Abstract submission guidelines

A. Overview

An important aim of the New Zealand Population Health Congress is to provide opportunities for the population health workforce to present their work to their colleagues and wider New Zealand audiences. These guidelines describe the process and steps. You will need to:

1. decide on fit with Congress streams and days (see Section B below)
2. decide on presentation format, e.g. oral, written (see Section C below)
3. prepare your abstract using the template provided
4. submit your abstract by 29 May 2014
5. revise your abstract (if accepted and revision is needed)
6. register to attend the Congress and arrange personal travel and accommodation
7. present your paper at the Congress (if accepted for oral presentation)
8. potentially work with the media (if your paper is very topical)
9. consider including your work in the Congress proceedings (if selected).

Important dates

- First call for abstracts: 3 March 2014
- Close of abstract submissions: 29 May 2014
- Notification of acceptance of abstracts: from 1 July 2014
- Early bird registrations open: 1 April 2014

B. Abstract streams and days

Although the Congress runs for three days, we are seeking abstracts for Days 1 and 2 only as Day 3 is being structured around a series of master classes which do not involve proffered papers. There are five broad streams for the Congress days. These are based on hauora (health and wellbeing) determinants, each of which has a series of suggested areas of focus. When submitting your abstract please indicate which stream it falls under. If your abstract does not easily fit one of these streams but you would still like it to be considered, please choose "Other”.

1. Effective governance and economics that work for hauora
   - Governance models that support participation, population health and equity
   - Reducing health inequalities and poverty
   - The political economy and health
2. **Inclusive cultural systems** that contribute to hauora
   - Improving Māori, Pacific and indigenous health
   - Life course epidemiology and improving child health
   - Improving population mental health, such as reducing youth suicide
   - Improving health for vulnerable groups

3. **Successful social systems and services** that enable hauora
   - Health in all policies
   - Health promotion and changing population health behaviours
   - Improving nutrition and exercise and reducing obesity, diabetes and related chronic diseases
   - The end of tobacco
   - Population health approaches to alcohol and other addictive substances

4. **Sustainable physical environments** that promote hauora
   - Sustainability in all policies
   - Healthy housing, sustainable cities, co-benefits
   - Climate change mitigation and adaptation
   - Reducing the population health impacts of infectious diseases
   - Population resilience to emergencies
   - Reducing injuries

5. **Innovative health systems and technology** that support hauora
   - Using burden of disease and cost-effectiveness analysis to support population health
   - Health promoting health services, particularly the role of primary care
   - High tech meets population health, including effective use of mobile-phones and the Internet
   - Sustainable health care, including greening our hospitals

When submitting your abstract please indicate which day would be most suitable, or indicate if you have **no preference**:

- **Day 1** Monday 6 October – Focus on **connecting with communities**, particularly indigenous communities of New Zealand and the Pacific e.g. population health programmes, community based initiatives.
- **Day 2** Tuesday 7 October – Focus on **connecting with policy, business and culture** e.g. healthy public policy, health promoting businesses, national-level epidemiological studies.

Examples of topics for potential papers are listed in Appendix 1, organised according to Congress streams and days.

C. **Presentations options**

For each abstract, please indicate your preferred presentation format from the following options:

- **Long oral** presentation (15 minutes = 10 for presentation + 5 for questions)
- **Short oral** presentation (7 minutes = 5 for presentation + 2 for questions)
- **Pecha Kucha** presentation (7 minutes, with 20 slides for 20 seconds each, no questions)
- **Written** summary (abstract published online following review)
- **Interactive workshop** (45 or 90 minute workshop on a specified topic using an interactive format chosen by presenter(s). NB: There are limited spaces for this option)

Following submission of your abstract, the Congress organising committee may contact you to discuss the way your presentation can best work in the context of the programme. As presentation time is limited, some presenters may be offered ‘short oral’ presentation formats or ‘written’ online abstract only.
D. Abstract format

The following formatting guidelines are provided to assist you with preparing your abstract. This will make it easier for the Congress audience to understand your work and what it means. It will also help the Congress organisers decide whether to include your work in the programme and where it best fits.

