nutrients that could have been implicated in the occurrence of gastric cancer.

Methods

The hospital-based case-control study was carried out in Krakow. During the period 2000-2003 192 incident cases of stomach cancer confirmed histopathologically and the same number of controls were enrolled. Controls were recruited from amongst patients with no history of cancer, admitted for conditions unrelated to digestive tract diseases, matched to cases by age (+/– 5 years) and gender.

Results

Our study showed protective effect of lower intake of saturated fatty acids and cholesterol on stomach cancer occurrence. Inversely, low intake of linolic acid has been found to be associated with the higher risk (OR=2.11; 95% CI: 1.18-3.77). We found also that low intake of b-carotene (OR=1.90; 95% CI: 1.10–3.29) and vitamin E (OR=1.92; 95% CI: 1.11–3.32) increased risk for stomach cancer. The results support the evidence that the intake of mineral components may play a role in the occurrence of stomach cancer. According to the obtained data, low intake of iron is a potential factor increasing the risk of stomach cancer (OR=3.02; 95% CI: 1.75–5.24), while low intake of calcium has lowering effect (OR=0.53; 95% CI: 0.31–0.90).

Conclusions

Prevention of stomach cancer should be focused on improving the dietary habits of the population in such a way that the intake of the nutrients could reach the appropriate level. The sensibly dietary advice that could reduce the risk of stomach cancer would be a diet with high intake of antioxidants.

Is fat the new tobacco? Strategies for addressing the obesity epidemic in Canada

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Issue

Obesity and its role as a risk factor for cardio- and cerebrovascular disease has become an important focal point for health promotion and policy initiatives in Canada. In 2001, 56% of Canadian men and 39% of Canadian women reported being overweight or obese. Rates of overweight in boys and girls aged 7 to 13 have doubled in the past twenty years and obesity rates in children in this age group were four to five times higher in 2001 than in 1981. Obesity represents the type of health threat that smoking posed 30 years ago when 47% of Canadians smoked. The longer term economic burden of overweight and obesity on the public health care system in Canada could be considerable.

Description

The HSFC has a mandate to address the obesity epidemic by creating and implementing strategies directed at individual, population and environmental levels. Experience with tobacco control and regulation has demonstrated that a broad range of interventions – from the provision of health promotion materials directed at individuals to a variety of public policy initiatives – can have a profound impact on cardio- and cerebrovascular risk factor modification. This presentation will discuss the extent to which effective strategies in tobacco control and reduction can be applied to addressing obesity in Canada. An outline of strategies being developed to combat obesity will be described.

Lessons

The HSFC's health promotion, health policy and advocacy approaches to reducing overweight and obesity in Canada require short- and long-term measures of their efficacy in addressing the problem. The HSFC needs to determine, on an ongoing basis, the baseline data to be gathered (both by ourselves and our partners) as well as the quantitative measures and qualitative data necessary to provide evidence on the outcomes of specific approaches. Conducting pilot studies or developing case studies within Canadian provinces to track and measure progress is an additional consideration.

Urban Problems and Health Promotion: Workshop of the EUPHA Section on Health Promotion

Aging, depression, social utility and urbanization

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2) Vicepresident of "Senior House"-Braila, Romania

Aims

a) To examine loneliness, correlated with health, social status and health care.

b) Exploring ways for reducing the incidence of depression.

c) Improving and maintaining the health of older people living in big towns.

d) Encouraging older people to become more involved in promoting health.

Growing urbanization and the collapse of traditional industry and agriculture result in disruption of economic systems that give older people mostly unpaid work. There is a decline in health, independence, due to reduction of social activity for people who retire. It is very important to ensure that aged people can cope and adjust the life crises they meet, so that they can overcome feelings of low self esteem, or loss of purpose in life.

Methods

a) Semi-structured and structured questionnaires filled anonymously; b) individual discussions; c) clinical exams.

Data were collected between February–May 2004 in "Senior House" Braila and the Ambulatory clinic of Rehabilitation -Bucharest.

Results

a) There is a predisposition in responding in a negative manner to life challenges and in the way of coping with life problems in older age.

b) Depression affects the physical status and the activity of daily living at the aged person.

c) Encouraging movement through exercise should be seen in a wider context, that enhances social interaction.

Conclusions

Promoting activities that stimulate the older individuals into engaging in activities and reducing routine, will in turn bring benefit for these persons' health. Retirement should not be seen as an excuse for not involving in activities of daily living which could transform people in "passive observers of life".

