Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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Welcome

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



OPENING WORDS *by*

Vincent Yzerbyt

*Professor and **Dean**, Faculty of Psychology, Speech Therapy, Sexology and Family Sciences, PSY, IPSY, UCLouvain*

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Session 1

SYMPOSIUM IN HONOR OF

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



KEYNOTE Speaker

Louise Potvin

PhD, Professor, School of Public Health, Université de Montréal and President of the IUHPE

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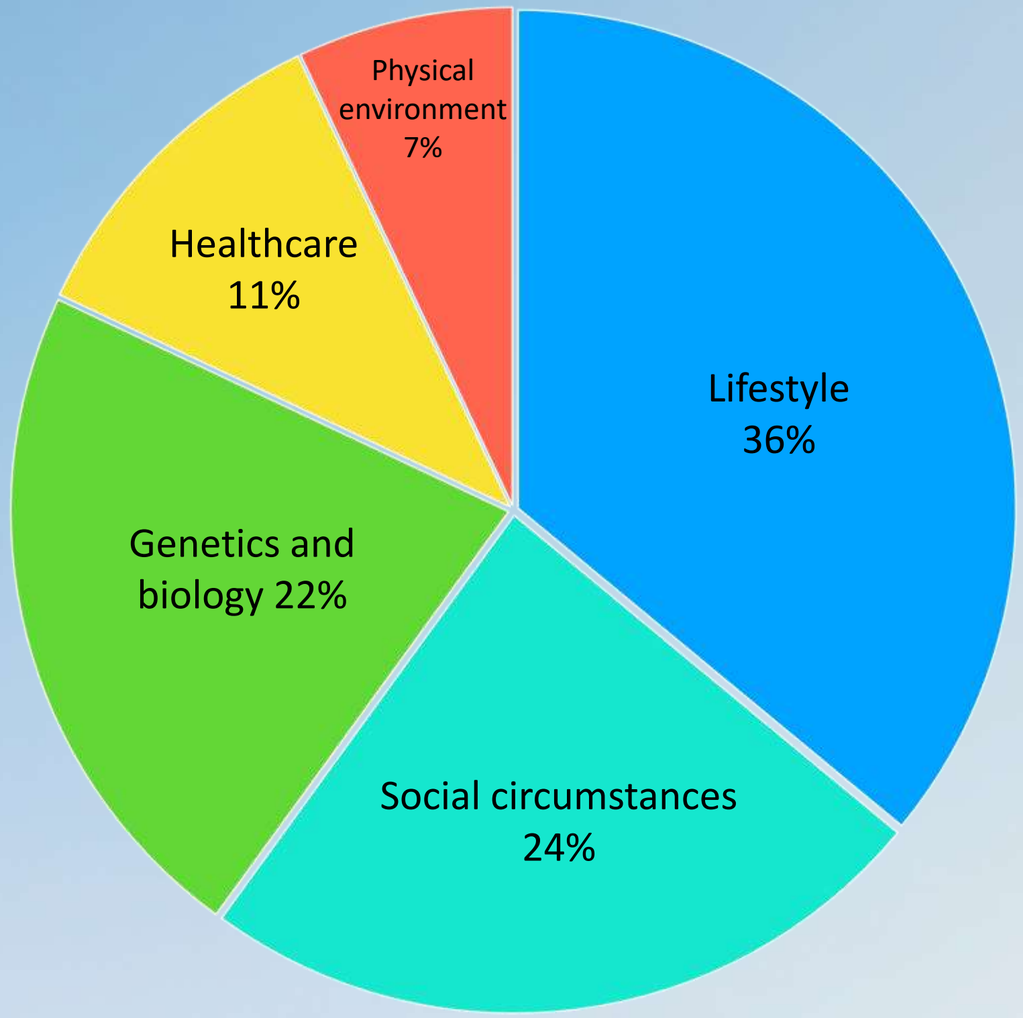
Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

The State of the Field of Health Promotion and the Need to Strengthen Advocacy Across the Full Spectrum of the Determinants of Health

Louise Potvin PhD
School of Public Health, Université de Montréal
President of the IUHPE

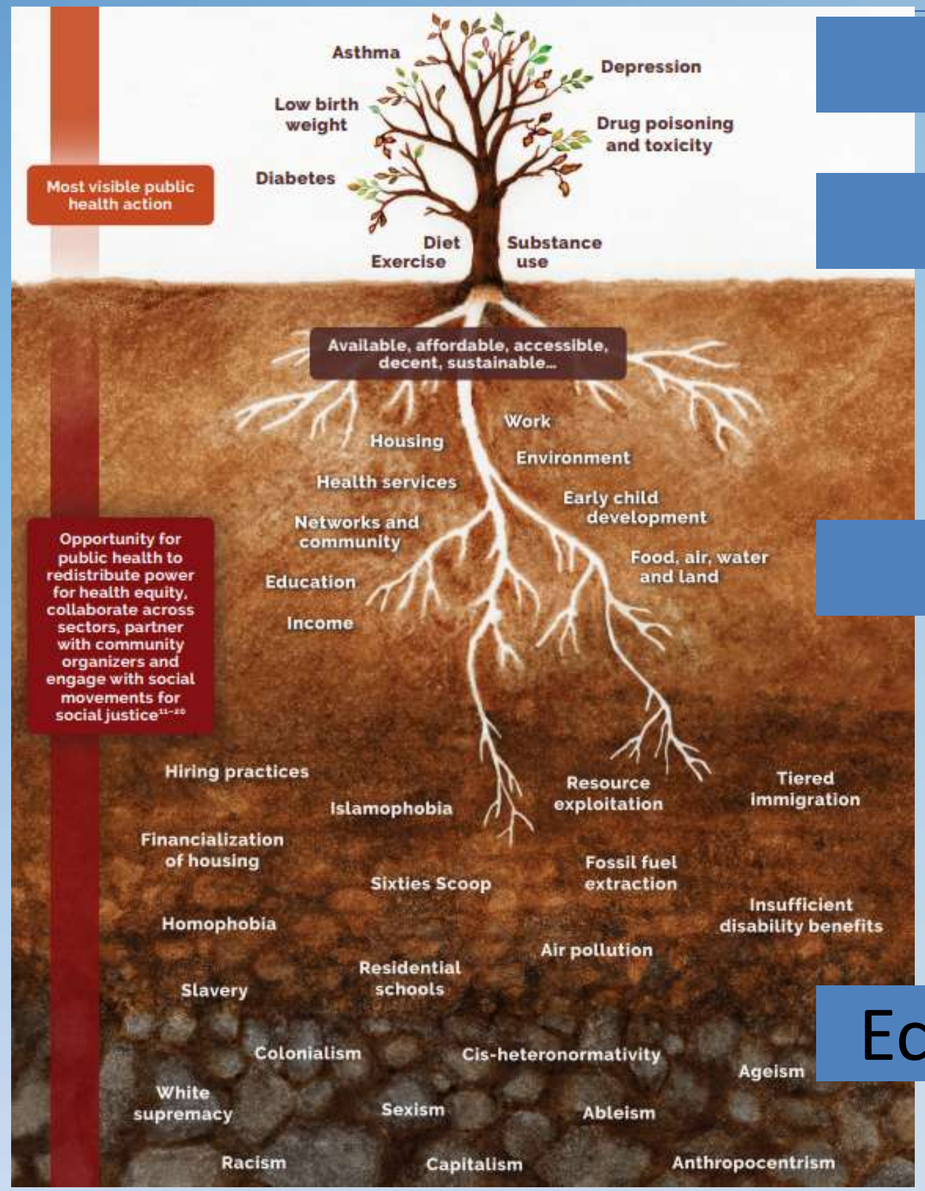
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The determinants of health



Source : https://www.goinvo.com/vision/determinants-of-health

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Pathological Process

Lifestyle

Social determinants

Ecological/Structural determinants

https://nccdh.ca/wp-content/uploads/2024/10/NCCDH_Lets_Talk_Determinants_of_health_EN_FV.pdf

Prevention targets and strategies

Pathological process: Secondary Prevention (screening)

- Early physiological signs

Lifestyle: Primary Prevention and Develop personal skills

- Individual behaviours and decisions

Social determinants: Heath in all policy, healthy environments, strengthen community

- Social conditions and resources in daily life

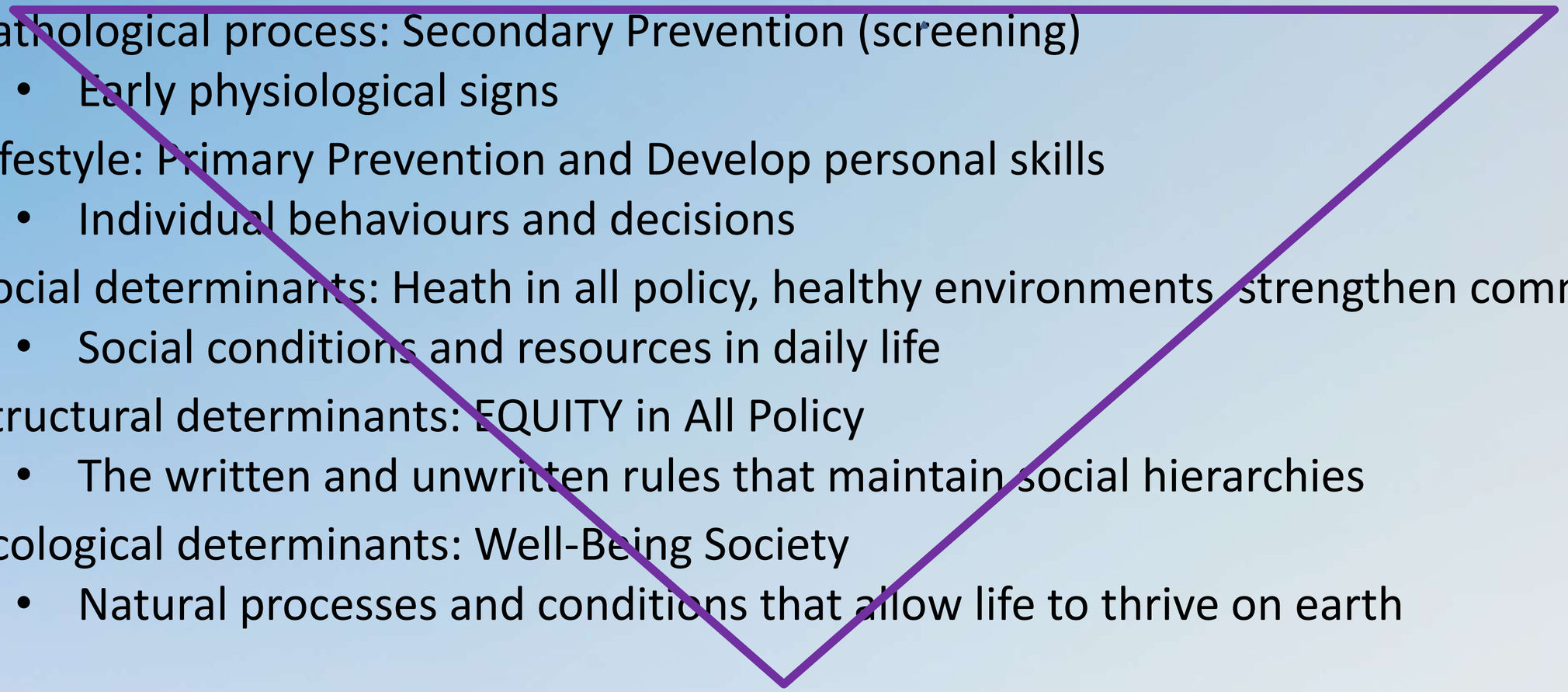
Structural determinants: EQUITY in All Policy

