to above 90%. However, the successful quit rates in relation to surgery differ with the type of intervention. Thus, the intensive interventions with at least four meetings including patient education, motivational counselling and pharmaceutical support are followed by the highest quit rates of 27% to 90%. Interestingly, the long-term effect is also significantly. (16)

In contrast, successful quitting is more seldom after the shorter programs – about one third to one fifth of the levels obtained in the intensive programs. The shorter programs often contain one or two meetings building on motivational counselling and supported by pharmaceutical. Though, the shorter programs may seem attractive in a surgical setting with a heavy work-load, they are not followed by a significant risk reduction surgery, such as lower complications after surgery (16).

Some of the randomised studies above have nested interviews of the patient expectations, and experiences. The aim of this literature review was therefore to gather insight into the patients’ preferences of participating in smoking and alcohol cessation intervention in the perioperative period.

Methods

Using the following online search strategy Interview* AND (Smoking OR alcohol) AND surgery AND postoperative complication* a total of 157 publications were found; 59 from Pubmed, 87 from Embase and 12 from Cinahl. The manual search from reference lists and infor-
mation from experts revealed two more studies. After excluding 35 duplicates, 108 of the 125 titles and abstracts were considered not relevant for the subject. Furthermore, 8 studies were excluded as 5 did not use an interview design and 3 did not involve the surgical patients. Thus, 9 publications were further evaluated and 7 of those fulfilled the inclusion, but not the exclusion criteria. They were therefore included (17-23). One publication only existed as detailed abstract (23), but the related quantitative study has been published afterwards (24). The 2 excluded full text articles evaluated relevant aspects of perioperative smoking and smoking cessation, but did not perform analyses and interpretation as requested for a qualitative study design (25;26).

Altogether, 6 of the 7 included studies explored the experiences of regarding perioperative lifestyle intervention on short time (Table 1), while the last study focused on the 1-year follow-up (18). All studies were performed as individual or focus group interviews by semi-structured interview guides.

| Table 1 Characteristics of the participants and methods in the six interview studies on patient preference of perioperative smoking and alcohol cessation intervention |
|---------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|
| **N** of participants           | (16)          | (17)           | (18)           | (19)           | (20)           | (22)           | (21)           |
| **Lifestyle**                   | Smoking       | Smoking        | Smoking        | Smoking        | Alcohol        | Smoking        | Alcohol        |
| **Period of Intervention**      | 6-8 weeks preop | 6-8 weeks preop | Few days preop | 4+4 weeks pre+postop | 6 weeks postop | 2 weeks preop + late postop | 6 weeks postop |
| **Type of intervention**        | Intensive program | Intensive program | Brief program | Intensive program | Intensive program | Intensive program | Intensive program |
| **Relation to intervention**    | Intervention group: 10 quitters 8 smokers | Intervention group Mixed quitters and smokers | Intervention group: 5 quitters 6 smokers | Control group | Prior to intervention start | Prior to intervention start | Intervention group |
| **Women**                       | 9             | Mixed          | 11             | 15             | 5              | 6              | 1              |
| **Men**                         | 9             | Mixed          | 11             | 12             | 8              | 6              | 10             |
| **Age (range of years)**        | 40-77         | 30-85          | 40-72          | 42-66          | 28-78          | (Not given)    | 43-77          |
| **Sampling**                    | Purposive sampling | Representative sampling | Representative sampling | All control patients | Data saturation | Representative sampling | Data saturation |
| **Analyses**                    | Long table-model | (Not given) | Ricoeur’s theory | (Not given) | Applied qualitative framework | Applied qualitative framework | Thematic network |

**Results**

The studies recruited 92 surgical patients (47 women and 45 men), ranging 28-85 years of age. Across the studies, the participants were positive and found it relevant to be offered the support from their hospital / clinic support to quit smoking and/or risky drinking prior to surgery.

**Intensive interventions**
The analyses and interpretation identified important facilitators for successful quitting, such as a competent counsellor, measurements like lung function and CO concentration, free nicotine replacement therapy, the relative long intervention program over 6-8 weeks as well as the smoke-free surroundings at the hospital. The major barriers were lack of support from the staff and psycho-social stress from family and friends to re-uptake smoking (17).

At follow-up after 1 year the patients agreed that improved health and money saving were the main reasons for successful quitting smoking. All wanted a longer intervention period than the 6-8 weeks. The facilitators for continuous quitting included low nicotine dependency, being a man and having a non-smoking spouse. Even a year after the operation still several participants...
Patients undergoing bladder cancer resection together with neo-bladder construction received the intensive smoking and alcohol cessation intervention very well. They did not have an urge to smoke or drink alcohol in the smoke- and alcohol-free surroundings at hospital. This patient group saw smoking and alcohol cessation intervention as an integral part of the surgical treatment. In contrast, after the 6 week program returning to everyday life was a barrier to continue successful quitting of smoking and risky drinking (22).

