ESHMS

EUROPEAN SOCIETY FOR HEALTH
AND MEDICAL SOCIOLOGY

BOOK OF ABSTRACTS

16th biennial congress
27-29 June 2016

HEALTHY LIVES

Technologies, policies & experiences

GENEVA SCHOOL OF SOCIAL SCIENCES
DEPARTMENT OF SOCIOLOGY

UNIVERSITÉ
DE GENÈVE

Table of Contents: Book of Abstracts

This document is subject to changes and will be updated regularly throughout the conference. For the most up-to-date information, please reference the most current document at: www.unige.ch/sciences-societe/socio/healthylives

Abstracts by Parallel Session

Note: If you wish to find a specific presenter or topic, we recommend that you perform a search within the PDF document by using the find or search function of your PDF reader. Simply type in the name of the presenter or keyword of interest within your search function in order to more easily find what you are looking for.

Welcome Message from the ESHMS President

Dear Conference Participants,

It gives me great pleasure to welcome you to the 16th Biennial Conference of the European Society for Health and Medical Sociology. The main mission of the ESHMS is to provide forums of interaction for active, innovative and critical social scientists devoted to the study of the sociological aspects of health and medicine. This year, I have a feeling that the theme of the conference invites scholars to explore the manifold impacts that technologies, policies and lived experiences enact on the health of Europeans and even people outside of Europe.

These conferences mark the highlight of the two-year cycles of our research society. As such, the decision to delegate the responsibility of hosting the conference is not taken lightly. For the 16th conference, we were fortunate enough to have the Department of Sociology at the University of Geneva as a local organiser. The local organising team has worked endlessly over the past two years to prepare a perfect conference for us. During our collaboration and exchange, I have been truly impressed with the expertise and efficiency of the local organising team. Therefore, I am convinced that the experience we will have will not only be memorable, but also particularly fruitful for scientific discussion.

I would also like to draw your attention to the prizes that the ESHMS traditionally awards. We will again award a best paper and a best poster prize. All presenters should also consider submitting their quality papers to a special issue of 'Social Theory & Health,' the journal with which we are affiliated. A call for papers will be delivered soon after the conference with the aim of showcasing the conference to a wider audience.

Finally, I want to thank the University of Geneva for providing us with the excellent facilities that further support our ambitious work. Looking back at the origins of the ESHMS, Geneva seems like an ideal and obvious location for the conference. Some of the main ambitions of the society's founders included bridging the gap between academic work and policy making as well as promoting comparative research across Europe and beyond. Geneva seems to be the ideal location to further these aims, as it is the host city to major international organisations in the field of health, from the World Health Organisation to the International Committee of the Red Cross.

I also sincerely hope that you enjoy the conference, both scientifically and socially, and thank you for your participation.

Sakari Karvonen
President of the ESHMS
THL – National Institute for Health and Welfare, Finland

Welcome Message from the Local Organising Committee

Dear Conference Participants,

We are very happy to welcome you to the University of Geneva for the 16th ESHMS biennial congress. Under the heading 'Healthy lives: technologies, policies and experiences,' the congress aims at providing a forum where we can discuss the imperative of good health. As proposed in the call for papers, we consider that a range of developments – including health literacy, personalized medicine, health and illness self-monitoring through mobile technologies, shared medical decision-making, the rising individualization of risks in health insurance - support the normative importance of leading healthy lives. These developments affect not only the experiences of healthy and ill individuals and their relationships with healthcare professionals, but also public health policies and the monitoring of population health. At the same time, sociological research emphasizes the various constraints that limit individuals' abilities to lead healthy lives, such as socioeconomic inequalities, instability of family ties, increasing requirements in job performance, inequalities in access to health care and challenges associated with ageing. Furthermore, studies have documented how some individuals deliberately challenge the imperative for health and youth by refusing medical treatments, by adopting risky behaviours, or by criticizing health-sustaining technologies and strategies.

These contradictions between the dominant norm of leading healthy lives and divergent health practices and understandings will be at the centre of the congress's discussions. We have been very pleased by the interest generated by the call for papers, ending up with 225 accepted abstracts. You made it possible to put a programme into place that reflects the diversity of theoretical references in our domain and the respective contributions of qualitative and quantitative studies. In addition to the three promising keynote conferences, we are confident that the presentations in the parallel sessions will illustrate the dynamics of current research in the sociology of health and medicine. We therefore wish you three days of fruitful academic exchanges and hope you enjoy your time in Geneva.

On behalf of the local organizing committee,

Claudine Burton-Jeangros
Department of Sociology
University of Geneva

Conference Location

The congress will take place at the University of Geneva in the Uni-Mail building.

Address: Boulevard du Pont d'Arve 40, 1205 Genève

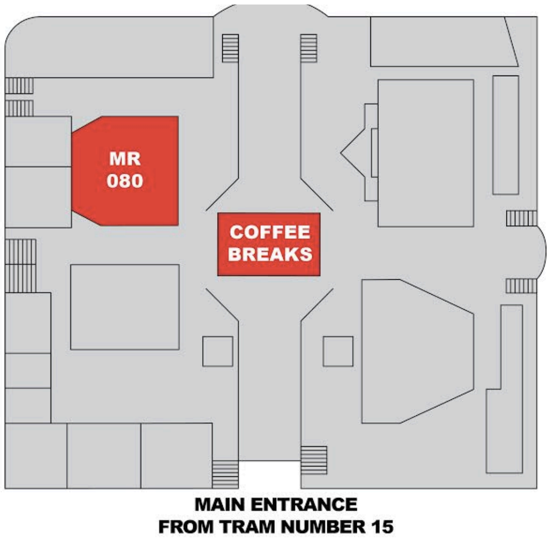
Tips:

1) You can get a **free ticket of public transport** when arriving at the airport. **Just before** crossing the customs (in the hall to collect your luggage), you can find a ticket machine. The ticket is valid for 80 min of transport. See the photo at the bottom of this page: http://www.gva.ch/en/DesktopDefault.aspx/tabid-441/760_read-4333/

2) At the hotel desk, ask for a “Geneva Transport Card”, free of charge. This card allows you to use public transport for free: https://www.geneve.com/en/good-to-know/free-public-transport/

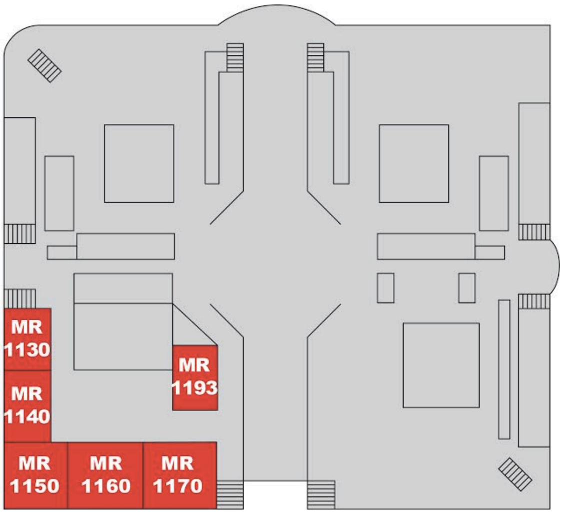
3) From the Geneva train station (Gare Cornavin), you can arrive to the Uni-Mail building by taking the Tram Number 15 (Direction Palettes) and by getting off at the Uni-Mail Stop.

Uni-Mail Layout – Conference Rooms and Session Numbers



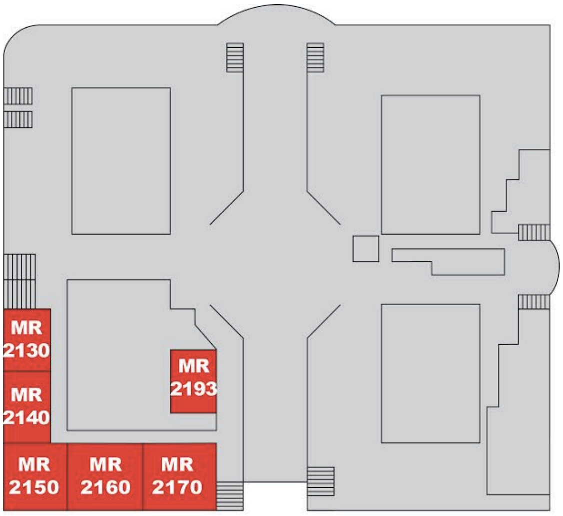
Ground Floor

Room Number	Session Number
Main Hall	Poster Session Coffee Breaks
MR080	Conference Welcome Keynote Presentations Round Table Discussion Closing Ceremony



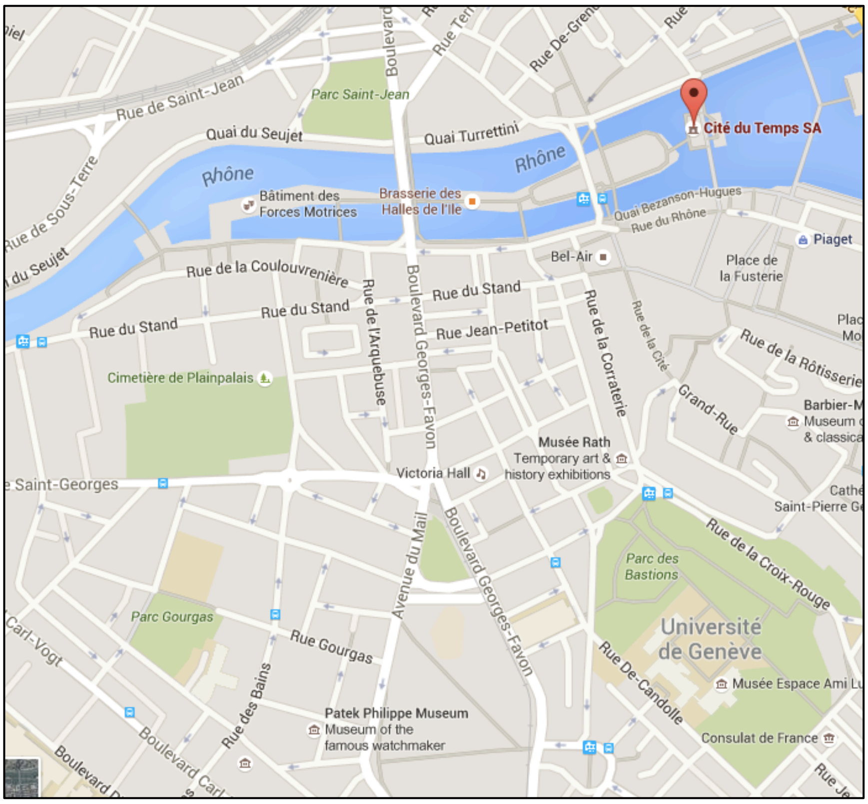
First Floor

Room Number	Session Number
M1130	1.1, 2.1, 3.1, 4.1, 5.1, 7.2
M1140	1.6, 5.4, 6.2, 7.3, 8.2
M1150	1.7, 2.6, 6.6, 7.1, 8.1
M1160	2.7, 3.6, 4.6, 5.7, 6.5, 7.5, 8.4
M1170	2.8, 6.3
M1193	Luggage Room



Second Floor

Room Number	Session Number
M2130	1.2, 2.2, 3.3, 4.3, 5.3, 6.1, 7.6, 8.5
M2140	1.3, 2.3, 3.2, 4.2, 5.2
M2150	Pre-Conference Workshop, 1.5, 2.5, 3.5, 4.5, 5.6, 6.4, 7.4, 8.3
M2160	1.4, 2.4, 3.4, 4.4, 5.5, 7.7, 8.6
M2170	3.7, 4.7, 5.8, 6.7, 8.7



Wine Reception

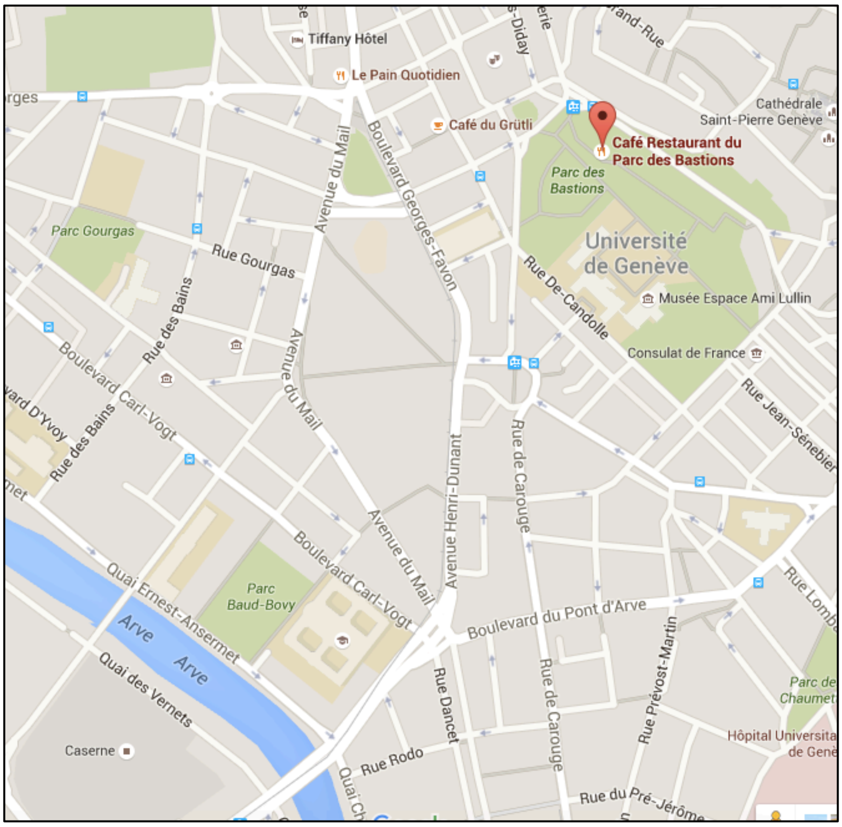
Monday 27 June 2016, 7:00pm

Cité du temps
Pont de la Machine 1
1204 Genève
Tél. +41 22 818 39 00
www.citedutemps.com

Conference Dinner

Tuesday 28 June 2016, 7:30pm

Café Restaurant du Parc des Bastions
Promenade des Bastions 1
1204 Genève
Tél. +41 22 310 86 66
www.bastions.ch



Conference Overview

Monday 27 June 2016

9:00am-12:00pm	**Pre-Conference Workshop**
11:00am-12:30pm	**ESHMS Executive Committee Meeting**
11:00am-	**Conference Registration**
1:00-1:30pm	**Conference Welcome**
1:30-2:30pm	**Keynote Presentation: Céline Lafontaine**
3:00-4:30pm	**Parallel Sessions 1.1 to 1.7**
4:45-6:15pm	**Parallel Sessions 2.1 to 2.8**
7:00pm-	**Wine Reception**

Tuesday 28 June 2016

8:00am-	**Conference Registration**
8:30-10:00am	**Parallel Sessions 3.1 to 3.7**
10:30am-12:00pm	**Parallel Sessions 4.1 to 4.7**
12:00-1:00pm	**Lunch**
12:00-1:00pm	**Poster Session**
1:00-2:00pm	**Keynote Presentation: Natalie Armstrong**
2:15-3:45pm	**Parallel Sessions 5.1 to 5.8**
4:15-5:45pm	**Parallel Sessions 6.1 to 6.7**
6:00-7:00pm	**ESHMS General Assembly**
7:30pm-	**Conference Dinner**

Wednesday 29 June 2016

8:30-10:00am	**Parallel Sessions 7.1 to 7.7**
10:30am-12:00pm	**Parallel Sessions 8.1 to 8.7**
12:00-1:00pm	**Lunch**
12:00-1:00pm	**Medical Sociology National Committees Lunch Meeting**
1:00-2:30pm	**Round Table: The Contribution of Health and Medical Sociology to Health Care and Health Policies**
2:45-3:45pm	**Keynote Presentation: Paul Higgs**
3:45-4:15pm	**Closing Ceremony and ESHMS 2016 Prizes**

Keynote Presentation

My Body, My Capital: Biocitizenship in the Era of Neoliberalism

Céline Lafontaine
University of Montréal, Canada

Monday 27 June 2016
Time: 1:30-2:30pm
Room: MR080, Ground Floor

Centered on the maintenance, control, improvement and extension of individual vitality, biocitizenship is characterized by a refocusing of policy on health issues. The biological body thus appears torn between two opposing movements: that of its development as a biological resource and that of its overvaluation as an identity support. Broken down into a series of elements (genes, cells, organs, tissues), the body is both the raw material essential to the deployment of the biomedical industry and recipient of biotechnological innovations. The valuation of "life itself" and the ideal of perfect health characterizing biocitizenship result in a representation of the body as capital. The maintenance and extension of health then appear under the angle of an investment that increases the "value" of individuals. This conception of the body as capital is reflected, for example, in the development of private banks of umbilical cords that encourage parents to invest in their child's biological capital. More generally, the conception of the body as capital motivates biocitizen to want to invest in maintaining their health by taking risk as in the case of medical tourism. Beyond hopes, suffering and anxiety experienced by patients facing illness, the body representation as individual capital is in fact a neoliberal culture that turns every patient in contractor.

Céline Lafontaine is professor at the Department of Sociology of the University of Montréal. She is interested in the issues in technoscientific development, notably the economic, social and cultural impact of biomedical innovation. She pursues research on the topics of regenerative medicine, nanomedicine and stem cell therapy. Her last book is entitled : Le corps-Marché. La marchandisation de la vie humaine à l'ère de la bioéconomie, Seuil, Paris 2014.

Keynote Presentation

Navigating the Uncertainties of Screening

Natalie Armstrong
University of Leicester,
United Kingdom

Tuesday 28 June 2016
Time: 1:00-2:00pm
Room: MR080, Ground Floor

Screening programmes are social interventions as much as they are medical interventions, and can pose challenging ethical, legal and social dilemmas. The sociological scrutiny of screening can be particularly useful both in informing the development and implementation of screening programmes, but also in developing sociological theory.

Debates and controversies about screening are rarely confined to policy makers and health professionals. Contestations about the science underlying population screening are common, and frequently enter the public sphere, engaging with wider societal themes and normative questions. The difficulty of establishing a screening test with maximum sensitivity and specificity (thereby avoiding as many false negative and false positive results as possible) is often underestimated and underrepresented in the popular press. Instead, pleas for new or extended screening programmes typically draw on discourses of rights or entitlements rather than the need to balance possible harms and benefits.

Recent years have seen a marked shift, at least in policy terms, towards screening based on an individual's informed consent, having weighed up the possible harms and benefits, rather than on an expectation of attendance. In turn, an increased focus on possible harms is evident within information material sent to those invited, and tools to help people make decisions about attendance are beginning to emerge. This paper will explore some of the challenges involved in trying to achieve this informed consent model in practice.

Natalie Armstrong is Senior Lecturer in Social Science Applied to Health in the Department of Health Sciences at the University of Leicester. A medical sociologist by background, her work focuses on using sociological ideas and methods to understand health and illness and to tackle problems in the delivery of high-quality healthcare. While her work covers many health topics, she is particularly interested in preventive services and women's and children's health. Dr Armstrong is an associate editor of the journal BMJ Quality and Safety, and has published widely in both health and social science journals. In 2012 she published 'The Sociology of Medical Screening: Critical Perspectives, New Directions' with Helen Eborall.

Keynote Presentation

Ageing, the Imperative of Health and the Shadows of the Fourth Age

Paul Higgs
University College London,
United Kingdom

Wednesday 29 June 2016
Time: 2:45-3:45pm
Room: MR080, Ground Floor

One of the major successes of the latter part of the twentieth century and the early decades of the twenty first has been the improvement in the health of the retired population. The reasons for this are diverse and much debated, but one of the consequences for older people is that they are now expected to participate in what has been called' the imperative of health' alongside people of all ages. Whereas once later life was seen as a time of passivity and acceptance of the conditions of old age it is now deemed to be an arena of both health prevention and the exercise of 'technologies of the self'. Pursuing 'fitness' may be tempered by age but it is only one of the challenges posed to the somatic cultures of the Third Age. As important is the capacity to demonstrate agency and distinction in 'ageing successfully' . As a consequence, it has been argued, not only are there differences between 'natural' and 'normal' ageing there is also a growing 'normative' dimension to the nature of health discourses in later life. This has been established in studies on physical activity in later life as well as being evidenced in the discourses of popular health products and diets. What has not been addressed in as much depth is the backdrop to the imperative of health in later life, namely the impact of the social imaginary of the fourth age upon those participating in the Third Age. This paper addresses this dimension of 'unsuccessful ageing' and draws out the relationship between these two very different discourses of old age and their implications for the study of health at older ages.

Paul Higgs is Professor of the Sociology of Ageing at University College London. He co-authored with Chris Gilleard of *Rethinking Old Age: Theorising the Fourth Age* (2015). Professor Higgs is an editor of the journal*Social Theory and Health* and has published widely in both social gerontology and medical sociology. He has also published *Medical Sociology and Old Age* (2008) with Ian Jones and co-edited *Social Class in Later Life*(2013) with Marvin Formosa. He is co-investigator on two ESRC / NIHR dementia research programmes and is a Fellow of both the Academy of Social Sciences and the Gerontological Society of America.

Parallel session 1:
1.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

French General Practitioners And The Planned Systemization of Preventive Care: Systematic and/or Equitable for Whom?

Géraldine Bloy, University of Burgundy LEDI UMR CNRS 6307 INSERM U1200, France

Co-authors: Laurent Rigal;
Faculté de Médecine Paris-Sud - Département de Médecine Générale et CESP INSERM U1018

Monday 27 June 2016
Time: 3-4:30pm
Room: M1130, First floor
Session Chair: Yannick Le Hénaff & the Research Group 19 “Health, Medicine, Illness and Handicap” of the French Sociological Association.

Prevention has never been fundamental in the traditional French private general practice. However, a recent public health turn, driven by health policies, intends to develop GP commitment in prevention by various means: organized screening (associating GPs), a treating doctor per person, guidelines, financial incentives. This presentation will question the effects of this shift from a former “laisser-faire” to a more systematic and regulated preventive approach - with large targets in the population followed by GPs - in terms of social differentiation in the dispensation of preventive care.

Our data comes fromtwo studies on private GPs’ practices:
-PrevQuanti study examined how main preventive cares were offered by 52 GPs from the Parisian area to 3600 patients, demonstrating important social gradients, either in favour or in disfavour of the bottom of the social ladder
-PrevQuali study, based on sociological interviews with 99 GPs on the same topics, specified the features and components of GPs’ practice styles, in general and for each type of care, paying attention to potential social differentiation or discrimination processes

The different tools recently introduced by health policies appear to have equivocal effects in terms of social differentiation and equity. Organized cancer screening, for instance, relayed by GPs, reduces social inequalities in accessing this care, but contributes to socially differentiated care pathways. Making GPs aware of social inequalities in the care they dispense sounds very sensible, but introducing financial incentives without considering the social composition of their clientele tends to make disadvantaged patients undesirable… Systematizing prevention through a reduction of doctor’s dependence on patient demand is also likely to affect the way patients are looked at or listened to: How are their (socially differentiated) preferences, lifestyle, and the personal efforts required taken into account? Social, ethical, and political issues are linked ambiguously in this systematization attempt.

Parallel session 1:
1.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

The duty to inform kinship in genetics : could we discuss a new preventive role for « family doctors » in France ?

Benjamin Derbez, Inserm - Iris, France

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1130, First floor
Session Chair: Yannick Le Hénaff & the Research Group 19 “Health, Medicine, Illness and Handicap” of the French Sociological Association.

Since 2011, the French bioethics law requires that anyone agreeing to perform a genetic test inform its relatives of any outcome which may affect them, in case of serious illness for which care, prevention and genetic counseling procedures are available. Otherwise, the person may allow professionals to carry out information to its family members by the mean of a anonymous procedure (standardized letter). But how is such a law implemented ? How does it change the lay-professional relationship ? How are responsibilities negociatied between these actors on a day-to-day basis ?

This communication will be based on the results of an ethnographic investigation on these issues in several medical units in the Paris area. One primarily working on genetic predispositions to breast and ovarian cancer (Institut Curie, Paris) and two dedicated to red blood cell genetic diseases (Henri Mondor Hospital in Créteil, and Paris Information and screening centre for sickle cell disease). On each site, we conducted observations over a period of six months, which have been completed by a series of interviews with professionals (n = 5) and the patients (n = 60).

The analysis of the data questionned the role of general practitioners in the effective implementation of information to kinship in genetics. If they sometimes initiate the genetic research, they could also be increasingly invested of the new mandate to monitor the familial information efforts made by their patients. Indeed, the close and durable links established between these professionals and their patients is a concrete way to ensure the effective circulation of information within families. Due to the action of the law in France, we are thus witnessing a redefinition of the boundaries between primary care and specialized care which reactivates, in a unprecedented way, the traditional role of "family doctor".

Parallel session 1:
1.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

General Practitioners' Prevention Practices: What Adjustments For Social Diversity with Patients Facing Chronic Conditions?

Cécile Fournier, IRDES, France

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1130, First floor
Session Chair: Yannick Le Hénaff & the Research Group 19 "Health, Medicine, Illness and Handicap" of the French Sociological Association.

Since 2009, patient education (PE) is considered by law as a right for all patients with chronic condition. Law also gives responsibilities to general practitioners (GPs) into organizing their practice setting in order to meet patients' requirement regarding prevention services. Different organizational and financial incentives are set up in regard with this objective. There is yet evidence that access to prevention -including PE- is inequitable.

What type of educational practices are developed for patients facing chronic conditions? How and under what conditions do GPs contribute to a more equitable access to PE?

We conducted a survey based on in-depth interviews with 32 GPs, diverse in terms of gender, age, conditions of practice (solo, medical group, multi-professional group), private or employed status, training or not in PE, and patients' social characteristics.

PE appears to be primarily developed during the consultations, through the unique relationship built with each patient. It sometimes follows the path of orientations towards other specific preventive resources. Beyond the influence of GPs' professional trajectories, training, and exercise conditions, the educational process developed is related to patients' social characteristics. PE access is often detrimental for patients belonging to the most disadvantaged groups, with whom GPs spend less time, have a prescriptive educational attitude rather than enhancing patients capabilities choosing their own objectives, and restrain their objectives to short term security skills instead of promoting skills for prevention of long term complications. However, some GPs develop educational approaches that allow a better access to prevention for the socially underfavoured patients. These approaches are facilitated by several dynamics linked to procedural or organizational innovation, to GPs' educational skills, and to the cooperation forged with a diversity of actors and resources, including community ones. We will discuss professional, ethical and political issues raised by these practices.

Parallel session 1:
1.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

'How to deal with who they are?' Preventive practices in French public primary health-care facilities

Laure Pitti, Université Paris 8 / CRESPPA-CSU, France

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1130, First floor
Session Chair: Yannick Le Hénaff & the Research Group 19 "Health, Medicine, Illness and Handicap" of the French Sociological Association.

This paper aims to study the effects of the social context on concrete preventive practices in everyday work primary care. "Social" here refers to patient diversity and/or deprivation that GPs, as frontline workers, are daily facing; it also refers to GPs' professional environment (private or public practice, in a privileged or deprived and/or diverse area), which may have an impact on the time they can spend on and the resources they can mobilize for preventive care.

This paper will focus on a case study: I will analyze concrete preventive practices in everyday work primary care through the example of a public primary health-care facility, located in a French deprived suburb near Paris where health inequalities are particularly stark. My data mainly come from a four-month ethnographic study, based on direct observations of the GPs' and nurses' everyday work, on interviews of all of them (n=9) and on the follow-up of a local preventive program, the so-called "Cervical smear tests for all!", set up in 2014-2015 and geared toward the screening of cervical cancer.

While authorized by the Haute Autorité de Santé, in the absence of a national organized program of cervical cancer screening, this local and innovative experimental program promotes a preventive care "from below", involving all the GPs, as well as nurses, of this health-care facility and not only the ones in charge of the gynecological monitoring. Such a preventive model is considered by these professionals as better suited to – or even imperative to effectively take into account - the social deprivation of their patients. Finally, I will analyze how these "from below" preventive programs, based on a new kind of professional cooperation including the whole chain of (para)medical categories, from nurses to medical secretaries, affect the traditional hierarchy of the medical profession.

Parallel session 1:
1.2 - Informal caregiving

Valued activities and informal caregiving in stroke, a scoping review

Sandra Jellema, Hogeschool van Arnhem en Nijmegen, Netherlands

Co-authors: Mandy Wijnen, Rob van der Sande; Hogeschool van Arnhem en Nijmegen

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Background. Informal caregiving in stroke is demanding and has diverse effects on caregivers' own activities such as work or leisure. To map the existing literature on this topic in this study a scoping review was undertaken.

Methods. CINAHL, Pubmed and PsycINFO were searched for studies on informal caregiving in community dwelling stroke-patients, published between May 2005 and May 2015 and written in English. The following search terms were used: stroke, caregiver or caregiving, family, spouse, meaningful activity, valued activity, role, occupation and leisure time. An additional search was done using Google scholar. Also topic specific experts were consulted for additional literature. Two researchers independently identified articles that met the inclusion criteria and independently extracted major findings. First, codes describing the topic and codes describing the content of a particular finding were allocated to the findings. Next, through thematic analyses of the codes, ultimately a description of the main topics and main outcomes of the identified studies could be given.

Results: The search yielded 625 studies, 33 ultimately met the inclusion criteria.

Topics found were: the challenges caregivers face in maintaining their valued activities, reasons for and consequences of their activity loss, strategies to either cope with their activity loss or resume their valued activities, and populations especially at risk for activity loss. Most studies found a decline in valued activities as a result of informal caregiving. Although activity loss was generally associated with a decline in health and wellbeing, no studies on professional support for caregivers in maintaining their valued activities were found.

Conclusion: Activity decline in stroke patient caregiving is common and has negative impact on caregivers' health and wellbeing. Health professionals should support informal caregivers in maintaining those activities that are important for their health and wellbeing.

Parallel session 1:
1.2 - Informal caregiving

Exploring informal carers' experiences in the context of organ transplantation in the United Kingdom (UK)

Rebecca Patterson, Institute of Health and Society, United Kingdom

Co-authors: Catherine Exley, Andrew Fisher, Lynne Stobbart; Institute of Health and Society, Institute of Cellular Medicine, Institute of Health and Society

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Although transplantation is a highly successful life-saving treatment, not everyone who may benefit from this procedure is listed for transplantation. The decision to recommend an individual for transplant in the UK depends on a number of factors, including the availability of informal support. Provision of physical and emotional support from informal carers, typically family or friends, throughout the duration of the transplant process is acknowledged to positively impact the wellbeing of transplant patients, improving their chance of long-term survival. Whilst the benefit to patients is well documented, the impact of providing such support upon informal carers has received significantly less attention. This study aims to address this gap, providing insights into how informal carers of transplant patients are affected throughout the transplant process. Qualitative methods were used to critically examine the views and experiences of 20 informal carers of heart, lung and liver transplant patients. Individuals were recruited through charitable organisations dispersed across the UK. Retrospective interviews were conducted with informal carers in the post-transplant phase (n=16) and longitudinal interviews with those recruited pre-transplant (n=4). A narrative interview approach was employed to facilitate open discussion. Interviews were conducted face to face or by telephone, depending on interviewee availability, audio recorded and transcribed verbatim. Thematic analysis was utilised to identify emergent themes. Data analysis revealed individuals providing support can be impacted in numerous ways throughout the transplant process, particularly in terms of: lifestyle, employment, wellbeing, roles and relationships. Initial overarching themes include: uncertainty, the role of expectations, loss, and identity transformation. The data demonstrate a range of strategies implemented to assist individuals in coping with their new-found situation (emotion work, information seeking, professional/social support). It is clear the transplant process impacts the lives of informal carers in numerous ways, the majority of which are perceived to be detrimental.

Parallel session 1:
1.2 - Informal caregiving

Former carers: a hidden population

Jacqueline Watts, Open University, United Kingdom

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Although unpaid informal carers provide the majority of care for older, ill and disabled people in the UK, they are members of a marginalised population. Conceptualised as a 'career', models of caregiving encompass the identification of beginning, a discernible temporal direction and an end of caregiving. Whilst the identification of the end or post-caregiving stage is not new, it has been described as the "ignored phase of caregiving careers" with

caregiving research in the last two decades tending to focus on the 'active' phase of caregiving. While an established body of literature from the fields of gerontology, sociology and nursing has documented the experiences and needs of informal carers, relatively little is known about the post-caregiving period and the experiences of the increasingly large group of former carers. This paper presents findings from a literature review that explored the experiences of former carers. Findings from the limited literature available suggest that former carers have unmet needs, experience the post-caregiving period as stressful and would welcome some form of continued support. It is argued that the post-caregiving period should be viewed as an integral part of the caregiving career, with recognition that former carers continue to have practical and psychological needs once caregiving comes to an end.

Parallel session 1:
1.2 - Informal caregiving

Surviving the transition from active to post-caregiving: experiences of former carers

Joyce Cavaye, The Open University, United Kingdom

Monday 27 June 2016
Time: 3-4:30pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

This paper focuses on the experiences of former carers; individuals who were previously unpaid informal carers actively providing care for a relative, but for whom caregiving has now come to an end.

The carer population in the UK is constantly changing. Current estimates put the number in the UK at 6.5 million, of which 30% to 40% take on a caring role each year, while for approximately 2 million their role as an unpaid carer comes to an end. These figures illustrate the dynamic nature of informal caregiving and suggest that the population of former carers is steadily increasing in size. Yet, former carers are almost completely overlooked by policy and practice, which tends to focus on providing support to those who are currently providing care.

Drawing on data from an online survey, this paper presents former carers' perspectives on negotiating the transition from active caregiving to post-caregiving. Participants were drawn from across the UK, were self-selected and had been former carers for between one and ten years. Variables reflecting the characteristics of care recipients, duration of caregiving, carers' wellbeing, employment status and sources of support were explored.

Findings suggest that former carers find it difficult to negotiate the transition into the post-caring period. They struggle with the psychological and emotional aspects of transition. Adaptation to a non-caregiving life is shaped by age and the level of support that is received but can be an isolating experience underpinned by a legacy of poor health and wellbeing.

Parallel session 1:
1.3 - Reproductive health through the life course

Timing of abortions, births and relationship transitions in Finland

Heini Vaisanen, University of Southampton, United Kingdom

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

Studies have shown union dissolution and fertility decisions are made jointly, but there is a lack of research taking induced abortion decision-making into account although relationship problems are one of the most commonly cited reasons for abortion.

I analysed the timing of union dissolutions, births, and abortions over the fertile span of women's lives. I used multi-level multi-process event-history modelling in order to take into account the time-invariant unobserved characteristics, which may influence both relationship and reproductive decision-making. I analysed a set of Finnish register data including birth, abortion and union histories for women born between 1965 and 1969 (N=17,883). The advantages of using register data include: no underreporting of abortions, and long follow-up periods without attrition. These women were followed from age 15 until they were in their early 40s.

The results show all these decisions were made jointly. Women who were more likely to be in unstable relationships had a higher likelihood of abortion than other women, but they also had higher fertility. There was a strong positive association between experiencing an abortion and a union dissolution within the same year. Interestingly, this effect was less strong for cohabiting than married couples. The likelihood of abortion by length of union was low throughout marriages, but showed a U-shaped curve for cohabiting unions. Union dissolutions were unlikely to happen the same year as women gave birth. This association was stronger for married than cohabiting couples. The unobserved characteristics associated with higher likelihood of birth were negatively associated with those of abortion. This was expected, as women often choose to have an abortion under different circumstances than they would ideally choose to give birth.

This study is the first to show how these three processes are correlated using comprehensive longitudinal data.

Parallel session 1:
1.3 - Reproductive health through the life course

Perspectives on masculinity and contraceptive behavior across Europe

Rozemarijn Dereuddre, Ghent University, Belgium

Co-authors: Piet Bracke;
Ghent University

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

Policy programs, reproductive health services as well as research primarily focus on contraception as a female sphere of influence. However, men's characteristics, preferences and their participation in the reproductive domain proved to be equally important. Two divergent trends in male contraceptive method use can be observed across Europe. On the one hand, men in Western Europe seem to associate engagement in the contraceptive domain as a threat to their masculinity. On the other hand, men in Central and Eastern Europe perceive this engagement rather as a source of masculinity. This study aims to elaborate on the complex intertwinements between gendered norms, both from his and her point of view, and contraceptive use. Data from the Generations and Gender Survey for five WE and eight CEE countries are used to test the hypotheses separately for each country, and for men and women. Preliminary results indicate that people who display more traditional gender norms are more likely to rely on traditional female methods instead of male methods in multiple CEE countries, and to practice female sterilization rather than male in Belgium. Moreover, two varying patterns are found for reversible contraceptives. Men and women with more traditional values are more likely to rely on reversible female contraceptives in WE whereas they are more likely to use reversible male methods in several CEE countries. Additional analyses are needed to further explore the complex dynamics that are at play, both between and within the WE and CEE region.

Parallel session 1:
1.3 - Reproductive health through the life course

Infrequent sex among married couples in sub-Saharan Africa : an alternative to contraception?

Marie-Claire Peytrignet, University of Geneva, Switzerland

Co-authors: Clémentine Rossier;
University of Geneva

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

Sub-Saharan Africa is the region of the world with the highest share of married women with an unmet need for contraception. Interestingly, recent studies have highlighted the lack of sexual exposure within married couples (outside the post-partum abstinence tradition). Infrequent sex is one of most important reasons of contraceptive non-use in sub-Saharan Africa among women who do not wish to have a child soon. Recent studies in Senegal and in Ghana have suggested that it is highly possible that women in these countries use abstinence as an alternative to family planning. Our aim in this paper is to explore whether this found association is in reality due to a reverse causation. Indeed, in a context where married couples have relatively infrequent sex, it is highly possible that fertility intentions might be significantly associated with sexual exposure. In order to test this hypothesis, we will be using Demographic and Health Surveys data from 30 countries in sub-Saharan Africa (from Western, Central and Eastern Africa). The first goal of this paper is to measure how long the average woman in each region spends without having sexual relations. We will then explore the associated factors of not having had recent sexual exposure through bi-variate analysis and then by the means of a logistical regression. We have analyzed every country separately, each region as whole, and the three regions grouped together. Our first results suggest that the lack of recent sexual exposure is highly associated with fertility intentions, and particularly for women who wish to stop childbearing. We have also found that, even controlling for age, being infecund is also highly associated with not having had sex recently, which is very likely to confirm that sexuality, across the continent, might be highly linked to childbearing.

Parallel session 1:
1.4 - Power of naming: from medical framing to the embodied experiences of women

In Black and White: Female Circumcision and Genital Cosmetic Surgery in the Swiss Media

Dina Bader, Institute of Social Sciences, Switzerland

Monday 27 June 2016
Time: 3-4:30pm
Room: M2160, Second floor
Session Chair: Dina Bader, Faten Khazaei & Vanessa Fargnoli

The Swiss law against 'Female genital mutilation' which entered into effect in 2012 prohibits all forms of ‘female circumcision’ (‘FC’) whereas it excludes regulation of so-called ‘female genital cosmetic surgeries’ (‘FGCS’). In order to explore this ‘double standard’, this presentation explores the visual representations of ‘FC’ and ‘FGCS’ in the Swiss press over a period of twenty years (1992 – 2012). My analysis of all articles of broadsheets and tabloids that highlight ‘FC’ and/or ‘FGCS’ as a central or at least prominent issue suggests that images of ‘FC’ and ‘FGCS’ can be classified in three categories: the ‘body’, the ‘tool’, and the ‘scene’. Firstly, ‘FC’ is represented by ‘personified bodies’ (e.g. portraits of black women and girls), while ‘FGCS’ is illustrated by ‘depersonalized bodies’ (e.g. naked or panty-wearing headless white bodies; or a white mannequin head). Secondly, some pictures represent the ‘tool’ used for the intervention, ‘rudimentarily’ for ‘FC’ (e.g. a - dirty and bloody - razor or knife), but ‘clinically’ for ‘FGCS’ (e.g. a clean scalpel). Thirdly, while other pictures depict the ‘scene’ as ‘violent’ for ‘FC’ (e.g. circumcision performed on a crying child), it is portrayed in ‘medical’ terms for ‘FGCS’ (e.g. a surgical intervention in a hospital setting). I argue that Swiss media images of ‘FC’ and ‘FGCS’ thus (re)produce and support the dichotomous frames which are also mobilized in recent political and medical discourses regarding non-therapeutic removal of female genitalia. In other words, ‘FC’ and ‘FGCS’ are represented ‘in black and white’; this metaphor highlights the dominant colors of these images and the racialized understanding of what constitutes a 'female genital mutilation' in Western countries.¨

Parallel session 1:
1.4 - Power of naming: from medical framing to the embodied experiences of women

The negotiation of medical treatments: contrasting experiences among Swiss HIV-infected women

Vanessa Fargnoli, LIVES, University of Geneva, Switzerland

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2160, Second floor
Session Chair: Dina Bader, Faten Khazaei & Vanessa Fargnoli

Studies on HIV-infected women remain rare and the singularity of the HIV-infected woman still has to emerge. The pre-analysis of 30 in-depth interviews of ordinary HIV-infected women, diagnosed before 2000, in the French speaking part of Switzerland, unearths how it is difficult and shameful for them to accept the “HIV-infected” identity and therefore to disclose their situation. The cumulus of non-status that characterizes these women – not belonging to any targeted group, living in an in-between condition (neither sick nor in good health), with a virus labeled as “undetectable”- seems to increase their feelings of guilt, of taboo and of illegitimacy overshadowed by the medical field. If for doctors, an undetectable viral load, thanks to antiretroviral therapies, defines a normal existence; for interviewees, it is how the disease affects their daily life that defines it. Therefore, a tension between an interpretation of good medical outcomes – a “medical normality” - and the ambivalent feelings of the concerned people – a “lived normality”- appears. Furthermore, although being HIV-infected may have become medically commonplace, socially, it is still stigmatized.

In this presentation, I question how these women accept or refuse their treatments, considering their ability (or lack of) to negotiate, to challenge and above all, to claim from their doctors, a certain control over their illness and their bodies. I am specifically interested here in the process of “wiping away” HIV traces and experiences. If everything is done to remove the traces of the virus, its consequences are quite real: negative side effects and impact on social interactions appear. Therefore two interconnected phenomena will be put under scrutiny: the status of “HIV-undetectability” and the invisibility of ordinary HIV-infected women.

Parallel session 1:
1.4 - Power of naming: from medical framing to the embodied experiences of women

When the body speaks: corporal dimensions of the medical definition of "victim of intimate partner violence"

Faten Khazaei, Center for the Understanding of Social Processes, University of Neuchatel, Switzerland

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2160, Second floor
Session Chair: Dina Bader, Faten Khazaei & Vanessa Fargnoli

Intimate partner violence is a highly contested subject in Swiss context. There is neither a consensus on its definition, nor a consensus on its underlying causes. Health care institutions therefore play a crucial role in shaping legitimate state responses to cases of intimate partner violence. However, in their interactions with victims, state agents often fail to acknowledge the highly gendered nature of this type of violence.

This paper is based on an ethnographic study. It examines how the healthcare professionals take physical and visible traces on the body as marker and proof of violence and doing so they leave apart the invisible consequences of psychological or sexual violence on victims. The body becomes a tool of legitimization or delegitimization of the story told by victims.

Fieldwork was conducted in a medical centre in western Switzerland. The centre specialises in supporting and examining victims of interpersonal violence. Participant observation during fifty medical consultations and six expert interviews with physicians and nurses conducting these consultations constitute the main source of data.

Based on my empirical findings I argue that the forensic documents provided by the medics play a crucial role in defining intimate partner violence. State investigators face the challenge of providing evidence for the victimhood of the – mainly female – persons affected by intimate partner violence.

The certification of traces of violence on the body of victims becomes a tool to establish and legitimise a victim's status. Recording mainly the story linked to visible marks of violence on the body, the healthcare institution amplifies a common suspicion regarding the sincerity of victim and her story. This shows the power of the medical practice of naming, which goes beyond the professional focus on providing healthcare.

Parallel session 1:
1.5 - Inequalities and social determinants of health

Socioeconomic inequalities in the utilization of general practitioners (GPs) and specialists

Erlend Løvø Fjær, Department of Sociology and Political Science, Norwegian University of Science and Technology, Norway

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

Background:

In Europe, previous studies have shown that lower socioeconomic groups tend to be more frequent users of general practitioner (GP), while specialist use is more common among higher socioeconomic groups. In this article, we examine socioeconomic inequalities in the utilization of GPs and specialists. Specifically, we examine factors related to physical and mental health, socioeconomic position and broader health determinants.

Methods:

Logistic regression models are employed using data from the 2014 wave of the European Social Survey on people aged 25 to 75. Health care utilization is measured by self-reported use of GP or specialist in the last 12 months. Separate analyses are performed for GP and specialist. Health status includes self-reported health, chronic conditions and depression. Socioeconomic position is measured using income and education. Other examined health determinants include social support and use of alternative health care.

Results:

Preliminary results suggest that a range of similar factors explain the use of GPs and specialists in Europe but those associated with socioeconomic position are stronger predictors of the utilization of specialist care. Chronic conditions are found to be the most important determinant for GP use, while poor health is most important for specialist use. Education and income have most influence on the use of specialists, with people having higher education and higher income reporting more use. Lack of social support decreases the probability of seeking specialist care. Use of alternative treatment increases the probability of using both GPs and specialists. When using the same variables, we are able to explain more of the variation in specialist use compared to GP use. This may indicate larger socioeconomic inequalities in the former group.

Parallel session 1:
1.5 - Inequalities and social determinants of health

Income inequality and enforced unmet need for medical care during The Great Recession in Europe

Jon Ivar Elstad, NOVA, Oslo and Akershus University College, Norway

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

Background. A worrying development during the current economic crisis in Europe is that access to medical care could have deteriorated. Developments differ much between countries, however. This paper asks whether countries with less income inequality have been more successful than inegalitarian countries in protecting access to medical care during an economic recession.