- The written and unwritten rules that maintain social hierarchies

Ecological determinants: Well-Being Society

- Natural processes and conditions that allow life to thrive on earth

Investment in research & advocacy



Pathological process: Secondary Prevention (screening)

- Early physiological signs

Lifestyle: Primary Prevention and Develop personal skills

- Individual behaviours and decisions

Social determinants: Heath in all policy, healthy environments, strengthen community

- Social conditions and resources in daily life

Structural determinants: EQUITY in All Policy

- The written and unwritten rules that maintain social hierarchies

Ecological determinants: Well-Being Society

- Natural processes and conditions that allow life to thrive on earth

Impact on health & equity

Pathological process: Secondary Prevention (screening)

- Early physiological signs

Lifestyle: Primary Prevention and Develop personal skills

- Individual behaviours and decisions

Social determinants: Heath in all policy, healthy environments, strengthen community

- Social conditions and resources in daily life

Structural determinants: EQUITY in All Policy

- The written and unwritten rules that maintain social hierarchies

Ecological determinants: Well-Being Society

- Natural processes and conditions that allow life to thrive on earth

Key facts on inequalities*

- 83% of countries have high income inequality (Gini coefficient above 0.4, accounting for 90% of the world's population.
- Income inequality between all individuals in the world has fallen since 2000, due largely to China; globally it remain very high, Gini coefficient of 0.61.
- Wealth inequality is far higher than income inequality. Globally between 2000-24, richest 1% captured 41% of all new wealth, while bottom half got 1%.
- Trickle down??? Since 2000:
  - average increase wealth for richest 1%: US$1.3M;
  - average wealth increased for lowest 50%: US$585.
- 25% people globally (2.3 billion) face moderate or severe food insecurity, is up by 335 million since 2019.

* Stiglitz, J. et al. (2025) *G20 EXTRAORDINARY COMMITTEE OF INDEPENDENT EXPERTS ON GLOBAL INEQUALITY*. https://www.gov.za/sites/default/files/gcis_document/202511/g20-global-inequality-report-full-and-summary.pdf

Key facts on ineq

Drivers of inequalities

1: Distribution of market in

- Distribution of asse ts but skills and social networks (so ting workers' wages.
- Distri tal, and rents

2 redistribution

-
- s and programs

INEQUALITIES ARE INCREASING
INEQUALITY IS A POLICY CHOICE

* Stiglitz, J. e (2025) *G20 EXTRAORDINARY COMMITTEE OF INDEPENDENT EXPERTS ON GLOBAL INEQUALITY*. https://www.gov.za/sites/default/files/gcis_document/202511/g20-global-inequality-report-full-and-summary.pdf

It is POWER that influences policy choice

Power (Martin Luther King): *The ability to achieve a purpose*



THE MILBANK QUARTERLY

A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Perspective

Why Evidence Is Not Enough: Power, Politics, and a Strategy Shift for Public Health

JONATHAN C. HELLER

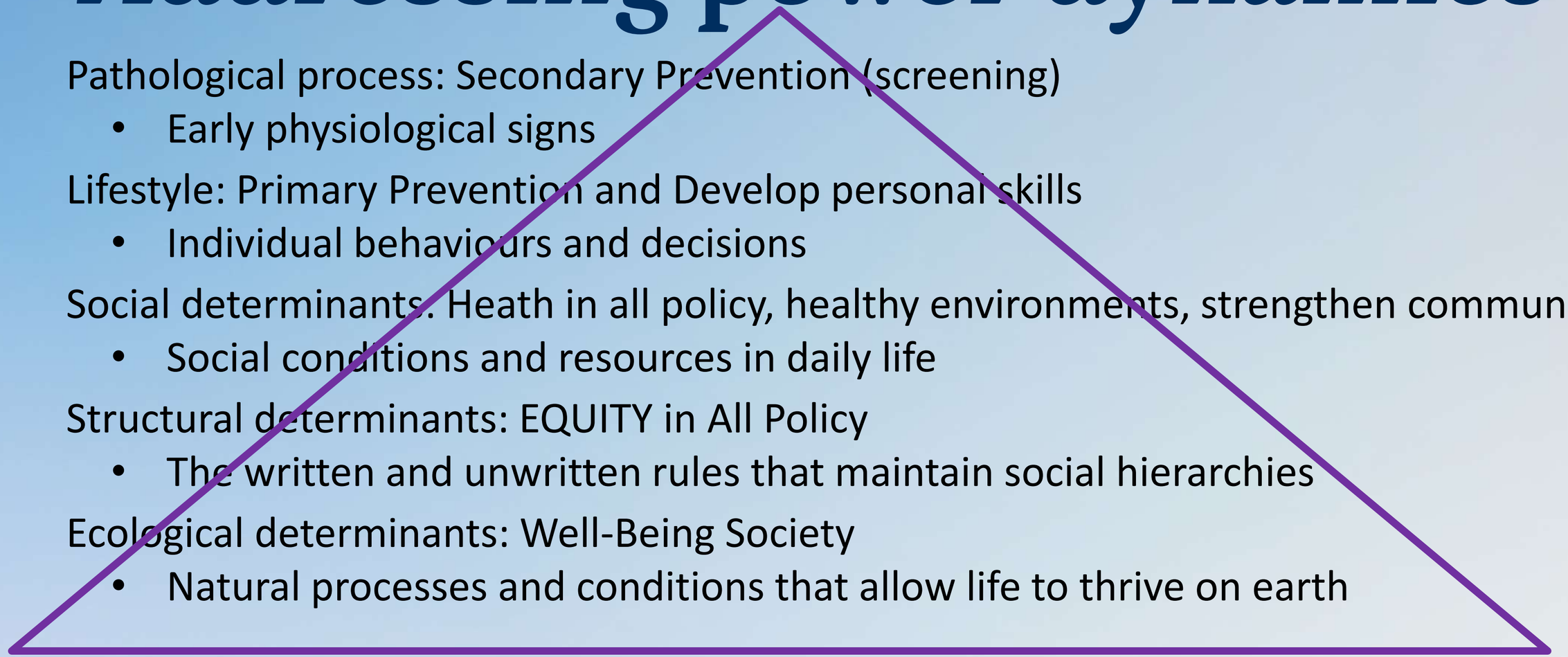
Population Health Institute, University of Wisconsin & the Health & Power Organizing Project

Table 1. Forms of Power[10,11]

Form of Power	Description
	Power derived from:
Knowledge	Information and technical expertise
Moral	Shaping the principles and actions that others believe to be right or wrong
Economic	Material resources, primarily through controlling the production of goods and services and through wealth
Political (or State)	Governing structures that legitimize the ability to regulate, punish, discipline, and (re)distribute resources
Ideological (or Discursive or Narrative)	Shaping how people make sense of the world and understand issues and events
Physical (or Military)	Use or threat of force or violence
People (or Solidarity)	People in relationship, working together in networks and alliances
Disruptive	Withholding consent, resisting, or noncooperation with the status quo

Heller, J. (2026). Why evidence is not enough: Power, politics and a strategy shift for public health. *Milbank Quarterly. https://onlinelibrary.wiley.com/doi/epdf/10.1111/1468-0009.70116*

Addressing power dynamics



Pathological process: Secondary Prevention (screening)

- Early physiological signs

Lifestyle: Primary Prevention and Develop personal skills

- Individual behaviours and decisions

Social determinants: Heath in all policy, healthy environments, strengthen community

- Social conditions and resources in daily life

Structural determinants: EQUITY in All Policy

- The written and unwritten rules that maintain social hierarchies

Ecological determinants: Well-Being Society

- Natural processes and conditions that allow life to thrive on earth

5 Strategic shifts for Public Health

BUILD *people power:* forming deep and long lasting relationships with like-minded civil society organisations

DEVELOP *ideological power*: investing in narrative infrastructure

STRENGTHEN *knowledge power*: diversifying forms of knowledge to create evidence, democratizing data and using it with other forms of power

JOIN WITH OTHER IN USING *disruptive power:* addressing the ecological and structural determinants of health and their impact

DISRUPT *economic and political power* over monied interests*:* strengthening democracy and governance

QUID for advocacy?

I**NCLUDE** power analysis in developing advocacy strategy

ADJUST strategy according to forms of power audience is responsive to and types of determinants addressed

DEVELOP alliances with organizations outside of the health sector

BROADEN messages beyond health to include ecological/structural determinants

Thank You

for your time
and attention

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



KEYNOTE Speaker

James Smith

Flinders University, Co-Director FHMRI Health Equity Impact Program

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Health Promotion, Equity & Gender Justice: Where Do Boys & Men Fit In?