The large majority of patients in the control group would have preferred to take part in the intensive intervention group, and many expressed that they were disappointed by being in the control group. Most participants agreed to take part in the perioperative smoking cessation study because they wanted receive the intervention (20).

**Brief intervention**

Only one study analysed the brief intervention program. The majority of women with breast cancer expressed a need for prolonged smoking cessation support instead of the brief intervention, which had only minor effect on quitting smoking in the perioperative period. However, the brief program had triggered their reflection upon smoking, health and addiction, and they experienced it as an opportune aid to escaping the social stigma of being a smoker (19).

**Expectations to the intensive programs**

The patient group with lung cancer found the programme highly acceptable and attributed emotional, informational, motivational and physical benefits to their participation (23). Also the patient group with ankle fracture saw alcohol intervention in relation to surgery as a good idea. However, they did not consider quit drinking as a major problem during their short hospital stay, because of the alcohol-free surroundings - and had all remained abstinent in this period. The patient opinions reflected their stage of readiness to stop drinking in the perioperative period, their general acceptance of supportive disulfiram as part of an alcohol intervention as well as their awareness of postoperative complications (21).

**Discussion**

An important result is that the large majority of patients welcomes intensive smoking and alcohol cessation intervention as part of the peri-operative care. Those receiving a briefer program strongly express need for more intensive intervention. Furthermore, the patients benefit from the smoke- and alcohol-free surroundings during hospital stay and the competences of the counsellor. Other facilitators are the expectation of fewer complications, improved health and saved money from quitting. The knowledge of unhealthy lifestyle as a risk factor for complications after surgery is related to motivation for changing lifestyle at surgery. It seems that the surgical patients prefer intensive intervention, as participants in the control group become disappointed of not being allocated to the intervention group; however, the briefer intervention may at least trigger reflections on smoking and health.

Numerous interview studies have been performed among smokers receiving different smoking and alcohol cessation programs (16). Many of them have taken place in the surgical setting, but very few studies have combined the perspective on successful quitting with the perspective of successful outcome after the operation, like the six studies included in our article (17-23). There are several bias and limitations in this article. First of all, those already introduced in the six original interview studies. Second, the generalisation from qualitative studies should be done very carefully, as the results are closely related to the context where the data are collected. In this case, the majority of the interviews have been performed in Sweden and Denmark, which make it difficult to generalise the results to other countries, cultures, patient groups and settings. Furthermore, the seven studies have used several different research methodology and performed the interviews at different time in relation to the operation (Table 1). On this background, it is interesting to identify the general positive attitude to and experiences from lifestyle intervention in the perioperative period.

In conclusion, it seems that patients are rather positive to intensive smoking- and alcohol cessation intervention in relation to surgery – across the included studies.

**Conflicts of Interests**

Nothing to declare.
References


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Abstracts selected for publication

At the 25th International HPH Conference in Vienna, 10 abstracts were awarded for their scientific level. The abstracts were chosen amongst all the abstracts presented in the Conference Abstract Book.

Effects of Using Situation Simulation Program in Nutrition Education on Healthy Eating Behaviors in Elementary School Children

CHANG Pei-Tzu, YANG Yu-Ru, YEUNG Chun-Yan

Introduction
According to the Nutrition and Health Survey in Taiwan (NAHSIT 2001-2002) one in three boys and one in four girls in elementary school were overweight or obese. The purpose of this study was to use Situation Simulation Program and shopping practice to boost the elementary school children’s nutrition knowledge, eating principles and behaviors.

Purpose/Methods
13 elementary school children voluntarily participated in this program. We measured their height and body weight before nutrition education intervention. The children were asked to fill out a questionnaire measuring their nutrition knowledge and practice before and after the intervention in order to evaluate its effectiveness. The teaching sessions of three days nutrition education intervention included learning healthy body control, healthy eating principles, healthy eating behaviors (my plate), nutrition facts labels and Traffic Lights foods. After completing the sessions, the children were assigned a task with a convenience store shopping practice. The children experienced various typical grocery products like milk, juice, cookies, etc and what they chose were recorded.