Methods. EU-SILC surveys 2008-2013 from 30 European countries are utilized, supplemented by Eurostat country indicators. Enforced unmet need for medical care due to costs, waiting lists, or travels are examined among respondents aged 30-59 years old (N=1.24 millions). Analyses are made with cross-tabulations and linear probability models using a multilevel technique which distinguishes between individual, period, and country levels.

Results. Large between-country differences in unmet need for medical care exist. During 2008-2013, unmet need increased in a majority of the 30 countries. Deteriorated access occurred especially among respondents in the lowest income tertile who also reported health problems. Access deteriorated more in countries where the crisis, in terms of reduced GDP, was more serious. The estimated effects on unmet need of a ten percent decline in GDP were more severe in inegalitarian countries than in countries with less income inequality, independent of the size of the country's GDP per capita.

Conclusions. During the economic downturn in Europe since 2008, unmet need for medical care increased, and this occurred in particular among vulnerable parts of the population. Larger social inequalities in access to medical care have developed during The Great Recession. Countries with a more egalitarian social structure in terms of less income differences tended to be more able to protect their populations, and especially disadvantaged groups, against deteriorated access to medical care during an economic crisis.

Parallel session 1:
1.5 - Inequalities and social determinants of health

Economic crisis and equity in the use of health services in Spain and Germany

Lourdes Lostao, Universidad Pública de Navarra, Spain

Co-authors: Siegried Geyer, Enrique Regidor;
Medizinische Hochschule Hannover, Universidad Compultense de Madrid

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

Background: During the economic crisis of 2008 public health expenditure increased in some countries such as Germany, but fell in others, for example Spain. This research evaluates the equity in the use of health services in Spain and Germany before and during the economic crisis.

Methods: Data from Germany are from the socioeconomic panel carried out in 2006 and 2011 and data from Spain are from the national health surveys carried out in the same period. The percentage of people who made a medical consultation and the percentage of people who had some hospital admission during the last year was calculated. The variable of socioeconomic status was household income. The relation between household income and use of health services was estimated by percentage ratio.

Results: Between 2006 and 2011, the frequency of use of health services increased slightly in Germany and decreased slightly in Spain. Neither in Germany nor in Spain were significant economic differences observed in the percentage of people who consulted a doctor in the two periods. In hospital admissions, the percentage ratios among the poorest people versus the richest people in 2006 and 2011 were, respectively, 1.37 (95% CI, 1.22-1.53) and 1.36 (1.23-1.52) in Germany, and 1.24 (1.10- 1.26) in 2006 and 1.08 (0.93-1.26) in Spain.

Conclusion: During the economic crisis, the socioeconomic pattern in the use of health services was not altered in Germany, while in Spain the frequency of hospital admissions has decreased more among the poor than among the rich.

Parallel session 1:
1.5 - Inequalities and social determinants of health

Inequality of incomes and the health of population of modern Kazakhstan

Lazzat Spankulova, Turar Ryskulov New Economic University, Kazakhstan

Co-authors: Adilet.Konirbay;
Al-Farabi Kazakh National University. R.B. Suleimenov Institute of Oriental studies CS MES RK

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

One of the terms of the health's preservation is the access to the high-quality medical services and medicines. The economic stratification of population according to the incomes is deepened by the limitations in the access to high-quality medical services for less wealthy members of society.

The held research of 1530 households in 2013 (the mistake of the selection is 2,5%) has shown that in Kazakhstan the poor households are extremely infringed in getting high-quality medical services and experience limitations on the medical services in comparison with high-income households. In result, 77% of households from the poorest group can't pay the visit to the surcharge doctor, at the same time the number of such among the high-income households is 8%. 87% of households from first and second high-income groups can not afford the purchase of the most necessary and relevant medicines, at the same time among the wealthiest households there are 12%.

According to the results of the research about 51% of the poorest households can't afford to go to sport sections and swimming pools, because it is expensive for them. By the same reason 87,5% of group of the poorest households and 79,3% of the second group – are not able to go to rest in the resorts, in result can't make investigations in their health.

Taking in to consideration the rapid increase of inequality on the incomes during the 90s, the difference of the health's state of the members of the poorest and richest groups is increasing.

The inequality of the material state causes the inequality on life level and health's state, and the discrimination in getting the education and medical services. The majority of the population get too low incomes in comparison with the amount of living wage, by this reason their human and labor potential are used inefficiently.

Parallel session 1:
1.6 - Vulnerabilities and health

Psychotropic medication and mortality: a register-based study among Finnish women and men, 1995-2013

Eero Lahelma, Department of Public Health, University of Helsinki, Finland

Co-authors: Tea Lallukka, Olli Pietiläinen, Timo Partonen, Ossi Rahkonen1;
Department of Public Health, University of Helsinki, Finnish Institute of Occupational Health, Helsinki, Finland, National Institute for Health and Welfare, Helsinki, Finland

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1140, First floor
Session Chair: Claudine Burton-Jeangros

Background: People with mental disorders have excess mortality risk. Studies have measured mental disorders using self-reported and diagnostic data, and often examined all-cause mortality. We used register-based information on types of psychotropic medication to examine subsequent mortality by major causes of death.

Methods: We studied employees of the City of Helsinki, 1995-2013 (37156 women; 10848 men). Employer's personnel register data were linked with prescribed psychotropic medication data from Social Insurance Institution of Finland 1995-2009. We included cumulative antidepressant medication divided into selective serotonin reuptake inhibitors (SSRI), tricyclic antidepressants (TCA), and benzodiazepines with derivatives (Z drugs). Causes of death were derived from Statistics Finland and included natural (cancer, cardiovascular diseases, other) and unnatural causes (suicide, other) 1995-2013. Log-binomial regression was used with 95% confidence intervals (CI).

Results: 25% of participants had SSRI, 6% TCA and 29% Z medication during the follow-up. There were 1174 deaths due to natural causes and 222 due to unnatural causes (93 suicides). Excess mortality risk varied by medication and cause of death, being strongest for suicides. Those with SSRI medication had 10.5-fold (CI 6.5-16.8), those with TCA 9.5-fold (CI 6.2-14.7), and those with Z drugs 5.8-fold (CI 3.7-9.0) suicide risk as compared to those without corresponding medication. The risks tended to further strengthen with cumulative defined daily doses, particularly for Z drugs. There were no gender or age interactions. Excess mortality risks were also found for the natural causes, but they were weaker.

Conclusions: Different types of psychotropic medication were associated with subsequent mortality. The association was particularly strong between antidepressants and suicidal mortality. Psychotropic medication is commonly used to treat mental disorders and its associations with mortality should be considered. The benefits and risks of psychotropic medication need to be carefully assessed.

Parallel session 1:
1.6 - Vulnerabilities and health

APSCO: An analysis of potential demographic and psychosocial moderators of the relationship between knowing the cancer diagnosis and depression

Csaba László Dégi, Babes-Bolyai University, Romania

Co-authors: Éva Kállay, Sebastian Pintea;
Babes-Bolyai University

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1140, First floor
Session Chair: Claudine Burton-Jeangros

Significant levels of distress usually accompany the entire cancer-experience.

Objective: The major objective of the present study was to investigate potential demographic and intrapersonal moderators of the relationship between knowing the cancer-diagnosis and the level of depression experienced.

Method: The present research has a transversal comparative repeated cross-sectional design (2006-2014), sampling following the proportional quota method. Research was conducted in the four major oncological institutes in Romania, obtaining a national sample of cancer patients, maintaining gender and ethnic rates, and permitting the investigation of the stability of the results from one assessment to the other.

Results: Results indicate that in the Romanian context, knowing the diagnosis is associated with a lower level of depression than not knowing the diagnosis, the results being similar in both assessments (2006-2014). Furthermore, from the explored demographic factors (gender, residence, age, and education), only age has a main effect upon depression (depression increasing with age), while education is the only factor from those analyzed, which has a moderator effect. Regarding the analyzed intra-individual variables, only dysfunctional attitudes, emotion-focused coping and lack of emotional support from the family (loneliness) have main effects upon the level of depression (i.e., higher levels of dysfunctional attitudes, emotion focused coping and loneliness are associated with higher levels of depression), while neither of them has a moderator effect on the relationship between knowing the diagnosis and depression.

Conclusion: These results are important in the improvement of the doctor-patient relationship, the management of cancer-related distress, and implicitly for the course of illness.

Parallel session 1:
1.6 - Vulnerabilities and health

Unhealthy lives: Suicides in Italian prisons

Maurizio Esposito, University of Cassiino and Lazio Meridionale, Italy

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1140, First floor
Session Chair: Claudine Burton-Jeangros

Background: The paper deals with the problem of suicides in Italian prisons. Starting from a general analysis on the concept and the theoretical approaches on suicide, we analyze the main studies on suicide in Italian prisons. We discuss the deterioration of Italian prisons mainly due to overcrowding, the presence of chronic diseases and the lack of planning for the social reintegration of prisoners.

Methods: we present and revise updated official statistics on suicides among prisoners in Italian prisons (years 2002-2015), to be analyzed and discussed.

Results: The main results show that the situation is critical, because suicide is the leading cause of death in Italian prisons and that this problem mainly affects the male prisoners of Italian nationality aged between 18 and 39 years old. Alarming trend data are not recorded in absolute value for the women prisoners.The situation changes in the percentage sense, showing an ability to adapt to prison life that for the female gender appears more difficult. Moreover, suicide is on the rise among foreign prisoners in recent years, probably due to the lack of being able to make use of alternative measures as house arrest.

Conclusions: the conclusions attest the need to provide the Italian prisons staff with a total approach treatment dealing with the cure and care of the detainee in difficulty, not only curing the specific symptoms but the whole person in a holistic sense.

Parallel session 1:
1.7 - Health policy

Selected Strategies for Pro-health Policy in Poland as Exemplified by Cytological Prevention. A Sociomedical Analysis

Włodzimierz Piątkowski, Maria Curie-Sklodowska University, Institute of Sociology; Medical University of Lublin, Independent Medical Sociology Unit, Poland

Co-authors: Anna Sadowska;
Maria Curie-Sklodowska University, Institute of Sociology; Medical University of Lublin, Independent Medical Sociology Unit

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1150, First floor
Session Chair: Karen Lowton

Introduction: The Population Program of Prevention and Early Detection of Cervical Cancer (Polish: PPPWWRSM) is an element of Poland's pro-health policy and involves sending systematic personal invitations for smear tests to risk-group women (aged 25-59) once in three years. The low attendance to these free tests prompted us to conduct an in-depth sociomedical analysis: one of the first representative studies into the problem in Poland. The objective was to describe and interpret women's attitudes towards preventive cytological tests and to diagnose the reasons why smear tests are avoided/postponed until later (health-risk behavior).

Methods: Qualitative and quantitative analyses were used. 80 free interviews were conducted, the resulting conclusions having been used to prepare the questionnaire. Personal interviews (CAPI) were conducted in the autumn of 2014 on a nationwide representative sample of 500 Polish women aged from 25 to 59 years (the population covered by the PPPWWRSM).

Results: Different patterns resulting from socio-cultural diversification (inter alia age, place of residence, education) manifested in attitudes towards prevention and motivation for participation in pro-health activities. Regrettably, the high degree of informedness about preventive tests does not translate into practicing pro-health behaviors (the degree of attendance – 61% out of 38% of women who said they had received invitations) or it is realized independently of the PPPWWRSM (38% of female respondents).

Conclusions:A critical sociomedical analysis of smear tests offered under the PPPWWRSM, based on Western model and implemented under different conditions in Poland, may be a valuable suggestion for an effective health policy. Our project demonstrates that it is necessary to take into account a multidisciplinary approach in studies on health behaviors.

The Project "The Problem of Attendance of Women to Cytological Tests in Poland. A Sociomedical Analysis" was financed from the National Science Center funds granted under the decision no. DEC-2011/03/B/HS6/04503.

Parallel session 1:
1.7 - Health policy

Humiliation via the Internet: A Threat for Well-Being?

Julie Alev Dilmaç, Cyprus International University, Northern Cyprus

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1150, First floor
Session Chair: Karen Lowton

According to the World Health Organization, health is defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

From sociological studies describing the harassment between colleagues in their working place, to psychological analysis of its impact on individuals’ mind, bullying holds a privileged place in various disciplines’ research. A huge literature exists about this aggressive behavior and its consequences: no doubt persist about the fact that bullying can negatively impact mental health and well-being and even can lead to physical injury, social problems, emotional problems, and even death. New forms of bullying also tend to emerge, such as cyber-humiliation that unlike traditional forms of humiliation, increase the risk of depression of the victim.

The goal of this paper is to grasp the place of bullying today in health communication. Mainly, we seek to understand how bullying is expressed through campaigns, official websites of various ministries. This paper will outline the central ideas behind communication campaigns in France that focus on public health issues, and especially those on bullying.

A number of questions will be taken into account: How bullying is sought to be prevented in France? What are the discourses and messages conveyed in French campaigns to raise awareness about this social as well as health threat? Which segments population is targeted in these messages? Are these messages targeting the right populations or segments of population?

To conduct this research, we have chosen to analyze the various means used in France in order to communicate information about bullying but also inform the potential victims. A look on the campaigns of official institutions, but also on official websites aimed to prevent cyber-bullying will be analyzed.

As a result, we can say that even if the cyber-bullying is a problem for all individuals in the society, the prevention campaigns seemed only focusing on teenagers and the category of “parents”. The population targeted in the campaigns and the one experiencing the bullying in the real life seem then completely different.

Parallel session 1:
1.7 - Health policy

Towards Health Care Democracy? Understanding Representation by Rare Disease Organizations through a Comparative Case Study

Julia Fischer, Erasmus University Rotterdam, Netherlands

Co-authors: Hester van de Bovenkamp;
Erasmus University Rotterdam

Monday 27 June 2016
Time: 3:00-4:30pm
Room: M1150, First floor
Session Chair: Karen Lowton

Healthcare policies and services are supposed to be attuned to the preferences of patients and health consumers. To make this happen patients and health consumers are increasingly asked to participate in healthcare decision-making. Many scholars point to health consumer and patient organizations (HCPOs) as promoting healthcare democracy. Suchlike studies take the democratic value of HCPOs for granted. However, we know too little about these organizations that claim to represent patients and health consumers.

In this paper we provide insight focussing on the way HCPOs handle representation. Scholars hardly use representation theory for analysing HCPOs. Yet exploring it as a case of representation is crucial to understand their contribution to democracy. Using the concept of the representative claim (Saward 2010) we explore how HCOPs construct representation and on what grounds they base their representative claims.

Our comparative case study concentrates on HCOPs that claim to represent rare disease patients and health consumers in Austria, Germany and the Netherlands. We conducted document analyses of both online and paper documents published by relevant HCPOs as well as semi structured interviews with their representatives.

Parallel session 2:
2.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

Social work with groups in Primary Care settings: experiences and strategies.

Joaquín Guerrero, University of Murcia, Spain

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1130, First floor
Session Chair: Géraldine Bloy & the Research Group 19 “Health, Medicine, Illness and Handicap” of the French Sociological Association

This paper is focused on group interventions developed in different regions of Spain by health professional. In particular, we are going to refer socio-educational and socio-therapeutic groups used for the prevention of mental problems in women and to support informal caregivers. Group interventions are coherent with the general principles of Prevention and Health Promotion, and they have been designed to increase the participation of people with a poor psychosocial well-being in alternative treatments to medicalisation. One of the main objectives pursued in these programmes is reduce the risk of developing mental health problems, identify emotional needs and promote personal capacities, skills and abilities that are directly related with the social adjustment. On the other hand, both strategies are relevant as a way to take control of their health and become health agents in their communities. These strategies include social workers as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community. This is one of principles of the Alma Ata Declaration (1978) to reinforce the primary health care giving priority to a multidisciplinary approach based on a bio-psycho-social model of health. According with the results of these programmes, carried out by primary care social workers in collaborations with other health professionals, we can affirm that the symptoms associated to anxiety and depression in women have been drastically reduced and all thus contributed to a better subjective health status. At the same time, women involved in group sessions felt more integrated in the community and they perceived a higher level of social support and empowerment.

Parallel session 2:
2.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

Exploring community pharmacy‘s health promotion role in dementia care

Petra Plunger, Alpen Adria Universität Klagenfurt, Austria

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1130, First floor
Session Chair: Géraldine Bloy & the Research Group 19 “Health, Medicine, Illness and Handicap” of the French Sociological Association

Background: The project “Dementia-friendly Community Pharmacy” aimed at re-orienting community pharmacy services in two Austrian provinces, thus promoting health and wellbeing for informal caregivers and people living with dementia.

Methods: Based on the principles of participatory health research, interventions have been developed in close cooperation with community pharmacy staff, caregivers, a the self health group, and the Austrian Chamber of Pharmacists. Self-reported knowledge, attitudes and skills of pharmacy staff have been assessed via a written questionnaire at baseline and after the intervention phase in community pharmacies. Narrative accounts describing experiences of pharmacy staff in implementing dementia care have been collected throughout the project, as well as descriptions of interventions developed.

Results: Pharmacy staff frequently encountered situations where specific communication skills and cooperation with other professionals were paramount in order to ensure good care. However, developing a health promotion role seems to be ambivalent for pharmacists: Personal experiences of caring, cooperation with other providers, enrichment of work, peer-support and feedback from caregivers promoted adopting a health promotion role. Challenges were scrutinizing the professional identity being science-based and focusing on factual knowledge, boundary work concerning responsibilities, dealing with the potentially „unlimited“ subject area of health promotion, as well as with organisational factors like time and privacy issues and the societal context, with dementia still being stigmatized.

Conclusions: In the field of health care, dementia is conceptualized as a medical condition, placing issues related to social, cultural and organisational issues of caring at the context level which seems unchangeable in terms of interventions or out of reach for health care professionals. The project was successful in developing knowledge and skills, as well as initiating organisational development in community pharmacies. At the same time, limits for developing health promoting interventions in one setting resulting from lack of integration of primary care became visible.

Parallel session 2:
2.1 - Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

An example of nutritional education in kindergarten school: sanitisation of food

Emilie Gaborit, Laboratoire CRESCO, Université Paul Sabatier, France

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1130, First floor
Session Chair: Géraldine Bloy & the Research Group 19 “Health, Medicine, Illness and Handicap” of the French Sociological Association

This research aims to study health education programmes within a school setting to understand the dissemination of health norms through the lens of nutrition and physical activity programmes.

An ethnographic method was used to carry out participant observation over a two year period within five kindergarten schools participating in an education programme focussed on nutrition names “Bien manger, bien bouger” (“Eat well, move well”). The programmes were led by three departmental offices of French national health insurance organisations (CPAM) in the Midi Pyrenees Region and aimed at 4 to 6 year olds.

An analysis of the implementation and context of the programme highlighted the “sanitisation” of nutrition and food despite the complex social practices and behaviours surrounding these notions. Food and nutrition thus becomes a sanitised practice to be regulated and acts as a “frontier object”, bringing together professionals from separate institutional sectors. A strong normalisation occurs via public policy, and the methods used in the classroom underscore a standardisation of practices which distance themselves from all cultural, religious and affective aspects of eating food.

An analysis of the nutritional programme implementation leads to questioning the underlying pertinence of an intervention focused on the acquisition of knowledge which aims to transform behaviours in young children. Describing school as normative, and producing social inequalities, programme uses the theme of health lead to an accumulation of norms. By analysing food and physical activity practices as indicators of lifestyles and social differentiation, we analyse that knowledge on how to “eat well and move well” to improve health, is more a reflection of attitudes learnt by experience rather than by reciting a lesson. This underlines the risk that such programmes may maintain if not exacerbate social inequalities of health from the earliest age.

Parallel session 2:
2.2 - Informal caregiving

Understanding Resilience in Informal Carers

Sarah Broadhurst, University of Kent, England

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Background: Many informal carers report suffering high levels of stress as a central part of the caregiver experience. Recently research has begun to examine the role of resilience in enhancing the capacity of individuals to ‘bounce back’, enabling them to continue to care. Resilience has been defined as ‘the process of, capacity for, or outcome of successful adaptation despite challenging or threatening circumstances’. This study aimed to understand the nature and complexity of the caring task, identify the emotions and the quality of life outcomes that informal carers experience, and to explore their perception of resilience and how it applies to their caregiving roles.

Methods: Focus groups were conducted with a range of informal carers who were caring for a variety of adults and children with differing needs. The focus groups were recorded, transcribed and then analysed using Grounded Theory. The software package Nvivo was used to support the analysis.

Results: Five themes were identified: the scale of the caring role; the carer as THE skilled helper; the hidden world of the carer; the personal resilience of the carer; and a resilient community.

Conclusions: The results suggest that the scale of the caring task for many informal carers is vast and complex. Much informal caregiving is performed behind closed doors and little is known about the hidden world of the informal carer. Whilst many of the carers reported poor quality of life outcomes, and experiencedf chronic stress, grief and oppression; they also tended to be extremely resourceful individuals who saw themselves as fairly resilient. Their perception of resilience matched models of resilience in the research literature. In conclusion, improving outcomes for carers and building resilience needs to focus not on the personal resilience of carers, but on the interplay between informal carers and the communities they live in.

Parallel session 2:
2.2 - Informal caregiving

Caregiving as a rewarding experience: the perceptions of carers of older people

Joyce Cavaye, The Open University, United Kingdom

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

This paper focuses on the rewards and satisfactions gained from unpaid caregiving. The literature has tended to emphasis the unremitting stressful and burdensome nature of unpaid caregiving. Because of the dominance of this discourse, the potential rewards and satisfaction derived from caregiving have been overlooked. There has however, been increasing criticism of this trend and it has been suggested that a realistic picture will not emerge until the rewarding aspects of caring have been explored in greater detail. Moreover, whilst the evidence supports the view that many carers experience caring as stressful, this does not help us to understand why so many continue and are reluctant to end their caregiving role.

Drawing on a qualitative study that explored the experiences of unpaid carers of older people, this paper presents their perspectives on the rewards and satisfaction gained from caregiving. Data was gathered through in-depth unstructured interviews and analysed according to the principles and processes of grounded theory. The iterative approach of constantly comparing data enabled the emergence and identification of common themes and core categories.

Findings suggest that caregiving is not a wholly negative experience. Unpaid carers do derive rewards and satisfaction from their caregiving role. These are related to: the nature of the personal relationship and the interaction between the carer and care recipient; the personal attributes of the carers such as their attitudes, beliefs and their general approach to life; and the outcomes or consequences of caregiving. These arise from carers' ability to either protect the care recipient from some negatively perceived outcome or to promote positive consequences such as the development of new skills and the prevention of institutionalisation.

Parallel session 2:
2.2 - Informal caregiving

Talking carers into being: contested identities and roles of accompanying persons in emergency department decision-making.

Debra Westlake, Plymouth University, United Kingdom

Co-authors: Susanna Rance, Heather Brant, Ingrid Holme, Catherine Pope, Jonathan Pinkney, Richard Byng;
Susanna Rance University of East London, Heather Brant University of Bristol, Ingrid Holme University of Ulster, Catherine Pope University of Southampton, Jonathan Pinkney and Richard Byng Plymouth University.

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Since the shift in UK health policy towards care in the community and the designation of family members as 'informal carers', carers have come to be conceptualised as resources, co-workers and, more recently, as co-clients with their own needs. This paper explores the negotiation of these roles and identities in interactions involving practitioners, accompanying persons (APs) and patients in emergency department settings.

Methods: We draw on secondary analysis of ethnographic observations and interviews from the Avoidable Acute Admissions project, a mixed-methods study of decision-making about acute admission and discharge in four hospital sites in South-West England.

Results: In the highly-charged environment of emergency departments, practitioners used rhetorical devices that invoked a carer identity to persuade APs to facilitate admission avoidance, effectively 'talking carers into being'. Some APs found it difficult to question the dominant moral order of family-network support for patients being sent home. However, in backstage conversations with researchers and in negotiations with practitioners and patients, APs used indirect strategies including humour and the 'leaking' of lifeworld accounts to resist carer identities. We developed a taxonomy of associations: where patient and AP aligned to construct a carer role; where neither party wished to define their relationship in this way; and where either the AP or the patient contested a carer identity and were possibly in conflict about hospital admission.

Conclusions: Our findings have implications for the role APs can play in influencing admit/discharge decisions and for the configuration of care that can be offered to patients when discharge is considered. Practitioners are aware that APs can provide valuable information about a patient's condition. By attending to APs in their own right, providers can also gain understanding about the recognition and support that APs require, whether or not they formally align themselves with an identity or role as 'carer'.

Parallel session 2:
2.2 - Informal caregiving

Explaining country variation in the proportion of informal caregivers and the intensity of informal caregiving

Ellen Verbakel, Radboud University Nijmegen, Netherlands

Co-authors: Per Stornes, Terje Eikemo;
Norwegian University of Science and Technology

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Background: Population aging will increase the demand for care in the near future. Several European governments are responding to this development by adjusting their health care system; they increase the role of informal caregiving. Previous literature showed a North-South divide in Europe regarding the prevalence of informal caregiving. The first aim of this study is to update and improve this picture by (a) using data from the European Social Survey 2015 and (b) including all types of informal caregiving and not solely care provided to parents. The second aim of this study is to explain differences in the prevalence of informal caregiving between countries, both with respect to the proportion of informal caregiving and the intensity (=hours) of informal caregiving. We examine a wide range of explanations, namely country differences in: composition of the population, the demand for care, care norms, formal care services, and legal obligations to support parents in need. Unlike previous studies, the large number of countries included in ESS enables us to test these explanations simultaneously to avoid confounded relationships.

Methods: We enrich the individual-level data of the European Social Survey (2015) with relevant macro-level characteristics. Multilevel analyses will be performed to formally test the hypothetical explanations for country variation in (intensity) of informal caregiving.

Preliminary and prospective results : Preliminary analyses (based on 15 countries currently available) revealed substantial cross-national variation: the proportion of informal caregivers ranged from 21.4% in Austria to 43.6% in Finland, and the intensity of informal caregiving among caregivers ranged from an average of 5.5 hours per week in Denmark to 17.2 in Austria). Interestingly, the two indicators of prevalence of informal caregiving were strongly negatively related. Our study will offer rich descriptive material on cross-national differences in (intensity) of informal caregiving as well as formal tests of explanations for these differences.

Parallel session 2:
2.3 - Reproductive health through the life course

The Happiness–Parenthood Link in a Context of Limited State Support: The Case of Switzerland

Ester Lucia Rizzi, Université Catholique de Louvain, Belgium

Co-authors: Malgorzata Mikucka;
Universite catholique de Louvain

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

To ascertain the effect of different institutional settings on the happiness-parenthood link, new studies examining various national contexts are needed. The current research extends previous analyses by considering a new set of panel data, that is, the Swiss Household Panel. Our aim is to ascertain to what extent previous results on consequences of parenthood for life satisfaction are generalizable to a new context characterized by low state support for families. We use fixed effects models controlling for unobserved heterogeneity to analyze changes in life satisfaction for both mothers and fathers. Sub-samples of our stratified analyses (by parity and by sex of parents) include between 3,000 and 6,000 persons. If our findings are overall consistent with previous studies, specific features of the Swiss context emerge: (i) the absence of a peak of happiness for women at the birth of the second child, (ii) the important decline in happiness in subsequent years, and (iii), for more educated women, a strong and significant decline in happiness already after the birth of the first child. We interpret our results in the light of the low level of state support for families in Switzerland and the role played by state policies. Some puzzling results appear also for men, showing no significant change in happiness at the birth of the first and second child.

Parallel session 2:
2.3 - Reproductive health through the life course

Intended and realised fertility in a life course approach

Maria Rita Testa, Vienna University of Economics and Business, Austria

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

Adults' intentions to have children compete with intentions in different fields of life. Studying how individuals construct their preferences among competing life goals and build intended family trajectories is a challenging task and pertains to an under-investigated area of research. In this analysis, we examine for the first time the correspondence between fertility intentions and reproductive outcomes over the individuals' life course using event history techniques and taking into account the 'interdependencies of parallel careers' (Dykstra and van Wissen 1999). The focus is on the following careers: childbearing, union, education, employment and migration. The theoretical background draws on the sociological theory of life course (Edler 1985). The life course approach emphasizes the salience of the historical and social context for the interaction of related careers (Mayer 2004). Hence, we propose a cross-country comparative longitudinal approach. The analysis uses the follow-up surveys of the GGS data for nine European countries including Hungary, Italy, the Netherlands, Romania, Austria, Estonia, Belgium, Lithuania and Poland. Piecewise regression models with interaction effects between reproductive intentions and intentions/events competing with childbearing are used. The outcome variable is the waiting time to the birth of a first or higher birth order child, as the models are stratified by parity, i.e., childless and parents. The key covariate is the intentions to have a child in the next three years. Preliminary results show that: 1) people form their intentions to have a(nother) child in a context of multiple life aims and childbearing competes with many other life goals; 2) all but resumption of study intentions support the realization of childbearing intentions; 3) Realization of intentions in parallel life domains support the realization of childbearing intentions but delay the birth of a child; 4) Life course approach is the appropriate framework to analyse the match between fertility intentions and outcomes.

Parallel session 2:
2.3 - Reproductive health through the life course

From nipples to powder: examining anthropometric characteristics as determinants of infant feeding patterns

Karen Vanderlinden, Ghent University, Belgium

Co-authors: Lieselot De Keyser, Ronan Van Rossem, Bart Van de Putte;
Ghent University

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

Rate of growth in infancy is an important indicator of infant mortality and morbidity, since reduced growth is a risk factor for disease susceptibility. Even though a mostly linear growth path is discerned for all infants, growth patterns between breastfed and formula-fed infants are different. As previous studies have fairly consistently shown for weight gain and length growth, breastfed infants display a downward trajectory in growth development beginning at 2 to 3 months until 1 year of life. However, previous studies work from the assumption that prolonged breastfeeding causes reduced growth. There is the potential for bias and Kramer (2002) points to a reverse causality possibility, where slow-growing infants falling off their growth curve trajectories may be deliberately supplemented or weaned in an effort to reverse those trends.

The aim of this study is threefold. First, we examine how feeding patterns evolve over time and the way this varies between maternal characteristics (poverty, education and ethnicity). Second, we focus on the way these infant feeding evolutions can be explained by infant anthropometrics alone. Finally, we investigate the extent to which the impact of infant anthropometrics on feeding choices is influenced by distinct maternal characteristics. We employ Foucault's notions of power and authority to frame the way in which mothers are influenced when doctors, literally, indicate their child's development on these growth curves.

We use IKAROS data collected by Kind en Gezin, a Flemish (northern part of Belgium) public institution which focuses on the welfare of young children and their families. We use population data of all infants born between 2006-2009, resulting in analyses on 295,319 newborns. Multivariate growth curve analyses are estimated to accurately model the causation path mentioned above.

Preliminary results show that mothers of babies with a lowered growth, indicated by lower SD scores on the growth charts, tend to change infant feeding patterns. This change results in a shift from breastfeeding to complementary feeding or bottle-feeding. Furthermore, there are marked differences regarding the causality link between growth development and infant feeding according to maternal education and ethnicity. Our analyses on this large prospective birth cohort show strong associations between baby growth and infant feeding patterns. Explanations, policy implications and directions for further research are discussed.

Parallel session 2:
2.4 - Health Literacy - a social determinant, moderator or mediator of health behaviors and health?

Does better health literacy support healthier life styles? Results from the European Health Literacy Survey

Jürgen Pelikan, University of Vienna, Austria

Co-authors: Kristin Ganahl;
University of Vienna

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2160, Second floor
Session Chair: Jürgen Pelikan

Background: It has been empirically demonstrated that there is not only a social gradient for health literacy, but also that health literacy is associated with relevant indicators of health. One plausible way in which health literacy could improve health is that more health literate people choose more healthy lifestyles. Therefore it is of interest to demonstrate effects of health literacy on indicators of lifestyle, and influences of lifestyle indicators on health.

Methods: In the HLS-EU study two measures of health literacy (HLS-Q47 & NVS Test) were included and indicators for four life style dimensions (physical activity, BMI, smoking, alcohol consumption) and two indicators of self-assessed health were measured as well. Data collection based on multistage random samples of about 1000 EU-citizens aged 15 or older with CAPI or PAPI methodology took place in in 2011 in 8 member-states of the EU (Austria, Bulgaria, Germany, Greece, Ireland, Poland, Spain, The Netherlands).

Results: While rather strong and systematic associations of health literacy with indicators of self-assessed health have been found, associations with indicators of life style or health risks were weaker and differed for different lifestyles and partly also considerably by country. Physical activity and BMI showed more consistent patterns than smoking and alcohol consumption. But there were significant associations of health literacy with physical activity and BMI, also when social confounders were controlled for. And physical activity and BMI were significant predictors of self-assessed health, also when social and other factors were controlled for. But one limitation of this study is its cross-sectional design.

Conclusions: At least for two lifestyle indicators it could be demonstrated that health literacy affects health via more healthy lifestyles or less health risks. Therefore improving health literacy can be a strategy for health promotion and public health to improve lifestyles and health of people.

Parallel session 2:
2.4 - Health Literacy - a social determinant, moderator or mediator of health behaviors and health?

Limited Health literacy in life course – results of the German Health literacy survey (HLS-GER)

Doris Schaeffer, Bielefeld University, Germany

Co-authors: Dominique Vogt;
Eva-Maria Berens

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2160, Second floor
Session Chair: Jürgen Pelikan

Introduction: The results of the HLS-EU indicated that a high proportion of the German population has limited health literacy, and that health literacy worsens with increasing age. But representative data for Germany are still missing. The aim of this study is therefore, to analyze the factors associated with health literacy in different age-groups in Germany.

Methods: A representative sample of 2,000 people from Germany participated in a cross-sectional survey using computer-assisted personal interviews (CAPI) in 2014. The questionnaire is based on the HLS-EU-Q from 2011. It is supplemented with questions regarding socio-demographics, chronic illness and health behaviour, health care utilization and personal factors. According to the HLS-EU the interviews were held as computer assisted personal interviews (CAPI). The effects of age groups on health literacy-level were assessed by chi-square test and logistic regression modelling.

Results: One in two of the respondents in Germany had limited health literacy (54.3%). The proportion of limited health literacy differs among age-groups. While 47.3% of the participants aged 15-29 years were categorized as having limited health literacy, 66.5% respondents aged 65 years and older had limited health literacy. Respondents of low social status and possibly limited newest vital sign (NVS) were more likely to have limited health literacy across all age-groups in the multivariate model than persons of high social status and adequate NVS. Among participants aged 30 and older low social status and having a chronic illness increased the chance of having limited health literacy.

Conclusion: Limited Health literacy is a public health problem – half of the German population have difficulties regarding health relevant tasks, older people more often have limited health literacy. The effect of socio-demographic and – economic factors varies considerably between age-groups. There is need for further analysis also taking objective measures such as knowledge, self-management, and health care use into account.

Parallel session 2:
2.4 - Health Literacy - a social determinant, moderator or mediator of health behaviors and health?

The old-age as a risk factor. Social, economic and health threats amongst the elderly.

Zofia A. Slonska, Institute of Cardiology, Poland

Co-authors: Agnieszka A. Borowiec;
Institute of Cardiology, Warsaw, Poland

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M2160, Second floor
Session Chair: Jürgen Pelikan

Poland is a country which is characterized by the dynamic process of population aging . One of its manifestations is the rapid growth of the old – age dependency ratio. In 2050 the ratio is to reach 66% for the urban and 53% for the rural areas. The aging process manifests itself as well by the progressive reduction of the potential support ratio. In 2050 the number of people aged 15-64 per 100 persons aged 65 and more will decrease from 458 to 169. The above situation let us expect in coming years the intensification of social, economic and health threats, which now appear after entering into a period of old age. The purpose of the study is to identify and analyze the selected social and economic factors, which are likely to restrict or even make impossible to the elderly the effective coping with health difficulties inevitably associated with aging.

The data come from the Polish part of the European Health Literacy Survey (HLS-EU), carried out in July, 2011. Data were collected in Polish by a standardized questionnaire, using CAPI in the random sample in size of n=1000, which was drawn from Polish general population aged 15+.

The results confirmed the significant relationship between the old- age and: lower income, lower level of self-assessed social position, lower level of self-rated health, lower level of health literacy, more frequent problems with everyday activities and others. Moreover they allowed to identify those in the elderly, who experience co-occurrence of disadvantages, such as low education, suffering from chronic disease, low income and low literacy. Among Poles 65+ they constitute 14.4% in contrast to the whole adult population where this category of people amounts to 3.7%. The study provide arguments for the intensification of multi-sectoral activities enabling the elderly active and healthy lives.

Parallel session 2:
2.6 - Health policy

Preferences for private healthcare in a National Health Service: the role of health system support, self-rated health and socioeconomic status

Pål Erling Martinussen, Norwegian University of Science and Technology (NTNU), Norway

Co-authors: Karin Dyrstad;
SINTEF

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1150, First floor
Session Chair: Karen Lowton

Background: Allowing people to purchase certain services outside of the public sector has generally not been regarded as a desirable policy for healthcare, since it may create a two-tier system, thereby intensifying the existing inequalities in health between people with high and low income. Still, one of the greatest pressures for change in modern health systems has been in the relative role of the private sector in the operation and, in some countries, the funding of health care services. During the last decades market-inspired reforms have even been implemented in countries with National Health Services (NHS). Methods: Building on a national survey among 7,500 Norwegians in 2014, we addressed three central aspects of private healthcare: 1) the restriction of private commercial activity, 2) the possibility to purchase private health insurance, and 3) the growth in private hospitals. The study employed multivariate analysis to uncover whether the attitudes are related to health system support, socioeconomic status and self-rated health, also controlling for other important factors such as age, gender, political sympathies and working status, etc. Results: The empirical results uncovered that there is large opposition against all three dimensions of private healthcare. The regression analysis showed that the willingness to increase the role of private sector is negatively associated with health system support, but positively associated with both income and health, while education is of little importance. Conclusions: This suggests that the concerns about the equity implications related to private health services may be warranted: assuming that the expressed preferences in our study reflect the potential demand for private services, an increasing role for private actors may lead to the development of a group of well-off and healthy users who demand almost all their health care from the private sector and who have little commitment to public funding of health care.

Parallel session 2:
2.6 - Health policy

Satisfaction with medical services in relation to changes in self-rated health by Polish elders -Courage

Beata Tobiasz-Adamczyk, Department of Medical Sociology, Chair of Epidemilogy and Preventive Medicine, Jagiellonian University Medical College, Poland

Co-authors: Katarzyna Zawisza, Aleksander Galas;
Department of Medical Sociology, Chair of Epidemilogy and Preventive Medicine, Jagiellonian University Medical College,
Department of Epidemiology, Chair of Epidemilogy and Preventive Medicine, Jagiellonian University Medical College

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1150, First floor
Session Chair: Karen Lowton

Process of political and economic transformation in Poland was associated with several reforms of health care system conducting across last 25 years, which did not bring expected positive effects improving the quality of medical care and generally have been criticized in public sphere . Older patients have been perceived as a group suffering from consequences of these inefficacious reforms and “forgotten“ actors of medical system.

The aim of the study was to assess relationships between attendance to different forms of medical care service by Polish older people and their self-assessment of positive or negative changes in health status in relation to patients’ satisfaction.

The cross–sectional study involving Poland, Spain and Finland (2011-2012). Results are based on 1408 face-to-face interviews performed in the representative general population sample of older persons 65+ yrs (62% women and 38% men).

Relation between satisfaction with medical care during the hospitalization and self-assessment of health status showed that dissatisfaction with medical care was associated with lack of observed positive changes in health or even made health worse. Logistic regression analysis confirmed that dissatisfaction with hospital care was significantly associated with lack of participation in decision–making process, lack of respect presented by physicians. Dissatisfaction with out-patients clinic services was influenced by lack of good communication between old patient and physician, lack of respect and lack of intimacy during the medical consultation.

General dissatisfaction with system of medical care was significantly depended on lack positive changes in health status after treatment, dissatisfaction with the last medical consultation and with the last hospitalization.

Parallel session 2:
2.6 - Health policy

Reasons for doctors moving to the "periphery" following a new wage agreement

Paula Feder-Bubis, Ben-Gurion University of the Negev, Israel

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1150, First floor
Session Chair: Karen Lowton

Background: At the end of a prolonged doctors' strike in 2011, a new wage agreement was signed between the Israeli Medical Association and the ministries of health and finance. It included financial grants for physicians who would begin to work in the "periphery", aiming to reduce the shortage of doctors in hospitals there, upgrade their working conditions, and improve medical care quality in periphery hospitals.

Study Objectives: a. To map doctors’ recruitment to hospitals in the periphery; b. To examine the motives that brought doctors to work in these hospitals; c. To elucidate doctors’ evaluations of their decision; d. To describe how (and especially where) these doctors see their professional future; e. To learn what additional strategies can attract physicians to the periphery.

Methodology: The study combined quantitative (mapping) and qualitative (in-depth, semi-structured interviews with residents who moved to the periphery) methodologies. The mapping was based on data from hospitals' human resource departments. Following the mapping, a maximum variation sampling of 54 doctors was undertaken. We used descriptive statistics for the analysis of data obtained from the mapping, and grounded theory for the analysis of the interviews.

Findings: Most of the physicians that started working in periphery hospitals were male, married and parents. About half of them chose specialties that also entitled them to the grant assigned to specializations "in crisis". The financial grant was among the professional and family considerations that brought physicians to work in periphery hospitals.

Conclusion: The availability of positions for physicians in periphery hospitals, combined with grants for physicians, alongside hospitals' characteristics, resulted in increased numbers of physicians in these hospitals. Infrastructure improvements in periphery hospitals and professional opportunities could retain them in the periphery.

Parallel session 2:
2.7 - Health promotion

Long-term evaluation of complex community interventions for health promotion and prevention: an inquiry of community capacities over ten years

Waldemar Suess, University medical center, Department of medical sociology, Germany

Co-authors: Stefan Nickel, Alf Trojan;
Department of medical Sociology

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1160, First floor
Session Chair: Tim Huijts

INTRODUCTION: Between 2005 and 2012 the health authority of Hamburg-Eimsbüttel carried out a prevention program for children and their parents in a disadvantaged neighborhood called Lenzsiedlung. The program consisted of 7 action fields in which various innovative activities and projects were undertaken to improve the health of the target groups. During all phases of the program three research projects were carried out, funded by the Federal Ministry of Education and Research.

GOAL: This presentation is focussing on the evaluation of (i) the demonstration phase, and (ii) the maintenance phase that is characterized by the loss of supporting networks and resources on the one hand and by the continuation of health promotion structures and activities on the other. The general research goal was the long-term assessment of community capacity building with the newly developed KEQ instrument (KEQ = Kapazitätsentwicklung im Quartier / capacity building in quarters).

METHODS: To measure community capacity building surveys were conducted each with 40-60 stakeholders of the Lenzsiedlung at five points in time. The instrument consists of 5 domains (participation, local leadership, available resources, networking and cooperation, health care) in 51-item-long form as well as 31-item-short form. Further research is projected about the in-depth description of the setting and its context, facilitating and restraining factors in the maintenance phase.

RESULTS: For the community capacities the overall positive trend since 2001 (t0 was measured retrospectively in 2006) is to be stressed. With the gradual phasing out of the social urban development since 2006, the process of capacity building seems to have entered a phase of consolidation. However, the t2 and t3 measures showed slight improvements (e.g. in the particularly important domain ‘health care’) or constant values. Only after the ending of the program in 2012 moderate worsening can be detected in a few aspects.

CONCLUSION: The results show ‘eclectic’ evidence for community-level health promotion. However, there are limitations both in theoretical and methodical respects: On the one hand, Lenzgesund was not the sole program in the quarters during the period of observation, so that its effectiveness is not distinctly assignable to single interventions. On the other hand, more than one approach should be used to check the results due to possibly one-sided experts’ perspective in the quantitative assessment (triangula.)

Parallel session 2:
2.7 - Health promotion

The ABC’s of Breastfeeding, a targeted intervention to encourage, inform and empower mothers and to increase breastfeeding initiation and duration

Susan Bodnar-Deren, Virginia Commonwealth University, United States

Co-authors: RaShel Charles, Basmah Karriem, Renada Lewis, and Alice Freeman;
Virginia Commonwealth University

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1160, First floor
Session Chair: Tim Huijts

The health benefits of breastfeeding are consequential to both mothers and children. While overall breastfeeding rates in the US have increased, significant sociodemographic and racial/ethnic disparities exist; young mothers of low socioeconomic status of color are unlikely to breastfeed. As a result, the CDC asserts that mothers and babies may benefit from targeted culturally sensitive support/interventions to start and continue breastfeeding.

Objective: To engage community based participatory research strategies to evaluate a U.S., community-based/peer-to-peer breastfeeding support and maternal health program (The ABCs of Breastfeeding) and to train young women who are participants in the program to become community researchers. The ABCs is designed to empower and educate economically disadvantaged women about the benefits of breastfeeding and engages new and expecting mothers in a peer-to-peer support model entitled “Sister Circles”.

Methods: Community Researchers were identified and trained by university researchers in study design and implementation. The team decided on a mixed methods approach (focus groups and surveys), developed focus group questions/protocols based on program participants input. Based on the outcomes of the focus groups, surveys will be developed and administered to past and current program participants.

Results: Preliminary data indicate that The ABC’s has been successful in working with 98 at-risk pregnant and postpartum mothers (ages 14-32) of color. Nineteen sessions were held in 2015. As indicated by post-test evaluations, 96% of participants increased their knowledge of infant mortality risk, proper nutrition and self-care techniques. 95% of all participants are breastfeeding. The most stated reason for not breastfeeding were: the fear of biting, work/school schedules, and making the transition to table food. The most stated reason for breastfeeding was the nutritional and health benefit to the baby as well as the weight loss benefit for the mom with possibly reducing the risks of breast cancer.

Conclusion: A culturally tailored peer-to-peer breastfeeding program has shown to be successful in increasing breastfeeding initiation and duration among high-risk mothers.