Health promotion can be integrated into all aspects of health.

Ethnic differences in prevalence of diabetes in pregnancy: a study from a general practice in Oslo, Norway

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Aim

To study ethnic differences in the prevalence of diabetes in pregnancy and pregnancy outcomes.

Methods

167 women, aged 19 to 42 years, who delivered in 2002–2003 from one GP practice (FB's), were included. Ethnicity was self-reported. An oral glucose-tolerance test (OGTT) was performed if age was ≥38 years, BMI >27 kg/m^2, and in all immigrant groups irrespective of age. Known diabetic (KD) & Gestational Diabetics (GD) diagnosed by 2 hr OGTT were further subdivided in two groups (7.8–11 mmol/l and >11 mmol/l).

Results

The sample size and mean age in the three ethnic groups were comparable (Norwegians N=60, age 31.7, Pakistani/Indians N=51, age 31.5, other immigrants N=56, age 30.1). Large and highly significant ethnic differences in the total prevalence of diabetes were observed, 86% in Pakistanis/Indians, 15% in Norwegians, and 70% in other immigrants ($p<0.001$). Only 7 (14%) of Pakistani/Indian women had normal OGTT, whereas 55% had 2-hour values >11 mmol/l, compared to 7% of Norwegians. Mean weight gain for subjects with GD was significantly greater among those with Pakistani/Indian origin (19.0 kg) than for Norwegians (17.1 kg, $p<0.001$). The impact of diabetes within the Pakistani/Indian group was striking, with an increase in mean birth weight of 0.9 kg (0.5 kg in Norwegians) and 1.7 kg for the GD and KD group compared to

non-diabetics. Complications were more frequent among those with diabetes (30% of Pakistanis/Indians had Caesarean sections).

Conlusion

The high prevalence of diabetes in pregnancy among Pakistani/Indian immigrants is alarming, and higher than reported earlier. The impact of diabetes on pregnancy outcomes in this group clearly indicates that diabetes in pregnancy is an important and serious public health issue in Norway, and possibly also in Europe. The ethnic differences are unlikely to be due to large selection biases, although among the Norwegians diabetics prevalence is most likely underestimated *(table 1 and table 2)*.

Oral health promotion among schoolchildren in Belgrade, Serbia & Montenegro

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In last decade of past century oral health status among schoolchildren in Belgrade was put aside cause well known circumstances in our country. Belgrade, capital of Serbia and Montenegro has 1,600,000 citizens distributed in 16 municipalities: 6 rural, 5 rural-urban and 5 urban. There is significant inequalities in oral health status of schoolchildren in these municipalities. As a part of National Preventive Dental Health Program oral health promotion was implemented among schoolchildren in Belgrade to rub out these inequalities in oral health status.

Aim

Aim of study is to show importance of oral health promotion for improving oral health status of targeted population, particularly to show rural–urban dimension of the oral health status and necessity for health promotion.

Method and material

It is social-medicine evaluation study, BEFORE–AFTER design. Indicators for measuring oral health status, used in study DMFT and CPITN are accepted by WHO. Statistically analysis is based on routine statistical reports. Targeted population were: 12 years old and 15 years old schoolchildren in Belgrade for period of 5 years (1996–2000).

Results

At start of NPDHP average DMFT=2,68, by the end of Program DMFT=3,13 for overall schoolchildren in Belgrade. In rural communities at start was average DMFT=3,26, by the end of Program DMFT=3,82, in rural/urban communities at start in 1996 year average DMFT=3,19, by the end in 2000.y, average DMFT=3,62. In urban municipalities average DMFT=1,5, by the end in 2000.y average DMFT=1,9. Index used in study for measuring periodontal status at 15 years old scholars CPITN=5,58/3 sextant and by the end CPITN=6,62/3 sextants overall.

Conclusion

Results showed there are high inequalities among oral health status based on rural–urban dimension. During the period of application of NPDHP oral health promotion had not shown expected results caused with circumstances in our country. Measures suggestion: Community mobilization is necessity to improve oral health status among schoolchildren in Belgrade and to erase inequalities in health between the rural and urban communities in big city, such as Belgrade.

Accepting otherness: experiences of the integration of 3–6 year old disabled children in an urban environment

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In spite of the world famous Hungarian special needs education background, the practice of integrating children with mild disabilities into sound communities is still in an experimental phase in Hungary. The questions of educating together or integrated education is coming more and more into the foreground in Hungarian educational public life as well, in apropos of grants available after joining the European Union.