Results
Among the 13 children (eight boys and five girls), mean age 9.2±1 years, mean height 140.7±9.2 cm, mean weight 46.9±8.4 kg were recorded, six children were overweight based on their age. The overall mean scores of nutrition knowledge were improved after education intervention. Furthermore, the attitudes toward checking nutrition facts label before making a decision and having a daily balanced diet were also improved after intervention. On the Traffic Lights foods selection, 85% of the children chose green light foods, 15% yellow and none red.

Conclusions
The Situation Simulation program had immediate effect and helped children to improve nutrition knowledge and correct eating behavior. We thus highly recommend this program to children in elementary school. This health-promotion program could boost children’s learning and enhance their confidence.

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Asylum seekers and healthcare seekers: healthy migrant effect and empowerment

MONICI Lucia, FORNACIARI Rossano, GRECI Marina, BONVICINI Francesca, PINOTTI Elettra

Introduction
Asylum seekers who land on the Italian coast are hosted on Italian territory by an extensive network of reception organizations. Local cooperatives with hosting facilities aim to meet people’s basic needs. Since 2014, the local Health Authority of Reggio Emilia has been working in close collaboration with cooperatives in order to recognize the refugees’ entitlement to healthcare and access to services.

Purpose/Methods
The local government authority provides information on the new arrivals to the cooperatives; they pass on the data to the other various levels (Administration and Outpatient Service). The Administration prepares the health cards for immigrants to have access to healthcare. People arriving on the territory are given a medical examination within a few days of their arrival, with the main purpose to detect contagious diseases. Active TB screening with chest X ray is performed. The Outpatient Service that provides health care and prevention activities is specialized for 20 years in the management of the immigrants.

Results
In the last two years 7500 examinations and 6424 vaccinations were carried out. Up to 31 August 2016, they were diagnosed 35 cases of scabies, 6 of pulmonary tuberculosis and 35 of latent tuberculosis infection; all patients have completed the prescribed treatment correctly. All women have an interview and an examination with a midwife. Cultural mediators were constantly present with the health care professionals and the patients.

Conclusions
These last two years of collaboration between Hosting Cooperatives and the Health Authority have seen a gradual improvement in the design of social-healthcare pathways to provide health assistance and of educational projects for the hosted immigrants; as part of the collaborativ relationship for the empowerment of asylum seekers, various professional training meetings of healthcare workers and educators have already been held.

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Health-related quality of life among subjects with long-term mental symptoms

SAHARINEN Tarja, KYLMÄ Jari

Introduction
There is a need for measuring health-related quality of life (HRQL) to supplement public health’s measures of morbidity and mortality. An individual’s subjective perception of physical, mental and social functioning and well-being is important in measuring HRQL. It is also necessary to assess HRQL in vulnerable populations and to produce knowledge promoting HRQL.

Purpose/Methods
The purpose of this study was to examine HRQL and its correlates among subjects with long-term mental symptoms (n=158) in a population-based sample in Finland. HRQL was measured using the RAND-36 including the physical (PCS) and mental (MCS) scores. Sociodemographic, somatic, and psychiatric factors were investigated with a self-rated health questionnaire, structured interviews, and standard clinical measurements. Pearson’s chi-squared test, an independent samples t-test and logistic regression analyses were used.

Results
Subjects with long-term mental symptoms had a poor HRQL in the physical, mental and social domains. The main correlates were life dissatisfaction and somatic diseases; in men alexithymic features, in women a low level of education, a frequent use of alcohol and depressive symptoms. A reduced working capacity and in women being a current smoker were associated with a poor HRQL. Long-term life dissatisfaction was a risk factor for poor HRQL. Sociodemographic and somatic factors were only weakly associated with HRQL.

Conclusions
When promoting HRQL it is important for nurses and other healthcare professionals to recognize mental health symptoms and co-operate in the early phase in a multiprofessional team. Among subjects with long-term mental symptoms it is necessary to note also their physical and social well-being and functioning. It is important to pay attention to alexithymic features in men and a frequent use of alcohol in women. Society can promote HRQL by supporting education, ability to work and financial situation particularly among vulnerable people.
An overview of systematic reviews of interventions to change diet-related behaviours in overweight or obese people

BROWNE Sarah, MINOZZI S, BELLISARIO C, Sweeney MR, SUSTA D

Introduction
This overview of existing systematic reviews (SRs) was conducted to evaluate the effectiveness of interventions in changing diet behaviour among overweight/obese adults in healthcare and community settings.

Purpose/Methods
SRs of randomised controlled trials (RCTs) testing dietary behaviour change interventions were identified through searches in Cochrane Library, PubMed, Embase and PsycINFO (1/2006 to 11/2015). The methodological quality of SRs were appraised using AMSTAR. 17 SRs were identified, 13 were not relevant and excluded.