Professor James Smith
ARC Mid-Career Industry Fellow (Young Men's Health)
Matthew Flinders Professor (Health & Social Equity)
Co-Director, Health Equity Impact Program
Flinders Health and Medical Research Institute
Flinders University



SYMPOSIUM IN HONOR OF
Stephan Van den Broucke

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08 Health equity within the context of boys and men's health

09 Policy and practice levers to elevate boys and men's health promotion

10 Key messages

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

My Background

- Applied public health researcher
- Eclectic academic background – human movement, education, public health, business mgmt.
- 25+ years in health promotion and men's health research, policy and practice contexts in Australia, primarily Indigenous health and wellbeing
- Global VP Scientific Affairs – International Union for Health Promotion & Education
- Positionality – father of four; white middle-class Australian male academic



Conceptual, ideological & philosophical framings of gender

- Gender broadly conceived as the structure of social relations and practices (i.e. social constructionism)
- Most contemporary understandings of gender (in health and social policy) are underpinned by feminism and/or feminist theory, and explicit focus on power relations
- Gender-Based Violence is a prominent focus in gender equity and gender justice discourses
- Misogyny and patriarchy are (rightly!) challenged
- Boys and men are often framed negatively (as perpetrators, misogynistic) or are (intentionally) absent from policy



Launch of the Australian Parliamentary Friends of Health Masculinities at Government House, 19 November 2025

Defining Gender Justice

"Gender justice envisions a world in which everyone can thrive irrespective of their position in gender relations. It recognises the diversity of needs and experiences of all people. Gender justice is both a goal and an approach. It aims to achieve both equity (equitable distribution of resources, access, and opportunities) and equality and non-discrimination for all. A gender-justice approach to health means that sex and gender differences should not create disadvantages for anyone's health; advances the universal rights of all people; requires overcoming patriarchy, discrimination, coercion, violence, poverty, and the anti-gender movement; requires the elimination of sex and gender discrimination; enacts and enforces non-discriminatory laws and policies; addresses the interaction of gendered aspects of social, political, economic, and legal drivers with health and wellbeing; ensures inclusion and diversity in leadership and participation in decision-making processes and institutions; and tracks progress in gender justice and holds decision makers and power holders to account."

Lancet Commission on Gender & Global Health (2025)

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Gender equality, gender equity & gender justice

- SDGs = Gender Equality
- Lancet Commission = Gender Justice
- Highly contested arena:

"Confusions and contestations about gender and gender equality profoundly affect how gender gets inadequately addressed in global health policies, programmes, and practices."

(Lancet Commission on Gender and Global Health, April 2025)




The Lancet Commissions

Achieving gender justice for global health equity: the *Lancet* Commission on gender and global health

Sarah Hawkes*†, Elhadj As Sy*†, Gary Barker*, Frances Elaine Baum*, Kent Buse, Angela Y Chang, Beniamino Cislaghi*, Jocalyn Clark*, Raewyn Connell*, Morna Cornell*, Gary L Darmstadt*, Carmen Simone Grilo Diniz*, Sharon Friel*, Indrani Gupta*, Sofia Gruskin*, Sarah Hill*, Amy Chiaying Hsieh, Renu Khanna*, Jeni Klugman*, Aaron Koay, Vivian Lin*, Khadija T Moalla*, Erica Nelson, Lynsey Robinson, Nina Schwalbe*, Ravi Verma*, Virginia Zarulli

(Hawkes et al., 2025)


Analysis

BMJ Global Health

Is 'gender equality in health' the right goal? Exploring issues of definition and measurement

Angela Y Chang [1,2] Sarah Hawkes,[3,4] Kent Buse,[3,4] Virginia Zarulli[5]

To cite: Chang AY, Hawkes S, Buse K, *et al*. Is 'gender equality in health' the right goal? Exploring issues of definition and measurement. *BMJ Glob Health* 2025;**10**:e017900. doi:10.1136/bmjgh-2024-017900

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ABSTRACT
Achieving 'gender equality in health' has been advocated by many as a key goal in health globally; however, we observe this goal has been defined differently by different users. In this paper, we explore the question of how progress towards gender equality in health has been defined and measured, and how the selection of indicators and targets can influence perceptions of who in a population is suffering disadvantage. We summarise the common population health measures—such as life expectancy and risk exposure—and illustrate how each of these measures may lead to different conclusions about gender equality in health. We call for more specificity when defining and measuring gender inequality in health, and propose expanding the focus from 'gender inequalities' (comparison between genders) to also addressing 'within-gender inequities' (a focus that incorporates addressing inequities within different gender identity groups).

SUMMARY BOX
⇒ Achieving 'gender equality in health' has been advocated as a key goal in health globally; however, this terminology has been defined differently by different users and can lead to 'cherry picking' of indicators to stress dis/advantage(s) for any particular gender identity group (eg, women or men) of interest.
⇒ This paper summarises how progress towards gender equality in health has been defined and measured, and how the selection of indicators and targets can influence perceptions of who in a population is suffering disadvantage.
⇒ The size and direction of inequality varies according to the indicator used: Life expectancy, childhood survival and exposure to common health-harming products show a male disadvantage, whereas the number of years lived with disability and some metabolic risk factors tend to be higher in females.
⇒ We argue that the degree of gender inequalities in health fluctuates with the measures used, and achieving equality, and reducing inequities, requires precise goals and a more specific understanding of where disadvantages lie, not just between genders but also within gender groups.

INTRODUCTION
Achieving 'gender equality in health' has been advocated by many as a key goal in global health.[1 2] But what exactly do people mean when they call for 'gender equality in health'? Do they mean improving women's health (particularly maternal or reproductive health), reducing the impact of gender discrimination on women's health outcomes, addressing the relatively low access to health services experienced by some population groups (eg, men's access to HIV testing and treatment)? Or narrowing the health gap between women and men[3–5]? Or do they identity groups (men, women, non-binary and others). Empirical studies on the relationship between 'upstream' gender in/equality indicators and health outcomes reveal a diverse set of findings that vary according to the upstream determinant being measured and the health outcome of interest.[3 5 6] In contrast, 'gender equality in health' is about

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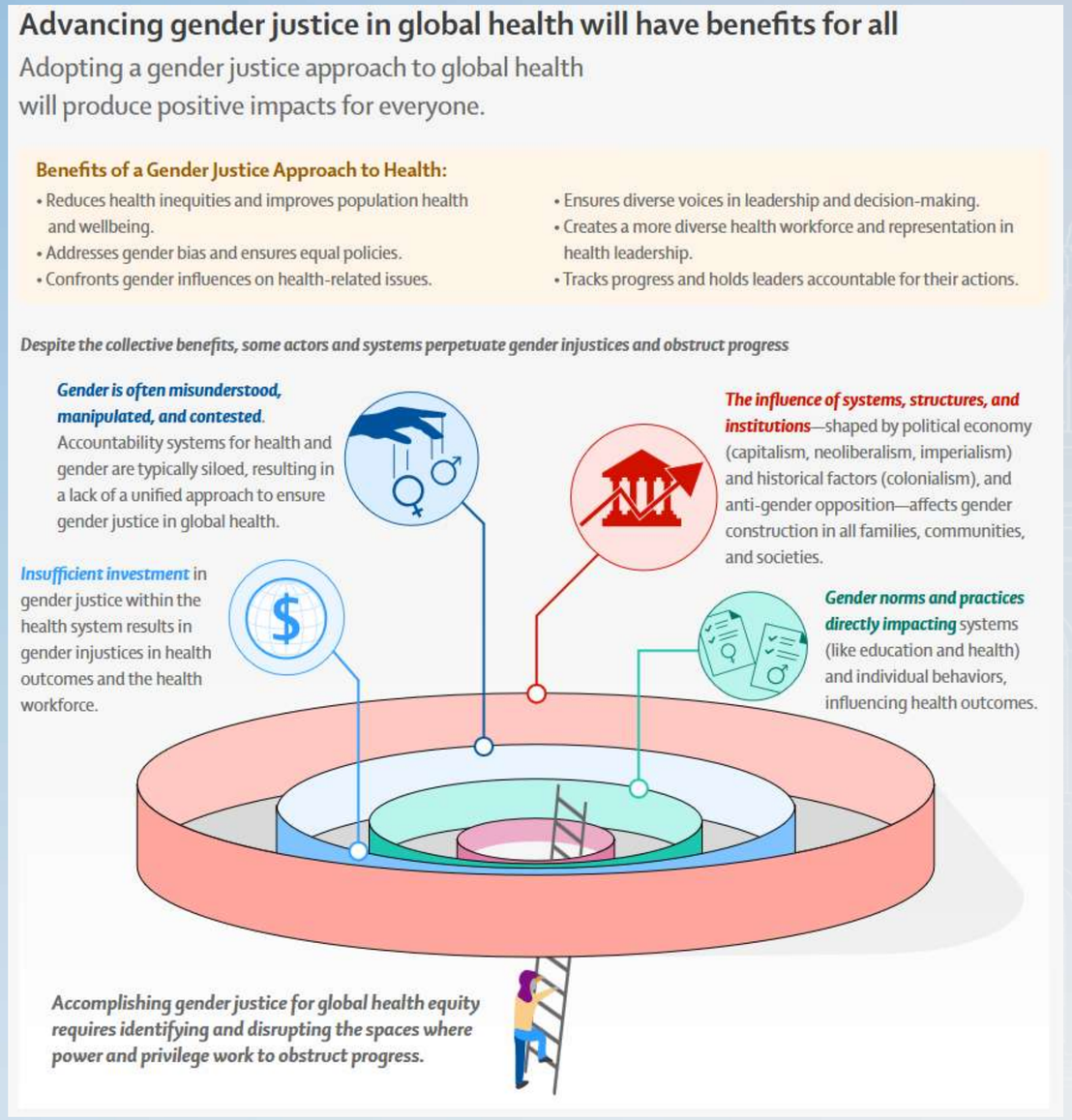
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[2]Danish Centre for Health Economics, University of

(Chang et al., 2025)

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Lancet Commission on Gender & Global Health