Parallel session 2:
2.7 - Health promotion

Health Promoting Residential Aged Care: A Follow Up of a Comprehensive Health Promoting Settings Project

Karl Krajic, FORBA Working Life Research Centre, Austria

Co-authors: Viktoria Quehenberger, Martin Cichocki; FORBA

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1160, First floor
Session Chair: Tim Huijts

In the past, healthy ageing programs have primarily focused on the “young old” (e.g. workplace health promotion). In the older groups, programs addressed primarily community-dwelling aged with larger health potentials. Health promotion agents hardly considered highly aged persons as possible target for programs, especially when in a functionally impaired state, . For this reason, health promotion considered aged care residencies as area for workplace health promotion, but not for a comprehensive settings approach, targeting health of all groups affected.

Between 2011 and 2013, a pilot project for health promoting aged care was conducted in Austria.(three units of Vienna’s larges aged care provider, 900 residents, 300 staff). Starting out with a systematic needs assessment, the project developed and implemented health promotion strategies and measures: (a) For residents, the project carried out a mobility enhancement intervention as RCT study, which demonstrated effectiveness; (b) several staff health measures were implemented; (c) for relatives of the residents, an involvement policy was developed. At management level, the organization adopted a health promotion policy and established central support structures. Evaluation used qualitative and quantitative methods. At the end of the pilot phase, internal and external stakeholders considered the project successful, but it was too early to observe impact of health promotion measures on everyday processes and on organizational culture.

Thus, between 2013 und 2015, researchers carried out a follow up project. This scientific follow up included evaluation of further program specification, roll out and sustainability of the interventions. .

The paper will report on experiences with overall implementation, results on the roll out of the mobility enhancement program and further development of the relatives’ program. It will discuss program rationale, implementation issues and viability of a health promoting setting approach in this context.

Parallel session 2:
2.7 - Health promotion

Promoting health, reducing gender inequalities, improving intercultural communications. Prevention of female cancer and sexually transmitted diseases

Mara Tognetti, University of Milano-Bicocca, Italy

Co-authors : Irene Viola

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1160, First floor
Session Chair: Tim Huijts

Immigrant people adhere sparsely to the prevention programs, as well as female cancers and sexually transmitted diseases (still rising among young people and migrant women).

The case study concerns two metropolitan cities of the Mediterranean area as Milan and Beirut: the first is characterized by a strong presence of immigrants (15%), the other by an health system based on private insurance, with a massive presence of refugees (Palestinians and Syrians) which covers more than a third of the Lebanese population.

The detection of healthcare needs consists of an exploratory "integrated" research that makes use of secondary sources of quantitative data and a qualitative survey on the field (in-depth interviews with stakeholders and focus groups with female patients).

The case study aims to produce a comparative analysis between different contexts of the Mediterranean, about both the policies of health prevention targeting women and young people, and the access of migrant people to healthcare and prevention services.

Parallel session 2:
2.8 - Wellbeing at work

Between-country differences in psychosocial work stress: the role of management practices of psychosocial risks in European countries

Thorsten Lunau, Institute for Medical Sociology, Germany

Co-authors: Thorsten Lunau, Nico Dragano, Johannes Siegrist, Morten Wahrendorf;
Institute for Medical Sociology, Faculty of Medicine, Centre for Health and Society, University of Düsseldorf, Germany, Faculty of Medicine, University of Düsseldorf, Germany

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1170, First floor
Session Chair: Olaf von dem Knesebeck

Background : In an ageing society maintaining health and employability of older employees is an important aim. A variety of studies identified certain psychosocial work stressors with negative health effects. The experience of psychosocial work stressors varies between countries and it is unclear if specific national management practices to deal with such stressors explain these differences. The aim of this study is to investigate if different health and safety management practices contribute to the explanation of between-country differences in psychosocial work stressors.

Methods: Two different data sources were used for this study. The `Survey of Health, Ageing and Retirement in Europe` (SHARE) and the `English Longitudinal Study of Ageing' (ELSA) provide individual data on psychosocial working conditions (job control, effort reward imbalance; 17 European countries n=12.658). These data are combined with a second data source. We use aggregated data from the Enterprise survey on new and emerging risks (ESENER) to measure health and safety management practices of psychosocial risks in European countries. The highest ranking manager responsible for the coordination of health and safety at work was interviewed. Six indicators measuring the proportion of enterprises in a country who implement the respective management practices were included in the analyses. Multilevel analyses were used to estimate the reduction of the between country variance.

Results: The results show that the prevalence of stressful psychosocial working conditions is significantly lower in countries with a more comprehensive management of psychosocial risks. In particular, several specific indicators contribute towards reducing the between-country variance of psychosocial working conditions (Information about whom to address in case of work related psychosocial risks; Psychologists are included in health and safety services; Implementation of procedures to deal with work-related stress).

Conclusion: Our results identify different types of psychosocial risk management practices that may help to reduce overall levels of psychosocial stress at work.

Parallel session 2:
2.8 - Wellbeing at work

Health of older precarious workers: econometric evidence from SHARE

Andrej Srakar, Institute for Economic Research, Slovenia

Co-authors: Valentina Prevolnik Rupel;
Institute for Economic Research, Ljubljana, Slovenia

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1170, First floor
Session Chair: Olaf von dem Knesebeck

In the article we present the results of the analysis about the older precarious workers and their health situation, based on the usage of Wave 5 of the SHARE survey. Although the topic of precarious work (not the least among the older people) is becoming ever more important in Europe, there has been very little empirical and econometric evidence on the issue in health sociology and/or economics. We try to remedy for this void by presenting a detailed econometric analysis to study the main question: “Are older precarious workers really discriminated in terms of worse health as compared to the older employed people?” We firstly present some basic descriptive statistics and bivariate analysis results and tests, followed by econometric results using finite mixture models to appropriately model the heterogeneity among precarious workers. Our results show that, contrary to the expectations, the health of older self-employed workers is generally in no way inferior to the health of older employees. Problems in health of the precarious workers emerge only when the analysis changes focus to those who are neither employed nor self-employed, while engaged in paid work (“true” precarious people). There are visible differences in the health status of employed older people and “true” precarious workers in almost all the indicators and in the vast majority of the 15 countries included. Nevertheless, our analysis points to a large heterogeneity among precarious workers which fall into two broad groups which we label “precarious workers for money reasons” and “precarious workers because of active ageing reasons”, with clearly visible differences among the two groups in income and health. We also study the effects of social exclusion on health status of precarious workers controlling for the endogeneity in the model. We conclude by policy implications of the analysis and paths for future research.

Parallel session 2:
2.8 - Wellbeing at work

Experienced School Principals’ Leadership Behavior and Teachers’ Health in Switzerland

Roger Keller, Zurich University of Teacher Education, Switzerland

Co-authors: Simone Schoch, Manuela Keller-Schneider;
Zurich University of Teacher Education

Monday 27 June 2016
Time: 4:45-6:15pm
Room: M1170, First floor
Session Chair: Olaf von dem Knesebeck

Teachers’ health is an important precondition for fulfilling the educational mandate. Nevertheless, findings indicate that a significant number of teachers reach their physical and emotional limits in the course of their work. Initial research findings from Germany indicate that school principals’ leadership behavior is associated with teachers’ health and psychological well-being. However, in Switzerland, the concept of school principals differs from that in Germany. In Germany, school principals’ main work areas lie in the school administration, whereas in Switzerland school principals often are pedagogical leaders. Moreover, in Switzerland the concept of school principals has only been introduced 5 to 10 years ago. As a consequence, neither the culture of leadership at schools, nor the role and tasks of school principals are clearly defined. Therefore, little is known whether the associations found in research in other contexts also apply to schools in Switzerland.

In this study, we examined which aspects of experienced leadership behavior are positively and negatively associated with teachers’ health and psychological well-being in Switzerland.

In the context of the study RUMBA, a sample of N = 264 teachers completed a questionnaire on their health complaints, psychological well-being, and perceptions of their school principals’ leadership behavior. Data were analyzed by multiple regression analysis.

The results showed - in line with other research - that the following aspects of the school principals’ perceived leadership behavior were positively associated with teachers’ health and psychological well-being: empathy, targeted management, leadership competence, and participative leadership.

Taken together, the current results demonstrate that experienced school principals’ leadership behavior plays an important role for teachers’ health and psychological well-being.

Parallel session 3:
3.1 - Social inequality, working conditions and health

Healthy work but not for all: occupational inequalities in job-related risk factors in Europe

Nico Dragano, University of Düsseldorf, Germany

Co-authors: Morten Wahrendorf, Kathrin Müller, Thorsten Lunau;
University of Düsseldorf

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Background: An unequal distribution of work-related risk factors between different occupational classes may contribute to health inequalities in the working population. Because of the high variety of occupational risk factors – both physical and psychosocial – it is necessary to study possible inequalities for a large set of single risk factor. In this presentation we investigate how various occupational hazards are distributed in the European working population. In particular, we study whether risk factors are linked to occupational class.

Methods: Analyses rely on data from the latest wave of the European Working condition Survey from 2010. We include the samples of the EU-27 countries with 34,529 employed men and women (n women: 17,540; n men: 16,989). Occupational position is operationalized using the EGP-class scheme. We calculate the prevalence for 16 single risk factors by EGP classes in the pooled dataset (weighted prevalences), and additionally, calculate a cumulative score of all exposures. All analyses are conducted for men and women separately in order to account for possible sex differences in exposure profiles.

Results: For both men and women, most of the physical and psychosocial risk factors studied are more common in the manual and the lower non-manual classes. Notably, differences are more pronounced for specific risk factors (e.g. lifting heavy loads; low decision latitude and skill discretion). The overall sum of risk factors is significantly higher in lower occupational classes.

Conclusion: Results suggest that a pronounced occupational inequality in the distribution of important occupational hazards exist in the European economies. Investigating single risk factors may help to identify specific factors to reduce inequalities in health with more accuracy.

Parallel session 3:
3.1 - Social inequality, working conditions and health

Health effects of unemployment in Europe during the Great Recession: The impact of unemployment generosity

Anne Grete Tøge,
Oslo and Akershus University College, Norway

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Social and economic security could be particularly important for health among unemployed. Nevertheless, knowledge is still lacking as to whether and how different policy contexts affect health when people move into unemployment. The aim of this paper is to investigate whether and to what degree the unemployment generosity explains why individual health effects of unemployment vary across Europe. The 2008–2011 longitudinal panel of the EU-SILC and fixed effects models are used to estimate the individual effects of unemployment on self-rated health (SRH). Social spending on unemployment is used as a proxy for the generosity of unemployment benefits and services. The results show that welfare generosity is associated with reduced negative effects of unemployment on SRH. For every PPS increase in adjusted spending, the negative effect of unemployment on SRH is reduced by 0.003 (SE = 0.001) and the change in SRH is improved by 0.002 (SE = 0.001) for each year following the transition, after controlling for time-variant confounders at the individual level and unemployment rate at the macro level. The association between spending on unemployment and cross-national differences in individual health changes as people enter unemployment provides a robust indication of the mitigating health effects of welfare generosity.

Parallel session 3:
3.1 - Social inequality, working conditions and health

The health associations of different types of employment and labour market positions in Belgium

Karen Van Aerden, Vrije Universiteit Brussel, Belgium

Co-authors: Christophe Vanroelen, Sylvie Gadeyne;
Vrije Universiteit Brussel

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

In recent decades, health inequalities have increased in many countries, among which Belgium. This paper focuses on two important mechanisms: individuals' labour market position and their social environment. Recent research indicates that both labour market inactivity and precarious work experiences cause serious harm to people's health. Concerning the health impact of a vulnerable social situation, factors that are frequently mentioned include the composition, material living conditions and employment situation of the household, as well as the lack or presence of individual coping resources.

This paper uses the Belgian data of the 1st Generations and Gender Survey (GGS), in which 6013 working-age respondents participated. First, Latent Class Cluster Analysis (LCCA) is used to construct a typology of labour market positions that includes different types of employment (based on the characterising working conditions), as well as unemployment. In second instance, binary logistic regression analyses are performed in order to relate this typology to individuals' general and mental health situation. Finally, different aspects of individuals' social situation will be added as control variables to take into account their role in the relationship between labour market position and general/mental health.

The typology of labour market positions contains five types of employment (standard, instrumental, precarious, portfolio and self-employment) and one form of labour market inactivity: unemployment. Results of the regression analyses show that individuals' labour market position is clearly related to their general and mental health. Health problems are most often related to unemployment or precarious employment. Several aspects of the social situation play an important role in shaping the relationship between labour market position and health.

Our results confirm that both the labour market position and wider social situation of individuals are important mechanisms generating health inequalities.

Parallel session 3:
3.2 - Reproductive health through the life course

Gene as 'cultural icon'? Mitochondria and the ambiguity of genetic material and genetic relatedness

Rebecca Dimond, Cardiff University, United Kingdom

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2140, Second floor
Session Chair: Claudine Burton-Jeangros

Background: In 2015 the UK legalised controversial IVF technologies known as mitochondrial donation, allowing women with mitochondrial disease to have healthy genetically related children. The techniques use part of a donated egg, which means the resulting child will have a third genetic contributor - the egg donor who provides mitochondrial DNA. Key to the mitochondrial debates were questions about the role and identity of the donor, and the imagined nature of her relationship with the child.

Methods: Data was collected for a three-year qualitative research project, involving interviews with women with mitochondrial disease, ethnographic observations of public meetings, and documents analysis of parliamentary debates and public consultations.

Results: The mitochondria debates reveal competing understandings of the symbolic importance of genes and meanings of 'genetic relatedness'. The mitochondrial gene, it seems, is not a 'cultural icon': judgements were made about the (in)significance of mitochondrial genetic material – that is does not contribute to 'personal characteristics' and that it contributes only 0.1% of total DNA. The debates reveal the priorities of supporting genetic relatedness for patients/patients, but a denial of the genetic relationship between child and donor. The technologies were considered germ-line, but not genetic modification. These declarations, which led to the techniques being legalised, need to be contextualised as part of a persuasive repertoire in a highly political and emotive debate.

Conclusions: The debates surrounding mitochondrial donation reveal ambiguities about the social significance, and meanings, of genetic material. The legacy of these debates, and the conclusions made by UK government, will be how they shape responses to future technologies, such as the newly emerging gene-editing techniques.

Parallel session 3:
3.2 - Reproductive health through the life course

Do Genetic Markers for Infertility Problems Predict Childlessness and Completed Fertility?

Jornt Mandemakers, Wageningen University, Netherlands

Co-authors: Nicola Barban, Melinda Mills, Harold Snieder; Oxford University, Oxford University, UMC Groningen

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2140, Second floor
Session Chair: Claudine Burton-Jeangros

The current abstract based on an older version of paper, which used less powerfull genetic risk scores. These will be updated in January 2016 to incorporate GWAS papers that came out in late 2015:

We present a novel approach to examine the influence of biological limits to reproduction. We use a set of validated genetic markers from published GWAS studies on phenotypes related to infertility (endometriosis and (early) menopause) in order to create polygenic infertility risk scores. We hypothesize that women carrying more 'infertility risk' alleles are at an increased risk of childlessness and decreased completed fertility. Second, we hypothesize that women from later cohorts and more educated women will be more vulnerable to genetically endowed infertility problems, as they may postpone childbearing to a greater extent. Furthermore, we expect that infertility problems may play a larger role at higher parities and/or at the end of the reproductive lifespan. Preliminary analyses using the Dutch LifeLines and the TwinsUK cohorts show that a higher genetic risk for early menopause (before age 45) is not related to childlessness, completed fertility or age at last birth. Analyses for endometriosis show that in both LifeLines and the TwinsUK women at a higher genetic risk for endometriosis are less likely to be childless at age 45 and have somewhat more children at age 45. There was no relationship with age at last birth. The interactions with year of birth and educational level were inconclusive. Future versions of this paper will replicate these analyses using the HRS (currently awaiting permission for the data) and also look at age at menarche to better capture the width of the reproductive window.

Parallel session 3:
3.2 - Reproductive health through the life course

Couples decision-making for infertility treatment: Effects of high costs and insurance coverage

Jasmin Passet-Wittig, Federal Institute for Population Research, Germany

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2140, Second floor
Session Chair: Claudine Burton-Jeangros

Background: In Germany, infertility treatment is costly and only 50% of the treatment costs for 3 cycles are reimbursed by statutory health insurance (SHI). To qualify for coverage, couples need to be married and there is an additional age limit for women (25-40 years) as well as for men (25-50 years). This study investigates social inequality during the decision-making process of infertile couples when seeking medical help.

Methods: We use data from the baseline survey of the PinK study, a cohort study of heterosexual couples visiting fertility clinics in two German federal states in 2012/13. Information was collected from new patients at fertility clinics using self-administered questionnaires. The main outcome is a measure of duration between the date at which couple notice a fertility problem and the first visit at a fertility clinic. A glm-model with gamma distribution and log-link is estimated based on data from 164 couple dyads.

Results: On average, 1.55 years (sd=1.4) pass from the point in time when one partner first perceives a fertility problem until the couple consults a fertility clinic. Of 116 couples with SHI, 45.7 % are not eligible for reimbursement; marital status is relevant in 92.5 % of these couples. Generally, a lower SES is associated with a significantly longer duration until the couple's first visit at a fertility clinic. Furthermore, couples not eligible for reimbursement by SHI need considerably longer compared to those eligible.

Conclusions: There is evidence that high treatment costs and patient co-payments are probably perceived as burdensome and in consequence prolong couple's decision-making process. In the case of older couples longer durations can be problematic because the probability of treatment success declines with age. In times where every third child is born by unmarried couples it does not seem adequate treat them differently from married couples in SHI.

Parallel session 3:
3.3 - Health professions in transition

Outpatient physiotherapy – between focussed bodily intervention and personal relationship

Marion Grafe, Martin-Luther University, Germany

Co-authors: Annette Probst, Johann Behrens;
University of Applied Sciences and Arts Hildesheim, Martin Luther-University

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Background: Outpatient physiotherapy in Germany is restricted by social law, e.g. regarding access to physiotherapy, reimbursement, frequency, type and duration of treatment. From another perspective physiotherapy can be defined as a person-related service. The outcome of those services mainly depend on a successful cooperation between the participants. While official guidelines and laws define physiotherapy as a provider of focussed bodily intervention, the service provider's perspective shows an additional field of demands.

Methods: A grounded theory study was conducted, in which interaction sequences of the physiotherapeutic work in outpatient practices were observed. Thereby, also the influence of the organisational context of the interactional work was considered. Eight physiotherapy sessions and retrospective think-aloud-protocols, as well as field protocols and 4 interviews were collected. The data comes from 9 physiotherapists working in outpatient physiotherapy practices in North-Rhine-Westfalia, Germany. The data was transcribed and analysed according to Strauss & Corbins coding paradigm.

Results: Physiotherapy in outpatient practice is characterised by an ambivalence of different directions in interacting with patients. On the one hand, the interaction supports the focus on bodily interventions, on the other hand the bodily interventions depend on the successful cooperation of physiotherapist and patient. This cooperation requires a personal and bodily encounter. Against the background of unflexible time frames, physiotherapists arrange a relationship, which enables the required cooperation. Therefore, physiotherapists developed strategies to prevent an affiliation which is too intensive. These strategies are needed to cope with unflexible time frames and the intimacy of the physiotherapeutic treatment.

Conclusions: Physiotherapy is characterised as a bodily and interaction intensive profession. Guidelines and laws partly suggest the potential standardisation. This part of the results suggests the nessecity to acknowledge interaction to be a key part of physiotherapy which needs to be reflected. Only by acknowledging this part of work, the possibilities and limitations of physiotherapy can be discussed. This discussion should aim to support the current changes in the profession regarding education and labour structures also in view of future demands, e.g. regarding the aging population.

Parallel session 3:
3.3 - Health professions in transition

Studying care and death of the elderly through death notices. The cases of Geneva and Valais, Switzerland

Marthe Nicolet, University of Geneva, Switzerland

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

In demographic terms, the rectangularization of the survival curve has increased the link between death and old age. In Switzerland, as in other developed countries, a large majority of deaths occur in very old age. This reality affects the representation of life's end and is a challenge for the management of care.

An original and underexplored data source to document the conditions around the end of life in old age is death notices published in the daily newspapers. They are resources providing valuable information regarding the deceased: sex, age, place of death, marital status, religion, number of children. Moreover, they show whether and how families mention or express gratitude to an institution, a physician or a medical team.

The research presented here specifically focuses on the differentiated practice of saying 'thank you'. First, the expression of gratitude highlights the complexity of care arrangements that accompanied the dying. The references to professional statuses allow us to draw the network that supported the elderly during the last stage of their existence. These networks are plural, with both formal and informal components.

Second, our approach is supplemented by a textual analysis of the words used by the family to thank. These words depend on the accompaniment. There emerge anthropological structures which refer to cultures of death, religion, family and social ties.

In a cross-cutting perspective, we compare Geneva, an urbanized area, and Valais, mountainous semi-urban area still characterized by the impact of Catholicism.

Parallel session 3:
3.3 - Health professions in transition

Desire for sex / desire for health: shaping a new area for healthcare interventions

Marilène Vuille, Institute for Gender Studies,
University of Geneva, Switzerland

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

In rich countries, the imperative of good health has indeed expanded to nearly all areas of life, including sexuality. 'Sexual health', coined by the WHO as involving 'a state of physical, emotional, mental and social well-being in relation to sexuality', allows for all aspects of sexuality to be considered from a health management perspective.

In this context, our study deals with the issue of decreased sexual desire, supposed to be a problem prevailing especially among women. Our qualitative methods include observation of medical and sexology conferences in France and in Switzerland, qualitative interviews, and analysis of scientific articles. Data were analysed from a twofold perspective of gender and of medicine and science studies in order to describe the development of an expertise on and remedies for treating 'sexual desire disorders'.

Our results indicate that since recreative sexuality is considered healthy, the decrease or lack of an individual's sexual desire is not only viewed as a possible problem in the life of her/his couple, but also as a risk of deterioration of her/his health and well-being. At the same time, sexual desire is depicted as precarious and endangered in all sorts of situations, such as aging (menopause) and chronic illness (cancer, cardiopathy, etc.). Therefore, attention to sexuality has been included within 'supportive care' (defined as treatment given to prevent, control, or relieve complications and side effects and to improve the patient's comfort and quality of life). Parallel to these conceptual shifts, a new field of 'sexual medicine' is developing within healthcare and medicine, with the opening of sexological consultations in specialised medical units (e.g. in oncology services), leading to new specialisation opportunities for professionals (nurses, psychologists, physicians from different specialties, but also socio-æstheticians).

Parallel session 3:
3.4 - Technologies and policies for healthy lives

Am I the Body I Am?: Self-tracking and the Organisation of Selves in Late Capitalism

Harley Bergroth, University of Turku, Finland

Tuesday 28 June 2016
Time: 8:30-10am
Room: M2160, Second floor
Session Chair: Raphaël Hammer

In the affluent west, recent years have seen a proliferation of various self-tracking devices in everyday lives. These devices, referring to near-body wearable trackers and sensors, have become a mainstream form of proactive and preventive health care as ideally people can track various aspects of their daily lives, such as activity levels, heart rate, sleep patterns and recovery, and adjust their bodies and lives based on this datafied self-knowledge.

By drawing from STS and cultural studies of the body, I investigate self-tracking as sociocultural technics of the body politic of late capitalism. The proliferation of trackers in everyday lives invites researchers to think what is not new in these "new technologies" and how they (are made to) work in a certain political context that promotes bodies-as-productive-machines and bodies as projects. Research data consists of 16 thematic interviews with Finnish self-trackers, observations in related events and autoethnographic reflections.

This paper is based on an article manuscript, which is part of my ongoing PhD research. I argue that while the hype around personal health technologies often promises data-driven empowerment for all, through the confirmation of the 'self' and purification of self-knowledge, self-tracking seems to be able to empower only those willing and able to work on the self, while often producing de-motivation and (self-)alienating consequences for the less privileged. The devices direct actions and lives based on standardized technical and moral definitions of decent bodies and their workings resonate on the affective level potentially strengthening the psychostructural divide between the normal and the pathological. By tracking technicalities of bodies, self-trackers often seem to track moralities of 'selves', especially in relation to the pathological 'other' within one's own body.

Parallel session 3:
3.4 - Technologies and policies for healthy lives

The fictional autonomy of the Quantified Self in the age of anxiety

Antonio Maturo, Università di Bologna, Italy

Co-authors: Veronica, Moretti;
Università di Bologna

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Huge expectations are held for the potential of health apps to reduce health expenditures. As stated in several important documents of the European Commission, apps can foster the autonomy and empowerment of individuals. However, we believe that emphasizing digital health and the "quantified self" is consistent with a neoliberal perception that poses some disadvantages to public health. With self-tracking features, health apps allow us to collect voluminous data on our behaviors and biometric values. These apps also enable us to elaborate on collected data and produce fine-grained statistics. Attractive graphs and vivid histograms create what appear to be realistic and reliable quantifications.

To test our hypothesis, we analyzed the most frequently downloaded apps for anxiety. We conducted content analysis on three anxiety apps and three mindfulness apps, with specific focus on two types of texts: the commercial description provided by the apps and the reviews provided by app users.

Our results show that the managerial language and graphics used in the apps depict users as self-entrepreneurs who work on themselves as though they were an enterprise with the mission of increasing emotional "productivity." A user is therefore portrayed as responsible for his/her health and wellbeing. The apps' emphasis on self-quantification is also consistent with the philosophy behind the latest DSM versions, which construct diagnoses on the basis of number and length of symptoms. Digital technologies can be said to serve as cues for individual self-surveillance, which can rapidly shift to 'inter-veillance' as individuals share their personal health data on social networks.

We conclude that anxiety apps bracket any reference to the social determinants of health and the responsibility of the state in ensuring the health of the community.

Parallel session 3:
3.4 - Technologies and policies for healthy lives

'Feeling Good, Like a Robot, Like a Pro': An exploration of users experiences of self-tracking fitness technologies

Emma Rich, University of Bath, England

Co-authors: Laura Blatherwick,
University of Bath

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Raphaël Hammer

A range of mobile health (mHealth) technologies are now available for people to self-track their health and fitness practices. These include tens of thousands of mobile applications (apps) designed to enable users to track, monitor and regulate aspects of their 'lifestyles' such as physical activity, body weight and diets. A more recent stage in the development of digital health now includes the rise of wearable health technologies, such as bands and patches which utilise connected technologies such as sensors and GPS to log data from a user's movements and behaviours. The use of such personal analytics and self-tracking reflects a broader movement called the quantified self' involving the practice of gathering, recording and often sharing such data via social media. This paper suggests that these technologies reflect the imperative for individuals to take responsibility for their health, utilizing digital self-surveillance to do so, without due recognition to social inequalities. Whilst governments and health agencies are embracing the capacity of digital technology to create more cost-effective health care systems, there is also a need to question the trends towards self-surveillance processes as part of a preventative health approach. In doing so, the paper offers a critical analysis of wearable technologies, and their increasing dependency on the optimization and exploitation of data. We draw from the findings of small-scale study exploring the experiences of users of the wearable fitness band Nike FuelBand in the context of the formation of an online community. Indeed one established characteristic of these self-tracking technologies is the production of lateral surveillance, through which individuals keep track of one another through sharing data online. Furthermore, as these fitness bands reflect the entanglement of bodies and technologies, we consider the implications of the shift towards increasingly prostheticised technological practices within the social, political and cultural context of healthism.

Parallel session 3:
3.4 - Technologies and policies for healthy lives

The transhumanism utopia

Catherine Déchamp-Le Roux, Université de Lille1-Clersé, France

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Over the past twenty years, the medicalization of the ageing process, which started with biogerontology, has speeded up as a result of new paradigms ranging from prevention to the end of dying. These new slants on ageing and longevity have been defined differently depending on the scientific or pseudo-scientific trends concerned. We have identified three trends: biogerontology, anti-ageing medicine and transhumanism. The transhumanism movement puts forward the idea of a humanity that is enhanced and has overcome biological limitations thanks to emerging technologies. This utopia could reorientate research on human ageing in a social context that is increasingly preoccupied by the impact on health systems of ageing populations and the economic fallout with the developing bio-economy. Our hypothesis is that this increasingly publicized utopia reinforces the idea that both individuals and society as a whole must fight against the ageing paradigm, no longer considered unavoidable. There are two paradigmatic representations of the human, ageing and longevity that appear to be totally opposed, but the available empirical data is not enough to evaluate the impact on public authorities. Social and scientific legitimacy is at stake.

Key words: transhumanism, medicalization, anti-ageing medicine, social and scientific legitimacy.

Parallel session 3:
3.4 - Technologies and policies for healthy lives

‘I don’t want to see myself as a disabled person’: How technology constructs disabled identities

Dana Zarhin, Tel Aviv University, Israel

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Despite the close link between disabilities and technologies, only few analysts have explored the role of technology in the construction of disability. This article addresses this gap by examining how the recommended treatment for Obstructive Sleep Apnoea [OSA], the Continuous Positive Airway Pressure [CPAP] device, create ‘disabled identities.’ Drawing upon in-depth interviews with 61 Jewish-Israeli OSA patients, this article shows that CPAP devices constrain daily and nightly activities as well as bodily functions in a way that makes patients feel and see themselves as disabled. Specifically, the devices disturb users’ sleep and breathing, diminish their independence, and disfigure their appearance, thereby disrupting both the fleshy body and the culturally preferred image of healthy, independent and attractive individuals. In response, many patients reject this treatment. The analysis provides insight into public perceptions of disability and show that both corporeality and culture play a role in the construction and experience of disability.

Parallel session 3:
3.5 - Inequalities and social determinants of health

Global deterministic patterns of socio-economic determinants of neonatal mortality at the country level

Filippo Temporin, London School of Economics, United Kingdom

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Terje Eikemo

While determinants of infant and child mortality have received broad attention in literature, socio-economic factors impacting neonatal mortality have only recently interested demographers and health researchers. By making use of macro data for 39 developing countries, this study aims at assessing the influence of deprivation (measured as lack of electricity in household’s houses, expressing the condition of lack of basic human needs), income inequality, education, rurality and women’s empowerment on newborn mortality. Univariate and multivariate regressions are used to assess the impact of the variables on neonatal mortality.

Maternal education and rurality are found to be significant determinants. In particular, the three consequent steps of the schooling path have different effects on the outcome, from the negative one of lack of education until the positive trend of having attended secondary school in reducing neonatal death rates. On the other hand, the more rural is a country, the more its neonatal mortality rate tends to be high. Deprivation and income inequality are not found to be significant predictors of neonatal mortality. However, their interaction term expresses the fact that the effect of deprivation is significantly worsened in those countries with greater income inequality.

The same models have been applied to infant mortality. Once more the importance of rurality is highlighted, while income inequality is found to be a significant predictor. In fact, generally the main determinants of neonatal mortality are related to antenatal and delivery factors, while infant deaths are mostly affected by environmental factors. Inequality materializes itself through widespread adverse housing and sanitation conditions, inadequate investment in public goods and social and geographical segregation leading to a more difficult access to the health system. This set of determinants has therefore a role on infant mortality, while neonatal one is not affected due to its stronger relationship with intrauterine factors.

Parallel session 3:
3.5 - Inequalities and social determinants of health

Educational expansion and inequalities in mortality – Fixed-effects analysis using longitudinal data from 18 European populations

Olof Östergren, Centre for Health Equity Studies, Stockholm University / Karolinska Institutet, Sweden

Co-authors: Olle Lundberg, Rianne de Gelder, Johan P. Mackenbach; Stockholm University / Karolinska Institutet, Erasmus MC, Erasmus MC

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Terje Eikemo

During most of the past century, populations in Western societies have become increasingly well-educated. It has been suggested that this educational expansion has contributed to the widening of educational inequalities in health. The purpose of this paper is to empirically explore the association between changes in educational distribution and changes in the magnitude of educational inequalities in mortality. We hypothesized that a smaller proportion of low educated is associated with higher mortality among the low educated, and that a larger proportion of high educated is associated with higher mortality among the high educated.

Data on education and mortality from 18 populations across 16 European countries during several decades were collected as part of the Demetriq project. We fitted fixed-effects models with interaction terms between individual educational attainment and educational distribution as predictors of mortality, controlling for cross-population variation and temporal trends in mortality.

A smaller proportion of low educated was associated with higher mortality among the low educated among both men and women. A larger proportion of high educated was associated with higher mortality among women, but not among men. The results further indicate that inequalities in mortality are larger when the proportion of low educated is small and the proportion of high educated is large, both among men and women.

The results confirm that the educational expansion that has taken place over the last decades may have contributed to the observed increase in educational inequalities in mortality. We identified several possible mechanisms that could contribute to this finding. The specific processes that link educational expansion with mortality need further analysis on more detailed data.

Parallel session 3:
3.5 - Inequalities and social determinants of health

The Fundamental Causes of Death Theory, Medical Technologies and Inequalities in Mortality

Katalin Kovács, Hungarian Demographic Research Institute, Hungary

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Terje Eikemo

According to the “theory of fundamental causes of mortality”, resources – owned by the privileged groups of society – such as knowledge, money, power and beneficial social relations are flexible resources which can be used for improving and maintaining health. According to the theory the appearance of new knowledge and new medical technologies would lead to increasing inequalities in mortality from those causes which are influenced by these new technologies or knowledge.

In this paper we investigate education-specific correlates of cause-specific mortality with the spread of some of these new technologies in Hungary. We selected those major medical discoveries which offer proven benefits for mortality from one or more causes of death and about which at least partial data are available for Hungary. These include the spread of hypertension-lowering medications and beta-blockers, as well as two prevention measures (mammography and cervical cancer screening). The first intervention is expected to be associated with mortality from hypertension and stroke, the second with ischaemic heart disease, and the screening programme is obviously related to breast and cervical cancer mortality. We expect the following changes in mortality trends: a) the penetration period of the spread of the medications in the second part of the 2000s and b) the introduction of the pilot screenings in 1995 or 1997 or the introduction of national screening programmes in 2002 and in 2003.

According to the expectations we found some limited evidence corresponding to the penetration periods of the appropriate medications in education-specific mortality from stroke and ischaemic heart disease. We found controversial results for education-specific breast cancer mortality and no effect of the interventions on education-specific (and overall) mortality from hypertension and cervical cancer.

Parallel session 3:
3.6 - Gender and health

Gender experience in the context of rare disease : how the relatives play a role

Yannick Le Hénaff, Normandy University, France

Co-authors: Stéphane Heas

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Zofia Slonska

Little is known about how gender, gender relations, and the experience of disease interact within the context of rare disease. We try to understand the vulnerability processes that we observed among women, drawing on literature about biographical disruptions and about care. We examine how the disease can disturb the scripts of hegemonic femininity but also how gender shapes this experience.

Drawing on 41 in-depth interviews conducted with patients and their relatives (aged 36 to 91 including 8 men) observations in hospitals and association's meetings, we are interested in rare disease experiences, which are poorly documented in the social sciences ; and in particular Pemphigus, which is a dermatological condition.

Our findings reveal that support is very gendered, especially within family. This gendered commitment is overwhelmingly "naturalized", which serves as an unstated justification for the lower implication of the male caring partner. Our analysis also show that interviewees do value horizontal social support (husband) more than vertical social support (parents or children). They do so in order to maintain their parental identity. Partnership appears as being more an advantage for men than for women in coping with the disease. Men are less likely to take on the caregiver role. This is especially notable among couples in their 40s and 50s. Women are more likely to involve in the domestic health area, and that trend is being exacerbated by the children's presence in the household. This isolation process is favored by the relative invisibility of the symptoms, in particular the tiredness, which made difficult the legitimization of the sick role. However, relationships can evolve greatly over time and depend on many processes. Furthermore, as our findings highlights, some women stand out due to their capacity to form new emotional ties outside their inner circle of relatives.

Parallel session 3:
3.6 - Gender and health

Gender inequalities in health: Narratives of childhood cancer survivors

Agnes Dumas, INSERM, France

Co-authors: Isabelle Cailbault, Christophe Perrey, Odile Oberlin, Florent De Vathaire, Philippe Amiel;
INSERM and Gustave Roussy Institute

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Zofia Slonska

Background: It is well-established that, in terms of mortality, women are healthier than men. Several explanations have been advanced, including biological, behavioral, psychosocial, or socio-structural factors. By looking at gender rather than sex, constructivist theories have shown the importance of gender stereotypes in the doing of health. However, there is only little empirical evidence of a differential between men and women who experience the same condition.

Methods: Using a qualitative methodology, this study sought to describe the subjective experience of childhood cancer, as perceived by very-long term survivors. Study participants were French members of the Euro2K cohort, an international on-going cohort study which assesses adverse effects of cancer treatment. A sample was constructed using random selection. Eighty childhood cancer survivors were interviewed through in-depth interviews. An inductive approach in data analysis was used.

Results: Participants (38 women, 42 men) were 35 years old on average at time of study (mean time elapsed since diagnosis: 30 years). For half of respondents, cancer had been a form of taboo within the family, during childhood and beyond, in adulthood. The differences between men and women, in this regard, were substantial. While women tended to disagree with their parent’s attitudes, men tended to approve it, and felt that they had been protected by the silence of their parents. Furthermore, while women were concerned for their health, expressing fears for possible iatrogenic effects, men often reported not having "sought to know more" about their illness: a noticeable part of them ignored the type of cancer they had or the treatments they had received as children.

Conclusions: Prevention of cancer’s late effects supposes to know the kind of therapy used. In this context, male survivors of childhood cancer seem to be disadvantaged via agency, through an adherence to hegemonic masculinity.

Parallel session 3:
3.6 - Gender and health

The reversed gender gap and the education gradient in health: A cohort perspective

Katrijn Delaruelle, University of Ghent, Belgium

Co-authors: Veerle Buffel, Piet Bracke;
University of Ghent

Tuesday 28 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Zofia Slonska

In recent decades, researchers have specified the relationship between education and health for gender, thereby paying attention to the fact that both the socialization and allocation function of education may be conditioned by gender. In this research, however, we argue that such studies are not complete without considering the socio-historical context in which the gender-specific linking pathways unfold. It is hypothesized that the reversal of the gender gap in education has contributed to over-time changes in the mechanisms that link education to women's health, and accordingly, has affected the gender differential in the education-health association. To test this hypothesis, we apply a hierarchical age-period-cohort analysis (HAPC) under the assumption of certain period effect restrictions on data from 30 countries of the European Social Survey (7 waves: 2002–2014). Analyses are based on a subsample of individuals between 25 and 85 years of age (N =250,976) and are conducted for men and women separately. The results confirm our expectation: the gender gap in the educational health gradient can in no way be considered as time-invariant. In older cohorts, women received greater health returns to education than their male counterparts. However, along with the substantial increase in female participation in tertiary education, the favorable effect of education on women's health has decreased to such an extent that men now generally gain greater health-related benefits from a college degree. This reversal is mainly due to the weakened socialization role of education across female cohorts. The exploratory results presented in this study may serve as a basis for future research.

Parallel session 4:
4.1 - Social inequality, working conditions and health

The impact of Polish women's professional situation on their general life satisfaction

Aleksandra Piłat, Jagiellonian University Medical College, Poland

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Background: The aim of the study was to determine a possible correlation between the professional activity of Polish women and their psychological and social well-being in several ways, such as subjective assessment of health, stress, emotion including depression, anxiety and other. This correlation was compared with women who had never worked.

Methods: The analysis was performed on cross-sectional data from the Courage in Europe study carried out in 2011 and 2012. For the purpose of analysis interviews with 2370 women from Poland were taken into account. 2170 of them had worked prior to the research. At the time of the study 787 women were employed. Face to face interviews were conducted using the structured questionnaire and computer assisted personal interview (CAPI). Data were summarized and presented as frequency counts and percentages. Chi-squared test was used to observe the difference between working and non-working women and their psychological and social well-being. Pearson's correlation coefficients were computed between some aspects of life and job in general.

Results: Significant relationship was observed between analyzed dimensions of psychological and social well-being. In each age group, working women were more satisfied with their health. Much less often they had problems with everyday activity. Correlation is noticeable between professional activity and mental health. Employed respondents were less likely to experience anxiety and depression. They also didn't have any serious problem with falling asleep and frequent awakening at night, which can be interpreted as an indication of a lower level of stress. Professional life had a significant impact on their interpersonal relationship.

Conclusion: Professional activity gives a sense of stability, reduces stress, impacts on self-esteem.

Parallel session 4:
4.1 - Social inequality, working conditions and health

Years spent in stressful work and depressive symptoms after labour market exit – results from SHARE

Morten Wahrendorf, University of Duesseldorf, Germany

Co-authors: Nico Dragano, Hanno Hoven, David Blane, Tarani Chandola

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Background: A growing number of life course studies shows that repeated exposure to work stress is related to poorer health, suggesting a dose-response relationship. To extend this research we investigate the relationship between the number of years spent in a stressful job and number of depressive symptoms after labour market exit.

Methods: We use data from the Survey of Health, Ageing and Retirement in Europe (SHARE), with detailed retrospective information on previous working careers for 4996 retired men and 3903 women collected 2008/2009 in 13 European countries. This includes information on years worked in the most significant job between age 30 and 65 together with levels of work stress (as defined by low control and low reward). To measure health, we use number of depressive symptoms (EURO-D depression scale). We apply a flexible approach (polynomials) to analyse the relationship between years spent in a stressful job and depressive symptoms.

Results: For both men and women, findings indicate a non-linear relationship between years spent in a stressful job and levels of depressive symptoms, with a constant increase of depressive symptoms between 1 and 15 years spent in stressful work and a weakening effect thereafter. Findings remain consistent after excluding respondents with short working careers, poor health prior and during working life, and additionally, after adjusting for country, age, education, marital status and childhood adversity. Importantly, we also observe important selections into stressful job, where people with childhood adversity and with restricted opportunities on the labour market (e.g. low educational attainments) spend on average more years in a stressful job.

Conclusions: Our findings support that the cumulative exposure to work stress is related to poorer health during retirement, and additionally, that working more years in a stressful job is part of larger trajectories of disadvantages throughout the life course.

Parallel session 4:
4.1 - Social inequality, working conditions and health

How the Work Environment affects Health? The Role of Organisational Commitment

Jožica Zajc, University of Ljubljana, Faculty of Social Sciences, Kardeljeva ploščad 5, Slovenia

Co-authors: Matic Kavčič;
University of Ljubljana, Faculty of Health Sciences

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Background: Good health is important in all aspects of life and work is no exception. Working conditions are one of the most important social determinants of health. Therefore, it is crucial to study the work environment's impact on health and avoid circumstances that might cause it to deteriorate. This study contributes some new insights for understanding the importance of the work environment for people's health. The aim of the paper is to analyse how different factors from the work environment (stressful working conditions, mobbing, organisational commitment, job insecurity, satisfactory payment, optimism and empowerment) influence health.

Methods: The latest public opinion research about health and work environment, Slovenian public opinion SJM 2011/1 on a representative sample (N=1082) of adult Slovenian inhabitants was statistically analysed. Bivariate (Pearson r, t-test) and multivariate linear regression analyses were used.

Results: The multivariate linear regression model shows that mobbing (Beta=-0.153, p=0.001) significantly deteriorates health, while affective organisational commitment (Beta=0.131, p=0.043) influences on it positively. With a higher p-value, optimism (Beta=0.098, p=0.057) influences health positively, while stressful working conditions (Beta=-0.082, p=0.089) influence it negatively. Continuance and normative commitment, job insecurity, satisfactory payment, and empowerment have no significant effect on health in the regression model, although bivariate correlations show that those factors affect health.

Conclusions: As individuals spend most of their non-sleeping time working, it is important to work in conditions that promote rather than deteriorate health. For better health, it is important that employees like to work in their organisation (have a high affective commitment) and have a generally high level of optimism, while stressful working conditions and mobbing deteriorate health.

Parallel session 4:
4.1 - Social inequality, working conditions and health

Self-employed workers: a blind spot of studies? Lessons from a mixed-methods study

Agnes Dumas, French Institute of Health and Medical Research (INSERM), France

Co-authors: Isabelle Cailbault, Philippe Amiel;
Inserm, Gustave Roussy Institute

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1130, First floor
Session Chair: Espen Dahl & Johanna Muckenhuber

Background: In Europe, 17% of the individuals within the labour force are self-employed workers. All over Europe, because of both the growth of information and communication technologies and the economic crisis, there has been an increase in the use of subcontracting, including to self-employed workers. In addition, recent market deregulation policies have enabled more people to enter specific activities as self-employed workers in several European countries. However, very little is known on the interrelation of work and health for this category of workers. Self-employed workers are a special category of workers, not only because of their status, but also because of the diversity of professions and social situations that characterize them. Can the observations made on the health of employees apply to self-employed workers?

Methods: We conducted a mixed-methods study assessing the impact of cancer on work-related issues. A quantitative study was conducted with a nationally representative sample of French cancer survivors (n=2,718). A qualitative study was nested in the cohort study: 65 in-depth interviews were conducted with participants of the cohort study who were self-employed workers.

Results: Data of the cohort study showed that self-employed workers were less likely to take sickness leaves and that they were more likely to return to work than employees, even when accounting for their socioeconomic status. However, the qualitative study showed that indicators used in the quantitative study were inappropriate for self-employed workers, and did not account for the differences in working conditions between employees and self-employed workers.

Conclusions: When studying the relation between working conditions and health inequalities, specific indicators should be used to assess the situation of self-employed workers. Moreover, the results of this study highlight the need to pursue reforms that have been initiated in several European countries in order to increase the social protection of self-employed workers.

Parallel session 4:
4.2 - Reproductive health through the life course

Calibrating reproductive times: ARTs and the postponement of childbirth in the UK and Switzerland

Nolwenn Bühler, De Montfort University, United Kingdom

Co-authors: Irenee Daly;
De Montfort University, Leicester, UK.