Two sample abstracts are included in Appendix 2 to illustrate the use of this format.

General points

Word count: Abstracts should be about 400 words, but may be up to 500 words provided the total abstract (including title and author details) does not exceed one page in length. Abstracts should not include tables or figures.

Font and paragraph formatting: 11-point Calibri font, single spaced, left justified, insert a line space between sections (including between the title, authors and each section of the abstract)

Numbers: Numbers less than 10 should be written as words (e.g. two), numbers over 10 should be written as numbers (e.g. 16)

Abbreviations: Define all abbreviations in full at the first mention with the abbreviation in parentheses.

References: These are not required. However there may be situations where they are particularly important and/or useful for readers (e.g. where the work presented has already been published). Up to three may be included. Use a numbered reference in the text in brackets such as “(1)” with the full reference at the end of the abstract in Vancouver style, e.g.


Abstract sections

Title: Use sentence case in the title (capitalise only the first word and proper nouns). Use bold font.

Authors: Enter the name of the author(s) as first name and last name. No titles/honorifics. Use superscripted numbers to indicate institutional affiliations. Indicate the presenting author (who is not necessarily the first author) with their email address to assist those who may wish to follow-up with them. Separate author names with commas. Give the proper name, city, and country for each institution. Separate each with a comma. For example:

Manu Miller1, Nigel Bachman1,2, Jo Olson (jo.olson@hi.is)3
1Hauora Trust, Napier, New Zealand
2Ministry of Public Health, Wellington, New Zealand
3University of Iceland, Institute for Experimental Pathology, Reykjavik, Iceland

Body: Abstracts should be divided into six sections as listed below. The content under each heading will vary depending on the nature of the population health work (e.g. whether the work was concerned with describing a population health programme or research project).

• Issue: Explain the population health issue being addressed.
• Aims: State what you wanted to achieve, ideally with a list of your main aim(s).
• Methods/Actions: Specify what you did and how you did it.
• Results/Achievements: Describe what you found or what was achieved.
• Conclusions: Clearly explain what your work or study means and how it adds to what is known.
• Implications: Describe the implications of your work for population health policy and practice, e.g. What should be done differently as a result of your work? Specific recommendations? What would you do differently next time? What were the main things you learned by doing this? Consider listing a set of practice dot points.
E. Abstract review process

Review process

All abstracts will be reviewed by the Abstract Review Committee and authors will be advised via e-mail whether their papers have been accepted or declined from 1 July 2014. If your abstract is accepted, you will either be allocated a time slot in the programme or your abstract will be selected for on-line publication. Selected abstracts may also be published as part of the Congress proceedings.

Selection criteria

1. **Relevance**: Paper has a good fit with Congress themes, offers something unique and/or required by Congress (e.g. to provide balance of content or geographic coverage)

2. **Importance**: Issue(s) addressed by paper have high population health impact (including a focus on hauora/health determinants), and high potential for health gain

3. **Interest**: Paper addresses an issue that is highly topical, presents novel findings, and addresses an area of general interest to the Congress audience

4. **Quality**: Methods/approaches show high scientific quality (e.g. original research or systematic review of evidence), go beyond description to draw out insights (what was learned, recommendations, new policy or actions), high quality abstract (well-structured, specific, detailed)

5. **Usefulness**: Describes or illustrates an important area of population health practice, addresses likely competence needs of the workforce, provides new ideas or approaches

F. Working with the media

Encouraging public awareness and debate on population health issues is very important. The media have a key role in facilitating this discussion and will be invited to the Congress.