Results
4 SRs, 3 high quality (Lara 2014; Mastellos 2014; Dom-browski 2010) and 1 medium quality (Taylor 2013), were eligible for inclusion in this overview. Two SRs evaluated RCTs within specific population groups: people of retirement age and males. Dietary behaviour change was the primary outcome for two SRs, while two evaluated interventions with other lifestyle components. Increasing fruit and vegetables intake is the most consistent and significant behaviour change across the SRs, especially among older groups. Reducing dietary fat is the next most effective outcome, however reducing total energy intake is less consistent between studies. Effective interventions were both short (2-12 months) and long (12-58 months) and were delivered by dietitians/nutritionists or trained counselors/research staff. Multiple face-to-face contacts combined with remote communications is the most effective modality. The site of delivery may be important for specific population groups, for example effective interventions with males were delivered in workplace and community settings.

Conclusions
This overview demonstrates that dietary interventions are particularly effective in increasing fruit and vegetable and reducing fat intakes in obese/overweight populations.

Effects of yoga on stress, stress adaption and heart rate variability among career women in Taiwan - A randomized controlled trial

SHIU Shau-Ping, LIN Shu-Ling, TENG Heng-Yi

Introduction
Work-related stress directly affects the physical and mental health of career women, and indirectly the organization and even the family members they care for. This study was done to examine the effects of yoga exercise on work-related stress and stress adaptation among career women.

Purpose/Methods
This is a parallel-arm randomized controlled trial comparing the outcome of participants who were randomly assigned to the experimental group (yoga, with 30 participants) with the outcome of those assigned to a control group for 12 weeks. The participants attended a regular 90-minute yoga class once a week. We measured work-related stress relief, stress adaptation and autonomic nerve activity improvements after classes.

Results
The results showed that those participating in yoga classes experienced a significant reduction in work-related stress (t = -6.25, p < 0.001) and a significant increase in autonomic nerve activity (t = -2.79, p = 0.006). In addition, compared to the control group, the participants in the yoga group significantly decreased their work-related stress (t = -3.26, p = 0.004) and significantly increased autonomic nerve activity when controlling the pre-test scores of work-related stress.

Conclusions
After participating in 12 weeks of yoga classes, career women experienced a reduction in work-related stress and an increase in autonomic nerve activity. They were able to relax and feel calm from the structured questionnaire of measured responses. These results can be used to help other related career women to reduce their work-related stress and balance of sympathetic and parasympathetic nerve activity.

Comments
Yoga is an effective activity for career women to help decrease stress and improve their health status. Medical institutions may consider offering regular yoga classes for career women as a means to assist them in learn-
Smoking and clinical aggression in a large health service: can we do better?

DEAN Emma, CORBEN Kirstan, MARUM Steve, WEIR-PHYLAND Janet, ANANDA-RAJAH Michelle

Introduction
Clinical aggression in a health service may escalate requiring a security response known as a ‘code grey’. Addressing the clinical drivers of code grey episodes is a high priority for health services in order to improve patient outcomes and minimise occupational risks.

Purpose/Methods
To understand the relationship between nicotine dependency and clinical aggression as part of an organisational review characterising the epidemiology, management and resource utilisation associated with code grey episodes. A retrospective audit was conducted of all code grey episodes occurring between 1 January and 31 December 2015, in a large metropolitan health service. Patients were identified from security records and clinical incident reports. Variables included socio-demographic and clinical risk factors, including drug and alcohol abuse, nicotine dependency, co-morbidities and resource utilization, including special nursing, security personnel and pharmacological/mechanical restraints.

Results
To date 713 code grey episodes in 341 patients have been reviewed. Characteristics include: 69% male (n=235), mean age 39 years (range 16-98 years), psychiatric diagnosis in 35%, dementia or cognitive impairment in 14%, and acquired brain injury in 10%. Of the code grey episodes reviewed, 70% (n=499) involved a patient who smokes (51% patient smoking rate), however a nicotine dependency assessment was performed in only 70% (n=349) of these episodes. Of the 53 episodes involving patients with high nicotine dependency (smoking heaviness index of 5 or 6), nicotine replacement therapy was not administered in 70%, despite recommendations for initiation in 87% and features of nicotine withdrawal in 75% of episodes.

Conclusions
People who smoke are overrepresented among patients with significant episodes of clinical aggression. Improved assessment and management of nicotine dependency in the hospital setting is a modifiable factor with potential to improve patient outcomes and staff safety.