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

In Euro-American societies the postponement of childbirth which puts women at risk of age-related infertility has increasingly become a matter of biopolitical concern. In addition, the right timing and age at which to have a child has become the nagging question at the core of individual women reproductive decisions. While women still live their lives against a personal and cultural backdrop which assumes they will become mothers, the decision to have children has become more complex. In response to "biological clock" discourses which point to the discrepancy between biological and social clocks, assisted reproductive technologies (ARTs) – and especially egg donation and egg freezing – have raised the prospect of liberating women from the constraints of biology and of enabling them to better synchronize conflicting temporalities. However, this promise has been criticized as creating false illusions encouraging women to postpone childbirth.

In order to contrast these public discourses, this paper, investigates the role played by ARTs in the rationalizations of women's decision to postpone childbirth and have a child. Drawing on two studies, one done in the UK, the other in Switzerland, it explores women's experiences of postponing childbearing. By focusing on two specific reproductive trajectories, we will highlight the role ARTs play in reproductive decision-making. We will specifically show how women navigate these conflicting temporalities, in their attempts to synchronize and calibrate better the social and biological constraints in their lives, and how the potential of ARTs to extend fertility is envisioned, experienced, and negotiated.

Parallel session 4:
4.2 - Reproductive health through the life course

Impact of Fertility Postponement on Waiting Time to Pregnancy and Reproductive Failure

Krzysztof Tymicki, Warsaw School of Economics, Poland

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

Changes in the timing of first birth constitute one of the most prominent and well-explored issues in modern demography. However, surprisingly little research has been focused on biological consequences of late reproduction. These consequences are related to so-called reproductive ageing which manifest itself in a significant and constant decrease in female fecundity beyond age of 30. We presume that late efforts to conceive might have a substantial effect on lengthening waiting time-to-pregnancy (number of ovulatory cycles preceding conception) and may lead in a extreme case to reproductive failure. It is also plausible to assume that late attempts to conceive leave less time for efficient ad successful use of assisted reproductive technologies. In the present study we aim at analysis of interrelation between fertility postponement and reproductive ageing measured by waiting-time-to-pregnancy. According to the main hypothesis, waiting time to pregnancy should increase with age of spouses. Using event history analysis we aim at finding the threshold age beyond which we observe increase in probability of reproductive failure. This threshold constitutes a natural limit to the postponement of reproduction. We use data from the first wave of the Polish GGS survey. In the standard GGS module on fertility we have included a set of questions aimed at measuring waiting time to pregnancy (from onset of deliberate efforts to conceive). The pilot study reveals that more than 70% of couples conceive within 3 ovulatory cycles of unprotected intercourse, although we observe a significantly lower rate of success (longer duration) for females over age of 30. Discussion of the results includes considerations concerning the effects of sub-fertility and reproductive failure on the increase in rates of involuntary childlessness and decrease in parity progression ratios. Furthermore we relate these issues to below replacement TFR and possible effects of reproductive ageing and late fertility on TFR.

Parallel session 4:
4.2 - Reproductive health through the life course

The medicalisation of infertility. Men's discourse between marginalisation and reproduction

Lia Lombardi, University of Milan, Italy

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2140, Second floor
Session Chair: Rozemarijn Dereuddre

BACKGROUND: Starting from the assumption that the discourses and practices related to infertility are part of the gender structure intrinsic in the social construction of health, this paper focuses on assisted reproductive technology (ART), and analyses, on the one hand, expert discourse and medical practices, and, on the other, patients' experience, thus portraying infertility as a socially and culturally constructed experience.

As a consequence, gender becomes a determining factor in the construction of sexual and reproductive pathology: while the male gender is mainly associated with sexuality, the female gender continues to be associated with reproduction. The emphasis on the medical and technological treatment of women's bodies reinforces and reproduces this stereotype, as shown in patients' narratives and in institutional discourse.

METHODS: This study draws on existing national and international literature and on secondary data. Men's narratives come from several qualitative studies, carried out with patients from three Italian infertility clinics (18 in-depth interviews).

RESULTS : Some significant issues emerge from the study:

a) Although data on male infertility are known, the issue is forgotten in public and medical discourse, and research on the topic is insufficient.

b) Men's involvement in the reproductive activity is not yet complete and this begs the question of "how and how much are they prepared to engage with it?", torn as they are between maintaining their hegemonic masculinity and their fathering role.

c) We are led to reflect on the future of gender differences and relationships. The question is: "could the new medical interest in the male reproductive functions add a further element to the already intricate picture of gender equality?"

d) Finally, we cannot overlook the social and cultural context in which ART is developing, both in relation to welfare policies aimed at parenting support, and in relation to stereotypes and prejudice towards infertility and gender roles.

Parallel session 4:
4.3 - Health professions in transition

Cultural Safety : Messages from the practice of Aboriginal Hospital Liaison Officers and Social Workers

Elizabeth Orr, La Trobe University, Australia

Co-authors: Helen Bnads;
Peninsula Health Network

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Creating cultural safety for Aboriginal people in hospitals in Australia is an implicit aim of Aboriginal health policy. The Australian Health Ministers' Advisory Council (AHMAC) Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (2004-2009) outlines an approach for all government jurisdictions, departments and funded services to create cultural respect, which is a prerequisite to cultural safety. The cultural respect framework aimed to influence corporate health governance, organizational management and the delivery of services in the Australian health care system. Increasing the Indigenous workforce and changing the culture of hospitals are additional elements in strategies to build cultural safety for Aboriginal people in the Australian health system.

Stories of practice from Aboriginal Hospital Liaison Officers (AHLOs) and Social Workers(SWs) provide anecdotal evidence about the translation of cultural respect into practice in hospitals. We will respectfully share messages for `good practice' from our work with Aboriginal patients/families and communities and highlights the challenges and rewards of AHLOs and SWs working together in hospitals. Drawing on the findings of one of the authors PhD research, we propose that Aboriginal and non-Aboriginal people working together as allies can not only improve the journey of Aboriginal people in hospitals but potentially create change from the ground up in hospital systems.

Ideas for continuing professional education of social workers and pathways for Aboriginal workers into higher education health courses will also be discussed with attendees at the presentation.

Parallel session 4:
4.3 - Health professions in transition

An Ethnography on the Landscape of Professional Relations: Reforms, Nurses and Cultural Politics

Ricardo A. Ayala, Department of Sociology, Ghent University, Belgium

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Current scholarship in the sociology of professions has given us fresh insights into the scenario of late 20th century reforms in healthcare and how this scenario has defied established organisational logics. This altered landscape is now the setting of transformations of the professions at the level of roles, relations, expectations, identities and cultural politics. This is an important case for more balanced forms of power relations between, for example, nursing and medicine.

By using ethnographic data from my doctoral research into the construction of nursing as a profession in Chile, this paper presents how contemporary nurses have set a new code of powers, and in the process liberated from and discarded old, tired values of preceding generations of nurses. The paper underscores that the success of, formerly-submissive, professions lies not only in the ability to adapt to their environment but also to manipulate it – different languages, principles, ideals, commitments; these are all part of nurses' new ideological device for controlling its power base.

Parallel session 4:
4.3 - Health professions in transition

Towards a modified socio-ecological model for community-based HIV care

Caroline Masquillier, University of Antwerp, Belgium

Co-authors: Edwin Wouters, Dimitri Mortelmans, Brian van Wyk, Harry Hausler, Wim Van Damme;
University of Antwerp, University of Antwerp, University of the Western Cape, TB/HIV Care Association, Institute of Tropical Medicine

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

As a chronic illness, HIV/AIDS requires life-long treatment adherence and thus sufficient attention to the psychosocial dimensions of chronic disease care. Within the context of human resource shortages, mobilizing community health workers (CHWs) has become an important strategy to provide long-term encompassing treatment and support for the growing number of HIV patients. This community-based support moves care closer to the person living with HIV/AIDS (PLWHA) and his/her social environment. Inspired by the 'socio-ecological theory', and more specifically the 'Individual-Family-Community-model', there is a need to investigate community-based treatment adherence support within the context of the household.

During the participatory observations, 48 community based treatment adherence support sessions in patient's houses were observed in a township on the outskirts of Cape Town, South Africa. Furthermore, 32 in-depth interviews were conducted with PLWHA, as well as 4 focus group discussions with 36 CHWs. By making use of Nvivo 10, the data was analyzed carefully in accordance with the Grounded Theory procedures.

This study presents a modified socio-ecological model for community-based HIV care, by integrating the sociological concepts of 'a patient with a hybrid identity' and 'HIV/AIDS competent contexts'. Results show that we should not only focus on the dominant community-level approach but also on the household level when building HIV/AIDS competent environments that enable and support the PLWHA's choice of health-enhancing practices. Furthermore, results indicate that community-based adherence support should be sensitive to the household context in which it is implemented to provide sustainable support to PLWHA on his or her care continuum. The proposed theoretical model could guide future HIV/AIDS research through insights into the importance of a health-enabling context in providing sustainable support for PLWHA. This theoretical framework on the facilitators of and impediments to lasting success of ART is essential, as antiretroviral treatment cohorts continue to expand in resource-constrained contexts.

Parallel session 4:
4.4 - Technologies and policies for healthy lives

Assistive technologies or technologies which assist: Conceptual insights from a dis/embedded ethnography in ATTILA

Matthew Lariviere, University of East Anglia, United Kingdom

Co-authors: Fiona Poland, Chris Fox;
University of East Anglia

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Assistive technology and telecare are championed by British policy makers as the panacea to helping people with disabilities remain and retain functional capacity to complete everyday activities. However, the recent negative outcomes from the Whole System Demonstrator trial which examined how effective telecare was for people with COPD, diabetes and unmet social care needs has cast doubt on the presumed effectiveness of assistive technology and telecare. ATTILA is an ongoing pragmatic randomised controlled trial which builds on the early evidence generated by the Whole System Demonstrator by evidencing whether people with dementia using assistive technology and telecare in their own homes can delay permanent moves into residential care. We argue that the complexity of assistive technology requires significant insight into the everyday lives of service users in order to help determine its effectiveness or, indeed, how effectiveness is meaningfully created in situ. We draw on ethnographic work with nine households taking part in ATTILA to examine in what ways and to what extent assistive technologies assist people with dementia or their unpaid carers with everyday life. We critically examine ethnographic fieldnotes to frame carers and people with dementia as bricoleurs engaged in adapting mass-produced devices to fit within their individual, lived socio-material realities. We additionally explore how and to what extent technology excluded from the scope of the trial ranging from therapeutic devices prescribed by occupational therapists to mundane, everyday, material objects can potentially "assist" by helping to maintain functionality and promote independence in different ways from electronic assistive technology studied within the trial. We suggest that many mundane, material objects may help to promote the livelihood and functionality of people with dementia and their informal carers whilst prescribed electronic assistive technology may introduce new challenges leading to their abandonment or require adaptation to appropriately match local needs.

Parallel session 4:
4.4 - Technologies and policies for healthy lives

Wearable Health Technologies for older, chronically ill patients

Katja von Storch, University of Cologne, Germany

Co-authors: Anna Schlomann, Christian Rietz, Maria Cristina Polidori-Nelles, Christiane Woopen;
University of Cologne, University of Cologne, University Hospital of Cologne, University of Cologne

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Current technological development creates promising perspectives for today's health care. The integration of technical devices provides new opportunities for improving quality of life and well-being, especially in older subjects with or at high risk of disability. Current research focuses on the technical feasibility and usability of wearable health technologies (WHT). Reliable data about psycho-social factors influencing the usage of WHT and subjective experiences of patients are largely missing. In order to fill this gap of knowledge, a prospective study is currently being performed consisting of a qualitative information collection on patients' perspectives and expectations with respect to WHT in advanced age. The observations gained through this first part of the project will be used to define the design of an intervention step to address efficacy and tolerability of a simple wearable tool in the aged as far as well-being and disease-relevant basic vital parameters are concerned.

The first part of the study is currently ongoing and first insights about possible factors influencing the usage of WHT are being gained. Ten elderly cardiovascular and diabetes type 2 patients (above 65 years old) as well as five relatives and five family physicians each undergo a semi-structured questionnaire-mediated collection of information on attitudes, experiences and expectations on WHT.

As early findings showed a broad spectrum of WHT use-impacting factors, we expect to identify specific information regarding each stakeholder group under study. Personal attitudes will be grouped and correlated to the results of the second part of the study to identify possible associations between stakeholders' expectations and efficacy of device intervention. These may in turn prove a reliable tool for clinical decision-making and well-being improvement in the elderly.

Parallel session 4:
4.4 - Technologies and policies for healthy lives

Acceptance factors of assistive technologies on smartphones amongst older adults in Slovenia

Andraž Petrovčič, University of Ljubljana, Faculty of Social Sciences, Slovenia

Co-authors: Nejc Berzelak, Vesna Dolničar;
University of Ljubljana Faculty of Social Sciences

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

With the uptake of information and communication technology (ICT) various assistive technologies (ATs) have been developed with the aim of facilitating the coping of older adults with their social and health conditions as well as of easing the burden of (informal) carers in providing assistance to care receivers. However, many of the ICT-based ATs, such as sensor-based smart home systems – which can provide real-time and continuous support and, therefore, allow older adults to live longer at home independently – were not massively adopted by end-users. On one hand, the scarce uptake stems from the material constraints related to technical requirements and financial investments needed for such ATs to be adopted by end-users. On the other hand, such solutions have been seldom recognized as user-friendly in the sense of being accessible and understandable for older adults as well as of being designed to fit well with their health and social care needs.

Alternatively, scholars have recently suggested that smartphones could represent a potential vessel for a more wide-spread adoption of ATs. A smartphone has become a very common personal device also among older adults. It can be used not only as a communication device but can also be extended into an AT for health care and social support purposes by developing mobile applications (apps) which take advantage of integrated sensors (e.g., accelerometer, GPS, gyroscope). In fact, many smartphone apps with integrated ATs for older adults are already available on the market.

Surprisingly, however, little is known about acceptance factors of ATs on smartphones. Prior research mostly focuses either on the acceptance of smartphones amongst older adults or investigates the adoption of stand-alone ATs. Hence, the aim of this study is threefold. First, drawing on the Technology Acceptance Model (TAM) it shall provide a systematic overview of factors associated with the adoption of smartphones and ATs amongst older adults. Second, it will present an integrated theoretical model with a set of hypotheses related to acceptance factors of ATs on smartphones. Lastly, the study will empirically test the model for a nation-wide survey data sample of 1600 older adults aged 55 and above, collected in Slovenia in December 2015. In addition to the verification of the hypotheses, the results of the structural equation models will be used to discuss the limits and possible future research directions in the field.

Parallel session 4:
4.4 - Technologies and policies for healthy lives

A longitudinal, qualitative exploration of patients' and carers' perceptions of potential telehealth use in Chronic Obstructive Pulmonary Disease (COPD)

Lisa Brunton, The University of Manchester, United Kingdom

Co-authors: Peter Bower, Cees van Berkel, Caroline Sanders;
The University of Manchester, Philips UK, The University of Manchester

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Chronic Obstructive Pulmonary Disease (COPD) is a condition causing debilitating symptoms (such as breathlessness) and has a high prevalence associated with material disadvantage. It is costly for Governments, being a major cause of emergency hospital admissions. Policy makers have promoted the use of remote monitoring technologies (such as telehealth) in order to reduce healthcare burden and promote improved self-management. There is some research to suggest that telehealth can be useful for COPD management, but there remain barriers to its uptake and sustained use. Previous sociological research has emphasised the importance of social context and relationship networks in defining adoption and use. A PhD study is underway to explore the barriers to using such technologies from a [potential] user perspective: patients, their informal carers and health professionals. Findings from longitudinal interviews conducted within the study will be presented. These aimed to gain a deep understanding of patients' needs of living with COPD over time, and to explore how remote monitoring technologies may help at different stages of the illness trajectory. 22 people with COPD and 7 of their informal carers were interviewed 3 times over a 9 month period. Thematic analysis, informed by a grounded theory approach is underway. Early findings indicate that (consistent with previous sociological research on chronic illness) people with unstable or more severe COPD experience 'good days and bad days' and respondents expressed a need for care that adapts and responds to the changes in their illness over time and social context. Therefore, respondents indicated a preference for 'personalised care' and telehealth that promotes 'social connectedness' with health professionals. Informal carers influence help seeking in emergency care and there is potential for them to play a greater role in the use of telehealth. Findings will have implications for the future design of technologies and implementation of services.

Parallel session 4:
4.5 - Inequalities and social determinants of health

The effect of growing up poor on early child development in Flanders – cohorts 2006 – 2009.

Lieselot De Keyser, Ghent University, Belgium

Co-authors: Ronan Van Rossem;
Ghent University

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M2150, Second floor
Session Chair: Terje Eikemo

Background. Early childhood is often to be the most important developmental phase throughout one's lifespan. Many studies have demonstrated that the socio-economic deprivation of a household negatively affects the neo- and perinatal health of children born into these households. This paper examines to what extent the socio-economic household background – measured by a poverty index and maternal education - influences birth characteristics and the physical development of young children during the first three years of their life. Methods. The administrative IKAROS dataset registers longitudinal data on the development of nearly all children in Flanders. The study uses data of children born between 2006 – 2009 (N = 291.230), which covers N=2.949.169 check-ups during the first three years of life. Physical health is operationalized by 2 parameters : weight-for-age and height-for-age. Poverty-risk is measured as an index, based on 6 household deprivation indicators : income, education, employment, stimulation, housing and health status. Results. First, maternal education better predicts differences in both weight- and height development than the poverty index does. Second, despite that differences are relatively small in present-day society, the size of the differences is more or less consistent during the measurement period. Third, the weight development of children of low-educated mothers is during the first six months a little retarded. From then on, these children overcompensate with higher weight-for-age z-scores than children of higher educated mothers. Discussion. Despite all initiatives in Flanders to reduce the effects of socio-economic inequalities on child development, a social gradient is still observable in the physical development of young children. As health problems early in life may be predictors of health status later in life, monitoring of all children from the conception on must remain a policy priority.

Parallel session 4:
4.5 - Inequalities and social determinants of health

Different health, similar disease: A cross-national study of SRH variation across educational levels with similar chronic conditions

Mirza Balaj, Department of Sociology and Political Science-NTNU, Norway

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M2150, Second floor
Session Chair: Terje Eikemo

Self-reported health (SRH) is frequently used to measure socioeconomic inequalities in health. While SRH has been shown to be a reliable marker of objective health, there can be a range of social, material and behavioral factors, which influence how people report the status of their health. In this study, we examine the relationship between chronic disease and SRH across different educational groups. Using data on 14 countries from the European Social Survey, our aim is to see whether there are cross-national differences in how SRH varies by educational group for people with similar experiences of chronic disease. Predicted probabilities are employed to determine the variation in self-reports of poor health by educational level given similar experiences of chronic diseases. Cross-national differences in this relationship might be explained by equivalent differences in living conditions, health behaviors or to the social environment of countries more broadly. By utilizing a regression-approach to examine the effects of individual-level on self-rated health, we add to the existing literature on health variances between European countries. To our knowledge, this is the first study to undertake such an analysis.

Parallel session 4:
4.6 - Gender and health

Is gender equality beneficial for quality of life? Results from Polish-Norwegian GEQ study

Barbara Wozniak, Jagiellonian University Medical College, Poland

Co-authors: Ewa Krzaklewska, Piotr Brzyski,
Øystein Gullvåg Holter;
Jagiellonian University, Jagiellonian University Medical College,
University of Oslo

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1160, First floor
Session Chair: Zofia Slonska

GEQ project aimed to investigate gender equality (GE) and the benefits it has for quality of life (QoL) in Poland as well as to compare the Polish results with the outcomes from Norway (study conducted by Holter in 2007). The study was based on a Norwegian method of measuring GE. The aim of the presentation is to discuss results of the survey conducted in Poland and to verify hypotheses on the relationship between GE and self-assessed QoL in men and women.

Material and methods: The sample population consisted of 1501 individuals that were randomly selected from the population of Poland. Data was collected in 2015 using a structured questionnaire including comprehensive measurements of GE and QoL. The following aspects of GE were covered: GE practices, GE attitudes, male-dominated resource distribution in couple, traditional gender formation and GE in childhood/youth. Self-assessed QoL was measured with use of GESQoLS index, covering 6 dimensions of QoL, which are as follows: somatic functioning, psychological well-being, social relations, material conditions, environment and life satisfaction. Statistical analyses were performed including SEM and regression analyses.

Results: Significant relationships were observed (for both men and women) between analyzed dimensions of QoL and each of the studied aspects of GE; particularly GE practices and GE attitudes were positively related to QoL. In both genders GE practices significantly influenced social and environmental dimensions of QoL; additionally GE practices were related to somatic functioning, life satisfaction and material conditions in women and with psychological well-being in men. GE attitudes significantly influenced somatic functioning, psychological well-being, social relations and life satisfaction in both genders. Environmental dimension of QoL was significantly related to resource distribution in couple and GE in childhood and youth.

Conclusions: Results from GEQ survey allow us to conclude that GE is beneficial for both men and women' QoL.

Parallel session 4:
4.6 - Gender and health

Lay consultation for illness symptoms: the role of gender, partnership status, and type of illness

Dorothea Böhr, University of Siegen, France

Co-authors: Nadine Reibling;
University of Siegen

Tuesday 28 June 2016
Time: 10:30am-12pm
Room: M1160, First floor
Session Chair: Zofia Slonska

When facing illness symptoms, consulting with one's social network is a major strategy for individuals to cope with illness. Empirical studies show that at least half the people contact their network regarding medical issues. Gender and relationship status strongly shape if, when, and who is contacted for discussing illness symptoms. Moreover, both men and women are more likely to discuss health issues with women demonstrating the strong role female network ties have for illness behavior. The present study investigates these patterns of network consultation.

The analysis is based on a novel dataset from the HEALSEE study, a representative survey of 3.000 Germans between 40 and 75 years old that experienced back pain, sleeping problems, or intestinal problems within the past three months. The present study uses descriptive analysis and multivariate logistic regression to investigate patterns of network consultation by gender, relationship status, different illness symptoms, and their characteristics (sensitivity, duration).

Gender plays an important role in the frequency and likelihood to consult the social network. Women are generally more likely to seek advice and contact more people, not only within the family but also friends and acquaintances. Additionally women have a higher likelihood to be the source for advice – both for man and women. The partner is often the first person for people in relationships to be asked for advice or help. People who don't have a partner are less likely to consult anyone and if they are, it's more likely to be a friend. Finally the kind of health issue is a crucial factor. People are more likely to talk about somatic than psychological symptoms.

The findings suggest that female relatives play the key role in lay consultation. This implicates the importance of recognizing the network's involvement when analyzing patient behavior surrounding diagnosis and treatment of minor symptoms.

Parallel session 4:
4.6 - Gender and health

Gender-related healthy ageing in Switzerland: subjective and objective health evaluations

Valentina Shipovskaya, University of Zurich, Institute of Sociology, Switzerland

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M1160, First floor
Session Chair: Zofia Slonska

Differences in longevity between the genders indicate the quality of demographic longevity in a country. Healthy ageing is closely connected to the general quality of life and involvement with the social environment. Men and women have different social preconditions with regard to healthy ageing, and therefore different benefits and risks. The purpose of this research has been to test empirically whether and how subjective and objective health differs among the population at the age of 50-plus by gender.

The analysis is based on the data for Switzerland, 1462 observations, from the Survey of Health, Ageing and Retirement in Europe (SHARE), which was released in 2006. A cross-sectional linear multivariate regression analysis for men and women has been conducted to estimate the impact of subjective self-reported health and objective evaluation (grip strength indicator). The independent variables refer to sociodemographic and socioeconomic status.

The data shows, that there are gender specific resources for healthy ageing and that the interdependence between subjective and objective health by gender differs. Women tend to accumulate health risks over the course of their lives to a greater degree, but might demonstrate "the subjective well-being paradox in old age". The additional bivariate analysis of objective and subjective health deficit has shown that while women have more objective health problems, they are healthier subjectively. Moreover, the biomarker demonstrates that the decline of women's grip strengths is almost linear with age.

The different effects of the combination between social involvement and social status on human health show the necessity of gender-oriented support policies in context of the active ageing policy framework in Europe. The contribution of this paper lies in highlighting (1) the gendered nature of ageing and health related previous life course events; and (2) the methodological importance of gender-sensitive interpretation of biomarkers.

Parallel session 4:
4.7 - Life course perspective on health: trajectories and transitions

Critiquing 'successful ageing' for a new ageing population: the case of cystic fibrosis

Karen Lowton, University of Sussex, United Kingdom

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Stéphane Cullati

Better understanding of rare or complex conditions and medical innovations that gathered speed in the second half of the 20th century have enabled life extension into adulthood for many groups of people, such as those with congenital heart disease, Down's syndrome or cystic fibrosis (CF), the most common autosomal recessive genetic disorder in Caucasian people. When CF was first described in 1938, average survival was less than one year. Today however, more adults than children live with the condition. Furthermore, median age of death of those with CF (currently 26 years in the UK), is rising at a rate faster than that of the general population in many Western countries, with those born at the beginning of this century predicted to live into their fifth decade. However, there is still no 'cure' for this condition, and with older age come significant chronic and complex associated health conditions, such as osteoporosis, CF-related diabetes, urinary incontinence in women, and obligations to maintain health, such as managing polypharmacy and attending regular clinic appointments. Furthermore, recent epidemiological work has suggested that social inequalities now influence the health outcomes and life expectancy of those with this genetic condition. This presentation draws on the gerontological theory of 'successful ageing' to locate older people with CF in the context of those of a more 'traditional' old age, with regard to experiences and expectations of health and receipt of care in later life.

Parallel session 4:
4.7 - Life course perspective on health: trajectories and transitions

Could you draw a picture of your illness? Insights from arthritis and renal insufficiency experiences

Carla Ribeiro, Institute of Sociology,
University of Neuchâtel, Switzerland

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Stéphane Cullati

Throughout the experience of illness trajectory, patients construct meanings in order to cope with illness, treatments and illness' consequences in everyday life. These meanings emerge from the way patients interpret their illness, the treatments and the interactions with medical professionals, family and other social actors, that occur in different contexts of life. This paper explores illness meanings from patients suffering either from arthritis or renal insufficiency, expressed, in the course of illness narratives, as images. Data comes from a study analysing the subjective experience of living with a chronic illness. The study was based on a longitudinal biographical approach, with qualitative biographical interviews. Our analysis shows that either for patients suffering from arthritis or patients suffering from renal insufficiency the uncertainty and unpredictability of the illness trajectory leads to meanings changes and thus to the change of the images that represents illness experience. Yet, for patients suffering from arthritis illness images are centred on pain and disability, while for patients suffering from renal insufficiency, the images are centered on treatments' characteristics, their regularity and the possibility of death.

Parallel session 4:
4.7 - Life course perspective on health: trajectories and transitions

Impact of living conditions on the perception of turning points in one's health: the case of Mumbai (India)

Aude Martenot, University of Geneva, Switzerland

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Stéphane Cullati

Ulrich Beck underlines that developing countries are more affected by the "new risk society". Thus, there is a high conjunction between poverty and other forms of vulnerability, corruption, and accumulation of hazards; social inequalities being widened and deepened by risks. In this presentation we consider the individual perception of the main turning points in one's life in a megacity of the South: Mumbai. In the subjective reconstruction of major turning points in the Western world, family history tends to prevail over health, educational and professional trajectories. Therefore, we enquire is: "In the memories of people living in Mumbai, facing persistent urban poverty, what is the presence of health?"

The analyses that we draw on for this presentation are based on two surveys conducted in the slums of Bandra East in 2012 and in the formal neighbourhood of Santa Cruz in 2014, both parts of Mumbai. There were interviewed approximately 1250 men and women aged 20-84 years, using questionnaires on the subjective perception of the life course. We compare the most significant turning points that these people considered as relevant. We look at the effects of age at the time of the survey (a cohort effect), of living conditions (comparing the two surveys) and of gender on the memory of accidents or diseases affecting the respondent or significant others.

Previous research identified a health phenomenon named the "double burden of disease" that disproportionately affects poor people in developing countries. This phenomenon is characterized by an increased risk of infectious diseases early in life and is cumulative, usually after a migration to unhealthy and polluted urban areas, with high susceptibility to develop cancer, diabetes and other chronic diseases. Thus, our main hypothesis is that these multiple burdens of diseases are a reality especially for slum dwellers.

Parallel session 4:
4.7 - Life course perspective on health: trajectories and transitions

Embodiment across childhood: understanding how health inequalities are produced and reproduced

Michelle Kelly-Irving, UMR 1027 INSERM, France

Co-authors: Cyrille Delpierre;
UMR 1027 INSERM, Toulouse, France

Tuesday 28 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Stéphane Cullati

The aim of this work is to use lifecourse theory to examine the early environment from the first moments of life to the beginning of adulthood, to define the concept of embodiment. Such a definition is helpful for formulating research questions and generating hypotheses in the study of health inequalities and how they become formed both over a life span and between generations. In the study of health over the lifecourse, previous authors have defined embodiment as the way in which the environment alters the body. Here, an interdisciplinary approach guided by lifecourse theory was used to examine and classify the environment in early life via a methodological workshop where researchers from different disciplines (sociology, demography, psychology, epidemiology, medicine) were asked to construct and then deconstruct lifecourses using vignettes. This work led to a definition of embodiment as consisting of three essential components. First, the early life environment was described as consisting of elements that may have direct or indirect effects on health in multilayered forms, an ecosocial or ecological systems perspective. Second, that elements of the environment interact via mechanisms to produce a biological response. Third, that the timing of the occurrence of these mechanisms in terms of human developmental processes and lifecourse transitions may alter the nature and effect of the mechanism and thus the subsequent response. The three components together form the embodiment dynamic, which occurs differentially in terms of the outer social-structural layers of the environment thus between populations. This definition of embodiment reformulates the concepts of programming, critical periods and accumulation in the classic lifecourse epidemiology framework, favouring the development of hypotheses that identify environmental elements and mechanisms leading to biological responses. In this way, the social-to-biological transition and how it produces health inequalities may be examined via specific and plausible hypotheses.

Poster session

Prenatal diagnosis. From medical practice framework to anticipation of disability. Comparison between France and Brazil

Veronique Mirlesse, HUG, Switzerland

Co-authors: Isabelle Ville;
Cermes3- Inserm- EHESS Paris France

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

Our research examines and compares prenatal diagnosis (PND) practices in France and Brazil once a fetal anomaly has been diagnosed. In Europe and North America, PND has developed directly in line with legislation on abortion and rooted the monitoring of pregnancy, as a way of preventing disability at birth. Its expansion to countries where access to abortion is restricted, as in Brazil, is led by the globalization of knowledge and techniques, and has to be adapted to local regulations.

These regulatory mechanisms affect not only how technical tools are used but also how the information is given to couples. Our objective was to analyse how the anticipation of disability emerges during the consultations. Our research is based on ethnographic observations led in reference centers for fetal malformations in France and Brazil.

During prenatal consultations, the anticipation of a disability systematically brings out fears of mental retardation and of the suffering which will be caused to the child, the couple or siblings, but our qualitative analysis shows that, in France, doctors use evidence-based medicine to inform couples and to reduce risks and uncertainties with a view to making a necessary choice to follow or interrupt the pregnancy. In public hospitals in Brazil, there is a different hierarchy of priorities: the primary focus is that of becoming a mother and having a life-born child. Risk is presented as being part of life and the dynamic aspects of medical uncertainty safeguard the future of the “sick” child within its family.

These differentiated approaches to risk and disability lead us to consider recent evolutions in the field of disability which have so far had little impact on PND. These evolutions consider disability to be a dynamic process resulting from an interaction between a given state of health and a given social situation.

Poster session

Sadness and depression: pragmatic medicalization in everyday life

Christian Bröer, University of Amsterdam, The Netherlands

Co-authors: Broos Besselling, Free University, Amsterdam, The Netherlands

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

This research addresses the impact of medicalization on social situations outside the clinical realm and among non-patients. It transcends biological and social determinism to put forward pragmatic medicalization as an outcome of the dialectical relationship between everyday life concerns and mental health institutions. This paper analyzes everyday social interactions concerning low mood and interrogates the hypothesis that the expansion of medical diagnosis and treatment has transformed common sadness into clinical depression. It charts the extent of and variations in medicalization and searches for interactional mechanisms driving medicalization.

The analysis is based on 316 observations of everyday life in the Netherlands, gathered with a purpose-built observational log. We observed and recorded interactions and situations in which sadness or depression were spontaneously expressed or referred to. The analysis shows that a psycho-medical approach to low mood is common in everyday life. However, sadness is not fully medicalized: sadness is partly reclaimed against medicalization, clinical definitions and treatment become normalized and less clinical in the process and sadness can be unrelated to clinical definitions and treatments. This happens while people are dealing with specific problems of everyday life. People’s most pressing concern seems to be how to make sense of low mood in the first place, even in cases of medicalization. This means that the availability of medical categories and treatment has not fully solved pragmatic concerns. We interpret this as part of the ongoing societal and clinical debates about the validity of depression. Across medicalized and non-medicalized contexts, a norm of happiness and active citizenship seems prominent, which thus seems to be a necessary but insufficient condition for medicalization. Yet, interactional conflicts with non-kin seem to push towards medicalization. The findings are clinically relevant in that they give access to lived concerns and demonstrate that depression diagnosis and treatment options only to some degree aid people in making sense of low mood in everyday life.

Poster session

Empowering civil actors for prevention and health-promotion under the Prevention Act in Germany

Lea-Sophie Borgmann, Berlin Institute of Public Health, Germany

Co-authors: Esther Kluba, Mathias Krisam, Frauke Gundlach; World Health Organization, Charité Berlin, Werner-Forßmann-Krankenhaus Eberswalde

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

In 2015, the German Government passed a new law on prevention and health-promotion (PHP) in order to increase disease prevention and health promotion activities for the following settings: day-care facilities for children, schools, small and mid-sized enterprises, nursing facilities and communities. As emphasized in the 1997 Jakarta Declaration of the WHO, the setting approach is crucial for targeting core groups and tackling health inequalities, which are usually neglected by common PHP programs.

The wide range of programs and activities existing in Germany appears across several online platforms and databases. However, these resources, run by public PHP stakeholders embedded in a complex network, make it difficult for setting-based actors to get the appropriate information and support in order to initiate, execute, fund and evaluate their low-threshold preventative projects.

By conducting qualitative research (stakeholder interviews and reviews of databases of PHP programs), the authors will summarize and channel these sources of information to provide guidance for the respective actors. They will create an innovative and intuitive online platform with information on approved Good-Practice PHP programs, including information on launching, funding, implementing, and evaluating civil actors' projects. This information and support will be tailored and adapted for each respective setting. A prototype will be designed for the setting 'schools' and is currently in progress.

Poster session

Barriers to health eating in Switzerland: a nationwide study

Carlos de Mestral, Institute of Social and Preventive Medicine (IUMSP), Switzerland

Co-authors: Silvia Stringhini, Pedro Marques-Vidal; Institute of Social and Preventive Medicine (IUMSP), Lausanne University Hospital (CHUV), Internal Medicine, Department of Internal Medicine, Lausanne University Hospital (CHUV)

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

Background: Several barriers can hinder healthy eating in the population. We aimed to assess the prevalence of self-reported barriers to healthy eating in Switzerland and examine their socioeconomic and demographic determinants.

Design: Using representative cross-sectional data from the national Swiss Health Survey 2012, we assessed, separately by gender, the prevalence of ten barriers to healthy eating and their association with demographic and socioeconomic determinants.

Results: The most prevalent barriers were “price” (43.2% in women, 35.8% in men), “daily habits, constraints” (39.8%, 37.5%), “fondness of good food” (38.8%, 51.0%), “time constraint” (34.8%, 29.0%) and “lack of willpower” (22.0%, 21.2%). The prevalence of most barriers decreased with age both for genders, increased for “fondness of good food” and remained constant for “price.” After multivariable adjustment, obese participants were more likely to report “fondness of good food” [Odds ratio (95% confidence interval) for obese vs. normal weight women and men, respectively: 1.63 (1.38-1.91), 2.02 (1.72-2.38)]. Participants with lower education were more likely to report “fondness of good food” [mandatory vs. tertiary women and men, respectively: 1.93 (1.62-2.39), 1.51 (1.26-1.81)], but less likely to report “lack of willpower” [0.45 (0.38-0.55), 0.40 (0.33-0.49)] and “time constraint” [0.61 (0.51-0.73), 0.78 (0.63-0.96)]. Participants with lower income were more likely to report “price” [lowest vs. highest quartile for women and men, respectively, 1.65 (1.43-1.90), 1.47 (1.26-1.71)] but less likely to report “lack of willpower” [0.71 (0.61-0.82), 0.40 (0.33-0.49)].Smoking, living situation, nationality and living area showed little or no association.

Conclusion: Several barriers to healthy eating were highly prevalent regardless of gender; the most important determinants were age, obesity, education and income, with different effects for each barrier. Our findings represent a public health challenge for which multi-faceted interventions are needed to simultaneously tackle several barriers.

Poster session

Childhood adversities and socioeconomic position as predictors of leisure-time physical inactivity in early adulthood

Laura Kestilä, National Institute for Health and Welfare (THL), Finland

Co-authors: Mäki-Opas Tomi, Kunst Anton, Borodulin Katja, Rahkonen Ossi ja Prättälä Ritva;
National Institute for Health and Welfare (THL), University of Amsterdam, National Institute for Health and Welfare (THL), University of Helsinki, National Institute for Health and Welfare (THL)

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

BACKGROUND:

Limited knowledge exists on how childhood social, health-related and economic circumstances predict adult physical inactivity. Our aim was a) to examine how various childhood adversities and living conditions predict leisure-time physical inactivity in early adulthood and b) to find out whether these associations are mediated through the respondent's own education.

METHODS:

Young adults aged 18-29 were used from the Health 2000 Study of the Finnish. The cross-sectional data were based on interviews and questionnaires including retrospective information on childhood circumstances. The analyses were carried out on 68% of the original sample (N = 1894). The outcome measure was leisure-time physical inactivity.

RESULTS:

Only a few of the 11 childhood adversities were related with physical activity in early adulthood. Having been bullied at school was associated with physical inactivity independently of the other childhood circumstances and the respondent's own education. Low parental education predicted leisure-time physical inactivity in men and the association was mediated by the respondent's own education. Respondents with only primary or vocational education were more likely to be physically inactive during leisure-time compared with those with secondary or higher education.

CONCLUSIONS:

There is some evidence that few specific childhood adversities, especially bullying at school, have long-lasting effects on physical activity levels.

Poster session

Role of Cultural Beliefs on Diabetes Self-Management Among Black African Population in the UK

Damilola Oyewole, Nottingham Trent University, United Kingdom

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

The research draws on a qualitative study to identify the impact of cultural beliefs on self-management behaviours and the significance of sociocultural approaches to health and illness among Black African people with type 2 diabetes. The study will examine lay perspectives and how they can contribute toward reformulating diabetes management policy in the UK in order to reduce health inequalities.

Type 2 Diabetes is a significant public health issue and one of the growing health problems particularly among Black African community, which presents a multi-faceted challenge to health care systems and expenditure in the UK. There are evidences that people from African descent with type 2 diabetes has poor health outcomes. Behavioural changes approaches to health promotion have increasingly been influenced by social, economic and collective model of health. However, the role of culture and health beliefs is yet to be integrated into such an approach when working with the Black African community in the UK. Realizing the multi-faceted nature of type 2 diabetes, integrated, cohesive and holistic approaches shaped by a sociocultural perspectives are important for promoting self-management practices among people with type 2 diabetes to avert any long-term complications, improve diabetes care delivery and reduce health inequalities.

Data will be collected through interviews conducted amongst the Black African community who live with type 2 diabetes and then, also, health practitioners to examine the difference in cultural understanding and interpretation of diabetes self-management behaviour within the cultural group. Better understanding of the relationship between the contextual determinants of healthy behaviours and outcomes among people with type 2 diabetes could facilitate the development of culturally sensitive interventions programmes that can help to modify beliefs, assist acceptability and support self-management lifestyle among this population.

Poster session

A study design to identify group-specific needs for a technology-based prevention to promote physical activity

Merle Toborg, Jade University of Applied Sciences, Germany

Co-authors: Myriam Lipprandt, Frauke Koppelin;
Jade University of Applied Sciences

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

Freedom of mobility is essential for autonomous living. However, due to decline in physical function, older persons´ mobility is often reduced. Study results show a preventive effect of regular physical activity on functional decline.

With the sub-project “Technology”, the Oldenburg institutions OFFIS – Institute for Information Technology, the Carl von Ossietzky University and the Jade University of Applied Sciences are aiming to develop a new method of prevention. This measure is intended to enhance the physical performance of people aged 70 and older by providing the user with technical assistance to perform regular exercise. The sub-project is affiliated to the AEQUIPA (“Physical Activity and Health Equity: Primary Prevention for Healthy Ageing”, Project No. 01EL1422E) research program funded by the German Federal Ministry of Education and Research.

The role of the Jade University “Technology” project team is to conduct a requirement study. The objective of this study is to collect information about how the prevention package can be adapted to provide equal access for different social groups. For this, the needs of the specific target groups are identified, taking into account cultural and gender-specific differences.

The requirement analysis has a multi-stage approach. In a first step, before the development of the prevention measure, the context of use (1) is identified. To this end, semi-structured interviews are conducted with 10-20 persons aged 70 and older. The interviewees are heterogeneous regarding gender, place of residence (urban/rural), socioeconomic status and ethnic background. Based on interview results, the users’ needs (2) can be identified and the requirements (3) for the exercise program and the technical system established.

The qualitative research design allows for the inclusion of different target groups in the developmental process. This approach is expected to enhance the acceptance and, thus, the up-take of the prevention measure.

Poster session

Factors associated with women's contraceptive choice through the life course: case of Russia

Alexandre Avdeev, Université Paris 1 "Panthéon Sorbonne", France

Co-authors: Irina Troitskaya;
Moscow State University, Russia

Tuesday 28 June 2016
Time: 12pm-1pm
Room: , Ground floor
Session Chair:

Russia was the first country in the world to decriminalize abortion in 1920 when only few primitive and low-effective contraceptive methods were in use. In the mid-1920s, in consequence of rapid fertility decrease combined with the absence of effective contraception induced abortion became the most common birth control method in the USSR.

In the 1960s, over 7 million induced abortions were yearly performed in the USSR. That meant that the Soviet family planning system was aimed at and adapted to pregnancy termination and not prevention. On the other hand, induced abortion became a banal phenomenon of the everyday family life, which resulted, in average, in 4 abortions per woman in the early 1970s. Such a situation was at the time identified as an “abortion culture of family planning”, with poor motivation to use modern contraception instead of abortion.

Even though, since 1990, under the influence of various factors abortion culture passes into history, its vestiges are still felt not only in Russia but in the whole post-Soviet area. They take a form of a low prevalence of modern contraception, especially among women who have already realized their fertility intentions.

We analyze the prevalence of different contraceptive methods on different stages of family formation in Russia. Particular emphasis is placed on the choice between traditional and modern methods as well as on transition from traditional method to modern one.

We use the individual records of “Reproductive Health Survey” held in Russia in 2011, completed with the data from “Generations and Gender” and “Demographic and Health” surveys for international comparisons.

The object of analysis is a contraceptive calendar which contains monthly information on contraceptive use, method switching and stopping etc. during a 5-year period preceding the survey. Explaining variables are the respondents’ marriage and pregnancy histories as well as their socio-demographic characteristics.

Poster session

Autonomy and good health as dynamic contructs: a source of clashes and solutions to providing patient centred care

Hester van de Bovenkamp, Erasmus University Rotterdam/
institute of Health Policy & Management, Netherlands

Co-authors: Jolanda Dwarswaard;
Rotterdam University, centre of healthcare innovation

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

Background: Self-management has become an important paradigm in healthcare. Policy-makers have high expectations of what it can achieve. It is believed to improve quality of care and life while respecting patient autonomy. In addition, self-management is expected to cut public spending. Because of the singular emphasis on these positive effects, self-management can be considered a ‘hurrah word’; it is difficult to argue against. The problem with such concepts is that they are not often subject to critical reflection. However, looking at the experiences with self-management in practice shows that the value of autonomy can conflict with the value of good health in several ways.

Methods: Qualitative interviews with nurses (n=16), patients with a chronic condition (n=20) and experts on self-management and medical ethics (n=6).

Results: We show several versions of the dilemma between ensuring good health versus patient autonomy. For example, patients who are active self-managers may make autonomous choices which increases their quality of life but not their health. Health care professionals find it difficult to deal with such choices. At the same time patients who do not want to become active self-managers, which can be interpreted as an autonomous choice, can clash with professionals who want to activate them because they feel this serves their patients’ health best. These clashes have to do with different interpretations of autonomy and good health amongst patients and the professionals they encounter.

Conclusions: Good health and autonomy do not naturally go hand in hand. These values can be seen as dynamic constructs, which is shown by the multiple ways they are interpreted in practice. These multiple interpretations can cause clashes between patients and professionals. At the same time, when these multiple interpretations are debated and reflected upon they can provide a solution to providing patient-centered care for patients who hold different values.

Poster session

Marital Happiness and Children among Japanese Couples

Chizu Yoshida, Kanto Gakuin University, Japan

Tuesday 28 June 2016
Time: 12:00-1:00pm
Room: Ground floor, Main Hall, Uni-Mail

This paper’s objectives are examining the relationship between marital happiness and the probability of having a child or children and changes in the level of marital happiness before and after childbearing. Data for this study consist of currently married men with wives aged 20-39 and currently married women aged 20-39 drawn from the Generations and Gender Survey in Japan (JGGS) conducted in 2004 and their follow up data. JGGS used the stratified two-stage probability sampling of Japanese men and women of all marital statuses aged 18-69 in 2004.

This study made a composite indicator of marital happiness from a questionnaire about degree of spousal agreement about different aspects of family life. This paper assumes a positive relationship between marital happiness and the degree of spousal agreement.

From analyses using logit model, women’s marital happiness doesn’t have significant impact on the first, the second or the third birth, and has significant positive impact on the fourth or more birth. Men’s marital happiness has a negative impact on the first birth at 10.8 percent level and positive impact on the second or more birth. Its degree of the positive impact increases according to birth order.