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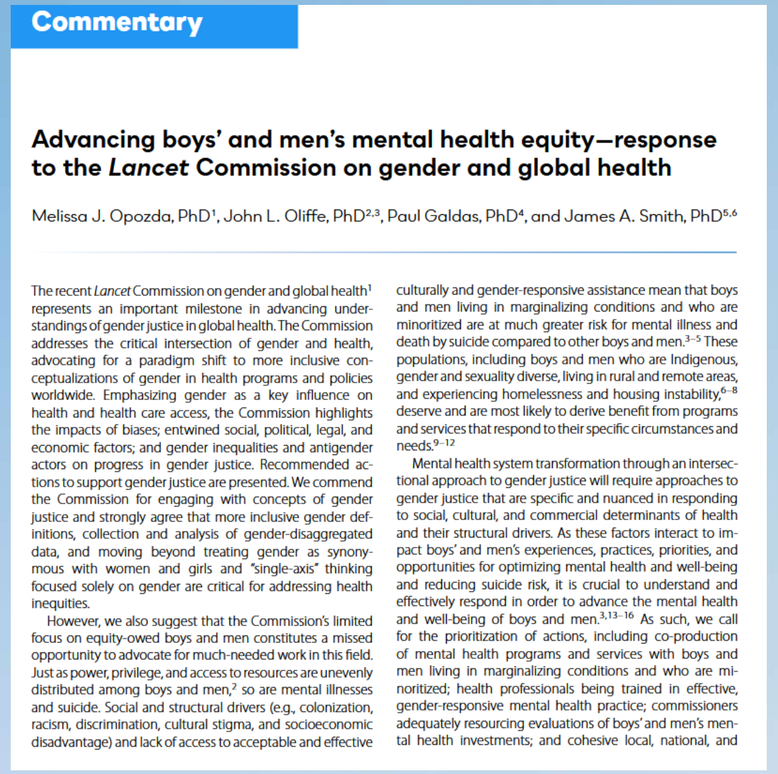
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Lancet Commission on Gender & Global Health



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Response to Lancet Commission on Gender & Global Health



Commentary

Advancing boys' and men's mental health equity—response to the *Lancet* Commission on gender and global health

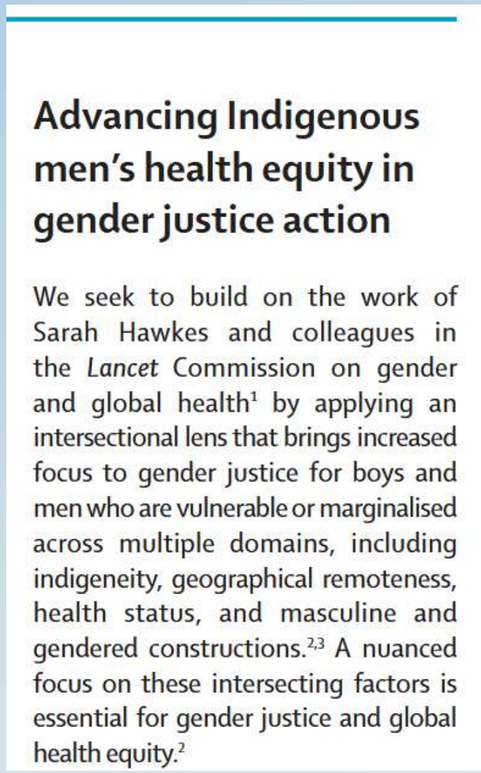
Melissa J. Opozda, PhD[1], John L. Oliffe, PhD[2,3], Paul Galdas, PhD[4], and James A. Smith, PhD[5,6]

The recent *Lancet* Commission on gender and global health[1] represents an important milestone in advancing understandings of gender justice in global health. The Commission addresses the critical intersection of gender and health, advocating for a paradigm shift to more inclusive conceptualizations of gender in health programs and policies worldwide. Emphasizing gender as a key influence on health and health care access, the Commission highlights the impacts of biases; entwined social, political, legal, and economic factors; and gender inequalities and antigender actors on progress in gender justice. Recommended actions to support gender justice are presented. We commend the Commission for engaging with concepts of gender justice and strongly agree that more inclusive gender definitions, collection and analysis of gender-disaggregated data, and moving beyond treating gender as synonymous with women and girls and "single-axis" thinking focused solely on gender are critical for addressing health inequities.

However, we also suggest that the Commission's limited focus on equity-owed boys and men constitutes a missed opportunity to advocate for much-needed work in this field. Just as power, privilege, and access to resources are unevenly distributed among boys and men,[2] so are mental illnesses and suicide. Social and structural drivers (e.g., colonization, racism, discrimination, cultural stigma, and socioeconomic disadvantage) and lack of access to acceptable and effective culturally and gender-responsive assistance mean that boys and men living in marginalizing conditions and who are minoritized are at much greater risk for mental illness and death by suicide compared to other boys and men.[3–5] These populations, including boys and men who are Indigenous, gender and sexuality diverse, living in rural and remote areas, and experiencing homelessness and housing instability,[6–8] deserve and are most likely to derive benefit from programs and services that respond to their specific circumstances and needs.[9–12]

Mental health system transformation through an intersectional approach to gender justice will require approaches to gender justice that are specific and nuanced in responding to social, cultural, and commercial determinants of health and their structural drivers. As these factors interact to impact boys' and men's experiences, practices, priorities, and opportunities for optimizing mental health and well-being and reducing suicide risk, it is crucial to understand and effectively respond in order to advance the mental health and well-being of boys and men.[3,13–16] As such, we call for the prioritization of actions, including co-production of mental health programs and services with boys and men living in marginalizing conditions and who are minoritized; health professionals being trained in effective, gender-responsive mental health practice; commissioners adequately resourcing evaluations of boys' and men's mental health investments; and cohesive local, national, and

(Opozda et al., 2025)



Advancing Indigenous men's health equity in gender justice action

We seek to build on the work of Sarah Hawkes and colleagues in the *Lancet* Commission on gender and global health[1] by applying an intersectional lens that brings increased focus to gender justice for boys and men who are vulnerable or marginalised across multiple domains, including indigeneity, geographical remoteness, health status, and masculine and gendered constructions.[2,3] A nuanced focus on these intersecting factors is essential for gender justice and global health equity.[2]

(Brickley et al., 2026)

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Gender equity in the context of men's health


Understanding gender equity in the context of men's health policy development

James A. Smith, Steve Robertson and Noel Richardson

(Smith, Robertson & Richardson, 2010)


EDITORIAL

WILEY

Equity, gender and health: New directions for global men's health promotion

(Smith, Watkins & Griffith, 2020)


International Journal of Men's Social and Community Health

Commentary

STRENGTHENING POLICY COMMITMENTS TO EQUITY AND MEN'S HEALTH

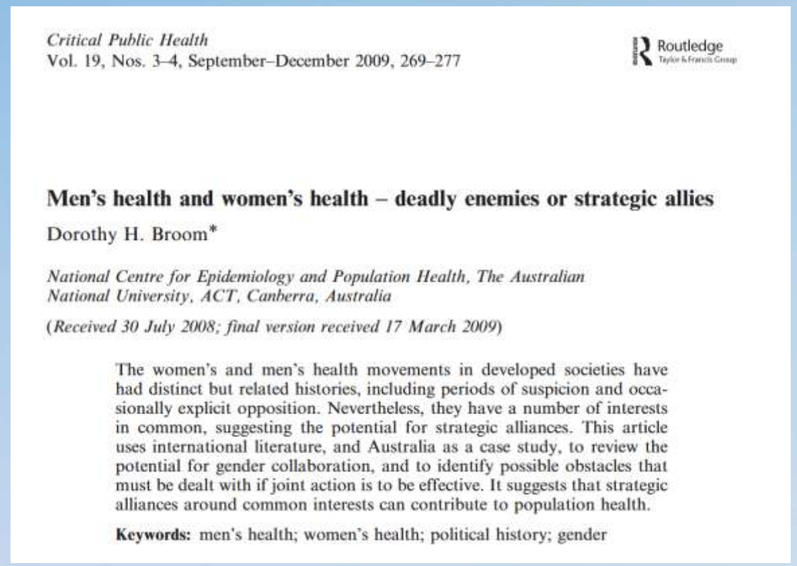
James A. Smith[1], Daphne C. Watkins[2], Derek M. Griffith[3], Noel Richardson[4], and Mick Adams[5]

(Smith et al., 2020)

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Historical tensions between men's and women's health

- An unproductive binary – men vs women (positioned as competitors for resourcing; concern over men's rights movement) = zero sum position
- Dismissive of diversity in relation to gender and sexuality



Critical Public Health
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Routledge
Taylor & Francis Group

Men's health and women's health – deadly enemies or strategic allies

Dorothy H. Broom*

National Centre for Epidemiology and Population Health, The Australian National University, ACT, Canberra, Australia

(*Received 30 July 2008; final version received 17 March 2009*)

The women's and men's health movements in developed societies have had distinct but related histories, including periods of suspicion and occasionally explicit opposition. Nevertheless, they have a number of interests in common, suggesting the potential for strategic alliances. This article uses international literature, and Australia as a case study, to review the potential for gender collaboration, and to identify possible obstacles that must be dealt with if joint action is to be effective. It suggests that strategic alliances around common interests can contribute to population health.