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Impact of a theory-based multi-component lifestyle intervention to control abdominal obesity and cardiovascular risk factors: 12-month results of a randomized clinical trial

KIM Hyekyeong, NAH Eunhee, KIM Myung, KIM Hyeyun, LEE Ji-Eun, SUN Yingning

Introduction
The prevalence of obesity and metabolic syndrome is rapidly increasing worldwide. A comprehensive program of lifestyle modification is considered the first option for losing weight and decreasing cardiovascular risks.

Purpose/Methods
The objective of this study was to evaluate the effectiveness of a theory-based lifestyle intervention in decreasing risks for abdominal obesity and cardiovascular diseases. The participants were 370 adults (aged ≥30) identified with abdominal obesity (182 intervention group and 188 comparison group) and additional cardiovascular risk factors. The intervention was developed as multiple behavioral intervention which combined individual health counseling with education and monitoring. Social cognitive theory and TTM were applied to develop intervention strategies. The comparison group was provided with minimal information. Health examination were measured at baseline, 3-month, 6-month, and 12-month at health promotion centers at Korea Association of Health Promotion in Korea both in 2013 and 2014.

Results
The prevalence of abdominal obesity was reduced by 27.8% (from 99.0% to 71.2%) in the intervention group and 20.3% (from 98.7% to 78.4%) in the comparison group after the 6-month intervention. In terms of cardiovascular risk reduction, significant improvements were found in BMI (P<.0001), waist size (P<.0001), systolic and diastolic blood pressure (P=.0012, P<.0001) and HDL cholesterol (P<.0001) among the participants.
of the intervention group after the intervention. In contrast, only BMI and diastolic blood pressure were improved significantly (P<.0001, P=.0033) among the participants of the comparison group.

**Conclusions**
Lifestyle intervention program was found to be effective for the reduction of abdominal obesity and cardiovascular risks of Korean adults. However, additional studies are needed to identify factors that could contribute to the improvement of obesity and related health risks.

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**Effectiveness of eHealth tools and other intervention components for fruit and vegetable intake**

**RODRIGUEZ-ROCHA Norma P, KIM Hyekyeong**

**Introduction**
Studies evaluating the effectiveness of a variety of eHealth tools for health behavior change have been published in the literature. However, there is a gap in terms of which eHealth strategies are most successful, and the characteristics that might be responsible for their effectiveness.

**Purpose/Methods**
This study tried to evaluate the effectiveness of the use of eHealth tools and other intervention components for the improvement of fruit and vegetables (FV) consumption. A meta-analysis of RCTs for FV eHealth interventions was conducted. Peer-reviewed studies were located through online databases. Studies had to be RCTs or quasi-experimental trials, using an eHealth tool as main intervention arm. A random-effects model was used and pooled Hedge's g was calculated for effect sizes (ES). Higgins I-squared test was used to assess for heterogeneity, subgroup analysis was conducted to evaluate for intervention characteristics.

**Results**
The analysis included 16 studies and 5774 participants. The most commonly used eHealth tools were Internet-based (n=9), and computer-based interventions (n=6). The overall ES was small, but statistically significant (ES=0.261, SE=0.055, 95% CI=0.153-0.368, p<.001), favoring eHealth interventions. The between-studies heterogeneity was large (I2=68.08%, p=.001). Tailored interventions (n=13) showed an overall significant positive ES of 0.28 (SE=0.061, 95% CI=0.157-0.396, p<.001), while non-tailored interventions (n=3) showed a non-significant small positive ES of 0.19 (SE=0.140, 95% CI=−0.089 to 0.459, p=0.186). When analyzing the ES by eHealth tool, SMS intervention showed the largest ES (0.970, p<.05).

**Conclusions**
The use of eHealth tools for the improvement of FV intake appears to be more effective than interventions not using these technologies. More research is needed in this area to determine the specific combination of eHealth tools and intervention components that could be more effective.

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**Extent of adoption of the WHO Best buys intervention for non-communicable diseases prevention policy formulation in Nigeria**

**OLUWASANU Mojisola, ABIONA Opeyemi, OLADEPO Oladimeji**

**Introduction**
Non-communicable diseases (NCDs) mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes are threats to human health and development and prevention remains a key approach for reducing its occurrence. The World Health Organisation emphasizes the “Best Buys” intervention as evidence-based options for addressing NCDs and countries are expected to integrate them into policies. Nigeria has developed some NCD policies; however there is a dearth of information on the extent of integration of the “Best Buy Interventions”. This study addresses the information gap.

**Purpose/Methods**
The study adopted a descriptive case study design guided by the policy analysis framework of Walt and Gilson. A mixed methods approach comprising desk review of 43 NCDs related documents on best buy interventions for the four major NCDs modifiable risk factors – tobacco use, harmful alcohol use, unhealthy diets and insufficient physical activity - and key Informant interviews with 44 policy makers adopted for the study. Data was integrated and analysed using NVIVO version 10.