From descriptive analyses about changes of marital happiness before and after childbearing, women’s marital happiness decreases after first and second childbearing, especially when they were working. Men’s marital happiness doesn’t change after first childbearing and decreases when they had no child and no birth from 2004 and 2007. It also decreases after second childbearing especially when their wives didn’t work.

The results imply that Japanese wives need a support, for example a child care service which is available for all working wives, in order to get happiness from their childbearing. If Japanese wives could be happier when they have a child, they might desire having more children.

Parallel session 5:
5.2 - Reproductive health through the life course

Women who kill their newborn: a mental health or reproductive health issue?

Julie Ancian, EHESS, France

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

"Neonaticide" refers to the killing of a newborn on the day of its birth. Clinical research highlighted that it is exclusively committed by the woman who gives birth, in the context of an unintended and concealed pregnancy and that the women have no identifiable signs of mental illness. Historians and anthropologists have shown that neonaticide has been used as a means of regulating fertility over time in many societies.

Yet today in France, the dominant discourse about women who kill their newborn focuses on their mental health and presumed trouble with maternity rather than on birth control issues. This communication aims to discuss results demonstrating that complex determinants of marginal reproductive conducts are invisibilized by the common idea that women have all the necessary legal means to avoid or to end unwanted pregnancies. It is based on a sociological study of neonaticide cases prosecuted in France (2005-2015), that compares different narratives: accounts that emerge from their judicial treatment (observation of 5 criminal trials); media coverage of 50 similar cases; and narratives proposed by women during their prison term.

The biographic interviews of women who committed neonaticide highlight the obstacles they encountered in implementing an efficient use of contraception, accessing abortion services within the legal deadline, or giving birth anonymously as authorized by French law. Financial vulnerability, exposure to intimate partner violence, social isolation and limited mobility were also major constraints.

Analysis confirms that well before the entry into the health system, a woman's capacity to decide and to act according to her own mind is embedded into a broad range of social relationships. The study of the lived experiences of women who have killed their newborns challenges judicial and mediatic discourses and provides food for thought on the notion of choice as applied to the reproductive life course.

Parallel session 5:
5.2 - Reproductive health through the life course

Stigma and postpartum depression treatement acceptability among black and white women in the U.S.

Susan Bodnar-Deren, Virginia Commonwealth University, Sociology and Institute for Women's Health, United States

Co-authors: Emma Benn, Amy Balbierez, Elizabeth Howell; Mount Sinai School of Medicine Departments of Population Health and Obstetrics, Gynecology and Reproductive Health

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

Objective: To measure stigma and treatment acceptability for four postpartum depression treatments and estimate its association with treatment acceptability among black and white mothers.

Methods: Using data from two postpartum depression randomized trials, this study included 481 black and white women who gave birth in a large urban hospital and answered a series of questions at six-months postpartum. Survey items included sociodemographic and clinical factors, attitudes about postpartum depression treatment, and stigma. The associations between race, stigma, and treatment acceptability were examined using bivariate and multivariable analyses.

Results Black postpartum mothers were less likely than whites to accept prescription medication (64% vs. 81%, p=0.0001) and mental health counseling (87% vs. 93%, p=0.001) and more likely to accept spiritual counseling (70% vs. 52%, p=0.0002). Women who endorsed treatment stigma versus those who did not were less likely to accept prescription medication, mental health and spiritual counseling for postpartum depression. Black women had lower rates of treatment stigma with regards to family, community, and workplace disclosure than did white women. In adjusted models, black women were half as likely as white women to accept prescription medication for postpartum depression, although this was of marginal significance. Lower rates of treatment acceptability among black women was not explained by racial differences in stigma.

Conclusions: Although treatment stigma is associated with lower postpartum depression treatment acceptance, stigma does not explain the lower levels of postpartum depression treatment acceptance among black women. More research is needed to understand treatment barriers for postpartum depression, especially among black women.

Parallel session 5:
5.2 - Reproductive health through the life course

Suicidal Ideation during the postpartum period

Susan Bodnar-Deren, Virginia Commonwealth University, United States

Co-authors: Kimberly Klipstein, Madeleine Fersh, Eyal Shemesh, Elizabeth Howell;
Mount Sinai School of Medicine, Psychiatry, North Shore LIJ Psychiatry, Mount Sinai School of Medicine Pediatrics and Psychiatry, Mount Sinai School of Medicine Dept of Obstetrics, Gynecology and Reproductive Health and Population Health Science

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2140, Second floor
Session Chair: Karen Vanderlinden

Objective: To examine the association between suicidal ideation (SI), 3-weeks, 3-months, and 6-months postpartum with demographic, psychosocial, clinical factors and depressive/anxiety symptoms (measured 24-48 hours after delivery), among a cohort of postpartum women.

Methods: This study included 1073 mothers who gave birth in a large tertiary New York City hospital (2009-2010). Later self-report suicidal ideation was assessed using the suicide measure from the Edinburgh Postnatal Depression Scale (EPDS) and from the Patient Health Questionnaire (PHQ).

Results: Two percent of participants presented with SI during the first six-months postpartum. In bivariate analyses, race/ethnicity, nativity, insurance, and language were significantly correlated with SI 3-weeks, 3-months and 6-months postpartum. Screening positive for depression and/or anxiety, assessed 1-2 days postpartum, was significantly correlated with later SI in bivariate analyses (0.178), as were antepartum complications (p=0.001), depressive history (0.001), and self-efficacy (0.045). In adjusted models, antepartum complications (OR=4.833, 95% CI=2.06-11.37) and depressive history (OR-3.779, 95% CI=1.513-9.442) were significantly associated with later postpartum SI. Heightened self-efficacy reduced the odds of later SI (p=0.059).

Conclusion: Findings suggest that suicidal ideation among a relatively healthy group of new mothers occurs with some frequency. Mothers with a past history of depression and antepartum complications may be at increased risk.

Parallel session 5:
5.3 - Health professions in transition

Investigating the Social Space of a Nursing Profession in Transition

Michael Gemperle, Centre Européen de Sociologie et de Science Politique (EHESS-CNRS), France

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Professional groups are usually studied as relatively homogeneous and autonomous social spaces. The nursing profession challenges this view not only by its subaltern position in relation to medical authorities, but also because of its "openness" to other social spaces. More than the members of other occupational groups, nurses have professional trajectories leading them into the administration or other sectors within the medical field, or even into sectors outside of this sphere. However, the nursing profession was affected by an important dynamic of "professionalization" in recent years. In addition to that, medical progress, changed social needs, but also increasingly severe public budget restrictions and the application of business principles have changed nurses' working conditions drastically in the last decades. Hitherto, there is still little knowledge on the key oppositions structuring the social space of this professional group, which often is considered exercising at the same time a delegate (medical) role and an "own" role.

Based on a survey on inpatient nurses in the canton of St. Gallen in Switzerland (N=812, collected in Summer 2014), this paper presents results on determinants of the social space of the nursing profession. The focus lies on differences and similarities in the social characteristics of the nurses, also due to their belonging to "generations" (in Karl Mannheim's sense) and to different qualification regimes. The analyses (Regression, Multiple Correspondence Analysis) take into account – besides the work environment (i.e. professional position, speciality) – factors such as the social origin, the educational trajectory and the professional qualification. Attention is also paid to the "ethos" of the respondents, conceptualized with Pierre Bourdieu as systematic ensemble of practical principles (and not as coherently formulated system of explicit principles). The results show a systematic correspondence between dispositions regarding the content of work, the working style and forms of distress, on the one hand, and the economic and cultural resources of the respondents, on the other.

The presented analysis is part of the three year-project "Nursing ethics in transition", funded by the Swiss National Science Foundation, combining quantitative, qualitative, and historical methods.

Parallel session 5:
5.3 - Health professions in transition

Physician Associates in General Practice in England: a challenge to professional boundaries

Vari Drennan, Kingston University & St George's University of London, United Kingdom

Co-authors: Jonathan Gabe, Mary Halter;
Royal Holloway, University of London, Kingston University & St George's University of London

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Like other health care systems, the National Health Service (NHS) in England, faced with medical staff shortages and rising costs, has looked to new staffing configurations. One solution has been to employ physician associates (PAs). PAs are trained in the medical model to assess, diagnose and commence treatment under the supervision of a physician. This paper explores the effects on professional boundaries of introducing a completely new professional group into health care services and the workforce. It draws on a study completed in 2014 of the effect of PAs working in general practice (the medical and nursing primary care services in the UK). From documentary analysis, interviews with professionals and managers at the macro level (e.g. officers of the Department of Health and Royal Colleges n=25) and at the micro with General Practitioners, nurse practitioners and practice staff (n=30) as well as observation at clinical and professional meetings, it is argued that the professional boundaries become malleable and subject to negotiation at the micro level of service delivery. However, at the macro level the stratification within professional groups creates nuanced responses from acceptance to hostility in the face of a new and potentially competing, occupational group.

Parallel session 5:
5.3 - Health professions in transition

The relationship between nursing and other health professions: challenges in the era of e-health

Barbara Sena, Unitelma Sapienza University, Italy

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2130, Second floor
Session Chair: Julie Page and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

In recent years, with the development of increasingly complex systems of care, the nurse's role has grown and acquired great importance in health care organizations. In particular, the process of professionalization that recently involved nursing in Italy has contributed to differentiate and strengthen the range of activities provided to the patient. These are gradually expanding to new forms of assistance, care, therapeutic education and prevention, thereby increasing the power of nursing in relation to other health professions. However, this evolution today appears to be still in progress.

In this context, the spread of new web technologies becomes more and more central, which contributes not only to strengthen the empowerment of the patient through the exchange of information on internet and new media, but also to create a hyper-specialization of many health occupations. This multiplies the division of labor in the health sector and creates the need to redefine roles, responsibilities and functions in health care organizations.

On this premise, this paper will try to analyze the main issues in the relationship between nursing and other health occupations, related to the changes introduced by new web technologies in health care organizations. We will use the results of some recent empirical studies in Italy in order to point out some critical and strategic opportunities for nursing that have emerged from the implementation of the so-called "e-health" tools. The focus will be aimed at understanding, in particular, the influence of new technologies on the development of growing interprofessional teams, the relationship between doctor and nurse and the reduction in medical dominance. The final aim of this work is to reflect on possible future developments in nursing in relation to other health occupations, with the support of e-health and its potential positive or negative consequences for health care organizations.

Parallel session 5:
5.4 - Imperative of good health and promotion of autonomy: a paradox?

Self-determination in managing genetic risk of breast and ovarian cancer: The perspective of the patients

Maria Caiata Zufferey, University of Applied Sciences of Southern Switzerland, Switzerland

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

Women carrying BRCA1/BRCA2 germline mutations have an increased risk of developing breast/ovarian cancer. To minimize this risk, lifelong surveillance and preventive measures exist. These measures are supposed to be optional, as self-determination is a central concept in human genetics and a crucial principle in many European laws related to genetic testing. At the same time, surveillance and preventive measures are strongly recommended by international guidelines. This paper explores how self-determination is experienced by women who are genetically at risk of breast/ovarian cancer, specifically in regards to decision-making about risk-reduction behaviors.

Following a grounded theory design, retrospective biographical interviews were conducted in Switzerland between 2011 and 2014 with 32 unaffected women at risk of developing genetic breast/ovarian cancer and aware of their predisposition for at least three years.

Findings indicate that women experienced self-determination in three different ways. In some cases, they felt that their self-determination was denied in the name of the decision they had taken to undergo genetic testing. The fact that they had decided to undergo genetic testing was considered proof of their desire to follow the medical recommendations. In other cases, women felt that their self-determination was forced in the name of an abstract ideal of autonomy. As a consequence, they were required to decide alone, even when they asked for greater involvement from health professionals. And finally, a few women felt that their self-determination was negotiated and shaped through their relationship with their health professionals, through a continuous process of confrontation between their personal doubts and desires, on the one hand, and the scientific evidence and suggestions, on the other.

This study shows that even though self-determination is crucial in human genetics, the way this principle is applied during the process of managing genetic risk of cancer may differ, depending on how physicians interpret it.

Parallel session 5:
5.4 - Imperative of good health and promotion of autonomy: a paradox?

Diabetes as challenging lifestyle. Technologies, experiences, and the duty to be/do well

Vincent Pidoux, Institut de psychologie, Switzerland

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

Background: Healthcare services and policies acknowledge more and more the need for models of care based on the active participation of people living with chronic conditions and the active preparedness of healthcare providers to respond to their needs. Trying to implement this kind of integrated model of care, initiatives such as the Programme Cantonal Diabète (PcD) from the Canton of Vaud (Switzerland) have been burgeoning in the Western countries for about two decades now. Such healthcare policies promote healthy behaviors both in the general population and among the people living with diabetes, through tools, knowledge and programs which effects as “dispositifs” of moralisation has not yet been studied from a sociological point of view.

Methods: Document analysis and interviews. We reviewed the reports, minutes, publications and guidelines edited by or related to the PcD, as well as blogs, patient activists initiatives and programs (through leaflets, hotlines, FAQs, forums, courses).

Results: Analysis of the sources and interviews showed that knowledge of ones own disease is mediated by tacit or explicit knowledge, experience and technologies, which delegate, embed, require or motivate people living with diabetes to stay well, and transform their condition into daily normalized lifestyle, which if they fail to maintain, leads to the worsening of the disease and work as a confirmation of the weakening of the control, and moral side of the diabetic people.

Conclusions: Further consideration must be done to better characterise whether (and which) technologies can help foster autonomy without including the often unintended moralisation effects on people living with diabetes.

Parallel session 5:
5.4 - Imperative of good health and promotion of autonomy: a paradox?

Between autonomy and non-compliance: a pragmatic approach to the analysis of the medical discourse on childhood obesity

Andrea Lutz, Université de Genève, Switzerland

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

In this paper, I will analyse the emergence of the principle of autonomy in healthcare and its paradoxes through the discussion of the case study of the medical management of childhood obesity in French-speaking Switzerland. In a pragmatic sociology perspective, based on the analysis of medical literature and semi-structured interviews I've conducted with health professionals, I will show how the notion of autonomy appears in the medical discourse on childhood obesity, especially in the way professionals describe, justify, and sometimes challenge their own practices and those of their colleagues. In the ideal vision of professionals, the medical treatment should foster the autonomy of obese children and their parents, by bringing them to adopt a healthier diet and lifestyle. However, this ideal rarely match with the description of their everyday work, in which they admit experiencing non-compliance, resistance and lack of motivation by children and parents. They especially point to the difficulty of generalizing the medical standards to all children and parents, because of their cultural and social diversity. Some professionals also express concerns regarding the moral and normative dimension of the medical treatment, which tends to promote a specific vision of childhood and parenting, and may therefore be perceived as stigmatizing by some families, but they rarely challenge the necessity of a medical intervention. Nevertheless, they acknowledge the fact that the treatment cannot take place without a minimal agreement between caregivers and patients on the means and goals of their relationship. Therefore, the main challenge for professionals is to successfully build a therapeutic alliance with children and parents, including in situations where their normative and moral horizons tend to diverge. In the moral economy of healthcare, this alliance seems to be central for the justification and legitimation of medical practices, since it testifies that the provision of care meets a demand coming from the patient and is not completely arbitrary.

Parallel session 5:
5.4 - Imperative of good health and promotion of autonomy: a paradox?

Non suicidal self-injury and the paradox of autonomy

Alvaro Jimenez, Université Sorbonne Paris Cité, France

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

Background: During the last few decades, there has been a significant rise in the prevalence of self-harm among adolescents on a global scale, particularly self-cutting. Self-injury has been understood as a method of self-help, a strategy of affective or cognitive self-regulation motivated by internal-emotional-neurological psychopathology grounded in an intolerable psychic tension. This perspective fails to consider self-injury as a social phenomenon framed in a complex system of interactions.

Problem and method: What makes self-injury an effective resource for individuals? What is its meaning and how is it experienced by individuals? This paper describes the experiences of adolescents who have self-injuried in Santiago (Chile) and Paris (France), from ethnographic observations and semi-structured interviews (n=30) in different mental health services. Finally, this paper discusses the tensions between the social imperatives of 'healthy life' and 'autonomy'.

Results: For adolescents self-injury is a behaviour that allows self-regulation of affects and anticipation of impulsion. Self-injury is not an impulsive act, in the sense of an identifiable and unique moment, but a process that involves a system of meanings and interactions. Self-injury emerges when the individual does not find a way to contextualize or manage an intense suffering through his social relations. This begins as a fuzzy behaviour, but gradually becomes a way of managing the daily malaise. To many adolescents, this is a resource that allows them to go without demanding health services or supporting institutions.

Conclusion: The aggression of the body tissue is not only a practice that aims to regulate the emotional experience (psychic homeostasis); but also a strategy to regulate the social experience or social situation. In others words, in daily life some individuals manage the expanding imperative for 'healthy life' and 'autonomy' by refusing medical treatments, and –paradoxically- by adopting risky behaviours as a resource to reach individual regulation (self-control) and 'subjective wellbeing'.

Parallel session 5:
5.5 - Technologies and policies for healthy lives

Social representations of pre-exposure prophylaxis (PrEP), an emerging HIV prevention option

Rusi Jaspal, De Montfort University, United Kingdom

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Pre-exposure prophylaxis (PrEP) is a novel bio-medical HIV prevention tool. Although PrEP has yielded encouraging results in clinical trials, opponents argue that PrEP poses a number of risks. This paper explores (1) coverage of PrEP in the UK print media and in the industry trade press, and (2) how a group of ethnically diverse HIV-negative gay and bisexual men perceive PrEP as a potential means of protecting themselves from HIV infection. Study 1 revealed two competing social representations of PrEP in the press: (1) as a positive development in the "battle" against HIV (the hope representation) and (2) as a risky setback in this battle, particularly for gay/bisexual men (the risk representation). These social representations mapped onto the following themes: (1)"The wonder drug": PrEP as a superlatively positive development; (2)PrEP as a weapon against HIV/AIDS; (3)The dark side of PrEP: uncertainty and risk. Study 2, the interview study with young gay/ bisexual men, found that individuals reproduced the risk representation in relation to their own sexual identities, although some acknowledged the hope representation in relation to others. They perceived social stigma vis-à-vis PrEP given its association with "high risk" groups, a category that individuals wanted to distance themselves from. The themes of (1) uncertainty concerning its effectiveness, (2) fear about toxicity, (3) shame in relation to condomless sex are discussed to elucidate participants' sense-making vis-à-vis PrEP. More generally, the social and psychological implications of social representations of PrEP are discussed in relation to sexual identity, behaviour and health among young gay/bisexual men. PrEP is discussed in terms of a novel HIV technology which can bring benefits for social and psychological functioning but potential challenges for other aspects of sexual health.

Parallel session 5:
5.5 - Technologies and policies for healthy lives

What elements contribute to health risk behaviour change among high school learners in sub-Saharan Africa?

Hamilton Pharaoh, University of the Western Cape, South Africa

Co-authors: Jose Frantz, Mario Smith;
University of the Western Cape

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Creating a platform for behavioural change to occur ultimately means persistently committing to meet the diverse and changing needs of individuals as well as incorporating the characteristics of their social, cultural and physical environments that place them at risk. A systematic review was chosen that aimed to explore and find empirical literature relating to school- based intervention programmes in order to ascertain the elements used within intervention programmes that successfully addresses health risk behaviour change. The articles were systematically collected and reported in a narrative form. The population was adolescents/youth/high school learners, the intervention had to focus on school based programmes and the outcome was related to reduction in health risk behaviour amongst the youth at high school level. The search strategy aimed to find published studies and was conceptualized at three levels: 1) database identification, 2) search terms and 3) search process. Inclusion and exclusion criteria were set with a time frame of 2002- June 2013. Fifteen articles were finally included to form part of the systematic review. Interventions seem to be most effective when they widen the scope and include other aspects such as life skills, sport, and parental education/involvement. The addition of sport was particularly powerful at increasing positive, more realistic attitudes and perspectives regarding the self and others and these elements in turn were successful at reducing health risk behaviours. Parental involvement was particularly effective at reinforcing positive effects of the intervention and maintaining long-term results. Based on the findings, the researcher would recommend an initial short-term, multi-theory approach intervention, which would be more cost-effective and therefore could be implemented in more settings, followed by regular booster programs throughout high-schools, as well as regular and long term follow ups to assess and keep track of the levels at which reduced health risk behaviours are maintained.

Parallel session 5:
5.5 - Technologies and policies for healthy lives

Motives and expectations for requesting clitoral reconstructive surgery after female genital mutilation/cutting – the Swedish experience

Malin Jordal, Department of Women's and Children's Health, Sweden

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2160, Second floor
Session Chair: Raphaël Hammer

Female genital mutilation/cutting can involve cutting of the clitoris, labia minora/majora and infibulation (narrowing of the vaginal opening). Due to high rates of immigration from countries where female genital mutilation/cutting is traditionally performed, an estimate of 38 000 women and girls living in Sweden may have undergone female genital mutilation/cutting. Reconstructive surgery of the clitoris has been available since 2014, and after media exposure in 2015, requests for surgery are increasing. This paper explores women’s motivation and expectations for requesting clitoral reconstructive surgery. The inclusion criteria were ‘women who have undergone female genital mutilation/cutting, sought care, and intend to go through clitoral reconstructive surgery’. The study is qualitative and fifteen women recruited at Karolinska University Hospital in Sweden were interviewed individually using semi-structured interviews. The interviews were analyzed using thematic analysis. Preliminary results reveal that the women had experienced long-lasting problems related to menstruation, sexual function, and body image. The women perceive their vulva as ‘abnormal’ and damaged as a result of the cutting. Some had previously sought solutions, including defibulation and therapy, for their problems. Being stigmatized in contact with male sexual partners and/or health care providers was said to prompt their request for surgery. While sexual sensations and orgasms were described, lack of sexual desire, pleasure and possibility to have an orgasm was prominent. Impaired femininity, not feeling ‘whole’, and wanting to reclaim what was violently and unjustly taken from them was a leading thread throughout the interviews. The women were uncertain, but hopeful of what the surgery could accomplish, however it held a promise of repaired sexuality, ability to attain ‘normal’ genitalia, and to look like other, non-mutilated women. In conclusion, women request surgery in an attempt to reclaim their bodies, take charge of their sexual well-being, and to become ‘normal’ in relation to the Swedish norm.

Parallel session 5:
5.6 - Inequalities and social determinants of health

Educational inequalities in depression: does an oversupply of the higher educated widens the gap?

Pieter Dudal, Ghent University, Belgium

Co-authors: Piet Bracke;
Ghent University

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2150, Second floor
Session Chair: Terje Eikemo

In recent decennia, a substantial part of the European labor markets are characterized by an oversupply of the higher educated. It is suggested that this structural labor market feature can increase job-competition between and within different educational groups and can have negative consequences for the socio-economic position of the lower educated. Hence, to gain more insight into the macro-mechanisms linking education to health, we address the question whether an oversupply of the higher educated further widens the educational gap in depression. In addition, we pay attention to the influence of oversupply on the mental health of the general population health.

Analysis are based on round 3 (2006), 6 (2012) and 7 (2014) of the European Social Survey. The final sample consists of 76.713 respondents aged between 20 and 65 in 25 European countries. Depression is measured using an eight-item version of the CES-D8. Since respondents are clustered in countries, we apply random slope multilevel-modelling to answer the research questions.

Results from cross-level interactions reveal that an oversupply of the higher educated does not influence the association between education and mental health implying that an oversupply does not widen the educational gap in depression. Additionally, results show a negative effect of oversupply on the mental health of the general population. This indicates that in countries with an oversupply of the higher educated, people are experiencing less depressive complaints.

Parallel session 5:
5.6 - Inequalities and social determinants of health

Health inequalities among Europeans: An intersectional comparative approach

Anna Gkiouleka, Queen Mary University of London, Blizard Institute, Centre for Primary Care and Public Health, United Kingdom

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2150, Second floor
Session Chair: Terje Eikemo

The concept of intersectionality seems to increasingly gain ground in public health research, urging us to acknowledge the heterogeneity of effects that generate health inequalities. The intersectionality framework focuses on the complexity of social positioning as this emerges from multiple interlocking social categories like gender, ethnicity and class. The latter are perceived as fluid and mutually constituted while the relationships among them as non-stable; challenging the idea of an a priori hierarchy. In this light, patterns of health inequality are perceived as the outcome of multiple and simultaneous effects of privilege and disadvantage as those are experienced by individuals depending on their social position. This premise broadens the scope of health inequalities research beyond income inequalities. The current paper contributes to this developing scholarship by presenting nuanced health outcomes for the European population deriving from intersecting social positions of privilege and disadvantage. This approach adopts an inter-categorical understanding of intersectionality which brings relationships of inequality among already constituted social groups to the centre of the analysis. Moreover, it disaggregates self-rated health data, deriving from the 7th wave of European Social Survey (2014), across the intersections of gender, occupational status and ethnic minority status. The results illustrate a refined depiction of health inequalities among different social groups shaped from the multiple combinations of the examined categories and highlight the disproportionate burden carried by those occupying multiple positions of disadvantage like ethnic minority women. The paper represents one of the few attempts to integrate intersectionality in comparative health inequalities research and aims to reinforce the on-going discussion about the need for theoretically informed health inequalities research, which will reflect the complexity of the issue and will recognise the multiple dimensions affecting population health.

Parallel session 5:
5.6 - Inequalities and social determinants of health

Social disparities in parental smoking and children's exposure to secondhand smoke at home in Germany

Benjamin Kuntz, Robert Koch Institute, Germany

Co-authors: Thomas Lampert;
Robert Koch Institute

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2150, Second floor
Session Chair: Terje Eikemo

Background: Smoke-free policies aim to improve indoor air quality and to protect the health of non-smokers. This study examines changes in child exposure to secondhand smoke (SHS) at home after implementation of public smoking bans in 2007/2008 based on nationwide data for Germany. Special attention is given to the impact of the parental socioeconomic status (SES) and parental smoking behavior.

Methods: Analyses are based on data of two waves of the German Health Interview and Examination Survey for Children and Adolescents (KiGGS) that were conducted from 2003-2006 and 2009-2012. We compare information from children aged 0-6 years (n=6,680 and n=4,455, respectively). To assess SHS exposure at home, parents were asked whether anybody is allowed to smoke in the household while their children are present. Current smoking behavior was determined for both parents. SES was quantified as an index based on parental education, occupational status, and income.

Results: Prevalence of SHS exposure at home among children aged 0-6 years decreased from 23.9% to 6.6%. Parental smoking rates declined from 49.8% to 41.8%. While social disparities in parental smoking increased, social disparities in children's exposure to SHS at home remained rather stable. Children with parents who smoke and children from low-SES families were most likely to be exposed to SHS at home. In both study periods and after adjustment for parental smoking behavior, children with low SES had a 6.6-fold higher risk for SHS exposure at home compared to children from high-SES households.

Conclusions: There is good reason to assume that the implementation of smoke-free legislation in Germany led to increased awareness of the health risks of SHS, lower prevalence of SHS exposure at home, and tobacco denormalization. Children whose parents smoke, and among them particularly children from low-SES households, should be considered more explicitly when implementing further tobacco control measures.

Parallel session 5:
5.7 - Risk behaviours

Sex and substance use among Italian university students. Risk perception and healthy behaviours

Michaela Liuccio, University La Sapienza, Italy

Co-authors: Chiara Borgia-Benedetta Martino;
University La Sapienza

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1160, First floor
Session Chair: Zofia Slonska

Sex and substance use among Italian university students. Risk perception and healthy behaviours

Prof.ssa Michaela Liuccio, Dott.ssa Chiara Borgia, Dott.ssa Benedetta Martino, Department of Communication and Social Research of the University of Rome La Sapienza

Background: A high number of health risk behaviors have been identified during emerging adulthood, and although the issue is discussed, especially among university students, these remain an exceptionally high risk category for sexual and reproductive health. Methods: The research evaluates the results of an anonymous web questionnaire concerning sexuality participated by 4733 students of the University La Sapienza of Rome from January to April 2015. The questionnaire consits of three parts: 1) biographic information and sexual habits; 2) risk perception; 3) psychosocial variables involved in condom use (intention, norms, beliefs, self-efficacy). It is assumed that "risk perception" plays an important role in risky sexual behaviors. Focus of the investigation are alcohol and drug use during sex, risk perception and healthy behaviours among students. Results: Alcohol and drug use during sex is not very common among Italian university students (most often alcohol, rarely drugs). Results also suggest that as students are putting themselves into real risk (alcohol and drugs during sex, sex in public places; past STIs) as they increase condom use and HIV testing. Conclusions: Many studies have shown that alcohol and drug use during sex can be understood either as a "prosthesis of socialization" to loosen inhibitions (especially females) or as a "support" for those that believe to suffer from sexual disorders. In both cases, the risk of exposure becomes secondary. This research highlights how substance use in connection to sex is not widespread among Italian university students, moreover among those few who do it, awareness of risk is relatively high so that urges them to more prevention measures.

Parallel session 5:
5.7 - Risk behaviours

Management of spillover effects of the risk-taking process in bodybuilding

Guillaume Vallet, Department of Economics, France

Institute of Sociological Research, Geneva, Switzerland

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1160, First floor
Session Chair: Zofia Slonska

Bodybuilding is often perceived as an “exotic” sport, and is often associated with deviance and underground culture. For many, bodybuilding brings up negative images of indulgence and of over-commitment, and raises important questions in a society that glorifies health as well as the body-beautiful. Indeed, because performance often raises question of risk-taking, bodybuilding often raises the issue of how far someone is willing to go to produce a body that is envied by many.

If in sport such a process is very diversified, risk-taking is defined here in two, at times interdependent, ways: 1) physical and mental; 2) social.

Although important, this paper does not deal with the question of why a bodybuilder is willing to take risks. These questions have already been studied within a gendered or a cost/benefit balanced pyschosociological framework. Rather, this paper proposes to investigate this issue in a novel way: we shall talk about the “how”, stressing the steps taken – or not – in the process of risk-taking that could be harmful to the bodybuilder with respect to the two features mentioned above. The underlying issue is whether there exists a breaking-point in the risk-taking process, entailing potential dangerous spillover effects for the bodybuilder, and how these are managed.

Based on interviews with 30 bodybuilders, we reach the following two conclusions:

- We identify 3 groups of bodybuilders: ‘fatalistic bodybuilders’, ‘denial bodybuilders’, and ‘under control bodybuilders'.
- The determinant factor in risk management is family, even though the family does not have the same impact on each bodybuilder.

Parallel session 5:
5.7 - Risk behaviours

Mutual Support and Recovery in the Russian Alcoholics Anonymous Online Community

Laura Lyytikäinen, University of Turku, Finland

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M1160, First floor
Session Chair: Zofia Slonska

In Russia, the paradigm of alcoholism as a disease is still in contrast to the general perception of alcoholics as being weak-willed. This presentation is based on an article, which studies alcoholism and recovery in Russia through the case study of the Russian Alcoholics Anonymous online group. It studies how people, who are seeking help for their drinking problems in this online community, come to incorporate a new self-understanding of a recovering alcoholic. The data of the research were collected from a Russian online support group for people struggling with alcoholism. It consists of 617 postings of more than 35 individuals. Data was analysed with qualitative content analysis using the RQDA software. The article shows how the online group acts as a virtual space where people can anonymously talk about alcoholism and engage with AA's 12-Step program. Typically, a new forum member goes through a process of admitting one’s problem with alcohol and coming to a new understanding of oneself as a person suffering from a chronic disease. This process includes creating a new relationship to alcohol, a new understanding of one's reasons for drinking, and a commitment to staying sober and to helping others to recover. The online community creates a space for engagement with AA's 12-Step program and service work of supporting other alcoholics in recovery in the Russian context, where face-to-face AA groups are scarce. When the state cannot deliver the services for problem drinkers or recovering alcoholics, people turn to the Internet to find alternative information and social support.

Parallel session 5:
5.8 - Life course perspective on health: trajectories and transitions

Configurations and dynamics of childhood obesity : a sociological model

Sílvia Silva, ISCTE-IUL, Portugal

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Childhood obesity is a remarkable social reality in contemporary societies. It articulates with the social relations that promote individualization and culpability of children and families, from the deposited beliefs in the biomedical model in which nutrition and physical activity are the main exponents of a paradigm based on the consideration of obesity as “disease”, in the possibilities of “cure” it, and in the urgency to fight against this new “epidemic”.

By the urgent need for understanding the social complexities inherent to obesity, namely to childhood obesity, nowadays predominantly represented as important social problem, it was essential to proceed to the identification of the settings and social dynamics of childhood obesity involved in its causes and consequences.

By the use of methodological triangulation, from the combinations of extensive and intensive methodologies, highlighting case studies by conducting interviews with children and families, it was revealed the importance of historical and civilizational present in interactions and social roles with implications on socialization processes responsible for the formation of provisions and ways children think and act.

The family appears as a central institution in this phenomenon, not only in the social reproduction of lifestyles, but mainly for its structure and dynamics of social relations. It was possible to define three types of family arrangements related to childhood obesity in Torres Vedras Municipality.

In the rise of childhood obesity are transformations in stable social relationships in the form of changes in daily life, family transitions or biographical crisis. Self-esteem, emotional and psychological situation, resilience ability and different forms of social integration in the face of these mutations affect the emergence of childhood obesity.

It was possible to build a sociological and a social intervention model focused on childhood obesity, which it is believed that may be replicated in other territorial contexts.

Parallel session 5:
5.8 - Life course perspective on health: trajectories and transitions

Migrant families trajectories in Badalona: A life-course approach to understanding health outcomes and behaviours

Florianne Gaillardin, IGTP, Spain

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Migrants are a key group affected by the Spanish 2008 economic crisis. Badalona in Catalonia presents a higher than regional average proportion of migrant residents. Health and behaviours indicators showed faster deterioration in migrants compared with autochthons with similar socio-economic characteristics.

Two competing paradigms offer explanations of health outcomes: one focusing on individual responsibility in behaviour change, the other seeking the root causes of ill health in social determinants. Using a life-course approach allows reconciling individual characteristics with past and present experiential and social context.

This study aimed to describe pathways through which migrants’ capacity to cope with stressful experiences is depleted or enhanced. A particular emphasis is put on family trajectories to understand the role of the family unit.

We interviewed all members above 16 in five migrant families with comparable socio-economic conditions and residing in Badalona since 2005. 15 individual semi-structured interviews were conducted. Families originated from the city’s largest migrant communities: Pakistani, Moroccan and Bolivian. Content analysis was done cross-sectionally and using family case studies.

Migrants reported a degradation of their perceived health status linked to migration and the economic crisis. This process unfolds differently within the family, with strong divergences between members.

Perceived health status depended on whether migrants were progressing against personal goals. Tension arose when personal goals were pursued in a context that did not allow for their fulfilment. Migration impact on perceived health is mediated by the capacity to cope with stressful experiences. Family ties and roles affect individual coping capacity. We observed two main non-exclusive evolutions: improved self-efficacy, and erosion of coping capacity.

A life course approach combines an individual perspective with an understanding of external factors that influence individuals’ coping capacity. It is promising for identifying resources to reduce health inequalities and promote health in vulnerable groups such as migrants.

Parallel session 5:
5.8 - Life course perspective on health: trajectories and transitions

School-age accumulation of disadvantage – a follow-up study of secondary school students in Finland

Sakari Karvonen, National Institute for Health and Welfare, Finland

Co-authors: Laura Kestilä, Pirjo Lindfors, Arja Rimpelä; National Institute for Health and Welfare, University of Tampere, University of Tampere

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Disadvantage is known to have roots at the early age. It may emerge in many forms at different periods of the life cycle. Following Urho Rauhala's model, we conceptualised disadvantage a multidimensional phenomenon covering health (health complaints), social (difficulties in prosocial behaviour), education (poor academic achievement), normative (conduct disorders) and economic dimensions (at least one parent unemployed). While earlier studies have focused on either identifying determinants of disadvantage or accumulation of disadvantage at a particular moment (cross-sectional), our study uses longitudinal data and several dimensions of disadvantage. Adolescent age has been characterized (e.g. by West 1988) to represent relative equality when it comes to health but we argue that this results from a narrow perspective on health. Here we broaden the perspective to disadvantage and analyse whether it is divided by family backround (parents' level of education, immigrant status, family structure) . By analysing a follow-up data of 9079 adolescents from the Helsinki Metropolitan Area we explore how disadvantage accumulates and intensifies over the three-year follow-up from the 7th to 9th grade (age 13 to 15). The first results show considerable accumulation of disadvantage at the beginning of the follow-up. Only 43.1% show no signs of disadvantage, whereas 5.4% report three or more forms of disadvantage. At the baseline, boys, students with immigrant background and those from low educated families show the highest accumulation of disadvantage. The follow-up analyses will show whether the accumulation intensifies over time and what its composition is.

Parallel session 5:
5.8 - Life course perspective on health: trajectories and transitions

Active ageing policies, social capital and health of older individuals – an international comparative perspective

Johanna Muckenhuber, University Graz, Department of Sociology, Austria

Tuesday 28 June 2016
Time: 2:15-3:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Background: It is known that a lack of social support is associated to bad health to bad mental health like depression and to worse wellbeing. One aim of active ageing policies (AAI) is to improve older individuals' inclusion in the society. Therefore we expect that older people living in countries with a higher rank in the AAI are better off in terms of social capital than those in lower ranked countries. In addition we expect that the impact of social capital is weaker in high-rank AAI countries than in low ranked ones.

This paper investigates and discusses the relationship between active ageing policies with social support and mental health and wellbeing.

Methods: At a national level the Austrian case will be investigated in detail. At the level of international comparison the association between social capital and health will be analysed regarding the differences between countries in their rank in the AAI. Cross level interactions will be discussed in particular.

In terms of methods and data multilevel analyses have been conducted using the data of the European Health Interview Survey (EHIS) 1 2006/07. The EHIS includes data of 16 countries amongst others Austria, France, Estonia and Greece.

Results: We can show that older peoples' mental health and wellbeing is more strongly affected by a lack of social support than younger ones'. In addition we can show the complex interplay between different aspects of active ageing policies with social support and with mental health and wellbeing of the older population.

Conclusions: We conclude that active ageing policies can have an influence on mental health and wellbeing of the older population, but it is necessary to analyse the different aspects of the policies in detail. In addition case studies would be important in order to better understand national specifics.

Parallel session 6:
6.1 - Health professions in transition

Health and medical pluralism: the professionalisation of CAM in the Swiss healthcare system

Jérôme Debons, University of Fribourg, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Background: Professionalisation of complementary and alternative medicines (CAM) in modern western countries is fully in line with a salutogenetic and holistic perspective on health. After a period of (re)emergence in the 1970s, CAM became more and more popular and in the 1990s, some of them were recognised and integrated into modern healthcare systems. In this presentation, I will focus on several aspects of this professionalisation process in Switzerland by analysing the role played by an emblematic CAM-medical group: the homeopathic physicians.

Method: Data come from a doctoral research (2010-2015) on the topic of profesional identity and careers of swiss homeopathic physicians. They include the analysis of professional and political litterature (from the 1980s until 2012) as well as empirical sources collected from qualitative interviews between 2011 and 2013 (26 homeopathic physicians and 20 non-homeopathic physicians were interviewed).

Results: The analysis shows that the homeopathic medical group was a key player in the legitimation process of CAM in this country. Since the 1990s –along with other CAM-medical segments–the group struggles for a better state recognition. Professionalisation materialises, among others, trough a codification of homeopathic knowledge and trainings, a denser network between members, political commitments and a move towards evidence-based practice. This professional movement –which eventually led to permanent incorporation of homeopathy into the compulsory health insurance (LAMal) in 2012– is also widely supported by CAM-users.

Conclusion:With reference to the session's topic, we may argue that homeopaths –and other CAM-medical segments– took a great advantage of the global dynamic on health issues and that this segment is of significant interest for the medical profession as a whole, enabling it to adapt to social and cultural changes since the end of the 1980s up to now.

Parallel session 6:
6.1 - Health professions in transition

Are we observing a professionalization of health promotion and prevention in Switzerland?

Julie Page, ZHAW Zurich University of Applied Sciences: School of Health Professions, Switzerland

Co-authors: Brigitte Ruckstuhl, Thomas Bucher; Gesundheitsförderung Prävention: Qualität - Konzepte - Geschichte, ZHAW Zurich University of Applied Sciences: School of Health Professions

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

Background: In Switzerland, the first bachelor programme in health promotion and prevention will start in September 2016. This fact can be seen as an important step towards the professionalization understood as the social process by which an occupation transforms itself into a true profession of the highest integrity and competence.

Aim: To explore whether the institutionalisation of the new bachelor programme in Switzerland is an indicator for the professionalization of health promotion and prevention in Switzerland.

Methods: In the course of the approval procedure for the new bachelor programme various studies were conducted such as interviews with stakeholders and needs assessment in Switzerland.

Results: The following results all concern the situation in Switzerland.
-National and regional structures, programmes and projects in health promotion and prevention have been set up.
-Postgraduate training in health promotion and prevention as well as in public health exists.
-Health promotion and prevention are existing occupational fields, however many people working in the areas are either over- or not adequately qualified.
-Demarcation (occupational closure) is observable.
-While various conferences exist, a professional body for health promotion and prevention does not.
-Research especially in health promotion needs strengthening.

Conclusions: The introduction of the bachelor programme in health promotion and prevention in Switzerland is a step in the professionalization of the area. The further development of the programme orientates its qualification on the existing European standards in order to make the graduates' competences transparent und enabling the health promotion practitioners to compete on the labour market. In the context of the continuing professionalization a balance needs to be found between those professional characteristics that are desirable and positive, while avoiding the negative attributes of professions which could undermine the whole purpose and philosophy underpinning the health promotion practitioner's role.

Parallel session 6:
6.1 - Health professions in transition

Health promotion, Beruflichkeit (professionalism/occupationalism), sociation

Ursula Streckeisen, University of Bern, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

The 'founding fathers' of sociology (Simmel, Durkheim etc.) considered Beruflichkeit a key principle of sociation in modern society: A Beruf has – in this classical view – a socially integrating power. Referring to Max Weber and Beck/Brater it can be defined as a delimited cluster of specialized performances that is socially institutionalized and related to an exclusive right to perform certain tasks (social closure, autonomy). The activities are conducted for gainful employment, but also with a commitment, and shape identities. Sociologists who analyse contemporary society partly proclaim an erosion of Beruflichkeit, partly an emergence of new forms of professions/occupations. Günter Voss suggests the concept of ‚individual profession/occupation' (Individualberuf), in the context of which the self-responsability is an important aspect.

The paper will explore the question, to what extent activities in the historically new field of health promotion can be regarded as 'berufliche' activities with a socially integrating function. Based on results reported in (mainly the german speaking) literature and on our own explorative research about school physicians, it is hypothesized that health promotion activities contribute in an indirect way to the sociation of the involved actors. We know that more and more actors engaged in the context of well institutionalized professions (often in the pathogenetic field of health) enhance their skills with health promotion-elements through further education, in a self responsible way. By doing so, they sucessfully raise their attractiveness on the labour market, and obtain additional responsabilities, but do not fundamentally change their Beruf nor their professional/occupational identity. Moreover, it seems that no social closure (monopolization) can be observed so far. We claim that a Beruf of health promotion does not arise up until now, but that undelimitable skills in health promotion become an element of successful 'cultivation' of individual professionalism/occupationalism with socially integrating power.

Parallel session 6:
6.1 - Health professions in transition

Medical coders - a new hospital profession in the area of tension between economic and professional orientations

Andreas Pfeuffer, FHNW Hochschule für Soziale Arbeit, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2130, Second floor
Session Chair: Naïke Bochatay and the Research Committee "Sociology of Health and Medicine" of the Swiss Sociological Association

The introduction of lump sum payments based on Diagnosis Related Groups in the German hospital sector entailed not only financial consequences for health service providers, but affected also employment, working conditions and working contents of the medical, nursing and administrative staff as well as their inter-professional relations.

Along with these developments and due to the intention to relieve the physicians of the burden of coding the DRGs, a labor market for so called "medical coders" ("Kodierfachkräfte") has emerged. These agents are primarily recruited from former nursing personnel, who have chosen to leave their former profession due to the deteriorating working conditions and health reasons. Another recruiting source are medical documentation specialists ("Medizinische Dokumentare") who are usually not skilled in a typical hospital profession.

The contribution discusses the formation of this new activity as a process of delegation of "dirty work" (E. Hughes) from the point of view of sociology of work and professions. It analyzes the ambiguous organizational position of medical coders, who are part of the accounting department of the hospital and have to impose the new economic imperatives on the health professionals. It demonstrates the foregoing working trajectories and the occupational qualification of the medical coders as key factors for the explanation of their professional identities and their practices.

The empirical base of the study is composed of in-depth interviews with hospital employees of all categories about the influence of hospital reforms on their day-to-day work, participant observations of the work of medical coders in two German hospitals in public ownership and an analysis of journals specialized in hospital and medical issues.

Parallel session 6:
6.2 - Imperative of good health and promotion of autonomy: a paradox?

Fourth agers' experiences of autonomy: comparing France and Switzerland

Pauline Mesnard, University of Lausanne, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

The promotion of a liberal conception of autonomy in long-term care policies has several consequences, especially in old age. It creates a duality between the third age and the fourth age. This new/last life stage indeed represents a target of eldercare policies to differentiate between older "dependent" care consumers and third agers characterized by their capacity to achieve "active ageing". This contribution analyzes the social meaning of autonomy in old age focusing on its institutionalized negative pattern, namely "dependency". The medical definition of dependency that is prevailing has to be criticized. I argue for a fundamental conception of dependency as human condition and a social conception of "relational" or "decentered" autonomy. The structure of eldercare networks and the meanings associated with the relationships of assistance are at the core of a new understanding of inequalities in the fourth age. How do fourth agers achieve autonomy within relationships of assistance? Using a comprehensive approach, this contribution focuses on the everyday experiences of older people in long-term care living at home across two European continental countries. I conducted a qualitative survey in France and Switzerland to study how fourth agers negotiate their autonomy in everyday life with their carers. In sum, this contribution is an attempt to understand what characterizes the social meaning of autonomy in several cultural contexts focusing on the collective regulation and subjective meaning of the relationship of dependency.