Keywords: men's health; women's health; political history; gender

(Broom., 2009)



Charting a course to men's health and wellbeing:

Applying a lens of power and politics to improve men's health outcomes

Lancet Series on Men's Health – Paper 3

Authors

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(Hawkes, In Press)

Understanding the evolution of men's health (promotion)

- Frequently focused on *men's individual behaviours* - such as delayed help-seeking - frequently tied to hegemonic masculinity (e.g. traits such as stoicism, independence, restrictive emotionality)
- Inadvertent perpetuation of *unhealthy/harmful masculine stereotypes* through men's health promotion (e.g. 'Man Up'; 'Be A Man'; 'Real Men Don't')
- *Settings-based approaches* have been popular (sports settings, pubs, workplaces)
- Contemporary issues: fathering/fatherhood; young men's health (e.g. influence of manosphere and looksmaxxing); influence of *structural, digital and commercial determinants*; mental health and wellbeing



(Fleming et al., 2014)



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‘Old school’ men’s health (promotion)







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Challenges of boys' and men's health promotion in a digital age



Special Issue: Healthy Technology Use in Schools: Implications for Screen Time, Social Media, and Smartphone Use

Journal of Psychologists and Counsellors in Schools

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Boyhood, Online Harms, and Strength-based Educative Approaches in an Era of Digital Restrictions

Garth Stahl[1], Rohann Irving[2], Yang Zhao[3], Melissa Opozda[2], Laura Scholes[4], Lisa Holohan[1], Mair Underwood[1], Murray Drummond[2] and James A. Smith[2]

Abstract

Partly in response to growing public moral concern about young people's social media consumption and how this affects their wellbeing, the Australian government has enacted legislation to limit social media access for young people under 16 years of age. While these measures are framed around improving student focus, wellbeing, and safety, public discussion has also intersected with broader anxieties about online masculinity-related content and its powerful influence on boys and young men (BYM). Within an education context, school psychologists and counsellors are increasingly called upon to respond to concerns from teachers and parents regarding the diverse range of risks that digital spaces can pose to BYM, including issues related to internet addiction, online gambling, body image, sexting, extremism, among others. While we have seen some investments in e-safety oriented educational interventions to address these issues, we have also seen notable critiques suggesting they are insufficiently informed by young people's perspectives and priorities. Drawing from 20 interviews with Australian BYM, this article captures how a diverse cohort of BYM navigate online spaces and their perspectives on its influence in terms of their identity formation, relationships, and wellbeing. We identify four key themes present in the data: (1) negotiating addiction and self-regulation; (2) social connection, belonging, and fear of missing out (FOMO); (3) engaging in comparisons with subsequent emotional consequences; and (4) reflecting on the importance of safeguarding. The research highlights the complexity of BYM's online experiences and challenges risk-focussed narratives by revealing their perceived agency

Sociology of Health & Illness

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE OPEN ACCESS

When Help Is Harm: Health, Lookism and Self-Improvement in the Manosphere

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ABSTRACT

How do online communities impact men's health? How does hegemonic masculinity harm men's health? In this paper, we analyse an online looksmaxxing community that receives 6 million unique visitors per month and is aimed at men seeking to improve their appearance. We qualitatively analysed 8072 discussion board comments in total. Our findings first demonstrate how users apply a hegemonic masculine gaze as they critique men's bodies (e.g., facial asymmetries and brow ridges). Second, we show how the community encourages men to substantially alter their bodies (e.g., with leg lengthening surgeries or by mewing). Third, we argue that the community subjects users to masculine demoralisation, wherein they are seen as failed men and encouraged to self-harm. Drawing on masculinities theory, we argue that looksmaxxing and similar self-improvement communities harm the health of the men who participate in them.



Article

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Beyond the Clickbait: Analysing the Masculinist Ideology in Andrew Tate's Online Written Discourses

Steven Roberts
Monash University, Australia

Callum Jones
Monash University, Australia

Lucy Nicholas
Western Sydney University, Australia

Stephanie Wescott
Monash University, Australia

Marcus Maloney
Coventry University, UK

Abstract

There is now an expansive literature on the manosphere – the loosely connected groups of digital communities that revolve around men's rights, aspirations and entitlements, and the perceived constraints upon these. Such studies have produced important critical insights into the collective and organized dimension of the networked harassment of women in digital settings, as well as highlighting the manosphere's craving to reanimate regressive modes of masculinity. At this time, however, scholars have written relatively little about the manosphere's high -profile key figures; so-called 'manfluencers'. While 'manfluencers' are symptomatic, rather than a cause, of unequal gender relations, their cultural traction and their role in amplifying misogyny situates these figures as worthy of sociological investigation. In this article, we are concerned with Andrew Tate, the

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Understanding the evolution of men's health (promotion)





Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

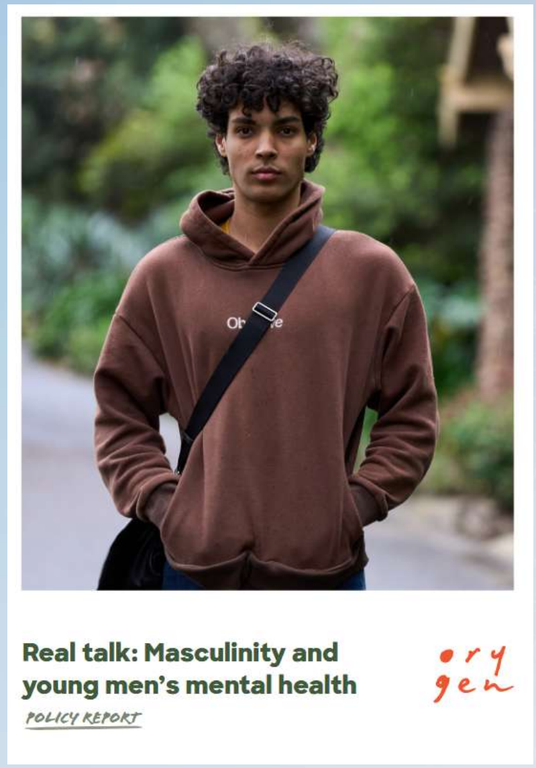
Understanding the evolution of young men's health promotion



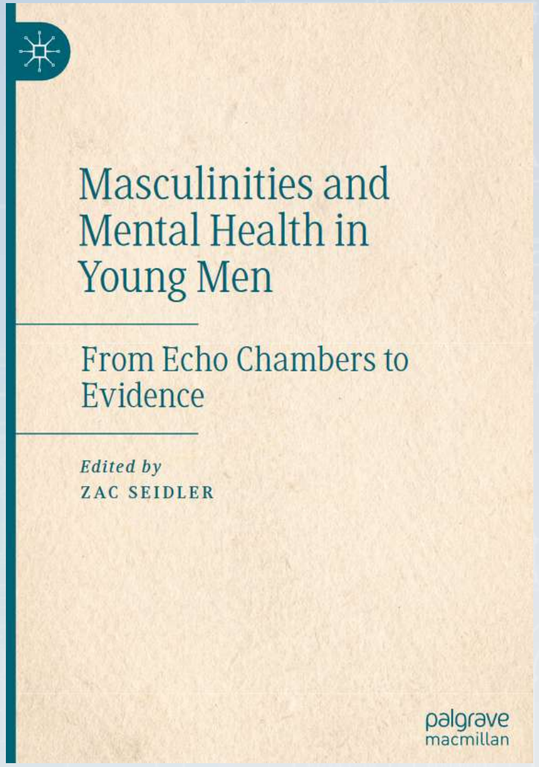
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(Seidler, 2024)

From hegemonic masculinity to healthy masculinities: A new era?

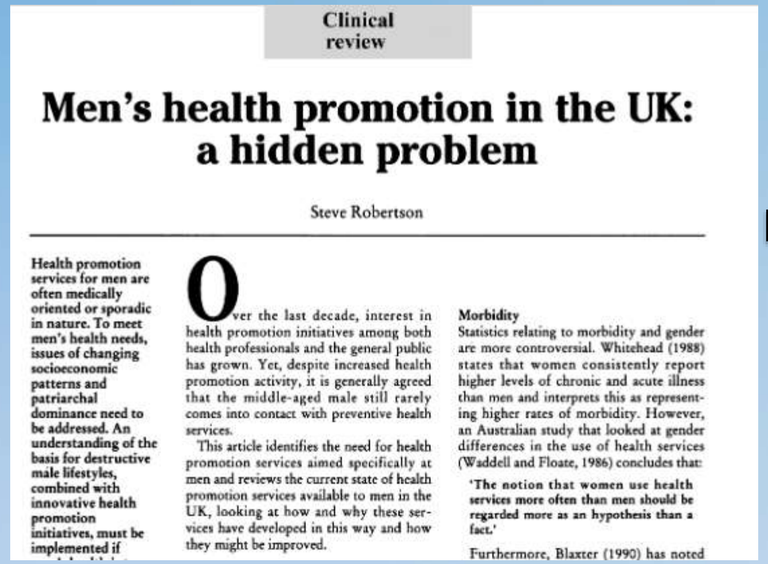
- Hegemonic masculinity - dominant explanatory framework, focused on gender norms/traits - stoicism, macho, restrictive emotionality (Connell, 1987)
- Contested masculinities (Connell,1995)
- Alternative/multiple masculinities – early 2000-2010
- Toxic masculinity – traits that are socially destructive, such as misogyny, patriarchy, homophobia, violence – 2015 onwards
- Healthy (or progressive/positive/caring) masculinities – focuses on positive attributes, response to DFV - 2020 onwards



(The Men's Project & Flood, 2024)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

An evolution of men's health promotion and masculinities?



Clinical review

Men's health promotion in the UK: a hidden problem

Steve Robertson

Health promotion services for men are often medically oriented or sporadic in nature. To meet men's health needs, issues of changing socioeconomic patterns and patriarchal dominance need to be addressed. An understanding of the basis for destructive male lifestyles, combined with innovative health promotion initiatives, must be implemented if

Over the last decade, interest in health promotion initiatives among both health professionals and the general public has grown. Yet, despite increased health promotion activity, it is generally agreed that the middle-aged male still rarely comes into contact with preventive health services.

This article identifies the need for health promotion services aimed specifically at men and reviews the current state of health promotion services available to men in the UK, looking at how and why these services have developed in this way and how they might be improved.

Morbidity

Statistics relating to morbidity and gender are more controversial. Whitehead (1988) states that women consistently report higher levels of chronic and acute illness than men and interprets this as representing higher rates of morbidity. However, an Australian study that looked at gender differences in the use of health services (Waddell and Floate, 1986) concludes that:

'The notion that women use health services more often than men should be regarded more as an hypothesis than a fact.'

Furthermore, Blaxter (1990) has noted

(Robertson, 1995)



Articles

Beyond masculine stereotypes: Moving men's health promotion forward in Australia

James A. Smith

Introduction

International commentary suggests that men are reluctant to seek help for health concerns.[1,2] This is reflected by lower health service use among men when compared with women, even when reproductive health services have been accounted for.[3] In turn, men's apparent reluctance to seek help and use health services limits preventive health discussion during medical encounters, check-ups and other health visits.[2-4] Noteworthy is that some commentary on men's health and health service use is akin to a male deficit model,[5] whereby men are positioned as 'behaving badly' with respect to their health.[2,5-7] As such, there is a need to address the underlying determinants rather than apportioning blame.[2,7] Given that little attention has been paid to gendered dimensions of health promotion, the health of Australian men remains suboptimal.[6,8-11] It appears that those belonging to the health promotion community, inclusive of practitioners, researchers and policy makers, are well positioned to address this concern.