**Results**
Tobacco use is the only modifiable risk factor with the most comprehensive set of best buy interventions. Harmful use of alcohol has no comprehensive policy
and only one of the best buy interventions - restricted access to alcohol, exist in the policies. Policies to promote healthy diet incorporate all the best buy interventions but there are no acts to regulate the activities of the food industry in respect of salt and trans-fat content of manufactured foods. In addition, the “best buy” intervention for physical activity is not integrated in policy documents.

Conclusions
These findings have grave implication on the country’s effort to effectively tackle the growing burden of NCDs. It underscores the urgent need to review the NCDs prevention and control policies to ensure the integration of the globally recommended “best-buy” interventions coupled with sustained political commitment and resource allocation for implementation.

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United States vs Sweden: Health counselling service in primary care

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Introduction
An ongoing Swedish-American study compares (1) primary care professionals’ engagement in lifestyle counselling, (2) patients’ need for support from primary care to change lifestyle and (3) the patients’ experiences of primary care interventions to meet those needs.

Purpose/Methods
The presentation is based on two cross sectional studies, one including four key questions on counseling for tobacco use, alcohol consumption, physical activity, and eating habits, that compares perspectives, attitudes, and practice among 180 Swedish and 86 US primary care providers (physicians, physicians assistants, midwives, and nurses), and the other 288 Swedish and 341 U.S. randomly selected patients, based on telephone interviews.

Results
U.S. providers rated counseling “very important” significantly more frequently than Swedish providers for tobacco, physical activity, and eating habits, and reported giving “very much” counseling more frequently than the Swedish providers did. Swedish providers rated their level of expertise in providing counseling significantly lower. A higher percentage of U.S. providers expressed a desire to increase levels of counseling “very much”. For 3 of the 4 lifestyle habits (except alcohol) the proportion of subjects needing lifestyle changes was higher in the U.S. The proportion that needed and would like to get lifestyle support from primary care was generally above 80% in both countries. The proportion patients reporting primary care initiated discussions on lifestyle was below 50% in Sweden and above 50% (with the exception of alcohol for men) in the U.S.

Conclusions
The studies indicate the needs of improvement for primary care in both United States and Sweden regarding how to better address nutrition, physical activity and tobacco habits. The study demonstrates high and quite similar patient expectations concerning lifestyle counselling in both countries.

Comments
The presentation is based on a research collaboration between Umeå University, Sweden and Bassett Research Network, Cooperstown, NY, USA.

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25th International Conference on Health Promoting Hospitals and Health Services

This year in April, the Austrian HPH Network of Health Promoting Hospitals and Health Care Institutions (ONGKG) invited all of their HPH colleagues and other interested to join the celebration of the 25th anniversary of international HPH conference. The conference took place within the walls of the magnificent and historic University of Vienna, which was founded back in 1365 and is one of the oldest universities in Europe.

Since the early years, when HPH was merely a European WHO initiative, a global expansion has taken place and today, the International HPH Network consists of more than 600 hospital and health service members from all over the world.

Due to the long history, a long list of exciting ideas, projects and events have taken place under the wings of HPH. To celebrate the history as well as a promising future for HPH, the focus and theme for this year's conference was: Directions for Health Promoting Health Care – Lessons from the past, solutions for the future.

Two days prior to the opening day of the conference in Vienna, the WHO-CC for Evidence-based Health Promotion in Hospitals and Health Services held this year's HPH Summer School and HPH Newcomers’ Workshop. Both events gave the participants, new within the HPH as well as experienced, opportunity to gain insights and inspiration in the area of Health Promotion in hospitals and health services.

The formal opening of the 25th International HPH Conference took place in the afternoon on Wednesday 12, and included presentations from a wide range of professionals giving an insight in the history of the HPH Network.

The formal opening was followed by the first of five plenaries, which aimed at introducing the participants to the celebration of the achievements from the past as well as identifying challenges for the future. The following four plenaries had the following titles:

- The role of health promoting health care to achieve the Sustainable Development Goals: steps towards 2030
- Transforming health care to empower and meet the health needs of refugees and migrants
- Contributions of health care to mitigating and adapting to climate change
- Reorienting health services and systems: 30 years after the Ottawa Charter

In the following days, the beautiful University of Vienna was transformed into a world of HPH and in addition to the five plenaries, a long list of oral presentations and poster sessions gave the participants an update and introduction to the many ongoing research projects and initiatives taking place to promote health promotion globally.