Parallel session 6:
6.2 - Imperative of good health and promotion of autonomy: a paradox?

Exploring a social construction on autonomy through public health opinion survey: Patterns and trends

Giovanna Gabriele, Department of Sociology, Faculty of Economics and Business, University of Barcelona, Spain

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

Public health is facing increasing pressures which are especially related to the processes of austerity, globalization and welfare change. While the health autorities role has been diminished, the responsibilities, duties and autonomy of individuals to be healthy and to have to maintain their own health through self-care, have increased. However, understanding autonomy relationally is by no means a simple matter. Some argue that the way that society is structured along education, class and gender lines negatively impacts autonomy. Despite this, the surveys and other sociological studies have forced a revision in the perception of autonomy out of classic sociodemographic variables, substituing a rigid and one-dimensional concept of an 'individual autonomy' for the more flexible and variegated view of the 'social autonomy.' In terms of critical reflection, the question may be asked: can positive autonomy ('be healthy') be able to change health behavior at societal level? Because of this, it becomes important to find out what autonomy is and how shapes behavior. In our research, we examined public perceptions of what impacts autonomy-related public health and what actions can be taken to improve social health behavior. We hypothesize that public opinion on public health affects autonomy representation and viceversa. Using data from the first survey on "public health" held in Spain (N=2000) and carrying out a comparative performance analysis of clustering, we demonstrate that attitudes, behavior patterns and degree of autonomy response schemes toward public health recommendations were more polarized in autonomous people than in less autonomous. Four behavioral profiles were defined. Additionally, we argue that relevance of disease representation may have not an influence on attitudes, leading to less sympathetic positions towards autonomy responsibility and high unhealthy risks. Combining health priorities and degrees of polarization shows that attitudes might be formed in the interplay between public opinion and autonomy patterns.

Parallel session 6:
6.2 - Imperative of good health and promotion of autonomy: a paradox?

Supporting autonomy: difficulties beyond the paradox

Samia Hurst, Geneva University Medical School, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

Autonomy in care contains an apparent paradox: free choice in an environment constrained by social norms. Implications of this paradox are visible in clinical ethics, where the requirements of respect for autonomy are more complex than their frequent depiction as something resembling obedience of the patient's will. Respecting the autonomy of patients in clinical care requires awareness of three different goals:

- avoiding abuse of power, paternalistic or otherwise;
- assisting patient decisions, by providing the help that we all need in order to make self-determined decisions;
- protecting patients against abuses of power by others.

Navigating these goals can be difficult. Assisting patient decisions can turn into a form of paternalism as clinicians attempt to convince rather than assist their patient. Distinguishing undue influence from accepted influence can also be challenging. Family members who insist that an elderly patient be admitted to hospital, for example, will sometimes truly convince but also sometimes lead her to yield to them. In a second case, social norms favorable to reproduction will increase the use of medically assisted reproduction. In a third case, marketing for sugar or tobacco represent a clear intention to infringe on personal autonomy. Persons do retain the option to disregard these messages and choose as they would have done without them, but this option is rendered more burdensome. Here, the burden is imposed by agents who may be restrained by social norms with the result that individual freedom would increase. All these cases present us with illustrations of the limits of self-determination understood as the absence of influence. All, however, also illustrate how supporting autonomy can enable persons to make more self-determined choices even within an environment constrained by social norms. In the third, the distribution of constraints is shown to be relevant in such an environment.

Parallel session 6:
6.2 - Imperative of good health and promotion of autonomy: a paradox?

The ubiquity and ambiguity of the use of autonomy in midwifery practice

Patricia Perrenoud, HESAV, Switzerland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig & Mélinée Schindler

The concept of autonomy has gained substantial importance in midwifery during recent decades and concerns several aspects of practice. Autonomy is firstly related to the objective of fostering women's freedom regarding care during birth. Secondly, autonomy is discussed with parents as a childrearing aim thought to be achieved through specific parental practices. Finally, autonomy is conceived in a logic of sociology of professions and concerns the scope of practice and decision making of midwives. These different meanings lead to a frequent use of the term autonomy which now belongs to professional clichés and is therefore seldom defined in daily practice. This presentation based on a 3-year anthropological fieldwork led in French speaking Switzerland, encompassing observations and interviews, will question several ambiguities regarding the use of autonomy in the relationship between midwives and families. For some midwives, more active with middle-class families, respect for women's autonomy forbids the use of personal references in the care encounter. Consequently, these midwives avoid sharing their experience of birth and childrearing practices, if they have any, regardless of the women's expectations. In other situations, some practical help can be denied to families, as this help is seen as a barrier to the aim of fostering the autonomy of families. In such cases, the conception of autonomy may interfere with equitable access to adapted care, which acknowledges actual capabilities of families. In addition, the same midwives provide care differently in different situations. They may develop the habit of providing an array of choices to parents regarding certain practices and omit doing so in another field of practice, leading to more authoritative attitudes. The use of autonomy and of related concepts such as responsibility and choice is thus embedded in contemporaneous forms of governance and potentially interferes with the experience of birth.

Parallel session 6:
6.3 - Symposium on SHARE

Session Introduction - SHARE's unique features for cross-national health research

Johanna Bristle, MEA, Max Planck Institute for Social Law and Social Policy, Germany

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1170, First floor
Session Chair: Johanna Bristle

This presentation provides an introduction to the session "Symposium on SHARE" and introduces features of the Survey of Health, Ageing and Retirement in Europe (SHARE) with a special emphasis on comparative health research. SHARE is a multidisciplinary and cross-national panel database of micro data on health, socioeconomic status and social and family networks. The data are available to the entire research community free of charge and are easy to access. The presentation highlights SHARE's unique combination of methodological features as described in the session description: (1) longitudinal data, (2) cross-national setting, (3) retrospective life histories, and (4) enhancement through linkage to administrative data or supplementary surveys among SHARE interviewers.

Parallel session 6:
6.3 - Symposium on SHARE

Immigrant-Native Differences in Health and Well-being among European Integration Policy Regimes

Gregor Sand, Max Planck Institute for Social Law and Social Policy, Germany

Co-authors: Stefan Gruber;
Max Planck Institute for Social Law and Social Policy

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1170, First floor
Session Chair: Johanna Bristle

Demographic aging and international migration have transformed the European population structure significantly. These days, large debates on immigration control and integration policies have been on the political agenda all over Europe. However, there is only a small understanding on how these policies affect the health and well-being of migrants, especially in later life.

This study analyses health disparities among elderly migrants and natives across several European countries. The outcome differences are brought into relationship with different immigrant integration policy models using the Migration Integration Policy Index (MIPEX). Two indicators of health are used: Grip strength as an objective measure of physical health and the CASP index measuring quality of life and subjective well-being.

Our results indicate that there are statistically significant differences between natives and migrants: Migrants show lower levels of both grip strength and well-being than the native population. The group differences remain statistically significant even when controlling for socio-demographic characteristics, chronic conditions and migration variables. Additionally, we find that the level of disparities between the two groups concerning health and well-being varies between countries. Current integration policies correlate with these country differences: The lower the MIPEX score the larger the immigrant-native gap. The disparities deteriorate with increasing age.

Parallel session 6:
6.3 - Symposium on SHARE

Health services utilisation in older Europeans: an empirical study

Andrej Srakar, Institute for Economic Research, Slovenia

Co-authors: Rok Hren, Valentina Prevolnik Rupel;
University of Ljubljana, Institute for Economic Research

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1170, First floor
Session Chair: Johanna Bristle

Living in old age is characterised by high prevalence of chronic diseases and by the coexistence of multiple morbidities in an individual. Although older people widely differ in terms of their health status, they are in constant need of a variety of health services. During past decades, these special needs of older people induced an increase in health services utilisation which in turn raised health care expenditures throughout industrialised societies. However, health care utilisation in older people is still inadequately understood, particularly regarding the differences among European jurisdictions, which have been well documented by the Organisation for Economic Co-operation and Development.

In our article, we used dataset of Wave 5 of SHARE to study the utilisation of health care in older Europeans (aged 50 and older) in 15 European countries: Austria, Belgium, Switzerland, Czech Republic, Germany, Denmark, Estonia, Spain, France, Israel, Italy, Luxembourg, Netherlands, Sweden, and Slovenia. We investigated cross-sectional relationships between factors such as age, gender, subjective perception of health, income or education and the utilisation of various types of health services (ambulatory care, medication, hospital and nursing homes). We also applied regression modeling (using OLS, logistic and Poisson models) to study the determinants of health utilisation (different socioeconomic and health variables) of older people. Preliminary results showed some significant differences between determinants of health utilisation in terms of probability and frequency of usage. Interestingly, income appeared weakly related to most of the variables of health utilisation. We also explored patterns between welfare regimes, taking Eastern European jurisdictions (including Slovenia) as a comparison category.

Results of our research are important for the management of health care facilities in terms of health care usage by older people, and can be of value to health care providers and policy makers in the field.

Parallel session 6:
6.3 - Symposium on SHARE

Cumulative disadvantages of non-employment and non-standard work for career and subjective well-being in old age

Valentina Ponomarenko, University of Luxembourg,
Luxembourg

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1170, First floor
Session Chair: Johanna Bristle

This paper investigates cumulative disadvantages of non-employment and non-standard work over the life course of individuals from 13 European countries born between 1930 and 1950. Unemployment, labour market inactivity and part-time work show negative effects for the career and subjective well-being in previous research. In two complimentary analyses, first, the career of older Europeans is analysed with sequence analysis methods to show how non-employment and part-time work are shaping careers and illustrate gender differences. In a second step, adverse career components are used to exemplify cumulative disadvantages on life satisfaction in old age. The Survey of Health, Aging and Retirement in Europe (SHARE) is used for the analyses. After optimal matching and clustering of the retrospective employment history, the results indicate that women experience more turbulent careers with more non-employment and part-time patterns. The analysis of life satisfaction shows that labour market inactivity and unemployment has negative effects in old age for men, but less for women. Part-time employment has not a straightforward effect for women and none for men.

Parallel session 6:
6.3 - Symposium on SHARE

Rating Your Health: An Examination of Non-Health-Related Factors and Differential Item Functioning in the Self-Rating of Health

Patrick Lazarevic, TU Dortmund University, Germany

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1170, First floor
Session Chair: Johanna Bristle

Cross-nationally comparative analyses are frequently based on respondents' self-rated health (SRH), assuming that SRH is comparable between different groups of respondents. However, this comparability is questionable due to manifold factors, such as differential expectations for ones' health, varying frames of reference, or cultural contexts. Also, it is highly likely that such ratings are influenced by non-health-related factors like personal, interviewer, or methodological characteristics. The present paper aims to identify such non-health-related influences on a person's SRH.

In a first step we predicted SRH via linear regression using a wide range of objective health factors based on the information of 14,400 participants of the fifth wave of the Survey of Ageing, Retirement and Health in Europe (SHARE). In a second step, we used a model covering factors such as interviewer characteristics, satisfaction with life, and the country of origin in order to explain the residuals of this first regression, and thus the variance steming from non-health-related aspects. All analyses were also carried out separately by gender and age-groups in order to identify differential response behaviors for these groups.

The basic health model explained a high amount of the variance, with only minor differences by sex and some differences by age-groups. As for the non-health-related model, consistent influences of the interviewers' own SRH, the general life satisfaction of the participant and the country of residence (with Swedes and Belgians reporting more positively) were overall found to explain a modest amount of variance, with some differences by gender and age-group. These results illustrate the necessity for researchers to take factors such as age-specific response behavior and non-health-related influences into account to provide a valid base for comparative research.

Parallel session 6:
6.4 - Inequalities and social determinants of health

Social-Economic Status, Work Conditions and Inequalities in Self-Reported Health in Ukrainian Working-age Population: Evidence from the ESS

Iryna Mazhak, Aarhus Institute of Advanced Studies, Denmark

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2150, Second floor
Session Chair: Sakari Karvonen

Framework. Relationship between socioeconomic status, working conditions, and inequalities in health is well examined. However, literature on inequalities in health-reported health connected with socioeconomic status, economic activity, and work conditions in Ukraine is scarce, and evidence of related social policy action on this problem is largely absent.

Methods. Data from the 2 - 6 rounds (5158 respondents at age 22-65 years) of a European Social Survey were used to examine how socioeconomic status, work conditions and economic activity influence self-reported poor health (poor SRH) of Ukrainian working-age respondents. The data were analyzed using the IBM SPSS 22 (logistic regression was used to assess the effect of the variables on poor SRH). Such variables as, socioeconomic status, economic activity, work conditions were created by using principal component analysis.

Results. A binominal logistic regression was performed to ascertain the effects of the socioeconomic status, economic activity, work conditions (the independent variables) on self-reported poor health (a dichotomous dependent variable), where all predictors were entered into the model in one step. The logistic regression model was statistically significant $\chi2(7) = 352.047$, $p < .0005$. The model explained 17% (Nagelkerke R2) of the variance in poor SRH and correctly classified 68.3% of cases. Sensitivity was 84.1%, specificity was 41.7%, positive predictive value was 70.76% and negative predictive value was 61.09%. Of the five predictor variables only variable of working conditions was not statistically significant ($p = .822$). Such variable as socioeconomic status ($p < .0005$) and economic activity ($p = .006$) were statistically significant. Females were more likely to report their health as poor then male as well as increasing age was associated with an increased likelihood of poor SRH.

Parallel session 6:
6.4 - Inequalities and social determinants of health

‘Being’ or ‘feeling’ healthy: determinants of objective and subjective health in broader Europe

Liubov Borisova, Uppsala University, Sweden

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2150, Second floor
Session Chair: Sakari Karvonen

BACKGROUND: The East-West health divide in Europe is well documented, in both objective and subjective health. Ever since the Cold War, the West European countries have fared better in terms of health than their Eastern neighbours. However, the question still remains whether this divide is determined simply by differing socio-economic conditions or whether determination of individual health is qualitatively different and cannot be generalised between East and West. Therefore, this chapter analyses the determinants of both objective and subjective health in Eastern and Western Europe.

METHODS: To better understand the differences of health determination in the East and West, multi-level analysis on the dataset of the European Social Survey (ESS) is performed. The data covers 30 countries and almost 300 thousand individuals over seven rounds, and provides proxies for the main socio-economic determinants and two measures of health: self-reported health and functional ability. Health determinants are measured at both the individual and country-levels, and are divided into economic, political, and social determinants, lifestyles and health care. The standard demographics – age, gender, education and marital status – are also controlled for.

RESULTS: The analysis reveals that determinants of objective and subjective health are not the same between East and West. Clear differences in determinants of health exist between West European and East European countries particularly in terms of objective health, measured through functional status. Furthermore, overall country context does not influence health as much in the East.

CONCLUSIONS: The results might signify that different processes occur in East and West Europe where health is concerned. All the findings once more reinforce the anomaly of the East European region, and recommend that researchers treat comparisons of different health indicators, as well as their determinants, between these two regions with a high degree of caution.

Parallel session 6:
6.5 - Lifestyles

The association between parenthood and partnership with risk health behaviour. The case of Germany

Elena von der Lippe, Robert Koch Institute, Germany

Co-authors: Petra Rattay;
Robert Koch Institute

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1160, First floor
Session Chair: Beatriz Xavier

Background: We investigate the relationship between parenthood, partnership and risk health behaviour of women and men in Germany. Usually, people living with partner and children experience higher social control, but at the same time may have higher time constrain, which influences health behaviour.

Methods: We use data from the GEDA-study carried out by the Robert Koch Institute in 2009-2010, collected using computer assisted telephone interviewing. In the analysis are included 20,717 people aged 18-45. Data on fruit and vegetable consumption, tobacco and alcohol intake, and physical activity are analysed using logistic regressions. All models are controlled for age, social status, health status, and employment.

Results: Living with partner is related to less smoking and alcohol consumption, both in men and women. Divorced men and women show higher physical activity than married one. Additionally, married or single women have healthier diet than the divorced ones.

Both, men and women smoke less and keep healthier diet when living with children. Mothers also consume less alcohol, and have higher physical activity than women without children.

The relationship between parenthood and health behaviour differs according to the number and age of children, especially in women. Mothers of young children tend to smoke less, have lower alcohol intake, and healthier diet than mothers of older children.

Discussion: Partnership and especially parenthood is positively correlated with most of the health behaviours, but the effects seem to be rather short-term. Obviously, in the period of pregnancy, birth and first years of parenthood especially women are willing to quit detrimental health behaviour. Prevention programs should aim at maintaining healthy behaviour in women and increasing men’s involvement in lifestyle change.

Parallel session 6:
6.5 - Lifestyles

The associations between neighborhood safety and leisure-time walking and cycling – a novel spatial approach

Tomi Mäki-Opas, National Institute for Health and Welfare (THL), Findland

Co-authors: Els Veldhuizen, Marieke Snijder, Anton E Kunst;
University of Amsterdam (UVA), Academic Medical Center (AMC),
Academic Medical Center (AMC)

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1160, First floor
Session Chair: Beatriz Xavier

Background: The relationship between neighborhood safety and leisure-time physical activity among adults is inconsistent. This study applied novel spatial analysis techniques to examine the associations of neighborhood safety with leisure-time walking and cycling, and assessed whether the associations varied across age, socioeconomic and ethnic groups.

Methods: The HELIUS data on the residents of Amsterdam aged 18 year and older was utilized (n=14 092). Cycling and walking during leisure-time (minutes per week) were measured using validated SQUASH questionnaire. Safety monitor data of Municipality of Amsterdam and socioeconomic as well as population density data of the Statistics Netherlands was linked to individuals by applying novel spatial techniques. Area-level indicators were estimated with various buffer sizes (100m, 300m and 500m) around central point of location in six digit postcodes (areas of 50 m2 on average). Linear regression models for leisure-time walking and cycling while adjusting for age, gender, individual and area-level SEP, area-level population density, ethnic background, chronic diseases and other modes of physical activity were conducted.

Results: Neighborhood safety within 500m buffer from home location was positively associated with cycling and walking during leisure-time. Residents aged 40-49 or 60-69 years and living in safe neighborhood cycled less during leisure-time compared to other age-groups living in less safe neighborhood. Those with high individual or area SEP and who lived in safe neighborhood cycled more during leisure-time compared to reference groups. Those with high individual SEP or those of South Asian Suriname background and who lived in the safe neighborhood walked less during leisure-time compared to their reference groups. These associations were only borderline significant. Across ethnic groups, no statistically significant variation between neighborhood safety and leisure-time cycling was observed.

Conclusions: Neighborhood safety promotes leisure-time cycling and walking, but the associations might vary according to age, SEP and ethnicity.

Parallel session 6:
6.5 - Lifestyles

Changes in educational differences in leisure-time physical activity – A 12 year follow-up study

Ossi Rahkonen, Dept Public Health, University of Helsinki, Finland

Co-authors: Jouni Lahti, Ansku Holstila, Eero Lahelma, Minna Mänty, Ossi Rahkonen;
Department of Public Health, University of Helsinki, Helsinki, Finland

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1160, First floor
Session Chair: Beatriz Xavier

Background: Cross-sectional studies suggest that among the lower educated physical inactivity is more common than among higher educated. However, there are only few prospective studies examining changes in leisure-time physical activity among different educational groups. We aimed to examine whether educational differences in leisure-time activity change over 12 years of follow-up among ageing employees.

Methods: Follow-up survey data were collected from 40–60-year-old employees of the City of Helsinki, Finland, at three time points: Phase 1 (2000-2002), Phase 2 (2007) and Phase 3 (2012). Educational level was categorized into three levels: higher (university degree), intermediate (e.g. vocational) and basic (primary school or less). Leisure-time physical activity was asked in four intensity grades using identical questions in each survey. The volume of leisure-time physical activity was assessed by approximate MET-hours per week. Incidence rate ratios (IRR) were calculated using generalized estimating equations (GEE) with negative binomial regression. Gender and age at phase 1 and time variant employment status, limiting long-standing illness and body mass index were used as confounders. The analyses included 5705 participants.

Results: At phase 1 there were minor educational differences in leisure-time physical activity. However, the educational differences in leisure-time physical activity widened over time as among the basic educated the mean MET-hours decreased, among the intermediate educated remained broadly the same whereas among the higher educated mean MET-hours increased. Leisure-time physical activity decreased among people with basic (IRR=0.90, 95% CI 0.87-0.93) and intermediate (IRR=0.96, 95% CI 0.94-0.99) education compared to those with higher education.

Conclusions: Educational differences in leisure-time physical activity widened over time among ageing employees. Physical activity should be promoted among ageing employees and retirees and especially among those with only basic education.

Parallel session 6:
6.6 - Welfare states

Economic crisis, austerity and social inequality in health in Europe

Kjetil A. van der Wel,
Oslo and Akershus University College, Norway

Co-authors: Ben Barr, Espen Dahl, Knut Halvorsen, Wen-Hao Chen, Therese Saltkjel;
University of Liverpool, Oslo and Akerhus University College and Statistics Canada

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1150, First floor
Session Chair: Tim Huijts

Background: The financial crisis in 2008 and the ensuing recession experienced by many European countries has had profound consequences for individual welfare and youth employment opportunities in particular. According to scholars, the crisis was further deepened by inadequate policy responses as many countries – not only those answering to the "Troika" – pursued austerity measures to balance national budgets.

The aim of this paper is to provide a comprehensive and coherent analysis of the effect of the "great recession" on health inequalities. By measuring and comparing different aspects of the crisis, from the more distal GDP changes to the more proximate changes in welfare spending and employment opportunities, the paper aims at shedding light on some of the mechanisms at work. Using individual level data from the European Social Survey allows us to investigate immediate and lagged effects of the crisis and assess the extent to which observed effects can be attributed to individual's experience of economic hardship and worklessness.

Methods: We use data from the European Social Survey, round 1 to round 6. In this study, we use data from 20 countries and a sample restricted to those aged 25-59 years old, leaving a sample of approximately 117 000 individuals. Multilevel methods were used to analyse individuals within country-year clusters. Country-level variation was accounted for by country dummies. Hence, the study analyses within-country country changes, rather than between-country variation.

Preliminary results: The study finds that all the three measures of the financial crisis (GDP change, unemployment rate change and austerity) were weakly related to increasing health inequality, and that the associations in part were explained by individual level economic hardship and worklessness.

Conclusions: The financial crisis was weakly to be related to increasing health inequalities in the short term.

Parallel session 6:
6.6 - Welfare states

Family policies and fertility: Analyzing the link between family policy institutions and fertility rates in 33 countries 1995-2010

Katharina Wesolowski, Stockholm University, Swedish Institute for Social Research, Sweden

Co-authors: Tommy Ferrarini;
Stockholm University, Swedish Institute for Social Research

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1150, First floor
Session Chair: Tim Huijts

This study analyzes the link between family-policy institutions and fertility changes in 33 countries 1995 to 2011 using new institutional data. We use newly collected data on family-policy legislation covering not only the frequently analyzed old OECD member countries, but also including new EU member countries as well as Russia and Ukraine. In order to evaluate the link between family policy and fertility, pooled time-series cross-section regression analyses are used with Total Fertility Rates (TFR) as the outcome variable and measures for gender-egalitarian and gender-traditional family policies as the main predictors. Moreover, female labor force participation, Gross Domestic Product (GDP), and unemployment are used as control variables. The results show that more extensive gender-egalitarian family policies and female employment are linked to higher fertility, while policies supporting traditional family patterns produce no statistically significant results. Analyses of the interaction between gender-egalitarian family policies and female paid work indicate that the impact of introducing more gender-egalitarian policies would be stronger in countries with lower levels of female labor force participation. Thus, the results lend support the argument that gender-egalitarian family policies might be a way to increase fertility rates of a country.

Parallel session 6:
6.6 - Welfare states

Job satisfaction among employees with activity limitations: role of socio-economic class and welfare policy (Europe)

Josephine Foubert, Ghent University, Belgium

Co-authors: Kjetil Van der Wel, Katia Levecque,
Ronan Van Rossem;
HiOA Oslo and Akerskhus University College, Ghent University,
Ghent University

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M1150, First floor
Session Chair: Tim Huijts

While countries focus increasingly on extending the working lives and the activation of people with activity limitations, little research has studied the work-related well-being of employees with activity limitations. This paper aims 1) to examine differences in job satisfaction between employees with and without activity limitations across Europe, and 2) to compare how these differences relate to differences in socio-economic class positions in the labour market on the micro-level and (changes in) active labour market policy (ALMP) and welfare generosity on the macro-level. Easily accessible and generous out-of-work benefits are criticized as threats to the sustainability of the welfare state and disincentives to work. This has led to the introduction of more employment stimulating policies in which ALMPs have played a crucial part. However, comprehensive welfare provision is also seen as a productive force that stimulates employment commitment and participation. We use data of the 2006 and 2012 European Social Survey focusing on the working population between 25 and 65 in 19 countries. Repeated cross-sectional multilevel and fixed effects analyses show that in all 19 countries people with activity limitations generally report a lower job satisfaction, which stays true after including socio-economic class relations and other work and employment related conditions. Changes in investments over time within a country and levels of welfare generosity did not alter the relationship. Higher investments in ALMPs were associated with smaller differences between employees with and without activity limitations. However, we also noticed that in countries with higher ALMP investments, employees with activity limitations are less likely to have a higher socio-economic positions in the market. This raises questions about the sustainability of ALMP investments and how to explain their positive impact on job satisfaction. Explanations might lie in the creation of societal work norms and the importance of work, independent from it characteristics.

Parallel session 6:
6.7 - Life course perspective on health: trajectories and transitions

Latelife employment histories and disadvantage at earlier life stages. Sequence analysis based on SHARE

Hanno Hoven, Centre for Health and Society, Institute for Medical Sociology, University of Düsseldorf, Germany

Co-authors: Nico Dragano, David Blane, Morten Wahrendorf;
Centre for Health and Society. Institute for Medical Sociology. University of Düsseldorf, International Centre for Life Course Studies in Society and Health. Department of Epidemiology and Public Health. University College London

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Background: Numerous studies have shown how sociodemographic and work-related factors affect the moment of retirement. Few studies, however, have summarized entire patterns of late life employment histories, and additionally, test the links between life course disadvantage (e.g. socioeconomic position and health) with specific types of late life employment histories.

Methods: We use data from the Survey of Health, Ageing and Retirement in Europe (SHARE), with detailed retrospective information for older men and women across 13 countries. Employment histories are measured in terms of annual information on the employment situation between age 50 and 70. To distinguish specific patterns of employment histories, we apply sequence analysis and identify eight different clusters of late life employment histories. Thereafter, we use information on adversity during childhood and midlife (in terms of socioeconomic position, health and education) and test its association to types of employment histories in sex-stratified analyses, adjusted for age, country-affiliation, and partnership.

Results: About half of the respondents belong to the first three clusters, characterized by histories as employees ending in retirement (early, middle or late). Two additional clusters are dominated by spells of self-employment with comparatively early or later retirement. Remaining clusters are either marked by part-time employment with retirement after age 60, by continuous domestic work, or irregular histories marked a spell of unemployment between work and retirement. Levels of early disadvantage are generally higher in clusters with earlier retirement and in irregular histories. In contrast, levels of disadvantage are lower in case of histories dominated by self-employment. Results remain significant after adjustments, and are similar for disadvantages during childhood and midlife.

Conclusions: Early disadvantage is linked to entire patterns of late life employment histories, where extended working lives are most likely in case of advantaged circumstances during childhood and midlife

Parallel session 6:
6.7 - Life course perspective on health: trajectories and transitions

Unemployment transitions and decreased self-rated health: The mediating role of income and financial strain

Anne Grete Tøge, Oslo and Akershus University College, Norway

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

Introduction: Research has shown that unemployment has a number of negative consequences, such as decreased income and poor self-rated health. However, the relationships between unemployment, income and health is not fully understood. Previous studies have investigated the health effect of unemployment and income separately; while how income mediates the health effect of job loss has gained less attention. This paper investigates whether the effect of unemployment on self-rated health (SRH) is mediated by low income, financial strain and/or material deprivation.

Methods: The analyses use data from the longitudinal panel of European Union Statistics on Income and Living Conditions (EU-SILC) over the four years 2008 to 2011. Individual fixed effects models are applied, estimating the longitudinal change in SRH as people move from employment to unemployment, and whether this relationship is mediated by household income, financial strain and/or material deprivation.

Results: Transitions into unemployment are associated with decreased SRH (-0.042, CI (-0.060 - -0.025). Absolute and relative changes in household equivalised income, as well as changes in subjective perceptions of financial strain are all associated with decreased SRH, nevertheless, none of these factors significantly reduce the association between unemployment transition and SRH.

Conclusions: Albeit income reductions, both in terms of absolute, relative and subjective terms, these effects are not found to mediate the effect of unemployment on self-rated health.

Parallel session 6:
6.7 - Life course perspective on health: trajectories and transitions

Wealth effects on levels and trajectories of allostatic load in later life

Ioana van Deurzen, Tilburg University, Netherlands

Co-authors: Bram Vanhoutte;
The University of Manchester

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

This study starts from the proposition that poverty is a source of chronic stress for those who experience it because of the daily hustles of dealing with inadequate and limited resources. Departing from a cumulative (dis)advantage perspective, we expect current circumstances to reflect differing levels of previous risk exposure. Risk exposure entails a holistic approach to negative influences on well-being, e.g., occupational, environmental and behavioral hazards, which has been expressed in more biological terms in the concept of allostatic load (AL). AL is a holistic way of understanding how chronic stress "gets under the skin" and leads to the development of disease, and can be understood as the price that body pays when constantly being in a state of alertness due to the constant confrontation with chronic stressors, a state of "wear and tear" of the body. We want to investigate to what extent wealth, gender and cohort differences are reflected in the level and trajectories over time of AL.

We use the English Longitudinal Study of Ageing (ELSA), a prospective panel study containing blood biomarkers collected during a nurse visit in 2004, 2008 and 2012, which allows us to measure the level of AL. These data allow us to perform growth curve models and to examine how both the level and the change in AL in later life are related to wealth. Our preliminary results suggest that throughout the period investigated, all respondents experienced an increase in AL. Poor respondents, women and those who are born after 1925 have a higher level of AL. Richer people have a steeper increase in AL when ageing, but this increase is not statistically significant.

Parallel session 6:
6.7 - Life course perspective on health: trajectories and transitions

Education and Health Across Lives and Cohorts: A Study of Cumulative Advantage in Germany

Liliya Leopold, European University Institute, Italy

Co-authors: Thomas Leopold;
University of Amsterdam

Tuesday 28 June 2016
Time: 4:15-5:45pm
Room: M2170, Second floor
Session Chair: Claudine Burton-Jeangros

The cumulative advantage hypothesis predicts health gaps across educational levels to widen with age. A recent addition, the rising importance hypothesis, further posits that this relationship has intensified across cohorts. Longitudinal evidence in support of both hypotheses is largely limited to the United States. German studies – mainly based on cross-sectional designs – have reported health gaps to remain stable or even to converge with age. This study presents more rigorous tests for the hypotheses of cumulative advantage and rising importance in the German context. The analysis draws on longitudinal data from 23 waves (1992 – 2014) of the German Socio-economic Panel Study (N = 4,648 respondents comprising 67,067 panel observations) to disentangle age and cohort effects on trajectories of self-rated health. Results show that health gaps between higher and lower educated people widen with age. Further analyses reveal that this divergence is gender-specific. Among women, health gaps are relatively small and remain stable over the life course. Among men, educational health inequality is profoundly – and increasingly – shaped by processes of cumulative advantage.

Parallel session 7:
7.1 - Biopolitical spaces, healthy bodies and inequality

Policy practices and embodied entanglements in the active living agenda

Simone Fullagar, University of Bath, United Kingdom

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1150, First floor
Session Chair: Oli Williams

This paper explores the UK active living policy assemblage that governs bodies and places through particular technologies (funding contracts, legislation, joint assessments, consultation papers), discourses and affective relations. Focussing on the localised context of Swindon as a regional English town with identified health inequalities, the analysis questions the static assumption that places are containers, sites or environments within which individuals can be motivated to be active. In 2013 legislative change shifted responsibility for public health to local government authorities that have also been governed by budget reductions over the past five years. Conventionally physical activity policies in the UK have sought to address inequality at the population level while targeting individual behaviour change through an emphasis on the 'barriers' that prevent movement. What remains concealed through this formulation of active living are questions about the materiality of local contexts, affects and power relations that shape embodied practices (class, race, gender, sexuality, disability, age). In contrast, I consider a relational understanding of place in terms of flows, embodied performance and cultural imagination that enables a more complex exploration of spatial practices and inequalities for policy practice. The insights of feminist and post-humanist theory offer different ways of understanding the entanglements of sensory bodies, non-human beings and entities, digital technologies and surfaces (lights, parks, bikes, cars, gyms, phones, facebook etc). The paper offers critical insights into the policy challenge of creating 'joined-up' solutions to complex social issues that affect participation in physical cultural practices.

Parallel session 7:
7.1 - Biopolitical spaces, healthy bodies and inequality

Whose experience matters in health (in)equality policy debates?: Children’s embodied physical and digital cultures

Annaleise Depper, University of Bath, England

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1150, First floor
Session Chair: Oli Williams

Over the past decade, the UK has witnessed a plethora of national policies aimed at increasing physical activity and preventing children and young people ‘at risk’ from developing lifestyles diseases associated with the so-called ‘obesity epidemic’. This article examines ‘A new strategy for sport: consultation’ document, to explore the government’s most recent endeavour to tackle health problems, unite communities through sport and encourage participation in active living through digital technologies. Through a discursive analysis of this recent health policy, I explore how language is used to construct neoliberal discourses of healthism in order to mobilise children and their families into active, responsible lifestyles. Guided by an interdisciplinary approach of physical cultural studies, this paper engages in conceptualisations of space to advance knowledge around children’s health and physical activity (in)equalities in new directions. Through this theoretical lens, the analysis emphasises the importance of understanding the affective contexts of children’s everyday spaces; the ways in which young individuals negotiate and embody physical (in)activity as a social practice.

Attention is given to how the bodies of young people are positioned in the policy document and how adopting active lifestyle practices is understood as an individual choice. This involves examining how young people’s choices to be active are frequently positioned as ‘rational’ and context free in government health policy. I further critique the absence of young people’s experiences of (in)active living from much of research that informs policy. I emphasise it is necessary to engage with what young individuals value about physical activity (identity, place, social connection) and contextual factors that constrain participation. This article suggests that local and national policy health strategies must consider the social, cultural, political and economic context that supports and constrains young people’s experiences of active living in the community.

Parallel session 7:
7.1 - Biopolitical spaces, healthy bodies and inequality

A Comparative Analysis of Health Representations, Lifestyles and Moral Responsibility in Poor Families in Europe

Monica Aceti, University Fribourg, Domaine sociologie, politiques sociales et travail social, Switzerland

Co-authors: Elke Grimminger, Sandrine Knobé, Simone Digennaro, Gilles Vieille Marchiset;
University of Dortmund, University of Strasbourg, University of Cassino , University of Strasbourg

Wednesday 29 June 2016
Time: 8:30-10am
Room: M1150, First floor
Session Chair: Oli Williams

In the rising context of an obesity crisis, individuals are claimed to take the responsibility for their own health. Embedded in this context, our research program (www.apsapa.eu) tries to understand the impact of healthism in discourses about fitness representations and transmissions of social health practices in families living in a socially disadvantaged situation, i.e. `poor´ in relation to the national level and more concerned with social health inequalities.

Methods: The official discourses were identified in a comparative analysis of the four national health promotion programs (CH, D, F and I). Focus groups with children aged 9-10 years (N=169) as well as interviews with parents (N= 37) were conducted. A comparative structured qualitative analysis in MAXQDA discovered central topics. Theory driven portraits of the parents completed the data analyzing process.

Results: In French families, the official discourse of the national health promotion program is omnipresent, but has less impact on everyday practices. In Germany, the mothers are the most important socialization agents for health practices. Although they are often overwhelmed, they look after their children´s health development by neglecting at the same time their own. In Italy, the mothers try to protect their children against health hazards caused by the environmental context: Washing hands and keeping their children inside the house are mostly named as health practices. On the contrary, the parents in Switzerland appreciate their environmental context and favor outside activities for their children. However, their discourse is characterized by moral tensions between ideal healthy lifestyle and socio-economic determinants.

Discussion: The family discourses reveal negotiation processes and ambivalence about the given resources and barriers to a healthy lifestyle. Especially socio-economic, cultural and political factors have an intersectional impact on the possibilities parents can fulfill the asked responsibility for their own health as well as for their children´s health.

Parallel session 7:
7.2 - Research in Medical Education

Interprofessional Collaboration in Internal Medicine: a Multi-Step Study

Naïke Bochatay, Unit of Development and Research in Medical Education, Faculty of Medicine, University of Geneva, Switzerland

Co-authors: Virginie Muller-Juge, Stéphane Cullati, Katherine S Blondon, Patricia Hudelson, Fabienne Maître, Nu V Vu, Georges L Savoldelli, Mathieu R Nendaz;
University of Geneva, University Hospitals of Geneva

Wednesday 29 June 2016
Time: 8:30-10am
Room: M1130, First floor
Session Chair: Naïke Bochatay and Zoya Horcik

Background: Research in medical education draws on methods from different fields, among which sociology. However, its goal often differs from that of other social sciences, as it usually aims to assess educational practice and quality of care by describing teaching methods, comparing educational interventions, or clarifying them. One aspect of research in medical education is therefore more applied than it is in other social science disciplines. We used different steps and methods to examine interprofessional collaboration between residents and nurses, so as to identify areas where it could be improved.

Methods: Semi-structured interviews were conducted with 14 residents and 14 nurses working on an internal medicine ward to explore their role perceptions for themselves and for the other profession. Following this, each resident was randomly paired with a nurse to manage two clinical cases in a simulated environment. These simulations were followed by individual debriefing sessions. We first analyzed data from the interviews and simulations, before comparing them to evaluate the association between residents' and nurses' perceptions of their role and their ensuing actions in practice.

Results: We identified themes for which residents' and nurses' role perceptions differed, and for which they experienced difficulties in applying elements that they viewed as components of their role in interprofessional practice. These themes represent topics for better role clarification, and for which interprofessional continuing education needs to be refined.

Conclusions: This study represents one example of how research in medical education is conducted. It illustrates ways in which knowledge gained from research in the health sciences education field may be used to address problems encountered by educationalists and by healthcare professionals. Thus, this study lends itself to an analysis of the similarities and differences that exist between research in medical education and research in other social sciences.

Parallel session 7:
7.2 - Research in Medical Education

Interplay between medical students' personal characteristics, educational environment and academic progression and career intentions: a cohort study

Zoya Horcik, University of Geneva, Switzerland

Co-authors: Anne Baroffio, Milena Abbiatti, Margaret Gerbase, University of Geneva

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Naïke Bochatay and Zoya Horcik

This presentation describes a cohort study which aims to establish links between medical student's personal profile and the impact of the learning environment.

One of the main goals of medical schools is to provide an accurate training that fulfills society needs as well as taking into account the personal characteristics and career choices of the students.

For example in Switzerland previsions show that in 2030, the number of family doctors will drop to 20% which is problematic in a high life expectany and aging society.

To date, little is known about the evolution of medical students and their training thought medical schools in Europa.

The main goal of our study is to describe the future population of medical practitioners and to understand if medical school meets it's former objectives. Specifically it aims to evaluate how the learning environment in the faculty of medicine in Geneva and the medical students' personality impact on the individual performance and career choices.

To do so, we selected surveys from Education and Psychology fields that aim to assess on students' personal characteristics (Socio-demographics data) cognitive (GPA, exams grades) and non-cognitive measures (personality traits, SPQ, values and motivation, coping style, Empathy) as well as the educational environment's perception (DREEM).

Cohorts of students were constituted and answered to a selection of these surveys once a year since 2011 (4th year of study in 2015).

The first results of the study already raise questions about various subjects such as the selection process through the studies, the evolution of the empathetic representation, and the evolution of personality traits. Some of these subjects will be investigated with complementary studies.

Parallel session 7:
7.2 - Research in Medical Education

Are unsuccessful applicants for medical studies lost for the health sector?

Ursula Meidert, Zurich University of Applied Sciences, Switzerland

Co-authors: Julie Page;
Zurich University of Applied Sciences

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Naïke Bochatay and Zoya Horcik

Background: The Swiss health sector has an increasingly wide gap between supply and demand on skilled health professionals. Moreover Switzerland is committed to the WHO global code of practice on the international recruitment of health personnel and therefore should train enough personnel themselves.

Goal: This study was commissioned by the Federal Office for Public Health and aimed at clarifying: 1. which education people follow who couldn't study medicine due to admission restrictions. 2. If these people had enough information on alternative educations in the health sector or if more information would have been needed. 3. If they could be motivated for an alternative education in the health sector.

Method: An online survey was conducted with all candidates for medical studies in Switzerland for 2011. A total of 21 interviews with directors of Bachelor training in health professions were held.

Results: A total of 1148 people participated in the survey. 75% of the unsuccessful applicants were still studying at a university but in other programs, half of which studied sciences. 20% of unsuccessful candidates began studies at a University of Applied Sciences, one third thereof a program in health professions. Only 41% of participants knew about programs for health professions at the level of Universities of Applied Sciences and 28% had an interest in them. The study showed that alternative education programs are not well known.

The interviews showed that the programs in occupational therapy, physical therapy, midwifery and nutrition & dietetics had also limited study places. The demand outnumbered the actual quota. Only the programs in nursing and medical radiology had capacity for additional students.

Discussion: Young people in the gymnasiums and unsuccessful applicants for medical studies should be provided with more information about alternative education programs in the health sector. At the meantime more study places should be provided.

Parallel session 7:
7.2 - Research in Medical Education

Enhancing supervision's efficacy in private clinical practice: a challenge for the clinical teachers

Virginie Muller-Juge, Faculty of Medicine, UIGP, Switzerland

Co-authors: Anne-Catherine Pereira Miozzari, Marie-Claude Audétat;
Faculty of Medicine, UIGP

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1130, First floor
Session Chair: Naïke Bochatay and Zoya Horcik

Background: The projected shortage of primary care physicians emphasizes the need to increase the primary care workforce. To achieve this aim, the Swiss universities develop clerkships in family medicine private practices. These family medicine clinicians, who are about to endorse challenging new roles as supervisors, need faculty development to assure the quality of clinical training.

This project is developed in collaboration with the other Swiss institutes of family medicine, and its purpose is to describe the actual responses and conceptual frameworks of these clinical teachers.

Methods: We chose participatory action research, in order to develop new practices and a collective pedagogical culture.

The research study was undertaken in three steps. First, participants supervised a standardized learner by responding to the educational needs expressed in three typical supervision scenarios; through a stimulated-recall technique, participants then answered questions about their conceptual frameworks used during these supervisions; and finally, received peer reflection. The study used a mixed methods design, combining standard content analysis of the qualitative data, with descriptive and correlational statistical analysis.

Results: 41 clinical teachers participated in the study. Preliminary results suggest that the clinical teachers used only few conceptual frameworks and supervise the students in very intuitive and implicit ways. We noticed that they are not conscious of the complexity of the double role which they have to assume as clinical teachers. However, with the research action used in this project and more specifically with the peer reflection offered to the participants, clinical teachers became aware of their strengths and weaknesses as supervisor.

Conclusions: These finding have important implications for developing training programs and for developing a culture of change. The action research is a way to develop new practices, make the clinical teachers conscious of their double role, train them and create a collective pedagogical culture.

Parallel session 7:
7.3 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

The vulnerable body: The postpartum care market in contemporary South Korea

Yoonjung Kang, University of Illinois at Urbana-Champaign, United States

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1140, First floor
Session Chair: Patricia Perrenoud

Oriental medicine has long elaborated the concept of “postpartum wind,” a postnatal disease that causes symptoms such as torpor, dizziness, bone pain, muscle soreness and/or depression, emphasizing the uniqueness of female bodily functions and the inherent danger of childbearing. The traditional health belief of the vulnerability of the postpartum female body has induced the postpartum care market in many East Asian countries. This paper examines the burgeoning postpartum care market in South Korea in which globalized Western biomedicine is hegemonic, whereas oriental (Traditional Korean) medicine is barely surviving under the rhetoric of “Koreanness.” Through an ethnography of residential postpartum care facilities which provide birthing women with intensive maternal body care for weeks at an extra cost, I shed light on the ways in which the female body is differently encoded and/or enacted reflecting social imperatives for health and beauty, conflicting medical knowledge, and individual aspirations for a better life. Particularly, I take a closer look at how the traditional postpartum healthcare beliefs and practices that stress risks for lifelong health problems caused by childbirth are revitalized in the biomedicine-oriented healthcare market in South Korean society. By illuminating how the postpartum care market effectively caters to Korean mothers loaded with concerns over uncertain future health and beauty, the paper demonstrates that the scope of risk and solutions for the perceived risk can be different depending on cultural values and socio-economic structures.

Parallel session 7:
7.3 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

The socially differentiated appropriation of the principle of prevention

Raphaël Dhuot, INRA, France

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1140, First floor
Session Chair: Patricia Perrenoud

The increased demand for scientific based knowledge about education promotes the emphasis on nursery education organised around medical knowledge, especially in infant nutrition. Food diversification, transition period from the exclusive milk diet to an adult-type diet, is considered crucial to the health of the child. Medical recommendations set out the risks of the postnatal period. This program is at its most developed point when illustrating a child "with atopic risk" increased. Socioeconomic properties of the household determine the probability of using this expertise, to address child nutrition, or to favour competing models, such as transmission of family values. Under these conditions, how to distribute a prevention principle, established scientifically, supposed to guide infant feeding?

“The French Longitudinal Survey from Childhood” allows for comparison of tobacco, alcohol and food consumption of the mother, before and during pregnancy, and the child's diet in its first year. We explain, statistically, the social distribution of maternal habits potentially harmful to the infant. We analyse the link between the evolution of these practices, which can reflect the identification of a risk, and food diversification of the child which crystallizes attempts, or not, to risk control.