The aim of the project was to create and try out the city level provision of the integrated education obligation specified in the Hungarian Education Act. Five kindergartens from Szeged took part in the project, where the integrated education of ten mildly disabled children was going on for three years. The main health promoting aim was to try out kindergarten methods suitable for creating the atmosphere of accepting otherness. This aim was partly fulfilled by training kindergarten teachers, nurses and kindergarten doctors for the task, and partly by the preparation of all concerned parents, within group sessions.

Though the legal and professional background had already been ensured for years, successful integration needed changes in organisation and approach as well. That is why we have created a health promoting work team from kindergarten teachers of the city and a multidisciplinary professional team containing special needs educators, psychologists and sociologists to fulfil the project.

The importance of preparing the whole kindergarten community (kindergarten educators, nurses and parents) was confirmed by questionnaire studies. The development of mildly disabled children is as a positive result as changes occurring in the community life of the sound children.

On the road towards successful integration the biggest difficulty we think was the smooth and harmonious cooperation of professionals who work mostly independent.

Table 1 Basharat F, et al. Diabetes in pregnancy, mean age and prevalence of gestational (GDM) and known (KDM) diabetes according to ethnicity

	Ethnic Norwegians n=60		Pakistanis/Indians n=51		Other immigrants n=56		Total n=167	
Mean age (years)	31.7		31.5		30.1		31.1	
Non-diabetics	51	(85.0)	7	(13.7)	17	(30.4)	75	(44.9)
GDM (IGT values)[a]	5	(8.3)	12	(23.5)	14	(25.0)	31	(18.5)
GDM (diabetis values)[b]	4	(6.7)	28	(54.9)	24	(42.9)	56	(33.5)
Known type 2 DM	0		4	(7.8)	1	(1.8)	5	(3.0)

Gestational diabetes divided in 2 groups:
a: 2-hour glucose value of 7.8–11 mmol/l after OGTT, corresponding to IGT in non-pregnant subjects.
b: 2 hour glc >11 mmol/l, corresponding to diabetic values.

Table 2 Basharat F, et al. Pregnancy outcome data by ethnic groups and diabetic status

	Ethnic Norwegians (n=60) Mean (SD)			Pakistanis/Indians (n=51) Mean (SD)		
Category	Week of delivery	Birth weight (kg)	Birth length (cm)	Week of delivery	Birth weight (kg)	Birth length (cm)
Non Diabetic (n=75)	39.3 (1.8)	3.5 (0.6)	50.0 (2.4)	40.4 (0.9)	3.1 (0.5)	48.0 (0.5)
GDM (n=87)	40.5 (0.6)	4.0 (0.2)	52.0 (0.5)	39.0 (1.5)	4.0 (0.7)	50.0 (2.2)
Known Diabetes (n=5)				38.0 (1.4)	4.8 (0.1)	54.0 (0.7)

The integrated education of mildly disabled children creates the foundations of the successful social integration of the disabled. This practice promotes the tolerance of sound people, and helps to pull down their prejudices. The social integration of the disabled might meet similar problems in the countries of Central-East Europe.

A systematic review of studies on sickness absence and disability pension: Workshop of the EUPHA Section on Social Security and Health

Organiser: Prof. Kristina Alexanderson[1]
Chairperson: Professor Mansel Aylward[2] CB

1) Professor, Section of Injury Prevention, Department of Clinical Neuro Science, Karolinska Institute, Stockholm, Sweden
2) Professor, Chief Medical Adviser, Dept for Work and Pensions, London, Great Britain

Introduction

The Swedish Council on Technology Assessment in Health Care has done a systematic and critical review of the scientific literature on sickness absence and disability pension. The aim of the project was to:

- Assess the scientific evidence about positive and negative consequences of being sickness absent.
- Review the research in sickness absence and disability pension, current knowledge of its causes and on sickness-certification practices of physicians.
- Identify areas where further research is needed.

A broad search for studies was done, using literature databases (Medline, PsychINFO, SSCI), reference lists, and personal contacts. Found publications were judged according to relevance, quality (according to set criteria) and the scientific evidence they provided. Studies addressing the following seven topics were reviewed:

- Reasons for sickness absence in general, irrespective of diagnoses.
- Souses of sickness absence with back or neck disorders.
- Sick leave and psychiatric diagnoses.
- Sick leave following stroke, MI, and certain heart procedures.
- Consequences of sick leave.
- 'Sickness presence'.
- Sickness-certification practices of physicians.