On Thursday night, the annual conference dinner took place on the Donau on the boat MS Admiral Tegetthoff.
News from the International HPH Network

General Assembly 2017, Vienna, Austria

On April 12, 2017, the annual HPH General Assembly (GA) took place in Vienna, Austria. It was the 23rd Meeting between the coordinators of the National/Regional Networks, the HPH Task Force Leaders, partners, and invited observers. and of course the WHO Collaborating Centre for Evidence-Based Health Promotion in Hospitals & Health Services in Copenhagen and the WHO Collaborating Centre for Health Promotion in Hospitals and Health Care in Vienna.

The General Assembly was arranged by the International HPH Secretariat and all sessions were chaired by members of the HPH Governance Board and by the WHOCCs.

The first order of business was a closed HPH Workshop for N/R Coordinators and the Task Force leaders to discuss the role of the Coordinators. After a short break, an open-door Workshop began, which gave networks, task forces, partner organizations, hospitals or other organizations the opportunity to invite some of their colleagues to take part in the workshop from the observer seats. The aim of this second workshop was to discuss the implementation of the 2016-2018 HPH Strategy.

The formal GA agenda opened with the progress report of the HPH Governance Board. Subsequently, the international HPH Secretariat gave a report on member status, balance and budgeting, as well as the 2015-2016 Progress Report with reports on the N/R Networks and TF fulfilment of the HPH Global Strategy 2013-2015.

Afterwards, the updated WHO HPH Standards were presented to the GA. The updated standards have a tested beta version, and with an expert hearing planned in spring, the finalization is expected in autumn 2017.

In the afternoon, the GA delegates were updated on the progress of the each of the HPH Task Forces as well as the two HPH Working Groups.

The GA had a vote for the 2019 conference host, with Poland given the conference to be held in Warsaw in June 2019. Estonia was decided for the 2020 conference.

Participants at the HPH General Assembly, April 12, 2017
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26th international HPH Conference in Bologna, Italy
Promotion Strategies to achieve Reorientation of Health Services: Evidence-Based Policies and Practices

The annual HPH Conference on Health Promoting Hospitals and Health Services will take place June 6-8, 2018 in Bologna, Italy next year.

The conference will open for abstract submission and registration in November 2017. Please remember, that early registration guarantee a reduced participation fee.

For more information, please visit the website: https://www.hphconferences.org/bologna2018
Cerebrospinal Meningitis Outbreak in Nigeria

Auwal Abdullahi

Cerebrospinal meningitis (CSM) is the inflammation of the tissues of the meninges (dura mater, arachnoid mater and pia mater) — covering of the brain and the spinal cord. It is an important cause of morbidity and mortality in many regions of the world (1-3). It may be due to infectious agents such as viruses, bacteria and fungi. Rarely, meningitis can be caused by certain medications. The signs and symptoms of CSM include headache, fever, vomiting, seizures, reduced consciousness, fatigue, nuchal rigidity, and positive Kerning’s and Brudzinksi signs. The disease can affect children, young adults and old people. However, children are at particular risks of developing serious complications. Cerebrospinal meningitis is transmitted through the nose and throat secretions such as during sneezing and coughing.

Although there is epidemiological transition from communicable to non-communicable diseases such as stroke, hypertension, diabetes mellitus, arthritis and sickle cell disease world over, infectious diseases still remain a burden in some developing countries. For instance, recently there was an outbreak of Cerebrospinal Meningitis in Nigeria involving 16 states of the Federation with a recorded 2524 cases and 328 deaths so far (4-5). In one of the states located up north of the country, in just the last 2 months, about 1864 cases and 215 deaths were recorded since the outbreak. This was according to the State Government Spokesman (5). Even in the past years, there were many reports of outbreaks that claimed many lives. This is not surprising as the country is known to be in the Africa Meningitis Belt along many other countries including her immediate neighbours, Niger and Cameroun. Thus, with the easy movement of people across the borders of Nigeria from these members of Africa Meningitis Belt coupled with the rapidly increasing population of Nigeria, and the not so well developed Primary Health Care Services, the country can make a very good customer for such outbreaks.

In response to the outbreak, the country’s Ministry of Health made some laudable efforts. The efforts were measures to properly diagnose, treat, and isolate the infected persons (4). However, these measures are only short term in nature and do not consider the patients’ situations in the medium and long term. This is because, in the medium and long terms and perhaps even in the short term, the infected persons may develop neurological and musculoskeletal and even respiratory complications. For instance, inflammation of the meninges may eventually injure the brain cells especially in the developing brain leading to mild brain injury or Cerebral Palsy. In either case, the affected persons may develop rigidity, which may eventually lead to development of contractures, reduced chest excursion and disability. Therefore, crit-
The lack at the measures will show that measures to prevent complications and in particular disability for those who have already been infected have not been emphasized in the laudable response by the Federal Ministry of Health.