In the upper and upper-middle classes, correcting or moderating risk practices are significantly correlated with a more prudent dietary diversification, while the lifestyles of the lower and middle-lower classes suggest a certain indifference to the prevention of risk.

Analysing the distribution of consumptions deemed medically inappropriate during pregnancy, and their links with child food, emphasizes the social markers of a certain culture of risk. So we show the appropriation of the prevention principle primarily concerns individuals, socially and academically, close to experts that define the risk and the rules of its mastery.

Parallel session 7:
7.3 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

Mala Leche: Interpretation of Risk and Medical Challenges to Exclusive Breastfeeding in Mexico

Jenna Murray de Lopez, University of Salford, United Kingdom

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1140, First floor
Session Chair: Patricia Perrenoud

This paper discusses mestiza women's maternity narratives and beliefs concerning mother's milk as a source of contamination for their baby and how risk is interpreted in the home. The narratives were collected as part of ethnographic fieldwork carried out for three months between 2011-2012 and a further eight months in 2013 in Chiapas, South East Mexico. During my fieldwork I came across repeated incidences where mother's milk or the mother's body itself was blamed for non-serious illness in a newborn. Despite public health messages promoting the benefits of exclusive breastfeeding, women were repeatedly told by individual doctors that existing medical problems or complications in birth meant that their milk was causing harm to their baby. Physical and emotional conditions could literarily turn a woman's milk bad (mala leche). This reinforced a notion perpetuated throughout the clinical management of pregnancy and birth that without intervention a woman was at risk of harming her child. In Mexico women who go against advice are seen (by doctors and the state) to be increasing their risk of complications and in doing so they are considered bad mothers. Adhering to medical advice defines women as good mothers because they are demonstrating risk averse behaviour. The advice given to women to replace breastfeeding with formula does not take into account the logics of intercultural norms that breastmilk can be made good again by treating the mother with non-medical interventions. In this paper I will argue that the women's narratives demonstrate that risk, recognised as a concept that goes beyond a socio-political definition, serves to construct cultural boundaries – between individual bodies, social groups within and between communities.

Parallel session 7:
7.4 - Inequalities and social determinants of health

The more, the merrier? Health effects of unemployment in 25 European countries during a crisis

Kristian Heggebø, Oslo and Akershus University College, Norway

Co-authors: Jon Ivar Elstad;
Oslo and Akershus University College

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Tim Huijts

Europe have been struggling with a deep and long-lasting economic crisis since 2008, which have resulted in high unemployment levels in several countries. Job loss is usually associated with income drops, re-employment difficulties, and health deterioration. Unemployment is therefore clearly an undesirable event, but is it easier to be unemployed when there is much of it around? Using EU-SILC panel data (2010-2013) and propensity score matching techniques, this paper investigates short-term health effects of unemployment – measured by self-rated general health – in 25 European countries experiencing diverging economic conditions. The included countries vary regarding both level of and changes in the unemployment rate during the investigated time window (e.g. high and rising in Portugal and Spain; high and declining in Lithuania and Latvia). There are three (potential) explanations for why the economic conditions should influence individual-level health effects of unemployment. First, the unemployed population will probably be positively selected on health (and other unobserved) characteristics when unemployment becomes commonplace. Second, there might be less stigma and self-blame associated with unemployment when the experience is widely shared. Third, unemployment might be more harmful for health during an economic crisis because re-employment chances are bleak. The results show no general trend towards there being less health deterioration due to unemployment when the experience is widely shared. However, the health effects of unemployment appears to be heterogeneous: both older individuals and the low educated seems to be quite vulnerable in several European countries. Overall, the presented results are not in accordance with the hypothesis known as 'the more, the merrier'.

Parallel session 7:
7.4 - Inequalities and social determinants of health

Mental health in unemployed youth: the role of educational attainment and feelings of demotion

Kelly Huegaerts, Interface Demography, Dept. of Sociology, Vrije Universiteit Brussel, Belgium

Co-authors: Kelly Huegaerts, Christophe Vanroelen; Vrije Universiteit Brussel

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Tim Huijts

BACKGROUND: Youth unemployment is a challenging social problem for many European societies. In Belgium, youngsters in the Brussels Capital Region are particularly affected by unemployment. Apart from its societal impact, youth unemployment is most harmful for those directly affected. Unemployed youth have less career success later in life and higher chances of experiencing mental health problems. Moreover, limited career success and mental health may reinforce one another, creating a vicious circle mediated by feelings of demotion.

AIM: to investigate in Brussels' unemployed youth the relationship between educational attainment and self-perceived mental health and the mediating impact of feelings of demotion.

METHODS: A dataset of unemployed Brussels school leavers (N 1.136; 45% males) aged 18-29 was analysed. The data was collected in 2015 through self-administered questionnaires among those invited to an information session on the EU Youth Guarantee provided by the Brussels Public Employment Service "Actiris". Mental health was assessed by means of the GHQ-12. Demotion was measured through an item list of 10 questions. Self-reported educational attainment, age and gender were included in the analyses. A full structural equation model including a path model and a confirmatory factor analysis with direct and indirect effects was estimated using Lavaan in R.

RESULTS: Educational attainment is related to both mental health and feelings of demotion. Our results show that higher educated youth have a worse mental health compared to low-educated youth as a direct effect. However the indirect effect going through demotion reverses this direct effect. So feelings of demotion strongly mediate the relation between educational attainment and mental health.

CONCLUSION: Feelings of demotion play an important role in the mental health status of young unemployed school leavers. Both mental health improvements and future career success may gain from policies aimed at increasing self-esteem and empowerment of young unemployed.

Parallel session 7:
7.4 - Inequalities and social determinants of health

What about feelings? Psychological well-being and unemployment in Portugal

Isabel Marcano Clemente, Interdisciplinary Centre of Social Sciences – CICS.NOVA, Portugal

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2150, Second floor
Session Chair: Tim Huijts

In this communication we present the results of a research developed in Portugal about psychological well-being and unemployment. A survey with 300 unemployed people (150 women and 150 men, aged 20 to 62 years) took place in 5 counties of Portugal in 2005/ 2006 and in 2013. By the same years, also several interviews of unemployed man and women have been realized in the same counties in order to get a qualitative look of the problem.

The data are exploratory by setting a first approach to the subject in Portugal.

Unemployment is a social and economic problem with impact on psychological well-being. We have identified phases in the psychological breaking process of the unemployed, since a shock first (not necessarily for everyone) to the fatalism, the last phase of adaptation to the unemployed status when unemployment persists at length. This includes also possible phases the optimism and pessimism.

We found reactions to unemployment like a dynamic process in the transition between stages, in contrast to a static approach.

Parallel session 7:
7.5 - Lifestyles

Family and health behavior in Europe: A multi-level analysis of social control in different contexts

Nadine Reibling, University of Siegen, Germany

Co-authors: Jason Beckfield, Tim Huijts;
Harvard University, Queen Mary, University of London

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Beatriz Xavier

On average, married persons and persons with children are in better health than non-married persons and non-parents which may partially be the due to less risk-taking and more health-promoting behavior among these groups. Social integration theory proposes that better health behavior results from the social control that family relationships entail. However, the impact of social control may depend on the way certain behaviors are viewed within the family and the larger social context. Therefore, this study investigates if the benefits of marriage and parenthood for health behavior differ between families with different educational background and between nations with different norms of health behaviors? This question is analyzed with the European social survey (wave 7) for alcohol andcigarette consumption (risk behaviors), fruit/vegetable consumption, and physical activity (health-promoting behaviors). The results of our multi-level model indicate that married persons smoke less and eat more fruits and vegetables than all other non-married groups. They also drink less than divorced and never married persons and are more physically active than the widowed. Persons who live with children smoke and drink less, but are also less physically active than persons without children. Benefits of family relationships vary with the level of education, particularly for risk behavior. Interestingly, the protective effect of being married for smoking and alcohol consumption is highest among the low educated and decreases with educational level, while living with children is only associated with less drinking and smoking among respondents with a higher level of education. For risk behaviors also the national contexts seems to matter as the benefits of being married differs between countries. In sum, family roles are associated with less risk behavior and to some extent more health-promoting behavior. However, whether and how social integration shapes health behavior depends upon the structural context in which these family relationships are embedded.

Parallel session 7:
7.5 - Lifestyles

Time budget of older people in Poland

Katarzyna Zawisza, Department of Medical Sociology , Chair of Epidemiology and Preventive Medicine,Jagiellonian University Medical College, Poland

Co-authors: Aleksander Galas, Beata Tobiasz-Adamczyk;
Department of Epidemiology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Beatriz Xavier

The process of aging is inextricably related with an increased risk of limitations in functioning and deterioration of health status. Simultaneously, observed for a long time changes in longevity are related to a postponement of limitation and diseases. The time budget data provide useful knowledge about the way older people spent their time, thus it may provide valuable information for health and social policy planning.

The aim of the study was the description of the way older people use their time (type, frequency, duration, social context of activity) by demographics (age, gender and level of education).

The sample for our investigation consists of 1284 people aged 65+ form general Polish population being a part of a cross-sectional study (COURAGE-in-Europe) conducted in 2009-2012.

The analysis showed that older people spent most of their time alone (around 67% of their awakening time) and the percentage of time spent in solitude increased among people aged 80 and over. Older adults allocated most of their time on physical inactivity, especially on watching television. Time spent on more demanding activities such as doing housework or shopping was lower among the oldest olds(80+). Total time engaged in daily living activities and in providing care to others was higher among women than men. Men spent more time on subsistence farming and more frequently reported riding a bicycle. Higher percent of men spent time on passive leisure activities (e.g. watching TV). Time spent in passive way decreased with increasing educational level, whereas there were no significant differences in the time spending on exercising or leisurely walking between people at different educational levels.

The study revealed frequent unhealthy behaviours among older adults in Poland and suggest implementation of some strategies to increase engagement in more demanding activities which may enable them to maintain good mental and physical functioning.

Parallel session 7:
7.5 - Lifestyles

The health and well-being of immigrants in Lombardy. Lifestyles and access to healthcare services

Lia Lombardi, ISMU Foundation, Italy

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M1160, First floor
Session Chair: Beatriz Xavier

BACKGROUND: Drawing on the ISMU Foundation (Milan) annual survey carried out between May and June 2015 on a sample of 3,500 immigrants living in Lombardy, the paper analyzes the data pertaining to some care attitudes with regard to healthcare and lifestyle (smoking habits, diet, physical activity and disease prevention) and to changes following the economic crisis. In 2015 a new variable, access to socio-healthcare services (such as family healthcare centers and their features), was introduced.

METHODS: Our research consists of a quantitative study based on crossing the main variables with socio-demographic indicators such as gender, age, education, income, and on how long the immigrants have resided in Lombardy.

RESULTS AND CONCLUSIONS: Among the most significant results obtained from the interviews, the following emerge:

1. more than 30% of respondents have changed their practices and care strategies, including care renunciation, as a consequence of the economic crisis in Italy;
2. care strategy is strongly influenced by structural variables such as gender, education, income and length of migration, while religious beliefs and geographical origins seem to be related to cultural variables;
3. compared to 2014, in 2015 there seems to be a relative improvement with respect to lifestyle: a reduction in smoking, an increase in the daily consumption of fruit and vegetables and an increase in physical activity;
4. the results relating to the practices in disease prevention are also very important: in Lombardy the percentage of immigrants who access prevention programs is still very low (about 50% compared to Italian citizens) and it varies according to nationality and geographical origin.

The results of this analysis can be also considered as an indicator of the "inclusion" of immigrants in Lombardy and of their chance to access healthcare and social services.

Parallel session 7:
7.5 - Lifestyles

Healthy Lifestyle and Pro-Consumer Orientation Amongst the Poles

Agnieszka Borowiec, The Cardinal Stefan Wyszyński Institute of Cardiology, Poland

Wednesday 29 June 2016
Time: 8:30-10am
Room: M1160, First floor
Session Chair: Beatriz Xavier

There are a lot of studies aiming at seeking determinants of healthy lifestyle but it is rarely taken into account the wider cultural context in which people choose behaviors that make up a healthy lifestyle. Consumerism seems to be a part of that cultural context in developed countries.

The aim of the study is to determine the relationship between a healthy lifestyle and pro-consumer orientation among Poles. A healthy lifestyle is understood, as defined Cockerham, as "collective patterns of health-related behaviour based on choices from options available to people according to their life chances", which consist of proper eating habits, restraining from smoking, exercises, etc. . Pro-consumer orientation is defined, according to the theory of consumer society, as a specific approach to reality, which involves the search for immediate satisfaction of the needs of pleasure and the feeling of meaning through the purchase and consumption of goods and services.

There will be presented the results of two surveys: the first, which was completed in 2013 in Warsaw on a quota sample of 500 entrepreneurs, managers and professionals, and the second, which will be conducted in April 2016 on national Polish sample of about 1,000 people.

Analysis of the data of the first indicates that the pro-consumer orientation is associated with certain behaviors conducive to health, like practicing certain sports or eating more meals throughout the day, but also with unhealthy behaviors such as drinking large amounts of beer, use of psychoactive substances, drinking energizing drinks, and adding salt to meals.

The results suggest that the pro-consumer orientation is positively associated with such elements of a healthy lifestyle, which symbolize membership in certain social groups and are fashionable and adversely with those that require constant self-control, and do not bring immediate benefits.

Parallel session 7:
7.6 - Subjective well-being and quality of life

Healthy and/or happy: The complex relationship between health and well-being in the age of preventive medicine

Maria Caiata Zufferey, University of Applied Sciences of Southern Switzerland, Switzerland

Wednesday 29 June 2016
Time: 8:30-10am
Room: M2130, Second floor
Session Chair: Ellen Verbakel

For the past 20 years, genetic tests have been available to identify individuals' predisposition to cancer due to specific gene mutations. In the event of adverse results, individuals know that they carry the mutation associated with the illness, but they don't know if or when the illness will develop. This probabilistic information is supposed to help people remain healthy, as it provides them with the possibility of adopting specific measures to minimize their risk.

In this paper, we explore the impact of the adverse genetic information on healthy individuals' subjective sense of well-being. Following a grounded theory design, qualitative interviews were recently conducted in Switzerland with 32 unaffected women who had been found to be at risk of developing genetic breast/ovarian cancer at least three years earlier.

The findings suggest that knowing that one is genetically at risk of developing cancer conveys an invitation to transform health into a program, i.e., into a set of planned activities realized in collaboration with the medical system in order to reduce the risk of developing cancer. While this health program is expected to increase individuals' subjective feeling of well-being as regards their health management, it does not unequivocally do so. It influences individuals' sense of agency in three different ways: it enhances, constrains and questions it.

The findings point out the ambiguous relationship between the new conceptualization of health promoted by preventive medicine and the individual's well-being. On the one hand, preventive medicine is committed to promoting people's health and well-being; on the other it brings with it its share of drawbacks. While health may indeed be one of the strongest predictors of individual happiness, working to maintain it, in the age of preventive medicine, is a paradoxical process that dramatically affects individual well-being.

Parallel session 7:
7.6 - Subjective well-being and quality of life

The Different Aspects of Health: Relations between Mortality, Morbidity, Functional Status and Self-Rated Health

Aija Duntava, Uppsala University, Sweden

Co-authors: Ilkka Henrik Mäkinen, Liubov Borisova;
Uppsala University

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Background: How different measurements of health are interrelated still remains unclear. Studies that emerged in the 1980s and 1990s proposing and testing different models for the structure of health aspects have not been continued, leaving underexplored areas and unanswered questions. The studies conducted so far were performed at the individual level only, and mainly in the U.S. They were also limited to the elderly population. The main objective of the current study is to explore interrelationships between different aspects of health: mortality, morbidity, functional status and self-rated health. The article proposes a modification of the previous models of health structure and tests it on the entire population (all ages) across 23 European countries.

Methods: The study utilizes national statistics from the World Health Organization (WHO), in combination with individual level data from European Social Survey (ESS), where variables are aggregated at country level. Structural equation modeling is employed in order to estimate causal pathways.

Results: In general, the results support the predictions from the proposed model regarding the interrelationships between the four latent variables each representing one of the health dimensions. Specifically, mortality, morbidity and functional status all have direct effect on self-rated health. Furthermore, morbidity has indirect effect on self-rated health through functional status. Yet a few exceptions among European countries are revealed.

Conclusion: The results of this European cross-country comparative study allows us to increase the generalizability of the health structure. The study clearly shows to be a stepping stone for further research and provides new insight into how health is structured. It also opens new research avenues in terms of adding socio-economic factors to the model and looking at the variation by age and gender both at the micro and macro level.

Keywords: mortality, morbidity, functional status, self-reported health, EU

Parallel session 7:
7.6 - Subjective well-being and quality of life

Can patients estimate health related quality of life better than general population: an empirical study

Valentina Prevolnik Rupel, Institute for Economic Research, Slovenia

Co-authors: Marko Ogorevc;
Institute for Economic Research

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2130, Second floor
Session Chair: Ellen Verbakel

In the research we present the results of the analysis of differences in preferences towards health states between patients and general population, based on the usage of face to face interviews among patients within Work Package 4 ADVANCE HTA EU FP7 sponsored project. Although the debate of advantages and disadvantages of using patients vs. general population preferences for valuing health states has been going on for more than a decade, there has been very little empirical evidence on the issue. We try to remedy for this void by presenting a detailed statistical analysis to study the main question: Do the preferences towards health related quality of life differ between the general population and defined patient groups? In search of an answer we conducted a survey departing from usual debate that compares experience-based vs. hypothetical health state valuation we compared hypothetical values of the general public to hypothetical values of the patients. Our hypothesis was that patients who adapt to the a disease attach higher utilities to the surrounding hypothetical health states compared to the general public. We firstly present basic descriptive statistics, followed by regression models used to detect the sources of the differences between preferences. The results show that there are significant differences in quality of life valuation between patients and general population. Looking into separate health dimensions of health state to determine the causes of the differences, the problems with mobility were not seen as importantly impacting quality of life and pain/discomfort and anxiety/depression were determined as more important for quality of life in patients valuations than in general population valuations. Patients are more experienced in valuing health states and using general population values for prioroty setting does not prove to be valid.

Keywords: preferences, utility, patients, priority setting, health realted quality of life, subjective health assesment

Parallel session 7:
7.7 - Mental health

Gender inequality and the gender gap in depression

Małgorzata Mikucka, Université Catholique de Louvain, Belgium

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Olaf von dem Knesebeck

Depression is the leading cause of chronic disability in developed countries, which strikes women more than men. Past research documented a range of socio-demographic characteristics associated with increased intensity of depressive symptoms. However, little is known about societal characteristics with affect the intensity of depressive symptoms and the gender gap in depression. This study uses data from European Social Survey (waves 3 and 6) to investigate the effects of Gross Domestic Product, income inequality, and gender inequality for the depressive symptoms among men and women. We account separately for the cross-country differences of the macro factors and their changes over time. Our results suggest that income inequality harms women particularly strongly, whereas both genders benefit from better economic conditions. Results for gender equality are mixed and vary across various measures of equality.

Parallel session 7:
7.7 - Mental health

Perceived job insecurity, unemployment and depressive symptoms: A meta-analysis of prospective observational studies

Tae Jun Kim, University Medical Center Hamburg-Eppendorf, Germany

Co-authors: Olaf von dem Knesebeck;
University Medical Center Hamburg-Eppendorf

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Olaf von dem Knesebeck

Background: It was shown that both job insecurity and unemployment are strongly and consistently associated with depressive symptoms. It is, however, less clear if perceived job insecurity and unemployment constitute a comparable risk for the onset of depressive symptoms. A meta-analysis was conducted to explore this issue.

Methods: In December 2014, relevant records were identified through the databases Medline, Embase and PsychInfo. Articles were included if they had been published in the last 10 years and contained a quantitative analysis on the prospective link between either job insecurity or unemployment with depressive symptoms.

Results: In 20 cohort studies within 15 articles, job insecurity and unemployment were significantly related to a higher risk for depressive symptoms, with the Odds Ratio (OR) being modestly higher for job insecurity (1.29, 95%-CI: 1.06-1.57) than for unemployment (1.19, 95%-CI: 1.11-1.28). Sensitivity analyses revealed that the effects were strongest in studies that examined younger respondents (< 40 years) and used an unadjusted statistical model. By considering the length of the observational period, it was shown that unemployment ORs were higher in shorter time-lags (under 1 year), while ORs for job insecurity were increased in longer exposure-outcome intervals (three to four years). Specifically for unemployment, ORs were highest in studies that did not control for potential health selection effects and that ascertained enduring unemployment. A statistically significant publication bias was found for studies on unemployment, but not for job insecurity.

Conclusions: The analyses revealed that both perceived job insecurity and unemployment constitute significant risks for increased depressive symptoms in prospective observational studies. By comparing both stressors, job insecurity can pose a comparable (and even modestly increased) risk for subsequent depressive symptoms.

Parallel session 7:
7.7 - Mental health

Do Immigrants Suffer More From Job Loss? Unemployment and Subjective Well-Being in Germany

Liliya Leopold, European University Institute, Italy

Co-authors: Thomas Leopold, Clemens Lechner;
University of Amsterdam, University of Jena

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Olaf von dem Knesebeck

This study asked whether immigrants suffer more from job loss than German natives do. Compositional, psychosocial, and normative differences between these groups suggest that various factors intensifying the negative impact of unemployment on subjective well-being are either more prevalent, more influential, or distinct among immigrants. Based on longitudinal data from the German Socio-economic Panel Study (1990–2012; N = 36,296 persons aged 20 to 64; N = 240,071 person-years), we used fixed-effects models to trace within-person change in subjective well-being across the transition from employment to unemployment and over several years after job loss. Results showed that immigrants' average declines in subjective well-being exceeded those of natives. Further analyses revealed gender interactions. Declines were smaller and similar among immigrant and native women. Among men, declines were larger and differed between immigrants and natives. Immigrant men showed the largest declines, amounting to one standard deviation of within-person change over time in subjective well-being. We conclude that psychosocial factors render immigrant men most vulnerable to the adverse effects of unemployment.

Parallel session 7:
7.7 - Mental health

The experience of mothers of adults with severe mental illnesses in Poland – a qualitative study of courtesy stigma

Anna Prokop-Dorner, UJ Chair of Epidemiology and Preventive Medicine, Poland

Wednesday 29 June 2016
Time: 8:30-10:00am
Room: M2160, Second floor
Session Chair: Olaf von dem Knesebeck

Mental illnesses prevail the most stigmatizing conditions in the contemporary European societies. The consequences of the co-occurring processes of labelling, stereotyping, separation, discrimination, loss of status and emotional reaction are so penetrating that they taint not only the social identity of individuals with mental illnesses but also of their relatives. This presentation bases on a qualitative study of the phenomenon of courtesy stigma as experienced by mothers of adult individuals with schizophrenia or depression in Poland. The qualitative content analysis of disclosures of women accompanying their adult children with mental health disorders published as posts on internet forums or articles in magazines devoted to mental health problems was performed. Additionally, in-depth interviews with women who are members of non-governmental organizations of family caregivers of individuals with mental disorders were conducted. The analysis of the gathered material took into account the significance of the socio-cultural and institutional particularity of the Polish society, especially the prioritized social values, gender roles as well as available forms of psychiatric care for patients and support for families. The study demonstrates the main dimensions of the subjective experience of courtesy-stigma among mothers of adults with mental illnesses in Poland. It also provides an insight into the process of positive coping with the consequences of stigmatization. Basing on the results, recommendation for initiatives supporting family caregivers were formulated.

Parallel session 8:
8.1 - Biopolitical spaces, healthy bodies and inequality

The spatiality of digital health practices: moving beyond the online-offline divide

Emma Rich, University of Bath, England

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1150, First floor
Session Chair: Simone Fullagar

Health providers now regularly encourage the use of mobile heath (mHealth) technologies which enable users to track, and monitor body data such as physical activity, exercise behaviour, body weight, and food consumption. Governments and health organizations continue to stress the opportunities afforded by these technologies, as a means of delivering a more effective and equitable health care system and offering unprecedented solutions to health problems. A burgeoning body of work argues that these mHealth technologies encourage practices of self-surveillance, self-monitoring and self-regulation, further promoting biopolitical practices of new public health. The prevailing critical approaches towards digital health tend to focus on how direct engagement with digital data generates particular health practices or shapes embodied identities. Whilst there is evidence that populations are much more inclined to use technology to monitor their health, rather less attention has been paid to understanding how different geographical, familial socioeconomic, spatial, and cultural factors shape, limit or provide opportunity for particular kinds of use of mHealth technologies and digital practices. This paper argues for a focus on digital health which avoids sharp demarcations between seemingly online/digital and offline/physical worlds and moves towards a non-dualist understanding of digital health practices. This compels us instead to think critically about spatiality and decisions about when, where, how and why we reach to mHealth in our everyday practices. Multi-source data collection, spatial-time maps and other novel methods may become increasingly important in understanding complex everyday digital health practices in real time, space and place; critical perspectives of this kind may help identify nuanced inequalities and disparities of mHealth across different socio-cultural groups.

Parallel session 8:
8.1 - Biopolitical spaces, healthy bodies and inequality

Parkrun, health and the enactment of body projects

Gareth Wiltshire, University of Bath, United Kingdom

Co-authors: Simone Fullagar, Clare Stevinson;
University of Bath, Loughborough University

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1150, First floor
Session Chair: Simone Fullagar

Background: The inactive, unfit and overweight body is commonly positioned as an object of individual intervention to reduce the risk of 'lifestyle' disease within advanced liberalism. The individualising of responsibility for health risk intersects with contemporary discourses of self-management that are enacted through a variety of body projects. In seeking to advance the sociological analysis of embodied practices this study offers the first detailed analysis of the rise of parkrun as a rapidly growing free community running event. Created by citizens rather than health professionals, parkrun offers a unique physical cultural practice through which to examine how active body projects are constituted in relation to discourses of healthy living. Methods: A geographically diverse sample of participants (N=20) took part in one-off telephone interviews. Interview transcripts were analysed systematically attending to the phenomenological and discursive dimensions through which embodied meaning is constituted. We identify three discursive formations through this analysis of running practices; (1) troubled bodies (2) enhancing bodies, and (3) healthy/unhealthy bodies. Discussion: This paper offers some theoretical and empirical insights into the embodied practice of running. We claim that parkrunners in this study draw on discursive resources around lifestyle health and individual responsibility to frame their experience in line with particular body projects. Parkrun events, therefore, provide a space to enact the different body projects that consider perceive as important in the achievement of health. We suggest that these projects are powerful because of the embodied nature of their experience and the pervasiveness of health discourse. Implications of this research are discussed in relation to physical activity promotion and policy. Conclusion: Parkrun is a new space for the enactment of body projects constructed through prominent discourses around health. Engagement in the events is experienced positively as a means to control and manage personal health status.

Parallel session 8:
8.1 - Biopolitical spaces, healthy bodies and inequality

Caught in the Current: Lifestyle Drift and the Inevitability of 'Citizen Shift' in Health Policy

Oli Williams, University of Bath, United Kingdom

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1150, First floor
Session Chair: Simone Fullagar

Historically, public health looked towards social and environmental explanations for the occurrence of illness and disease. More recently advanced liberal forms of governance have created a new public health approach which focuses attention on how individuals 'choose' to behave. Despite the current trend towards moral individualism, area-based initiatives (ABIs) have been popularly used by advanced liberal governments to address the social causes of inequality. By highlighting the significance of structural inequalities, these initiatives appear to acknowledge the problematic nature of approaching social issues as matters of individual moral responsibilities alone. However, they also continue to draw heavily on the discourse of individualism thus limiting their potential to engage the vulnerable populations they target. Therefore, these initiatives are particularly susceptible to the wider health policy trend known as 'lifestyle drift': a process whereby policies aimed at addressing structural inequalities tend, over time, to adopt a behavioural approach.

Although this drift is recognised at the level of policy little is known about how and why it occurs at the level of delivery. This paper draws from data collected during sixteen months of ethnography, involving observation, interviews with staff and participants and analysis of documents, in a deprived English community where ABIs have promoted active-lifestyles and significantly increased local physical activity opportunities. Analysis shows that over time the relevance of initially identified barriers to participation experienced by local residents was largely ignored and institutional responsibility became contested. Therefore, a development of the process of lifestyle drift was observed at the level of delivery. This development has been conceptualised as 'citizen shift'. It will be argued that such developments are endemic to advanced liberal health policies and detrimental to promoting health equity. Suggestions are made as to how research-based interventions could increase the robustness of future policies aiming to address health inequalities.

Parallel session 8:
8.2 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

Does risk culture end with the immediate postnatal period?

Patricia Perrenoud, HESAV, Switzerland

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1140, First floor
Session Chair: Jenna Murray de Lopez & Solène Gouilhers Hertig

Previous research has discussed the presence of a risk culture during pregnancy and birth, resulting in medical interventions for women. Medical discourses emphasize the need for women to give birth in hospital settings to ensure their and their infant's safety. In the Swiss context of care, most women consequently give birth in hospital settings, where they stay for a few days. Over the last few decades within the public system, postnatal stays in hospital have shortened from 5/6 days in the 1980s to 2/3 days currently. Consequently, a universal, insurance-funded service of house calls, meant to support women and provided by community midwives, has been implemented throughout Switzerland. This presentation, based on 3 years of fieldwork encompassing interviews and observations, will focus on the discrepancies experienced by women and midwives between an overall culture of risk and actual screening and care practices in the postnatal period. Two topics emerge from the experiences of women and midwives. First, midwives meet many women whose initiation of breastfeeding has barely been supported during the hospital stay, often resulting in difficulties in the early days back home. Second, some women living in vulnerable circumstances leave hospital without an adapted support, resulting in danger for their and their infant's physical safety. These observations lead to several questions discussed during this presentation. 1. While some authors have criticised the excess of the risk perspective, are there domains in which risks are not considered? 2. If risk culture has been developed conjointly with an increased medicalisation of birth, could it be that some risks which are avoidable without medicalisation and through a reinforcement of physiological processes might not be acknowledged? 3. Could the working conditions of health professionals interfere with the risk avoidance objectives of decision makers in the health sector?

Parallel session 8:
8.2 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

"I don't care how much he weighs, if he were not well, I would know". Perception and risk management during breastfeeding initiation at home

Caroline Chautems, University of Lausanne, Switzerland

Wednesday 29 June 2016
Time: 10:30am-12pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig

In the current perinatal context, where breastfeeding is identified as the best option for feeding babies, the choice to formula feed is seen as a risky practice. But breastfeeding is also a generator of specific concerns, particularly related to the inability to quantify the amount of milk ingested by babies, and as a result, the perceived lack of control regarding their weight gain.

Since May 2014, I have been conducting an ethnography with independent midwives, who I accompany during postnatal home visits in Vaud, Switzerland. These midwives practice "global care", which includes prenatal, childbirth and postnatal care.

Supporting mothers in breastfeeding initiation, leads them to create for themselves a "custom made" model of risk management concerning the baby's weight gain, and have to set their own limits of what is "acceptable risk". Free from institutional protocols, independent midwives argue for a qualitative assessment of breastfeeding, primarily perceived as a relational process between mother and child.

By shifting the attention from the sensitive issue of weight gain to other evaluation criteria of breastfeeding, midwives recognize parents as the experts in understanding their own baby. They restore their position of full actors in the decision process concerning the appropriate reaction in case of unsatisfactory baby weight.

The choice of giving birth at home results from a reflection work led by parents, and generally also includes a breastfeeding "project". Therefore, in situations they identify as risky, midwives have to enter a negotiation with parents, for an intervention such as "supplementing" with formula. However, from their perspective, the first priority remains to maintain breastfeeding.

Beyond breastfeeding, parents who give birth at home tend to create their own risk culture, which is reflected in other aspects of care and decisions about their child's health. Supported by their midwife, but often criticized by other health professionals who do not share the same health care culture, a tension sets in between the defense of their practices and the dominant risk culture.

Parallel session 8:
8.2 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

Self- or Co-Surveillance? Couples' Management of Risk Related to Alcohol Use During Pregnancy

Raphaël Hammer, University of Health Sciences (HESAV) - University of Applied Sciences and Arts Western Switzerland (HES-SO), Switzerland

Co-authors: Yvonne Meyer, Stéphanie Pfister Boulenaz;
University of Health Sciences (HESAV) - University of Applied Sciences and Arts Western Switzerland (HES-SO)

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1140, First floor
Session Chair: Gouilhers Hertig

Background: Reflecting the pervasive internalisation of risk discourses by lay people, the concept of self-surveillance has been widely used to describe how women respond to risks surrounding pregnancy and how they take the moral responsibility for foetus health. Such a perspective disregards the influence of the everyday context on pregnant women's experience. In particular, little research has addressed the role of the male partner in managing the risk related to alcohol. This presentation aims at examining how the issue of alcohol use is perceived and discussed within the couple relationship.

Methods: This communication is based on a series of 30 joint semi-structured interviews conducted with couples expecting a first baby in Switzerland. Thematic analysis was applied to the data.

Results: Once they were aware that they were pregnant, all women decided to change their drinking habits, either by abstaining or by strongly restricting their alcohol consumption. These decisions were assumed by the women and had been rarely discussed with their partner. Although drinking or not during pregnancy was a matter of individual choice, most male partners played an active part. Besides the non-interference attitude, some were supportive of the woman's decision of abstinence or of having an occasional drink as not risky. Others exercised control over their partner's behaviour or reasoning in subtle ways. Uncertainty about a safe level of alcohol consumption resulted in disagreements or tensions between both partners, revealing moral issues, such as being a good mother and woman's autonomy.

Conclusions: The inclusion of partners offers a deeper understanding of the microsocial context that shapes women's management of risks during pregnancy. Our analysis shows that male partners may exert co-surveillance for the sake of the foetus' health and suggests the inescapability of risk culture.

Parallel session 8:
8.2 - Challenging risk culture in the context of pregnancy, birth and the postnatal period

Tinkering with risk-oriented protocols in perinatal care at home.

Irene Maffi, University of Lausanne, Switzerland

Co-authors: Sara Veltro,
Independent midwife

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1140, First floor
Session Chair: Solène Gouilhers Hertig

This paper is a dialogue between an independent midwife and an anthropologist who has given birth at home and works on reproduction in cross-cultural contexts. It is based on ethnographic material collected in Italy and Switzerland and on auto-ethnography.

We intend to explore the strategies independent midwives and couples use to adjust medical protocols for homebirth to their specific needs and desires. How do the various actors deal with their feelings about and representations of pregnancy, birth and breastfeeding when they are not conform to protocols? Are the risk-oriented protocols reinterpreted and altered by the negotiations between midwives and couples? What kind of geography of responsibilities emerges from the arrangements taking place between midwives and couples? Who can take the decision to bypass or subvert the protocol? Can this subversion be justified by non-conventional definitions of risk? We hope to deconstruct this category and show how different notions of risk can allow to tinker with protocols elaborated within a biomedical and technological setting.

Parallel session 8:
8.3 - Inequalities and social determinants of health

How nativity affects racial and ethnic differences in six-month breastfeeding in a cohort of diverse U.S. women

Susan Bodnar-Deren, Virginia Commonwealth University, Departments of Sociology and Institute for Women's Health, United States

Co-authors: Katherine Legare, Amy Balbierez, Elizabeth Howell;
Mount Sinai School of Medicine

Wednesday 29 June 2016
Time: 10:30am-12pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

Breastfeeding rates, in the U.S. fall short of Healthy People 2020 goals, particularly for minority women with disparities mirroring socioeconomic inequalities. However foreign-born women living in the U.S are more likely to breastfeed than are native-born women. An understanding of how nativity affects racial/ethnic differences may help in the development of interventions to increase breastfeeding. Objective: To examine the association between nativity and race/ethnicity with 6-months breastfeeding status and to explore the type/number of breastfeeding problems that a cohort of diverse women encountered after initiating. Methods: 854 women were interviewed 24-48 hours after delivery and again at 1, 3 and 6-months postpartum to assess breastfeeding, clinical and psychosocial status. Bivariate and multivariate analyses were conducted to examine the association between six-month breastfeeding and nativity, race/ethnicity, sociodemographic, clinical and psychosocial factors Results: U.S.-born women were significantly less likely to breastfeed 6-months postpartum than were foreign-born women (OR=0.503, CI: 0.32-0.78). Among U.S. born women, black (OR=0.168, CI: 0.08-0.33) and Latina (OR=0.112, CI: 0.06-0.23) women were less likely to breastfeed than were white women. However, among foreign-born women, there were no significant differences in breastfeeding rates between black and white women. The majority of black women (68%) reported no breastfeeding problems compared to white and Latina women (44% and 45%) (p=0.05). White women (35%) were more likely to report painful breasts/engorgement than were black (22%) and Latina women (27%) (p=0.03). They were also more likely to report problems with inability to balance breastfeeding with other responsibilities, latching, and the baby seeming hungry. Conclusion: We found significant racial/ethnic differences in breastfeeding in a diverse cohort of women in the U.S. However, this difference was only present in U.S. born women when compared to foreign-born women. Differences in breastfeeding problems among women were common, and did not account for racial/ethnic differences in breastfeeding rates.

Parallel session 8:
8.3 - Inequalities and social determinants of health

Do older people from higher SES benefit more from physical activity than those from lower SES?

Florian Trachte, First Department of Medicine of Clinic
Lippe-Detmold, Germany

Co-authors: Siegfried Geyer, Stefanie Sperlich;
Medical Sociology Unit of Hannover Medical School

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2150, Second floor
Session Chair: Stéphane Cullati

Background: The relevance of socioeconomic status (SES) and physical activity (PA) on health in older age has been demonstrated in many studies. However, little is known about possible interaction effects between PA and SES on self-rated health in older age.

Methods: Focusing on people aged 65 to 84 years it was investigated whether the effect of PA on self-rated health differs according to SES (school education and income). Analyses were based on data from German Socioeconomic Panel study (GSOEP). We used two consecutive years in order to demonstrate a cause-effect relationship between PA and SES (2007) with self-rated health as outcome (2008). By using binary logistic regression analyses, odds ratios (OR) and synergy indices (SI) were calculated.

Results: High SES and PA increased the chance of good self-rated health in older age. The effect of SES on health decreased in the presence of PA while the effect of PA on health remained statistically significant in the presence of SES. SI indicated poor evidence for interaction effects between PA and SES on self-rated health.

Conclusion: Our findings suggest that privileged older people do not benefit more from being physically active. It rather indicates that all older people independently from SES take health advantage of being physically active.

Parallel session 8:
8.4 - Lifestyles

Wellbeing in Labor Market: A False Illusion

Fiorella Maria Bernadette Capuzzo, Consiglio regionale della Lombardia, Italy

Wednesday 29 June 2016
Time: 10:30am-12pm
Room: M1160, First floor
Session Chair: Karen Lowton

The Italian economic scenario is characterized by a sort of destablishment caused by raising taxes, inadequate social measures, unemployment, aging population, corruption and migrants' invasion although in the last years the Italian government has outlined a lot of policies aimed to reform Italy's labor market.

The Workplace Wellbeing Charter is nowadays a great opportunity all over the world for workers and employees to demonstrate their commitment to the health and well-being of their workforce and represents an easy guide to realize a supportive and productive environment in workplaces.

The legislative decree n. 150/2009 has introduced in Italy a system of annual verification of the level of health and well-being of workers/employees in organizations of all sizes, of the evaluation system adopted and of the judgment expressed by the boss.

This article focuses on the well-being analysis led in the Regional Council of Lombardy in 2014.

The research according to the article 14 of the legislative decree aimed to know employees' opinions about the standard of health, wellness, relationship, evaluation system and management.

Goal of this research was to encourage a positive mood, to reinforce the institutional vision and mission of the administration and to contrast corruption.

Employees should fill up a questionnaire with 82 items. The principal questions were about self-confidence, health, stress, discrimination, evaluation system, boss appraisal.

The result was really astonishing: in such a privileged workplace all tested groups – but the managers – expressed a negative estimation. A much more negative opinion was expressed by men in comparison with women, elder than younger and employees who had a longer service.

So the real question is: how far is wellness a false illusion in the Regional Council of Lombardy.

Parallel session 8:
8.4 - Lifestyles

Is living in a high building bad for your self-rated health?

Pieter-Paul Verhaeghe, Ghent University, Belgium

Co-authors: Ad Coenen, Bart Van de Putte;
Ghent University

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M1160, First floor
Session Chair: Karen Lowton

While the construction of high-rise buildings is a popular policy strategy for accommodating population growth in cities, there is still much debate about the health consequences of living in high flats. This study examines the relationship between living in high-rise buildings and self-rated health in Belgium.

We use data from the Belgian Census of 2001, merged with the National Register of Belgium (N = 8,486,811).

Results from multilevel, logistic regression analyses show that residents living in high-rise buildings have considerable lower odds to have a good or very good self-rated health in comparison with residents in low-rise buildings. This negative relationship disappears completely, however, after controlling for the control variables, which suggests that residents' worse self-rated health in high-rise buildings can be explained by the strong demographic and socio-economic residential segregation in Belgium.

In addition, there is a weak, but robust curvilinear relationship between floor level and self-rated health within high-rise buildings. Until the fifth floor, self-rated health remains stable. But from the fifth floor or higher, the likelihood to have a good or very good self-rated health diminishes slightly.

Parallel session 8:
8.4 - Lifestyles

Towards a better understanding of ill health and living conditions

Jorid Anderssen, UiT The Arctic University of Norway, Norway

Co-authors: Trude Gjernes,
University of Norway

Wednesday 29 June 2016
Time: 10:30am-12pm
Room: M1160, First floor
Session Chair: Karen Lowton

People living in Norway have overall one of the best health and one of the best health care systems in the world. However, people living in the northern part of Norway are scoring low on most health indicators. People from Finnmark County, which is the northernmost county in Norway, have the lowest score on almost every health indicators for good health. Both women and men in Finnmark have for instant 2,5 years shorter life expectancy than the rest of the population of Norway. This means that the people of the north are deprived of some of their health potential and they are limited in their participation in a welfare society like Norway.

Such inequalities cannot be explained by biological variation alone, living conditions in its broadest sense may be some of the explainable factors. In this project, we want to identify living conditions that influence health of people living in the north of Norway. The project study people in their everyday life, since their health choices and their health possibilities are deeply rooted there. Qualitative interviews with a number of people in different communities in the north of Norway will be conducted in 2016. Some of the main questions are: What are their health related habits and how do they understand their living conditions? In our study we want to get information about their constraints and information of how they frame their health. Statistics about different health indicators will also be gathered and rearranged to explain health inequalities. The study also address how the local community adjust for healthy living.

This is a project in process, and the achieved results will be presented at the conference.

Parallel session 8:
8.5 - Subjective well-being and quality of life

Narratives of recovery from serious illness and injury: core narratives and missing scripts

Sarah Earthy, University of Hertfordshire, United Kingdom

Co-authors: Judith Sleney, Hilary Thomas;
University of Surrey, University of Hertfordshire

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Introduction: Narrative research is a well-established, although contested, method within the sociological study of health and illness including both theoretical typologies of narrative form (e.g. Frank 1995, Bury 2001) and empirical studies of a specific illness. Largely absent is comparative consideration of how the cultural associations of the type of illness (Sontag 1979) frame patients' narratives, or of recovery as distinct from illness and treatment, and physical injury as distinct from illness.

Method: Secondary qualitative analysis was undertaken on 146 interviews with patients who had experienced heart attack, acute leukaemia, a critical state of health requiring admission to intensive care or serious injury. The data were collected by the Health Experiences Research Group, University of Oxford and the UK Burden of Injury Study. This paper is part of the ESRC funded project 'Getting Back to Normal? Patients' Experiences and Expectations Following Major Illness or Injury'.

Results: Interviewees' narrative accounts included common features, e.g. bodily and biographical disruption, suggesting elements of shared core narratives concerning the meaning of serious illness and, by extension, injury. However, significant differences were also evident between accounts of the different health events. Narratives of heart attack were orientated towards deflecting blame away from self, whilst those of leukaemia emphasised recovery from treatment as well as illness and the need for continuing vigilance. Narratives of intensive care and injury were less characterised by core narratives implying an absence of clear cultural scripts, with consequences for sense-making and compassion fatigue amongst family, friends and others.

Conclusions: Bury's concept of core narratives, as distinct from contingent and moral narratives, highlights differences between narratives of recovery from four different types of health event. Health events with less clear cultural scripts are less readily understood, experienced and rendered in narrative form by patients, with consequences for relationships with significant others.

Parallel session 8:
8.5 - Subjective well-being and quality of life

Household structure as a determinant of well-being among older people in Poland

Katarzyna Zawisza, Department of Medical Sociology , Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College, Poland

Co-authors: Aleksander Galas, Beata Tobiasz-Adamczyk;
Department of Medical Sociology, Chair of Epidemiology and Preventive Medicine, Jagiellonian University Medical College

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Due to demographic, economic and social transitions the manner of living of older people has been changed considerably as compared to the past generations. These changes have been especially observed in Poland for the last several years. The household structure has also changed due to the ongoing changes in demographic, economic and social processes. However, there are limited studies, which analyzed the relationship between household structure and well-being of older people, taking into account not only living alone or in couples, but also considering whether the couples live alone, with children or with others.

The study aimed to assess of the role of household structure as a determinant of well-being measured by the Day Reconstruction Method(DRM) and overall life satisfaction in older people in Poland.

The sample for the investigation consists of 1284 people aged 65+ form general Polish population being a part of a cross-sectional study (COURAGE-in-Europe) conducted in 2009-2012. Face-to-face interviews were performed by specially trained interviewers at respondent’s home.

Subjective well-being was measured by DRM and overall life-satisfaction. An indicator of the household structure was created considering a kinship of household members and respondent's marital status.