Acknowledging that men's health promotion interaction is limited is an essential first step.[12-15] Existing scholarship suggests that men are tentative to respond to health promotion efforts and are hesitant to change health behaviours at both an individual and societal level, except perhaps in relation to smoking and unsafe sexual practices.[4,15-18] In the context of

(Smith, 2007)



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Advance Access published 1 July, 2008

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DEBATE

Men's health promotion: a new frontier in Australia and the UK?

JAMES A. SMITH[1,2*] and STEVE ROBERTSON[3,4]

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SUMMARY

The field of men's health has grown markedly over the past few decades. Increased activity specifically relating to men's health promotion in both Australia and the UK has been noted during this period. There has, however, been a reticence to critically examine men's health promotion work within a broader discourse relating to gender and gender relations. Indeed, the vast majority of health-related gender discussion to date has been focused on women's health experiences and their health practices. In this paper, we argue that grounding men's health within this broad gender discourse is important for building an evidence base in, and advancing, men's health promotion work at a range of levels. We specifically explore the research, practice and policy contexts relating to men's health in Australia and the UK, and describe the facilitators for, and barriers to, promoting men's health. We conclude by suggesting that a critical gender lens ought to be applied to current men's health promotion work and provide strategies for researchers, practitioners and policy makers to move towards this new frontier.

(Smith & Robertson, 2008)

Healthy masculinities in policy and practice



(Vic Health, 2020)

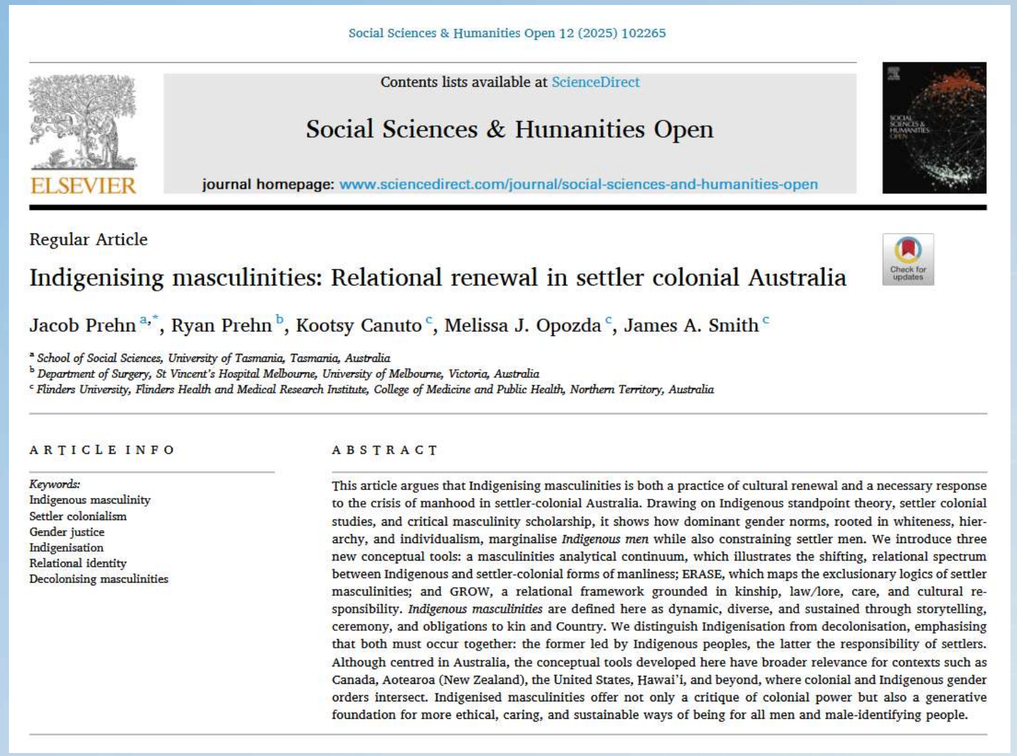


(Our Watch, 2022)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

From hegemonic masculinity to healthy masculinities: A new era?

- Indigenous masculinities
- Healthy masculinities
- Measuring masculinities – Healthy Manhood Index



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Regular Article

Indigenising masculinities: Relational renewal in settler colonial Australia

Jacob Prehn [a,*], Ryan Prehn [b], Kootsy Canuto [c], Melissa J. Opozda [c], James A. Smith [c]

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[b] Department of Surgery, St Vincent's Hospital Melbourne, University of Melbourne, Victoria, Australia
[c] Flinders University, Flinders Health and Medical Research Institute, College of Medicine and Public Health, Northern Territory, Australia

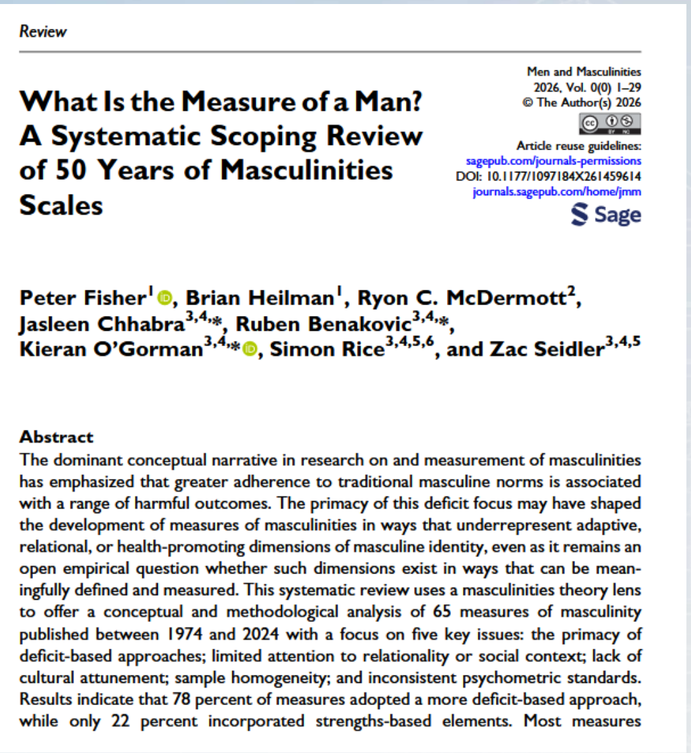
ARTICLE INFO

Keywords:
Indigenous masculinity
Settler colonialism
Gender justice
Indigenisation
Relational identity
Decolonising masculinities

ABSTRACT

This article argues that Indigenising masculinities is both a practice of cultural renewal and a necessary response to the crisis of manhood in settler-colonial Australia. Drawing on Indigenous standpoint theory, settler colonial studies, and critical masculinity scholarship, it shows how dominant gender norms, rooted in whiteness, hierarchy, and individualism, marginalise *Indigenous men* while also constraining settler men. We introduce three new conceptual tools: a masculinities analytical continuum, which illustrates the shifting, relational spectrum between Indigenous and settler-colonial forms of manliness; ERASE, which maps the exclusionary logics of settler masculinities; and GROW, a relational framework grounded in kinship, law/lore, care, and cultural responsibility. *Indigenous masculinities* are defined here as dynamic, diverse, and sustained through storytelling, ceremony, and obligations to kin and Country. We distinguish Indigenisation from decolonisation, emphasising that both must occur together: the former led by Indigenous peoples, the latter the responsibility of settlers. Although centred in Australia, the conceptual tools developed here have broader relevance for contexts such as Canada, Aotearoa (New Zealand), the United States, Hawai'i, and beyond, where colonial and Indigenous gender orders intersect. Indigenised masculinities offer not only a critique of colonial power but also a generative foundation for more ethical, caring, and sustainable ways of being for all men and male-identifying people.

(Prehn et al, 2025)



Review

What Is the Measure of a Man? A Systematic Scoping Review of 50 Years of Masculinities Scales

Men and Masculinities
2026, Vol. 0(0) 1–29
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Sage

Peter Fisher[1], Brian Heilman[1], Ryon C. McDermott[2], Jasleen Chhabra[3,4,*], Ruben Benakovic[3,4,*], Kieran O'Gorman[3,4,*], Simon Rice[3,4,5,6], and Zac Seidler[3,4,5]

Abstract

The dominant conceptual narrative in research on and measurement of masculinities has emphasized that greater adherence to traditional masculine norms is associated with a range of harmful outcomes. The primacy of this deficit focus may have shaped the development of measures of masculinities in ways that underrepresent adaptive, relational, or health-promoting dimensions of masculine identity, even as it remains an open empirical question whether such dimensions exist in ways that can be meaningfully defined and measured. This systematic review uses a masculinities theory lens to offer a conceptual and methodological analysis of 65 measures of masculinity published between 1974 and 2024 with a focus on five key issues: the primacy of deficit-based approaches; limited attention to relationality or social context; lack of cultural attunement; sample homogeneity; and inconsistent psychometric standards. Results indicate that 78 percent of measures adopted a more deficit-based approach, while only 22 percent incorporated strengths-based elements. Most measures

(Fisher et al, 2026)

Criticality of centering gender relations and intersectionality

- More can be achieved through a gender-relations approach (i.e. joining men's and women's health agendas more intentionally)
- Intersectionality enables a greater focus on men's health equity (particularly among equity-owed groups of boys and men)
- WHO World Report on SDoH Equity (2025) – calls for greater research emphasis on intersectionality and structural determinants