The following persons conducted the review: *Alexanderson K[1], Allebeck P[1,2], Hansson T[2], Hensing G[2], Jensen I[1], Mastekaasa A[3], Norlund A[4], Perk J[5], Wahlström R[1], Vingård E[1].*

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Aim

The aim of this workshop is to report results from the review and discuss consequences of this for future research and international research cooperation.

Presentations

- Risk factors for sick leave – a systematic review of general studies. *Arne Mastekaasa*, professor, Oslo, Norway
- Sick listing and its consequences, sickness presenteeism, and sick listing because of low back and neck/shoulder disorders and pain. *Eva Vingård*, professor, Stockholm, Sweden
- Towards evidence based knowledge on sickness absence, psychiatric disorders and alcohol problems – a systematic literature review. *Gunnel Hensing*, Ass prof, Gothenburg, Sweden.
- Studies on return to work after stroke and MI, and on sickness certification practises of physicians. *Kristina Alexanderson*, professor, Stockholm, Sweden

Risk factors for sick leave – a systematic review of general studies

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This paper provides a narrative review of the empirical literature on risk factors for sick leave and disability pension. The purpose of the review was: (1 to provide an overview of the field, focussing in particular on the identification of under-researched areas; 2) to evaluate the evidence on the effects of specific risk factors. After scrutinizing more than 600 publications found in bibliographic databases and in reference lists, 188 relevant publications were identified. 97 of these were found to be of sufficient quality with regard to design, response rate, statistical methods, etc.

Not unexpectedly, the importance of working conditions has received the most attention in sick-leave research. Also, the importance of family structure (marriage and children) and lifestyle factors have been studied rather extensively. Some relatively neglected areas are: the causes of demographic differences in sick leave (gender, age, social class), employee attitudes and workplace cultures, and insurance/compensation schemes. Also, there are in general few studies on the causes underlying disability pensioning.

Regarding the family, we found no satisfactory evidence that marital status and children living at home were associated with sickness absence. However, we found limited scientific evidence for an effect of divorce. As for work-related factors, there is some evidence for effects of physically stressful work and work autonomy. There seems to be a correlation in time between unemployment and sickness absence, but there is little on the causes of the association. There was moderate scientific evidence that the amount of sickness absence is influenced by the design of the social insurance system, but insufficient evidence on the magnitude of change required to influence the level of sickness absence.

With regard to disability pension, the number of studies was small. However, we found moderate scientific evidence for the effects of socio-economic status, which could be explained partly by exposures during childhood.

Sick listing and its consequences, sickness presenteeism, and sick listing because of low back and neck/shoulder disorders and pain

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Sick listing is frequently used but its consequences are not very well described. Possible consequences can be measured at different levels; here consequences for the sick-listed person were focused. Sick listing might have both positive and negative effects, for example on disease development, health, work, social life, and life style. Some of these factors are investigated in single studies, but evidence of any consequences are lacking due to few studies.

When a person has an impaired work capacity because of a disease but still works the term sickness presenteeism is used. A problem with this terminology is that it implies that being at work when not perfectly healthy is an exceptional status. However, most persons with a diagnosed disorder or disease are not sick listed but working. Sickness presenteeism is therefore not a good term to use in a scientific context. Investigations have shown that sickness presenteeism is frequent but no evidence on the consequences for the individual or the work place can be stated.

Sick listing because of low back and neck/shoulder disorders is frequent but the scientific knowledge about causes for sick listing because of these common diagnoses are rare. Few studies exist and most of them are investigating men working in industry. Studies on women, white collar worker, and employees in the public sector are lacking. However, there was a scientific evidence for that the following factors were related to sick listing with these diagnoses: High physical workload, forward bending, working in awkward positions, and low job satisfaction were associated with both short- and long-time sick listing. A specific back or neck diagnosis and earlier sick listing because of that were associated with both short- and long-time sick listing. Self-reported pain and disability were associated with long-term sick listing. Long duration of the present employment reduced the risk of short-time sick listing.

Towards evidence based knowledge on sickness absence, psychiatric disorders and alcohol problems – a systematic literature review

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Background and aim

The aim of this presentation is to report the results of a review of