The experience well-being is in greater lever differentiated by the household structure than the overall life satisfaction. The results showed that living only with children was associated with poorer well-being than living only with a spouse. Living with both a spouse and children was associated with better assessment of well-being but worse life satisfaction. Living in multigenerational household (spouse and children/children-in-law and grandchildren) was reflected in poorer well-being.

The study supports the role of household structure as an important determinant of well-being and life-satisfaction. Therefore household structure has to be considered as an important covariate in the well-being/life satisfaction research and seems to be a factor considered in some social interventions.

Parallel session 8:
8.5 - Subjective well-being and quality of life

Neurosurgeons' Social Power - does it enhance their lives?

Katarzyna Salamon, Jagiellonian University, Collegium Medicum, Poland

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Research 'The significance of social power attributable to doctors' professional roles and its influence on their quality of social life-illustrated by exemplary analysis of American and European neurosurgeons' will present the mechanisms by which social power is transmitted into the medical professions, using examples of American and European neurosurgeons, and referencing the correlations between these mechanisms and quality of social life. The Main Question: How the social power attributable to their profession influences the quality of American and European neurosurgeons' social life?. The Main Goal: The research will evaluate the impact that the high level of neurosurgeons' social power has on their social lives, and the differences in these correlations between the US and Europe. The social power will be analysed by life-and-death decision-making process, and position in medical hierarchy. Quality of social life will be analysed by: physical and mental health, social belonging, formal interactions and personal relationships and self-esteem. Hypotheses: The high level of neurosurgeons'social power attributable to their professional roles has a negative influence on the quality of their social lives. In the US neurosurgeons have a greater degree of social power than in Europe, arising from their autonomy in life-and-death decision-making processes, prestige and greater income. The research will test my hypothesis that the social power of neurosurgeons is inversely correlated with quality of social life - the opposite of commonly held opinion. In the US the social power is distributed over a wider range of professional neurosurgical roles than in Europe, so the results should show a lower quality of social life among American neurosurgeons. Methodology: individual interviews, comparative analyses, biographical method. The Plan of Analysis: 1)Neurosurgeon Profession in the US and Europe – biographical characteristics of 100 neurosurgeons 2)Social Power Concept in the professional roles of neurosurgeons in the US and Europe 3)Correlations between social power and quality of social life – interviews with 100 neurosurgeons in the US and Europe. Conclusions: The research will present the mechanism by which social power is transmitted into the medical professions and referencing the correlations between these mechanisms and quality of social life.

Parallel session 8:
8.5 - Subjective well-being and quality of life

The Evolution of Job Strain of the European Youth During the Period 2000 to 2010

Johanna Muckenhuber, University Graz, Department of Sociology, Austria

Co-authors: Laia Olle, Christophe Vanroelen, Hannah Volk; Department of Sociology, University Graz, GREDS-EMCONET, Universitat Pompeu Fabra, Interface Demography, Department of Sociology, Vrije Universiteit Brussel

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2130, Second floor
Session Chair: Ellen Verbakel

Introduction: The association between job strain and poor health is well established. Younger workers are generally more exposed to detrimental working and employment conditions, particularly job strain. Therefore it is important to investigate evolutions and variations in job strain among young workers. Macro-economic, but also labor market institutionalization and unionization degrees in European countries may affect the distribution of job strain. We assume higher job strain among young workers in countries with lower levels of labor market institutionalization, low GDP/capita and irregular economic cycles.

Methods: We have performed an international comparison and a trend analysis of the European Working Conditions Surveys 2000/01, 2005, 2010. Analyses included all workers and employees aged between 20 and 24 years in the European Union 15 (N 10758). We adopted descriptive statistics as well as multi-level modelling.

Results: Along with a decrease of the share of young workers with indefinite employment contracts between 2000/01 and 2010 (from 65% to 52%), high strain jobs rose among this group of workers (from 11% to 17%). Major reductions are seen regarding control over working time arrangements.

As expected, there is a relation between labor market institutionalization (as macro-level variable at the country level) and perceived job strain while trend-related results cannot be provided yet.

Conclusions: Our results show an increase of harmful working conditions among the young working population during the last decade (grow of temporary employment as well as job strain). Research implications indicate the need to monitor the effects of young workers' employment quality and job strain on health and health inequalities.

Parallel session 8:
8.7 - Experience of chronic diseases

To be or not to be a COPD patient: measuring the experience of chronic illness

Lise Monneraud, University of Bordeaux, France

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Zofia Slonska

Background. This paper focuses on the psychosocial impact of Chronic Obstructive Pulmonary Disease (COPD) on patients' lives.

As COPD is highly prevalent but underreported, underdiagnosed, and partly invisible, the issue of naming is central. Indeed, as illness exists before diagnosis, the experience of COPD is more than an experience of disease: it is an experience of coping with symptoms not always labeled as "disease" but impacting social roles and identities.

Understanding the individual impact of COPD implies to analyze social representations of COPD, to confront medical and personal labeling and to assess the impact of naming on the perception of the disease.

Methods. Our study is part of a French multicenter research program on occupational COPD in the general population. The sociological approach involves 69 subjects, picked in the cohort on a voluntary basis. It is based on semi-structured interviews, focusing on what individuals tell about their disease and their illness trajectory.

Results. Our study provides new data on the way patients name and consider their illness, despite medical labeling. First the announcement of the diagnosis (i.e. the medical framing of the disease) does not always mean a disruption in the life-course of a healthy individual. Chronic disease does not systematically foster biographical disruption and long-term effects on identities. Even when it does, it is not always linked to an explicit naming of the disease. Patients may label themselves as "healthy", "old", or sick, whatever medical framing. Individual naming and experience are not always in line with medical naming.

Conclusions. These results provide new elements allowing to up-date and specify theoretical frameworks on the disruptive dimension of chronic disease and illness representations. This model must be specified and refined, in order to measure exactly what is disruptive and to understand the possible gap between medical and personal naming of illness.

Parallel session 8:
8.7 - Experience of chronic diseases

Attitudes of Cardiovascular Patients Towards Leading Healthier Lifestyles

Beatriz Xavier, CICS.NOVA New Lisbon University, Portugal

Co-authors: José Resende;
CICS.NOVA New Lisbon University

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Zofia Slonska

In a research work with hypertensive patients we studied the integration of medical regimens in their daily lives. Interviews were conducted with 41 chronic hypertensive patients, focusing on the analysis of three main aspects: the process of disease interpretation; the way in which patients' behaviors are shaped by the construed meanings; and the processes of coping with the disease on a daily basis.

The results reveal that hypertensive patients have distinct perspectives about the disease and being ill. Patients who are classified as being at risk perceive and cope with this new condition in different ways within their daily lives. We have identified three standard models of "being a hypertensive patient": proactive, compliant, and detached.

Based on this research, we can conclude that hypertensive patients who are followed-up and guided through the process of leading healthier lives, through the individualization and internalization of medical and social norms by adopting healthier eating habits, practicing physical activity and complying with the treatment, show different and unique ways of acting and combining medical information with the experience of coping with the disease and their everyday experiences.

The patients' self-assessment on what they should do and what they actually do reveals the idea of non-compliance with basic hygiene principles, and its consequent moral judgements. Hypertensive patients use the concepts and ideas of moderation, care and balance as mechanisms of operationalization between the medical recommendations and their behaviors. In fact, patients agree on the principles for a healthier lifestyle recommended by the doctor, and they are aware of the possibility to make choices about diet and exercise. However, this is seen as a result of personal effort and will against the structural trends of organization of work and consumption and therefore very difficult to accomplish.

Parallel session 8:
8.7 - Experience of chronic diseases

PrEP Online: A Virtual Ethnography of an HIV Prevention Method

Michael Deml, Université de Genève, Switzerland

Wednesday 29 June 2016
Time: 10:30am-12:00pm
Room: M2170, Second floor
Session Chair: Zofia Slonska

Approved by the FDA in 2012, PrEP (pre-exposure prophylaxis), also known as Truvada, has since been sparking interest and controversy for stakeholders of HIV/AIDS prevention. This antiretroviral medication, demonstrated to be 92-100% effective when taken daily (depending on the study examined), prevents users at heightened risk of infection from contracting HIV. Much of the research on PrEP has thus far been produced within the 'hard sciences' of biomedicine and public health. While indispensable in determining the success of PrEP, this type of research focuses on epidemiological models and analyses regarding the efficacy of this medication and tends to gloss over PrEP users' experiences. Therefore, PrEP users may be facing challenges not mentioned in the biomedical literature, which will likely prove to be important to consider for the implementation of this prevention method.

This paper's goal is to add plurality to the discussion on PrEP by bringing work from the social sciences. This presentation will include results from a larger project that examines the Facebook group entitled 'PrEP Facts: Rethinking HIV Prevention & Sex' (composed of more than 14,000 members) in which members discuss their thoughts on and experiences with PrEP. I will consider content analysis of Facebook posts and discussions (from January to June 2016), group members' responses to an online survey, and interviews with group members and moderators. The questions guiding this presentation are: How can this Facebook group and its members' discussions complement the existing literature and assist health-care professionals and the medical community to better implement PrEP as a tool in HIV prevention? More particularly, what are some of the obstacles, about which the medical community might not be aware, that may be affecting user adherence rates for this prevention intervention? Finally, how can this Facebook group be seen as exemplifying ways in which stakeholders of HIV/AIDS prevention manage their health?

Round Table:

The Contribution of Health and Medical Sociology to Health Care and Health Policies

Prof. Piet Bracke, Department of Sociology,
University of Ghent, Belgium

Dr. Paula Feder-Bubis, Department of Health Systems Management,
BenGurion University of the Negev, Isreal

Dr. Yves Jackson, Department of Community Medicine and Primary
Care, Geneva University Hospitals, Switzerland

Dr. Nathalie Roebbel, Department of Public Health, Environmental
and Social Determinants of Health, World Health Organization,
Geneva, Switzerland

Wednesday 29 June 2016
Time: 1:00-2:30pm
Room: MR080, Ground Floor
Moderator: Claudine Burton-Jeangros, Department of Sociology, University of Geneva

As illustrated by the very existence of ESHMS, health and medical sociology is a dynamic field of social science research in Europe. Empirical studies document the contrasted experiences of health and illness in the population (health inequalities, social construction of illness), the changing relationships between lay individuals and professionals (shared medical decision making, patient centred family focused care, health literacy), the social transformation of the medical profession, or the organizational challenges of health care systems against population aging and the increase of multiple chronic conditions. Theoretical analyses, offering critical perspectives on taken-for-granted developments in medicine and public health, further reinforce the field. The round table aims at discussing the applicationof this social science knowledge to the actual healthcare activities and to policies addressing health issues. What role does health and medical sociology play in a context of healthcare reforms, reformulation of health professionals' training, and reduction of healthcare costs? Does the contribution of health and medical sociology vary across countries (development of the discipline, its presence in the social sciences and in the medical institutions, funding of research)?

Pre-Organized Sessions

Sessions 1.1 & 2.1

Professionals Delivering Prevention in Various Primary Care Contexts: New Issues and New Challenges for Preventive Action

Organiser: Géraldine Bloy,
University of Burgundy, France,
on behalf of the Réseau Thématique 19 “Santé, Médecine, Maladie et Handicap” of the Association Française de Sociologie

This session will focus on primary-care professionals, who face new issues in today’s epidemiological context. Institutions and public health policies are (re)investing in preventive care and targeting ever more guidelines, incentives, or even injunctions, at these professionals, encouraging them to make prevention a priority and to adopt a normative role towards the population, in many aspects of people’s lifestyle and life-course. As frontline workers, they are privileged intermediaries of contemporary biopolitics. At the same time, they must often deal with global resource restrictions. They are concretely confronted with the consequences of austerity policies on health and with growing social inequalities, which affect the way preventive messages can be delivered and received. Promoting healthy habits in this context is challenging for professionals and raises new issues.

Numerous professionals with different types of professional status are charged with prevention in primary care. They work in different environments, with different means, and can have different views about their tasks. Across Europe, some participate in programs dedicated to prevention, while others have to integrate prevention into a broader mandate. Each has different levels of legitimacy and autonomy in the organization of their work, depending on how primary care is organized at the national level, but also on micro-scale configurations and resources. Some appear constrained in applying top-down procedures while others try to remain free to decide by themselves what to do. Some engage in experiments, where traditional relationships and cooperation between different types of professionals can be reshaped and collective learning processes developed (or can fail). Generation or gender effects on the dispositions and positions of healthcare professionals should also be taken into account.

The aim of the session is to better understand this diversity by learning more about the effects of the social context on concrete preventive practices in primary care. Do organizational or procedural innovations affect the contents, the terms and conditions of the preventive message delivered? Are these institutions and public health policies in the process of deeply remodeling the attitudes and practices of professionals? Is professionalism “from inside” considered or reshaped, for primary care physicians and for less established groups of workers? Although this session is dedicated to professional issues in preventive care in their work context, it aims to deal with the social conditions of the professionals’ concrete encounters with patients: Does this changed context reshape the time spent with them? How is patient social diversity taken into account and dealt with in preventive care? Do professionals face special patient reluctance to accept preventive care associated with new procedures or with the difficult socio-economic context, or are things becoming easier for them?

Presentations are expected to explore these questions using empirical data. All types of preventive care, from traditional counselling about lifestyle to screening using cutting edge technologies (for instance, in genetics) can be considered, since they come within, in given contexts, the confines of primary care professionals. Attention to social inequalities in preventive healthcare would be appreciated.

Pre-Organized Sessions

Sessions 1.2 & 2.2
Informal Caregiving

Organiser: Ellen Verbakel,
Radboud University Nijmegen, The Netherlands

Due to population ageing and rising life expectancy, Europe will face an increasing demand for long-term care. Dealing with - and anticipating future - rising health costs, many governments are directing towards a larger contribution of informal care. Informal care can be defined as support provided to people with health care needs by their informal network (mainly relatives) with respect to personal care or housekeeping tasks. Not only do governments welcome informal care out of budget reasons, informal caregiving is also supposed to enhance cohesion in society and to make citizens more socially engaged. In contrast to these potential positive consequences for society, literature suggests that informal caregiving has negative consequences for the individuals involved: informal caregivers experience a caregiving burden and lower levels of well-being; receivers of informal care may face lower health care quality to the extent that informal care substitutes formal (professional) care.

This session welcomes research that enlarges knowledge about informal caregiving in Europe and its consequences. Several perspectives are interesting in this respect:

1. Policy The aim of increasing the contribution of informal caregiving is frustrated by other demographic developments, such as increasing female labour force participation, declining family size, rising childlessness, and rising divorce rates. In other words, while demand for informal caregivers is rising, their supply is in decline. Policy makers will be interested in knowing how to recruit sufficient caregivers and how to organize the health care system most effectively and efficiently. Research is needed that sheds light on how the organization of informal caregiving – possibly in combination with formal care and voluntary work – looks like in European countries and what policy measures appear to be successful.

2. Informal caregivers Informal caregiving may be a time-intensive as well as a strain-inducing task. In many cases, it is the circumstances rather than voluntary choice that make someone an informal caregiver. Informal caregiving then is an ‘extra task’ that needs to be incorporated in daily work and family life. Caring can involve difficult tasks and a complex relationship with the care receiver (e.g. in case of dementia), which may produce uncertainty, stress, and sadness. On the bright side, informal caregiving may also bring positive outcomes, such as intrinsic joy, a rewarding feeling, and companionship. Research is welcomed that investigates the consequences for informal caregivers, for instance with respect to their health, life satisfaction, work and family life.

3. Care receivers Informal care may bring the advantage of being cared for by someone one is familiar and likely close with. On the other hand, informal caregivers likely lack professional knowledge and training about the health situation of the needy person. Moreover, not every needy person has access to a network of informal caregivers. Research is welcomed that studies the consequences of (absence of) informal care for care receivers for example in terms of health outcomes, perceived quality of the health care they receive, and life satisfaction.

Pre-Organized Sessions

Sessions 1.3, 2.3, 3.2 & 4.2

Reproductive Health through the Life Course

Organisers: Rozemarijn Dereuddre, Department of Sociology, Ghent University, Belgium & Karen Vanderlinden, Department of Sociology, Ghent University, Belgium

Reproduction affects everyone and the reproductive decisions that people make throughout their life are social events reflecting certain values, norms and structures within society. It concerns individuals, significant others, families, health professionals, as well as governments and welfare states. This makes qualitative, quantitative and interdisciplinary research especially relevant, and it enables sociologists to bridge the micro-macro divide. Sociology of reproduction is not a new study domain within the sociology of health and illness, but it is however considered as a niche subfield, or even forgotten or overlooked.

A session regarding reproductive health invites researchers working in this field to meet, strengthen their network and exchange research ideas. Because topics concerning reproductive health are often embedded within other subdomains such as gender and health, risk behaviours, welfare states, inequalities and social determinants of health and health policy, services and promotion, other sessions are also of interest to these scholars.

This session's focus will be on different aspects of reproductive life course and its health related outcomes. As such, papers related to the following are welcome: (1) Determinants and consequences regarding men's and women's fertility behaviour, including research on contraceptive choices, childbearing decision making and assisted reproductive technologies, (2) Maternal and paternal wellbeing, which is closely linked to some key subjects in sociology such as social stratification and inequality, migration, mobility and network, the conditions in which birth takes place, and work-family conflict, (3) Prenatal and postnatal health care, with a focus on policy and practice, health professionals and medicalization (e.g. breastfeeding practices and its association with social inequalities).

The session welcomes papers using different methodological techniques, and encourages comparative research – both within and across counties – and research that pays attention to both the micro and macro context. Papers will be grouped according to topic expertise and methodological likeness. An announcement will be posted through several University elists (in Belgium), Departments of Sociology and Medicine across Europe and abroad. Another forum is the Belgian Health Care Knowledge Centre (via Dr. Wendy Christiaens), which enlists sociologists as well as health care professionals.

Pre-Organized Session

Session 1.4

Power of Naming

Organisers: Dina Bader, Institute of Social Sciences, University of Lausanne, Switzerland, Faten Khazaei, Centre for the Understanding of Social Processes,
University of Neuchâtel, Switzerland &
Vanessa Fargnoli, Swiss National Centre of Competence in Research "LIVES",
University of Geneva, Switzerland

The quest for healthy bodies, lives, and lifestyles reflects the growing importance of medical institutions that have the legitimacy and power to classify people, to define "normal" existence, and to name and transform status and identities. The definition of "good health" and "healthy behaviours" is intrinsically related to what is defined, by contrast, as unhealthy, ill, or deviant. To the extent to which it identifies, names, and frames life situations, behaviours, and bodies (e.g., as "ill" or "healthy"), the (bio-)medical paradigm takes part in the production and reproduction of social norms. By doing so, it goes beyond its main sphere of action with radical implications that will be explored in this panel.

Indeed, the requirement of medical validation for transforming situations and experiences of illness remains questionable. In this panel, we will consider discourses and practices of medical legitimacy through the lens of "corporal proof". On a macro level, the power of medical validation in shaping the definition of "social problems" such as "female genital mutilation" will be examined. On a meso level, the attribution of (or refusal to attribute) a victim status by medical services measuring levels of violence through the examination of physical traces of violence on bodies will be explored. On a micro level, subjective feelings and strategies of HIV-infected women challenging medical HIV normalisation will be discussed.

The first paper provides a frame analysis of newspaper articles on female circumcision and female genital cosmetic surgery by focusing on the construction of "social problems" in medical discourse. The second paper presents an ethnographic study of a healthcare service that specializes in supporting victims of all types of interpersonal violence. It considers the central role played by forensic documents in certifying traces of violence on the body, thereby legitimising or delegitimising a victim's status, the acknowledgement of which could provide the necessary judicial grounds for seeking legal reparation. The third paper focuses on the tension between what is regulated as a positive medical outcome of a treatment and what is experienced by HIV- infected women who resist this imperative of "normal health with HIV" by adopting personal strategies that ensure a certain "quality of life" rather than a "quantity of life".

Pre-Organized Session

Session 2.4

Health Literacy: A Social Determinant, Moderator or Mediator of Health Behaviours and Health?

Organiser: Jürgen Pelikan,
University of Vienna, Austria

Finally, health literacy as a concept and measure has arrived in European health sciences and health sociology. There are now definitions and instruments available developed by European scientists and data surveyed on European populations. In contrast to most US American definitions and measures which focus primarily on clinical health literacy of patients, the European Health Literacy Survey (HLS-EU) definition and instrument has a broader public health meaning, including besides skills for health care also necessary skills for doing decisions and actions related to disease prevention and health promotion. Therefore this instrument mainly has been used on general populations, and thus has also measured health literacy for peoples´ roles of workers, consumers and citizens and not just as patients. Such a broad concept of health literacy easily and adequately relates to the title of this ESHMS conference Healthy lives: technologies, policies and experiences. It can be asked, how and in how far does health literacy contribute to a healthy life, or more concretely, to a healthy life style and better health outcomes. In this context there is an ongoing debate in what way does health literacy influence health behaviors and health, as a specific social determinant or by mediating or moderating the impact of other determinants. The session will address these issues by offering and discussing empirical studies from different countries using the HLS-EU and other instruments.

Pre-Organized Sessions

Sessions 3.3, 4.3, 5.3 & 6.1
Health Professions in Transition

Organisers: Research Committee "Sociology of Health and Medicine,"
Swiss Association of Sociology;
Julie Page, School of Health Professions,
University of Applied Sciences,
Zurich, Switzerland

Chronic diseases along with the general population's increased attention to health issues - are challenging today's health care systems. The central value of health in our societies has been reinforced, with increased attention paid to disease management, risk prevention and health promotion. Health has been partly reinterpreted in a salutogenetic perspective, and the "preventive self" has become a socially leading figure. The public's expectations towards their health care system are changing as a result of the wider access to knowledge about health and disease provided by new information technologies. Demographic trends and medical advances keep fuelling the growing costs of health care, and economic, especially managerial criteria determine more and more the thinking and the acting in the health care system. Lay people are regularly involved in activities around health and disease, through their permanent surveillance of behaviours influencing health, but also through the care they provide to the chronically ill.

These multifaceted changes are influencing the fields of action and the work conditions of those who are active in the health sector. Health and disease are approached through more and more complex and multi-centred processes, and the boundaries are shifting between classical medicine and institutions that not only heal the sick but also preserve the health of the healthy. The medical profession has been progressively losing the dominant status it had at the time such pioneers as Parsons and Freidson were writing. Long-existing bodies of health professionals struggle with newly emerging professional groups to obtain recognition and status in the system. New training programmes for professionals orientated towards long-term therapy or health promotion – for example for nurses or occupational therapists – are helping redefine the respective activities and roles of health occupations. This changing division of labour generates tension – or even conflict – between professions and between professional associations. To facilitate the organisation of this complex system health professionals are expected not only to acquire specialised and science-based knowledge, but also obtain additional qualifications in interdisciplinary work and co-operation, and self-reflection.

The planned session aims at analysing and explaining these transformations of health professions in the social and organizational context of recent decades.

Pre-Organized Sessions

Sessions 5.4 & 6.2

Imperative of Good Health and Promotion of Autonomy: A Paradox?

Organisers: Solène Gouilhers Hertig, Institute of Sociological Research,
University of Geneva, Switzerland &
Mélinée Schindler, Institute of Sociological Research, University of Geneva, Switzerland

The autonomy of patients is now an unavoidable issue in the medical field. With the rise of the therapeutic turning (taking into account the experiences of patients in the therapeutic relationship), paternalism is being fought, which is now considered anachronistic. To make way for new forms of relationships between caregivers and patients, therapeutic turning is geared more towards negotiation, information sharing and decision-making on the part of the individual, giving the patient increased rights. Informed consent forms, supposed to demonstrate compliance with this patient autonomy, are increasingly developing in research and daily clinical practice. In these informed consent forms, some caregivers alert against possible abuses related to bureaucratization and prosecution of care.

The concept of autonomy is considered to be the ideal outcome of a therapeutic relationship, however, the concept of autonomy in care contains a paradox: free choice in an environment constrained by social norms. Although an ideal, autonomy is insufficiently debated. Autonomy is difficult to obtain because inequalities around health are growing, caregivers still have broad flexibility to determine the course of action and at the same time good health is promoted and people are expected to maintain their good health. To analyse this notion in its complexity, it's important for the social sciences to research and discuss this issue. The concept of autonomy has resulted in different practices: What it produces in terms of adverse effects around the vision of health and individual responsibility, how to articulate individual, professional, and community responsibility, how this has changed the relationships between patients and caregivers, and what are its limits.

It is hard to reconcile the social imperative to be in good health with the respect for autonomy, because autonomy can lead to risk-taking or denial of medical treatment. The patients may also request that the professional make the decisions for them. The difficulty is between how the professionals combine the requirement of autonomy with user support and shared decision-making, especially in complex and uncertain situations. Reflections on inequalities in health and autonomy are too little discussed in the research. How can the relationship between inequality, relations of power and autonomy be analysed using the social sciences?

We invite researchers in the social sciences to offer contributions around a critique of the concept of autonomy. Abstracts that rely on empirical corpus, as well as those with a more theoretical reflection are welcome.

Pre-Organized Session

Session 6.3
Symposium on SHARE

Organiser: Johanna Bristle, MEA,
Max Planck Institute
for Social Law and Social Policy, Germany

The Survey of Health, Ageing and Retirement in Europe (SHARE) is a multidisciplinary and cross-national panel database of micro data on health, socioeconomic status and social and family networks of approximately 110,000 individuals (more than 220,000 interviews) from 20 European countries (+Israel) aged 50 or older. The data are available to the entire research community free of charge and are easy to access. Comparative research often struggles with comparability of the data obtained in the different settings. In SHARE, comparability is ensured by ex-ante harmonization of questionnaire design and translation, central coordination and monitoring of fieldwork procedures, and a central and harmonized data preparation and release procedure.

The proposed session introduces features of the SHARE data with a special emphasis on comparative health research. The aim is to bring together empirical papers using SHARE and to highlight the potential of these data for applications in the fields of health and medical sociology in the European context.

Demographic change is one key challenge of European societies with a growing older population. Therefore, it is of enormous interest to better understand how healthy ageing is possible, how health develops over time and why health outcomes are so different across countries. Datasets like SHARE enable researchers to identify pathways and policy-makers to make informed, evidence-based decisions. This is primarily facilitated through SHARE's unique combination of methodological features: (1) repeated measures of the same individual over time covering a time span from 2005 until today (longitudinal data), (2) policy variation across countries (cross-national setting), (3) collecting retrospective life histories on conditions in childhood, family background, employment histories and health (life-course perspective) and (4) enhancing these data by linking them to administrative data or combining them with additional data from surveys among SHARE interviewers.

This session compiles papers on the various fields of health research which are covered in SHARE to show a broad variety of relevant research. This includes (but is not restricted to) assessments of subjective and objective health in a cross-national context; health and wellbeing for specific subgroups of the older population like migrants, caregivers, or socially-excluded individuals; access to health care and long-term care under different welfare and health regimes; mental health; inequalities and social determinants of health; and the interplay of individual health behaviours and health care systems.

Pre-Organized Session

Sessions 7.1 & 8.1

Biopolitical Spaces, Healthy Bodies and Inequality

Organiser: Oli Williams, University of Abertay Dundee, United Kingdom, Dundee & Simone Fullagar, University of Bath, United Kingdom

One of the most enduring influences of the new public health approach has been establishing the necessity of adopting a healthy lifestyle as an individual moral responsibility. The short-comings of such an approach become ever more apparent in times of economic crisis. Such crisis has characterised the recent history of nations across Europe further exacerbating existing inequalities. Despite broad acceptance of the ‘social determinants’ of health the policy trend of ‘lifestyle drift’ has proliferated through an intensified focus on individualised responsibility. The social ‘conditions of possibility’ that constitute healthy living have been neglected in research that has tended to polarize around behaviour change or population focused interventions. The realm of everyday practices (leisure, work, technology, family, social networks, etc.) and their relation to health is an area requiring further critical exploration.

This session examines how inequalities are spatialised through discourses that bring together ideas of place, the healthy body, digital technology and the materiality of citizens’ everyday lives. Specific attention will be drawn to questions concerning how local places are invented and acted upon through a sociopolitical imaginary and how this can inhibit or enhance the capacity of local communities and individuals to embody health. Tensions between policy objectives and the material circumstances of citizens lives will be explored in terms of material, affective and discursive relations of power.

Pre-Organized Session

Session 7.2
Research in Medical Education

Organiser: Zoya Horcik, Unit of Development and Research in Medical Education, Faculty of Medicine, University of Geneva, Switzerland & Naïke Bochatay, Unit of Development and Research in Medical Education, Faculty of Medicine, University of Geneva, Switzerland

Research in medical education aims to understand and generate concepts related to medical training and practice, as well as to evaluate actions and developments in practice. By better understanding concepts or mechanisms related to medical education and practice, this field seeks to improve teaching and contribute to the development of new practices that address societal needs in terms of healthcare and health services. The ultimate goal of research in medical education remains to improve quality of care.

In this session, we will explore some examples of how research is designed and conducted by medical educationalists, emphasizing how sociological research methods have been both adopted and adapted to fit medical education's purposes. We will do so by discussing various research projects conducted by members of the Unit of Development and Research in Medical Education (UDREM) and the Unit of General Internists and Paediatricians (UIGP). These Units are part of the Faculty of Medicine at the University of Geneva and collaborate both with the University Hospitals of Geneva and with practitioners in private practice. Researchers involved in these Units have expertise in diverse areas related to health sciences education, such as interprofessional collaboration, development of clinical reasoning, clinical competence teaching, new technologies for teaching, and academic trajectories of medical students.

This session will cover research projects at different stages, from projects that are currently running to projects that were recently completed. It will provide attendees to our session with an overview of some methods used in medical education research and will raise questions about how teaching and research can mutually influence each other. Through this session, we also wish to highlight how sociological research methods have influenced other fields, stressing the similarities and connections between research in sociology and research in medical education.

Pre-Organized Sessions

Sessions 7.3 & 8.2
Challenging Risk Culture in the Context of Pregnancy, Birth and Postnatal Period

Organiser: Patricia Perrenoud,
University of Health Sciences in Lausanne
(HESAV), Switzerland &
Solène Gouilhers Hertig, Institute of Sociological
Research, University of Geneva, Switzerland

For more than 20 years, risk has been the subject of countless reflections in the social sciences, leading to an in-depth understanding of this complex phenomenon. As a totalizing phenomenon in modern Western societies, risk has found an even more prominent place in the health field. Representations and practices proposed by health professionals, health policy makers and patients have been analysed, leading to a better understanding of the links between risk, medicalization and technicalisation of almost all life stages. Negative health issues targeted by surveillance and intervention policies are varied and occur in different places and times. The transformation of dangers into risks and public problems vary accordingly, resulting in a historically, geographically and socioculturally specific construction. Research also shows that in times of a “risk society”, science and rationality are considered as the only legitimate processes allowed to construct risks.

Considered as hallmarks of risk culture, pregnancy and birth have received thorough attention from social scientists. Risk avoidance has been pointed out as a contributor to many changes in the management of pregnancy and birth, including the rise of a surveillance pattern leading to numerous preventive medical and surgical interventions. Risk, medicalization and technicalisation of pregnancy and birth have consequently been criticised highlighting the lack of freedom experienced by women, the toll on their bodies and the climate of fear and guilt surrounding both women and professionals. Paradoxically, medicalization and technicalisation of birth are more and more identified as the potential sources of new risks. According to several authors, risk culture is deemed to be so strong that pregnancy and birth might no longer be considered, experienced or managed outside of this framework. While social scientists follow up technological innovation and implementation in health care, which has led to a relevant social critique of risk culture, the authors of this symposium question whether the critique of risk and related medicalization of birth has come full circle. They therefore propose to explore niches in which the experience and the care of pregnancy and birth either does not correspond to the characteristics of risk culture or reinterprets these characteristics to create alternative representations and practices. This session therefore explores ways in which:

A. The experience and the management of pregnancy, birth and the postnatal period are developed outside of the scope of risk and surveillance, knowingly or unknowingly, momentarily or permanently.

B. Risk and surveillance can be coped with outside of the scope of negative emotions and feelings such as fear, guilt, shame and anger.

C. Risk culture is used in unexpected ways in the experience and in the management of pregnancy and birth, for instance in attempting to redefine or personalise the risks.

D. A variety of initiatives are used to counterbalance the expression of the dominant culture of risk about pregnancy and birth.

Index of Presenters, Contact Information and Session Numbers

Last name	First name	E-mail Address	Session number
Aceti	Monica	monica.aceti@unifr.ch	7.1
Ancian	Julie	julie.ancian@gmail.com	5.2
Anderssen	Jorid	jorid.anderssen@uit.no	8.4
Avdeev	Alexandre	Alexandre.Avdeev@univ-paris1.fr	Poster session
Ayala	Ricardo A.	RicardoAlexis.AyalaValenzuela@UGent.be	4.3
Bader	Dina	dina.bader@unil.ch	1.4
Balaj	Mirza	mirza.balaj@ntnu.no	4.5
Bergroth	Harley	hamber@utu.fi	3.4
Bloy	Géraldine	gbloy@u-bourgogne.fr	1.1
Bochatay	Naïke	Naike.Bochatay@unige.ch	7.2
Bodnar-Deren	Susan	smbodnar@vcu.edu	2.7, 5.2, 8.3,
Böhr	Dorothea	boehr@soziologie.uni-siegen.de	4.6
Borgmann	Lea-Sophie	lea.borgmann@charite.de	Poster session
Borisova	Liubov	liubov.borisova@soc.uu.se	6.4
Borowiec	Agnieszka	aborowiec@ikard.pl	7.5
Bristle	Johanna	bristle@mea.mpisoc.mpg.de	6.3
Broadhurst	Sarah	sbroadhurst@brookes.ac.uk	2.2
Brunton	Lisa	lisa.brunton@postgrad.manchester.ac.uk	4.4
Bühler	Nolwenn	nolwenn.buhler@dmu.ac.uk	4.2
Caiata Zufferey	Maria	maria.caiata@supsi.ch	5.4, 7.6
Capuzzo	Fiorella Maria Bernadette	fiorella.capuzzo@consiglio.regione.lombardia.it	8.4
Cavaye	Joyce	joyce.cavaye@open.ac.uk	1.2, 2.2
Chautems	Caroline	caroline.chautems@unil.ch	8.2
De Clerck	Cindy	cidecler@vub.ac.be	8.6
De Keyser	Lieselot	lieselot.dekeyser@ugent.be	4.5
de Mestral	Carlos	carlos.de-mestral-vargas@chuv.ch	Poster session
Debons	Jérôme	jerome.debons@gmail.com	6.1
Déchamp-Le Roux	Catherine	catherine.dechamp-le-roux@univ-lille1.fr	3.4
Dégi	Csaba László	csabadegi@gmail.com	1.6
Delaruelle	Katrijn	katrijn.delaruelle@ugent.be	4.6
Deml	Michael	michaeljdeml@gmail.com	8.7
Depper	Annaleise	a.f.depper@bath.ac.uk	7.1
Derbez	Benjamin	bderbez@gmail.com	1.1

Last name	First name	E-mail Address	Session number
Dereuddre	Rozemarijn	rozemarijn.dereuddre@ugent.be	1.3
Dhuot	Raphaël	raphael.dhuot@ivry.inra.fr	7.3
Dilmaç	Julie Alev	jadilmac@gmail.com	1.7
Dimond	Rebecca	DimondR1@Cardiff.ac.uk	3.2
Dragano	Nico	dragano@med.uni-duesseldorf.de	3.1
Drennan	Vari	V.Drennan@sgul.kingston.ac.uk	5.3
Dudal	Pieter	pieter.dudal@ugent.be	5.6
Dumas	Agnes	agnesdumas@free.fr	3.6, 5.1
Duntava	Aija	aija.duntava@soc.uu.se	7.6
Earthy	Sarah	s.earthy@herts.ac.uk	8.5
Elstad	Jon Ivar	Jon.I.Elstad@nova.hioa.no	1.5
Esposito	Maurizio	m.esposito@unicas.it	1.6
Fargnoli	Vanessa	vanessa.fargnoli@unige.ch	1.4
Feder-Bubis	Paula	federbub@bgu.ac.il	2.6
Fischer	Julia	fischer@bmg.eur.nl	1.7
Fjær	Erlend Løvø	erlend.fjar@ntnu.no	1.5
Foubert	Josephine	josephine.foubert@ugent.be	6.6
Fournier	Cécile	ce.fou@free.fr	1.1
Fullagar	Simone	s.p.fullagar@bath.ac.uk	7.1
Gaborit	Emilie	gaborit.emilie1@yahoo.com	2.1
Gabriele	Giovanna	giannagabriele@gmail.com	6.2
Gaillardin	Florianne	florianne.gaillardin@gmail.com	5.8
Gemperle	Michael	michael.gemperle@ehess.fr	5.3
Gkiouleka	Anna	a.gkiouleka@qmul.ac.uk	5.6
Grafe	Marion	marion.grafe@gmx.de	3.3
Guerrero	Joaquín	jguerrero@um.es	2.1
Hammer	Raphaël	raphael.hammer@hesav.ch	8.2
Heggebø	Kristian	kristian.heggebo@hioa.no	7.4
Horcik	Zoya	zoya.horcik@unige.ch	7.2
Hoven	Hanno	hanno.hoven@med.uni-duesseldorf.de	6.7
Huegaerts	Kelly	kelly.huegaerts@vub.ac.be	7.4
Hurst	Samia	samia.hurst@unige.ch	6.2
Jaspal	Rusi	rjaspal@dmu.ac.uk	5.5
Jellema	Sandra	sandra.jellema@han.nl	1.2

Last name	First name	E-mail Address	Session number
Jimenez	Alvaro	alvarojimol@gmail.com	5.4
Jordal	Malin	Malin.Jordal@kbh.uu.se	5.5
Kang	Yoonjung	benzeiten@gmail.com	7.3
Karvonen	Sakari	sakari.karvonen@thl.fi	5.8
Keller	Roger	roger.keller@phzh.ch	2.8
Kelly-Irving	Michelle	michelle.kelly@inserm.fr	4.7
Kestilä	Laura	laura.kestila@thl.fi	Poster session
Khazaei	Faten	faten.khazaei@unine.ch	1.4
Kim	Tae Jun	t.kim@uke.de	7.7
Kovács	Katalin	kovacs@demografia.hu	3.5
Krajic	Karl	karl.krajic@univie.ac.at	2.7
Kuntz	Benjamin	b.kuntz@rki.de	5.6
Lahelma	Eero	eero.lahelma@helsinki.fi	1.6
Lariviere	Matthew	m.lariviere@uea.ac.uk	4.4
Lazarevic	Patrick	Patrick.Lazarevic@TU-Dortmund.de	6.3
Le Hénaff	Yannick	yannick.le-henaff@univ-rouen.fr	3.6
Leopold	Liliya	liliya.leopold@gmail.com	6.7, 8.6
Liuccio	Michaela	michaela.liuccio@uniroma1.it	5.7
Lombardi	Lia	rosalia.lombardi@unimi.it	4.2, 7.5
Lostao	Lourdes	llostao@unavarra.es	1.5
Lowton	Karen	k.lowton@sussex.ac.uk	4.7
Lunau	Thorsten	thorsten.lunau@uni-duesseldorf.de	2.8
Lutz	Andrea	andrea.lutz@unige.ch	5.4
Lyytikäinen	Laura	laulyy@utu.fi	5.7
Maffi	Irene	irene.maffi@unil.ch	8.2
Mäki-Opas	Tomi	tomi.maki-opas@thl.fi	6.5
Mandemakers	Jornt	jornt.mandemakers@wur.nl	3.2
Marcano Clemente	Isabel	marcano.isabel@gmail.com	7.4
Martenot	Aude	aude.martenot@unige.ch	4.7
Martinussen	Pål Erling	paal.martinussen@svt.ntnu.no	2.6
Masquillier	Caroline	caroline.masquillier@uantwerpen.be	4.3
Maturo	Antonio	tonio.maturo@gmail.com	3.4
Mazhak	Iryna	irynamazhak@aias.au.dk	6.4
Meidert	Ursula	mede@zhaw.ch	7.2

Last name	First name	E-mail Address	Session number
Mesnard	Pauline	pauline.mesnard@unil.ch	6.2
Mikucka	Małgorzata	mikucka.m@gmail.com	7.7
Mirlesse	Veronique	veronique.mirlesse@hcuge.ch	Poster session
Monneraud	Lise	lise.monneraud@u-bordeaux.fr	8.7
Muckenhuber	Johanna	johanna.muckenhuber@uni-graz.at	5.8, 8.5
Muller-Juge	Virginie	virginie.muller-juge@unige.ch	7.2
Murray de Lopez	Jenna	j.murray-de-lopez@salford.ac.uk	7.3
Nicolet	Marthe	marthe.nicolet@unige.ch	3.3
Orr	Elizabeth	lizorr@iinet.net.au	4.3
Östergren	Olof	olof.ostergren@chess.su.se	3.5
Oyewole	Damilola	dammteex02@yahoo.com	Poster session
Page	Julie	julie.page@zhaw.ch	6.1
Passet-Wittig	Jasmin	jasmin.passet@bib.bund.de	3.2
Patterson	Rebecca	r.a.patterson@ncl.ac.uk	1.2
Pelikan	Jürgen	juergen.pelikan@univie.ac.at	2.4
Perrenoud	Patricia	patricia.perrenoud@hesav.ch	6.2, 8.2
Petrovčič	Andraž	andraz.petrovcic@fdv.uni-lj.si	4.4
Peytrignet	Marie-Claire	marie-claire.peytrignet@unige.ch	1.3
Pfeuffer	Andreas	andreas.pfeuffer@fhnw.ch	6.1
Pharaoh	Hamilton	hpharaoh21@gmail.com	5.5
Piątkowski	Włodzimierz	anna.sadowska@poczta.umcs.lublin.pl	1.7
Pidoux	Vincent	vincent.pidoux@unil.ch	5.4
Piłat	Aleksandra	aleksandra.pilat@uj.edu.pl	4.1
Pitti	Laure	laure.pitti@cnrs.fr	1.1
Plunger	Petra	petra.plunger@aau.at	2.1
Ponomarenko	Valentina	valentina.ponomarenko@uni.lu	6.3
Prevolnik Rupel	Valentina	katka.rupel@gmail.com	7.6
Prokop-Dorner	Anna	a.e.prokop@gmail.com	8.6
Rahkonen	Ossi	ossi.rahkonen@helsinki.fi	6.5
Reibling	Nadine	reibling@soziologie.uni-siegen.de	7.5
Ribeiro	Carla	carla.ribeiro@unine.ch	4.7
Rich	Emma	E.Rich@bath.ac.uk	3.4, 8.1
Rizzi	Ester Lucia	ester.rizzi@uclouvain.be	2.3
Salamon	Katarzyna	k.salamon2@op.pl	8.5

Last name	First name	E-mail Address	Session number
Sand	Gregor	sand@mea.mpisoc.mpg.de	6.3
Schaeffer	Doris	doris.schaeffer@uni-bielefeld.de	2.4
Sena	Barbara	barbara.sena@unitelma.it	5.3
Shipovskaya	Valentina	valenship@gmail.com	4.6
Silva	Sílvia	silviamcsilva@gmail.com	5.8
Slonska	Zofia A.	slonska@post.pl	2.4
Spankulova	Lazzat	spankulova@mail.ru	1.5
Srakar	Andrej	andrej.srakar@ier.si	2.8, 6.3
Streckeisen	Ursula	ursula.streckeisen@phbern.ch	6.1
Suess	Waldemar	suess@uke.de	2.7
Temporin	Filippo	F.Temporin@lse.ac.uk	3.5
Testa	Maria Rita	maria.rita.testa@wu.ac.at	2.3
Tobiasz-Adamczyk	Beata	mytobias@cyf-kr.edu.pl	2.6
Toborg	Merle	merle.toborg@jade-hs.de	Poster session
Tøge	Anne Grete	anne-grete.toge@hioa.no	3.1, 6.7
Tognetti	Mara	mara.tognetti@unimib.it	2.7
Trachte	Florian	trachte.florian@mh-hannover.de	8.3
Tymicki	Krzysztof	krzysztof.tymicki@sgh.waw.pl	4.2
Vaisanen	Heini	h.e.vaisanen@soton.ac.uk	1.3
Vallet	Guillaume	guillaume.vallet@upmf-grenoble.fr	5.7
Van Aerden	Karen	kvaerden@vub.ac.be	3.1
van de Bovenkamp	Hester	vandebovenkamp@bmg.eur.nl	Poster session
van der Wel	Kjetil A.	kjetil.wel@hioa.no	6.6
van Deurzen	Ioana	i.a.vandeurzen@uvt.nl	6.7
Vanderlinden	Karen	karen.vanderlinden@Ugent.be	2.3
Verbakel	Ellen	E.Verbakel@maw.ru.nl	2.2
Verhaeghe	Pieter-Paul	pieterpaul.verhaeghe@ugent.be	8.4
von der Lippe	Elena	vonderlippee@rki.de	6.5
von Storch	Katja	k.storch@uni-koeln.de	4.4
Vuille	Marilène	marilene.vuille@unige.ch	3.3
Wahrendorf	Morten	wahrendorf@uni-duesseldorf.de	4.1
Watts	Jacqueline	jackie.watts@open.ac.uk	1.2
Wesolowski	Katharina	katharina.wesolowski@sofi.su.se	6.6
Westlake	Debra	debra.westlake@gmail.com	2.2

Last name	First name	E-mail Address	Session number
Williams	Oli	osw21@bath.ac.uk	8.1
Wiltshire	Gareth	g.r.wiltshire@bath.ac.uk	8.1
Wozniak	Barbara	barbara.wozniak@uj.edu.pl	4.6
Xavier	Beatriz	xavier.beatriz@gmail.com	8.7
Yoshida	Chizu	chizuy@kanto-gakuin.ac.jp	Poster session
Zajc	Jožica	jozica.zajc@fdv.uni-lj.si	4.1
Zarhin	Dana	zarhinda@brandeis.edu	3.4
Zawisza	Katarzyna	katarzyna.zawisza@uj.edu.pl	7.5, 8.5

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