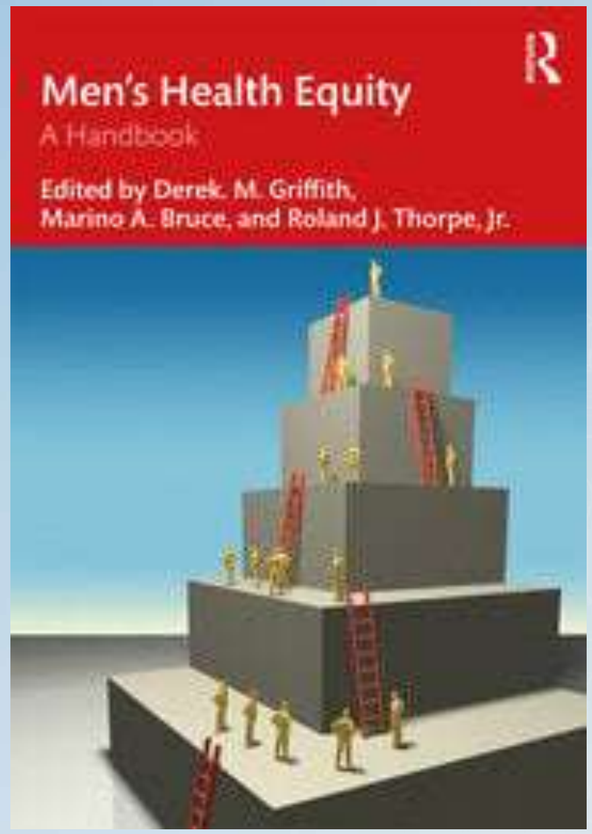


(WHO, 2025)

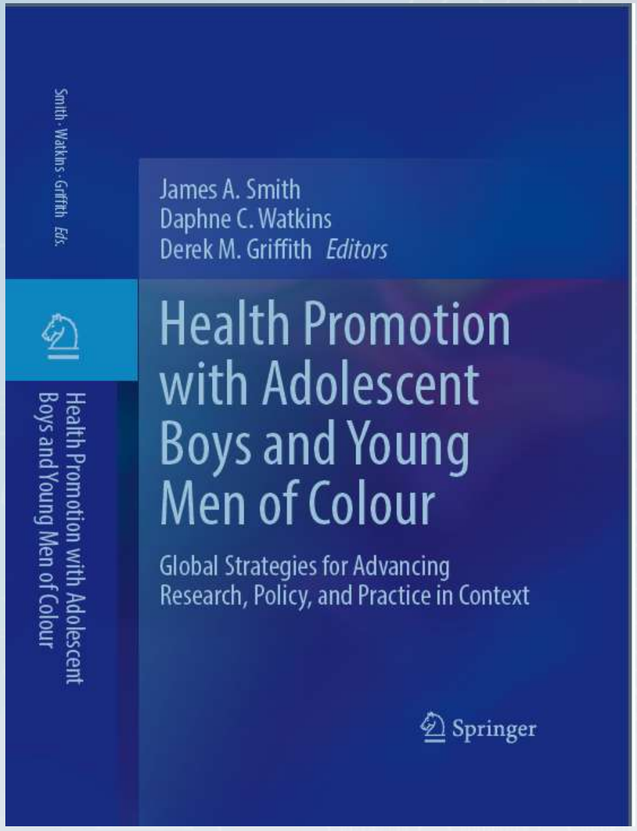
Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Health equity within the context of boys and men's health

- A contradiction in terms
- A focus on equity-owed or under-served populations of boys and men
- Health equity vs gender equity
- Global North vs Global South



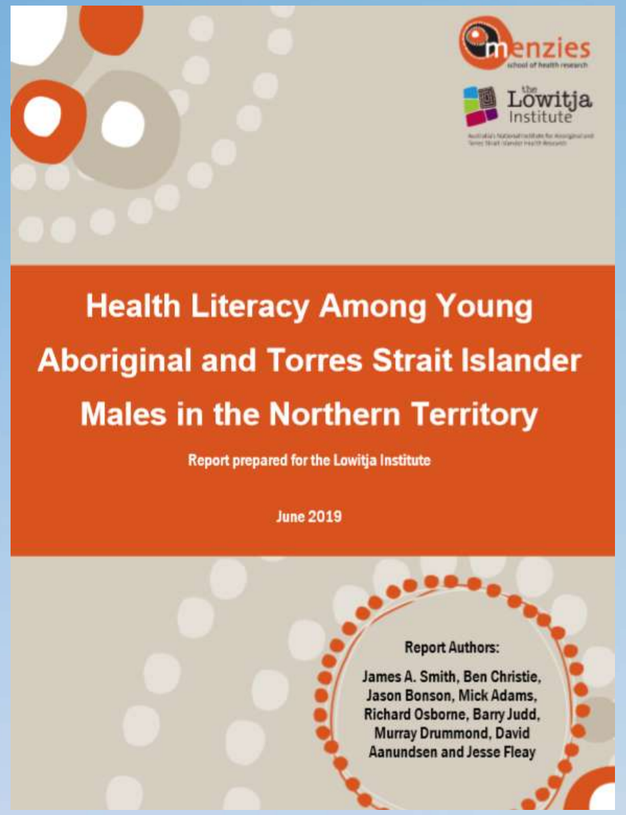
(Griffith, Bruce & Thorpe, 2019)



(Smith, Watkins & Griffith, 2021)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Health equity and First Nations Male Health in Australia



(Smith et al., 2019)


Promoting Men's Health Equity – Original Article

'Dudes Are Meant to be Tough as Nails': The Complex Nexus Between Masculinities, Culture and Health Literacy From the Perspective of Young Aboriginal and Torres Strait Islander Males – Implications for Policy and Practice

American Journal of Men's Health
May-June 1–17
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sagepub.com/journals-permissions
DOI: 10.1177/1557988320936121
journals.sagepub.com/home/jmh
SAGE

(Smith et al., 2020)


Received: 29 February 2020 | Revised: 17 June 2020 | Accepted: 10 September 2020
DOI: 10.1002/hpja.421
Check for updates
SPECIAL ISSUE ARTICLE
Health Promotion Journal of Australia
WILEY

Using social media in health literacy research: A promising example involving Facebook with young Aboriginal and Torres Strait Islander males from the Top End of the Northern Territory

James A. Smith[1,2] | Anthony Merlino[1] | Ben Christie[1] | Mick Adams[3] | Jason Bonson[4] | Richard H. Osborne[5] | Murray Drummond[6] | Barry Judd[2,7] | David Aanundsen[8] | Jesse Fleay[3] | Himanshu Gupta[1]

(Smith et al., 2020)


Opozda et al.
International Journal for Equity in Health (2024) 23:165
https://doi.org/10.1186/s12939-024-02253-w

International Journal for Equity in Health

RESEARCH Open Access

Navigating the cultural adaptation of a US-based online mental health and social support program for use with young Aboriginal and Torres Strait Islander males in the Northern Territory, Australia: Processes, outcomes, and lessons

Melissa J. Opozda[1], Jason Bonson[2,3], Jahdai Vigona[2,4], David Aanundsen[1], Chris Paradisis[2], Peter Anderson[5], Garth Stahl[6], Daphne C. Watkins[7], Oliver Black[8], Bryce Brickley[2], Karla J. Canuto[2], Murray J. N. Drummond[9], Keith F. Miller Jr.[7], Gabriel Oth[10], Jasmine Petersen[11], Jacob Prehn[12], Maria M. Raciti[13], Mark Robinson[14,15], Dante Rodrigues[4], Cameron Stokes[2], Kootsy Canuto[1*†] and James A. Smith[2*†]

Background Despite disproportionate rates of mental ill-health compared with non-Indigenous populations, few programs have been tailored to the unique health, social, and cultural needs and preferences of young Aboriginal and Torres Strait Islander males. This paper describes the process of culturally adapting the US-based Young Black Men, Masculinities, and Mental Health (YBMen) Project to suit the needs, preferences, culture, and circumstances of Aboriginal and Torres Strait Islander males aged 16–25 years in the Northern Territory, Australia. YBMen is an evidence-based social media-based education and support program designed to promote mental health, expand understandings of gender and cultural identities, and enhance social support in college-aged Black men.

Methods Our adaptation followed an Extended Stages of Cultural Adaptation model. First, we established a rationale for adaptation that included assessing the appropriateness of YBMen's core components for the target population. We then investigated important and appropriate models to underpin the adapted program and conducted a non-linear, iterative process of gathering information from key sources, including young Aboriginal and Torres Strait Islander males, to inform program curriculum and delivery.

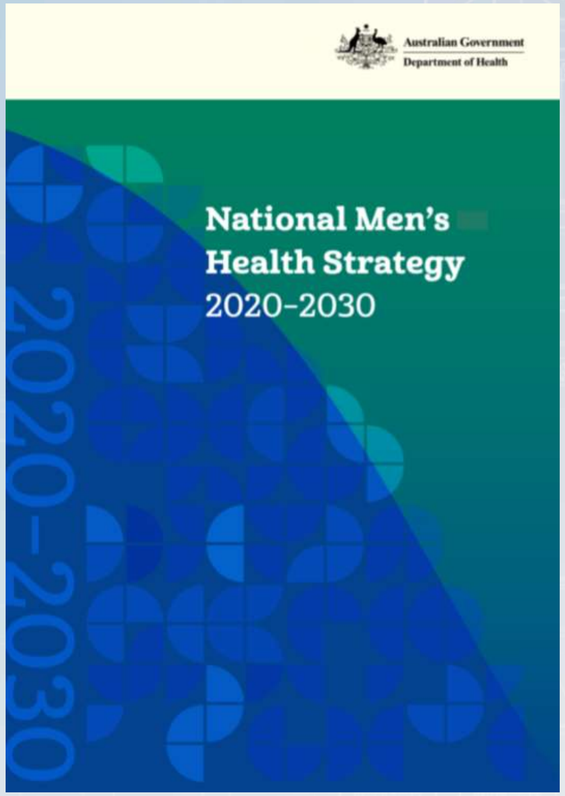
Results To maintain program fidelity, we retained the core curriculum components of mental health, healthy masculinities, and social connection and kept the small cohort, private social media group delivery but developed two models: 'online only' (the original online delivery format) and 'hybrid in-person/online' (combining online delivery with weekly in-person group sessions). Adaptations made included using an overarching Aboriginal and Torres Strait

(Opozda et al., 2024)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Policy and practice levers to enhance boys and men's health promotion