When submissions have closed the Congress media team will look through the abstracts that have been accepted and choose those that are likely to be of wide interest. To help them decide, the Congress media team may contact you asking to see a copy of your presentation (e.g. your PowerPoint). If your presentation is chosen and you agree, the media team will work with you in the weeks preceding the Congress to prepare a media release about your presentation. This would be released to the media at the time you present. The media team will also talk with you about possibly doing media interviews during or after the Congress.

Please be assured the Congress media team will respect any sensitivities around your research and findings. Nothing will be released to the media without your full knowledge and approval.

If you have concerns about the media covering your presentation, you will have the opportunity to indicate that during the abstract submission process and in discussions with the Congress media team.

G. Publication post-Congress

When the Congress is over, presentations are usually published online. This is for those who missed the Congress or who would like to revisit something they found of benefit.

However, we understand there may be reasons you would not like this to occur and we will respect those reasons. During the submission process you will have the opportunity to tell us not to publish your presentation on-line.

Selected abstracts may also be published as part of the Congress proceedings. You will have an opportunity to revise and update your contribution prior to final publication.
Assistance with creating and presenting an abstract is available, and is particularly offered to first-time presenters. For further information, contact Sue Wells s.wells@auckland.ac.nz or phone +64 9 3737599 ext 82463

If you have difficulties using the abstract submission website contact Rachel Cook Conference Innovators Ltd +64 9 281 5588 or +64 21 918 524 or rachel@conference.co.nz
## Appendix 1: Examples of potential topics organised according to Congress Themes and Days

<table>
<thead>
<tr>
<th>Themes</th>
<th>Areas of focus - examples</th>
<th>Day 1: Connecting with communities</th>
<th>Day 2: Connecting with policy, business and culture</th>
</tr>
</thead>
</table>
| • Governance and economics that work for hauora | • Governance models that support participation, population health, and equity  
• Reducing health inequalities and poverty  
• The political economy and health | • e.g. Empowering communities to improve population health: Successful models from Aotearoa | • e.g. Would shifting from gross domestic product (GDP) to a genuine progress indicator (GPI) improve population health in NZ? |
| • Inclusive cultural systems that contribute to hauora | • Improving Māori, Pacific and indigenous health  
• Lifecourse epidemiology and improving child health  
• Improving population mental health such as reducing youth suicide  
• Improving health for vulnerable groups | • e.g. Successful implementation of the wahakura and safe sleeping environment to prevent SIDS | • e.g. Impact of the Expert Advisory Group on Solutions to Child Poverty Report |
| • Social systems and services that enable hauora | • Health in all policies  
• Health promotion and changing population health behaviours  
• Improving nutrition and exercise and reducing obesity, diabetes and related chronic diseases  
• The end of tobacco  
• Population health approaches to alcohol and other addictive substances | • e.g. Effective nutritional improvement programmes in schools | • e.g. Impact of liquor licensing law changes on reduced alcohol related harm |
| • Sustainable physical environments that promote hauora | • Sustainability in all policies  
• Healthy housing, sustainable cities, co-benefits  
• Climate change mitigation and adaptation  
• Reducing the population health impacts of infectious diseases  
• Population resilience to emergencies  
• Reducing injuries | • e.g. Pacific peoples voices in climate change mitigation | • e.g. Implementing the Housing Warrant of Fitness in NZ to improve the quality of rental housing |
| • Health services and technology that support hauora | • Using burden of disease and cost-effectiveness analysis to support population health  
• Health promoting health services, particularly the role of primary care  
• High tech meets population health, including effective use of mobile-phones and the Internet  
• Sustainable health care, including greening our hospitals | • e.g. Role of nurse practitioners in delivery of screening services | • e.g. Estimating the benefits of a national bowel cancer screening programme |
Appendix 2: Examples of Abstracts

Sodium content of New Zealand breads from 2007 to 2010: implications for health policy

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Issue: Population sodium intakes in New Zealand (NZ) currently exceed recommendations for good health. Bread is a major contributor to dietary sodium, and in 2007 the Heart Foundation (HF) of NZ set a voluntary target for bread manufacturers of 450mg/100g.