During an outbreak like this, an interdisciplinary response to the disease is most desirable. To this end, the Neurological, Musculoskeletal and Respiratory Physiotherapists who are experts in the rehabilitation of people with neurological, musculoskeletal and respiratory conditions— involving prevention at the secondary and tertiary levels, can play a major role. Consequently, the people affected will need to be evaluated for impairment of brain function and signs and symptoms of musculoskeletal and respiratory complications. Those with signs of the impairment in brain function such as motor function, may benefit from Neuroplasticity induced specific rehabilitation such as task specific training, stretching and/ or Range of Motion Exercise and therapeutic positioning to prevent contracture, and Chest Physiotherapy to prevent respiratory complications (6-8). Hopefully, the task specific training can help to prevent mal-adaptation of the brain in case of impaired motor function. This is because, the brain especially that of the child is very malleable, and can therefore learn very quickly under training. And when the window period (early post brain impairment) is utilized, this may optimize functional adaptation through use dependent plasticity (9); and prevent the impairment from progressing to a severe form.

Similarly, preventing contracture from developing can prevent surgery or disability in the future. Surgery can be costly especially to those who earn below $1 per day. Secondly, cost of disability in terms of psychological burden, poverty and productivity cannot be overemphasized. Additionally, Chest Physiotherapy can help prevent lungs collapse, accumulation of secretions and airway obstruction. The types of Chest Physiotherapy that can be given to these patients include Chest Expansion Exercises, Percussion, Clapping or Shaking with Postural Drainage and Deep Breathing Exercise to dislodge and drain accumulated secretions. Thus, advisably, anywhere there is an outbreak of meningitis; Physiotherapists have invaluable contributions to make especially in the area of secondary and tertiary levels of prevention. Therefore, stakeholders such as National and State Governments and the WHO should ensure that Health professionals whose services are needed are assembled to help curtail public health problems an outbreak may come with. Indeed, a stitch in time may save nine lives in the future.

References
News from the International HPH Network

Hong Kong Network – a small but active network

The first two Hong Kong based hospitals joined the international HPH Network in 2012 in relation to the HPH Conference held in Taipei, Taiwan, and with four member hospitals it is one of the smallest National/Regional HPH Networks. But the diminutive size does not mean that the network is not strong on ideas and projects. We have interviewed Alan Siu Yuk Lun the coordinator of the Hong Kong Network about their projects and organisation.

We know you have a strong focus on involving the community in your projects, can you enlighten us in some of your project and how you involve your community in your Health Promotion activities?

Overall we tend to Structure health programs and lifestyle management activities to fit the needs of the community and we engage in collaborative effort to achieve disease prevention.

In 2015, we developed a team focusing on Healthy Training and Development and in 2017 the team extended their work to include Diabetic Risk in the Health Program. Under the projects, the team holds a series of training activities in the community where the participants can have their risk for lifestyles related diseases assessed and informed about it.

Another example of our community commitment is our projects with kindergartens where we have a focus on increasing the intake of fruit and vegetables for children and their parents. This project is done in collaboration with a local NGO and is under application for funds through the Health Government.

A final project, I would like to highlight is our Corporate Health Screening project where we screen employees for lifestyle risk factors. In collaboration with the corporates administration, a group is

In the Western hemisphere, most people have limited knowledge about traditional Chinese Medicine, but in Hong Kong the health sector encompasses both the traditional and the western approach. Can you elaborate on how the patients and relatives perceive Health Promotion?

Traditional Chinese Medicine is normally perceived with fewer side effects and is today used as supplements to the more Evidence-based western approach. The traditional Chinese Medicine is perceived with a better overall effect upon physical wellness compared to Western Medicine. The Evidence-based lifestyle management approach is used to bridge the two management domains.

Thank you very much for the exiting insight in the Hong Kong Network.

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About the Hong Kong Network

The Regional HPH Network consist of four members:

Hong Kong Adventist Hospital, Tsuen Wan
Hong Kong Adventist Hospital, Stubbs Road
Jockey Club Tin Shui Wai Community Health Centre
The University of Hong Kong, Shenzhen Hospital

The Regional Network is coordinated by Regional Coordinator Alan Siu Yuk Lun from the Lifestyle Management Center at Hong Kong Adventist Hospital.

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Cooking class for patients and relatives