Aims: The aims were to assess changes in the sodium content of NZ breads from 2007 to 2010 and compare current sodium values against Australian breads and the 2007 HF target.

Methods/Action: Sodium values were collected directly from Nutrition Information Panels of all packaged bread products at two major supermarkets in NZ and Australia in 2007 and 2010. Mean sodium values were calculated by year and compared between countries. The proportion of NZ products meeting the HF target was calculated for each time point.

Results/Achievements: The mean sodium content of all NZ breads decreased from 469mg/100g in 2007 to 439mg/100g in 2010. In 2007, the mean sodium content of Australian breads was lower than NZ breads (434mg/100g), but did not change over the four year period (435mg/100g in 2010). The proportion of NZ breads meeting the HF target increased from 49% (2007) to 90% (2010; p<0.01) with similar trends observed across all bread categories (White, Wholemeal, and Mixed Grain).

Conclusions: Voluntary initiatives have improved the sodium content of some NZ breads, yet substantial scope for further reformulation remains. The mean sodium content of breads in NZ (439mg/100g) is below the HF target (450mg/100g), but above the more stringent Australian target (400mg/100g).

Implications: Key implications for policy include: regular review of sodium targets for bread manufacturers (including the 2007 HF of NZ target); monitoring of the food supply to validate the success of voluntary manufacturer initiatives; and consideration of Government leadership to further reduce sodium in the national food supply.
“However hard a person works, things just keep coming up”: an evaluation of the effect of BPharm student participation in the Missouri community poverty simulation

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Issue: Since 2012, pharmacists have been obligated by the Pharmacy Council of New Zealand (PCNZ) to practice pharmacy in a culturally competent manner. The PCNZ’s range statement describing culture includes socioeconomic status. The School of Pharmacy looked for innovative teaching material to incorporate into the BPharm curriculum and found the Missouri Community Action Poverty Simulation, an American simulation which aims to sensitise participants to the realities of life faced by those living on low incomes. The simulation provides a safe environment to assist participants begin to understand what living in a low-income family might be like.

Aims: We aimed to assess whether participation in this experience resulted in students unfamiliar with issues associated with living on a low-income developing a non-judgemental, more compassionate attitude towards those in this situation and, as a result, becoming more empathetic, effective pharmacists once in practice.

Methods/Action: A kit was purchased from the Missouri Association for Community Action and the questionnaire modified to accommodate one hundred students and reflect the New Zealand environment. Changes made included “translations” of American welfare terms, and using New Zealand statistics. The Auckland City Mission, which provides specialised health and social services to marginalised individuals, was approached for advice and asked whether they would be willing to provide staff to role play six key roles: two social workers, a social welfare receptionist, two social welfare agency staff and the pawn broker. We trialled and evaluated the simulation with our year two pharmacy students in 2012. Students completed anonymous paired, pre and post simulation questionnaires. 16 statements with Likert scale response options were used to monitor changes in beliefs and attitudes towards those living in poverty. In order to collect students’ views on the simulation, four additional free text questions plus a section for additional comments were also added.

Results/Achievements: 88 out of 94 students completed the pre and post questionnaires. Free text comments indicate that the simulation was well received and that many students had their views and assumptions about poverty, and those living in poverty, changed through participation in it. The pre and post changes in attitudes varied in magnitude and direction and proved difficult to analyse statistically.

Conclusions: Despite the mixed responses collected from the quantitative data, when looked at together with the free text responses the results indicate that for many students, participation in the poverty simulation sensitised them to the realities of living on a low income and challenged and changed some of their negative stereotypical views.

Implications: The involvement of The Auckland City Mission was crucial with regards to the provision of advice on the appropriateness of running the simulation, in addition providing to authenticity and credibility to the exercise. This involvement has resulted in the development of a productive relationship between The School of Pharmacy and The Auckland City Mission and could be the beginning of a long-term collaboration (1).