- Invest in National Men's Health Policies – e.g. Ireland, Australia, Brazil, Iran, UK, Canada
- Identify under-served populations of boys and men in broader health promotion, public health and preventive health policies and frameworks
- Partner with women's health scholars, advocates and practitioners (i.e. gender-relations approach)
- Adopt cross-government (HiAP) partnerships spanning health, education, social services, justice, housing and employment sectors
- Pursue strengths-based and assets-focused approaches to boys and men's health promotion (particularly with adolescent boys and young men)
- Shift beyond individual behaviour/lifestyle change towards strategies focused on structural and systemic reforms



(DoH, 2019)

Key messages

- Adopt strengths-based approaches to health promotion with boys and men
- Ensure that marginalised voices of boys and men are positioned within discussions about gender equity and gender justice
- Adopt an intersectional approach – particularly that focused on addressing cumulative impacts if disadvantage
- Adopt a gender-relations approach – more can be achieved for all genders by doing so
- Invest in the monitoring and evaluation of men's health promotion initiatives (and publish!)
- Prioritise transnational partnerships in boys and men's health (learning across countries)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Thank You

for your time and attention

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

iPSY

UCLouvain

Session 2

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



KEYNOTE Speaker

Faten Ben Abdelaziz

(PhD) Technical Lead for Health Promotion, Department of Health Determinants, Promotion and Prevention, WHO headquarters, Geneva, Switzerland

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Ottawa at 40: Health promotion in a changing world

Extending Ottawa's logic into the policy challenges of the 2020s

Dr Faten Ben Abdelaziz

Technical Lead, Health Promotion

Department of Determinants, Promotion and Prevention, WHO-HQ

Ottawa changed the way we think about health

Health promotion is about enabling people to increase control over their health.

But that requires changing the conditions that shape health:

- **healthy public policy;**
- **supportive environments;**
- **stronger community action;**
- **personal skills and agency;**
- **reoriented health services.**

The principles still hold

- **Equity**
- **Participation**
- **Empowerment**
- **Community action**
- **Supportive environments**
- **Intersectoral action**

Health is created where people grow, live, learn, work and age – through access to resources, opportunity, power and supportive conditions.

Forty years of widening the lens

Empowering People → Strengthening Communities → Supportive Environments → Healthy Public Policy → Social Determinants & Equity → Well-being Societies

Health promotion is about enabling people to increase control over their health

OTTAWA CHARTER (1986)

- Build healthy public policy
- Create supportive environments
- Strengthen community action
- Develop personal skills
- Reorient health services

FROM HEALTH FOR ALL → TO WELL-BEING FOR ALL

GENEVA CHARTER FOR WELL-BEING (2021)

- Equitable economies
- Public policy for the common good
- Planetary health
- Universal health coverage
- Digital transformation for well-being

Ottawa 1986 → Adelaide 1988 → Sundsvall 1991 → Jakarta 1997 → Mexico 2000 → Bangkok 2005 → Nairobi 2009 → Helsinki 2013 → Shanghai 2016 → Geneva 2021

What the journey added

Phase	Milestones	What was added
Foundations	Ottawa (86), Adelaide (88)	Healthy public policy, equity, participation, accountability
Broadening the determinants	Sundsvall (91), Jakarta (97), Mexico (00), Bangkok (05)	Supportive environments, social determinants, globalization, commercial and environmental influences
From principles to systems	Nairobi (09), Helsinki (13), Shanghai (16)	Implementation, intersectoral action, Health in All Policies, sustainable development
Towards societal well-being	Geneva (21)	Well-being, equity, planetary health, sustainable development and whole-of-society action

From changing behaviours to changing systems

INDIVIDUAL Level

- Healthy lifestyle
- Social determinants of health
- Settings
- Health literacy

Small gains for a few

Greatest gains come from changing the conditions that shape health

National level

- Healthy Public Policy
- Health in All Policies
- Systems thinking and settings approach

Large population impact

How to respond when risks emerge beyond national borders? e.g. AI, pollution, ..

FROM CHANGING BEHAVIOURS → TO CHANGING THE SOCIAL, ECONOMIC, COMMERCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH →TO NATIONAL GOVERNANCE

A changing world is reshaping the conditions for health

Planetary
- climate and environmental pressures

Social
- widening inequalities, demographic change, conflict and declining trust

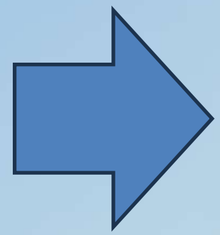
Economic
- insecurity, changing labour markets and commercial pressures

Technological
- AI, digitalization and new ways of living, working and communicating

These transitions interact – and increasingly shape health across sectors, borders and generations.

The challenge is no longer only to respond – but to shape the systems producing risk and opportunity

Traditional emphasis
Respond to individual risks
Act within sectors
Address national problems
Protect health after shocks



Emerging requirement
Shape upstream determinants
Govern across sectors
Respond to transboundary and systemic forces
Build conditions for resilience and well-being before shocks

Health promotion must increasingly shape governance, policy, investment and societal systems – while remaining grounded in equity, participation and empowerment.

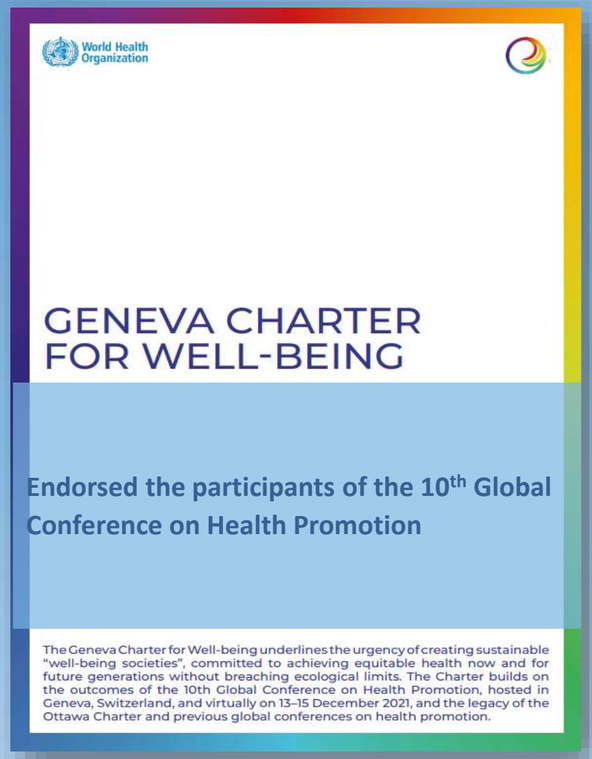
From promoting health to shaping the conditions for societal well-being

A well-being approach applies health-promotion principles to the way societies govern, invest, regulate, participate and measure progress.

Health promotion and well-being serve as critical pathways

- Shape policy and governance
- Connect action across sectors
- Strengthen agency and collective action
- Orient development towards health, equity and well-being

2022 Geneva Charter for Well-being


World Health Organization

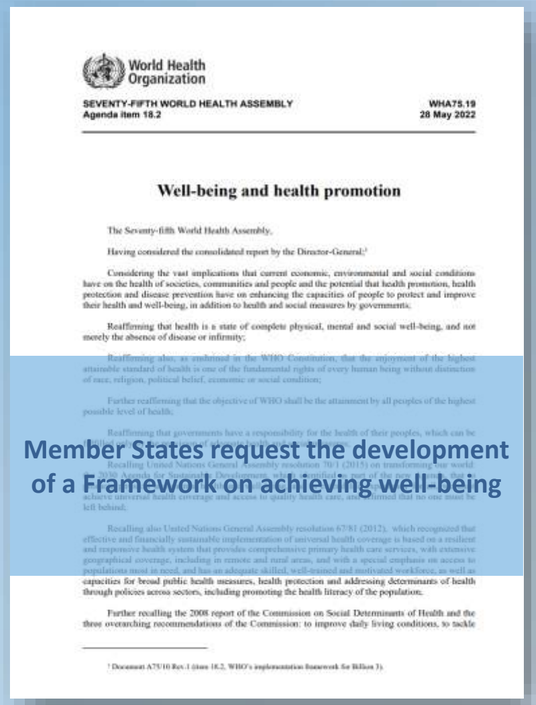
GENEVA CHARTER FOR WELL-BEING

Endorsed the participants of the 10th Global Conference on Health Promotion

The Geneva Charter for Well-being underlines the urgency of creating sustainable "well-being societies", committed to achieving equitable health now and for future generations without breaching ecological limits. The Charter builds on the outcomes of the 10th Global Conference on Health Promotion, hosted in Geneva, Switzerland, and virtually on 13–15 December 2021, and the legacy of the Ottawa Charter and previous global conferences on health promotion.

2022 World Health Assembly

Resolution WHA75.19 on Well-being and health promotion


World Health Organization

SEVENTY-FIFTH WORLD HEALTH ASSEMBLY
Agenda item 18.2

WHA75.19
28 May 2022

Well-being and health promotion

The Seventy-fifth World Health Assembly,

Having considered the consolidated report by the Director-General;[1]

Considering the vast implications that current economic, environmental and social conditions have on the health of societies, communities and people and the potential that health promotion, health protection and disease prevention have on enhancing the capacities of people to protect and improve their health and well-being, in addition to health and social measures by governments;

Reaffirming that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity;

Reaffirming also, as enshrined in the WHO Constitution, that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition;

Further reaffirming that the objective of WHO shall be the attainment by all peoples of the highest possible level of health;

Reaffirming that governments have a responsibility for the health of their peoples, which can be

Recalling United Nations General Assembly resolution 70/1 (2015) on transforming our world: the 2030 Agenda for Sustainable Development, which, as specified as part of the new Agenda, that no

achieve universal health coverage and access to quality health care, and affirmed that no one must be left behind;

Recalling also United Nations General Assembly resolution 67/81 (2012), which recognized that effective and financially sustainable implementation of universal health coverage is based on a resilient and responsive health system that provides comprehensive primary health care services, with extensive geographical coverage, including in remote and rural areas, and with a special emphasis on access to populations most in need, and has an adequate skilled, well-trained and motivated workforce, as well as capacities for broad public health measures, health protection and addressing determinants of health through policies across sectors, including promoting the health literacy of the population;

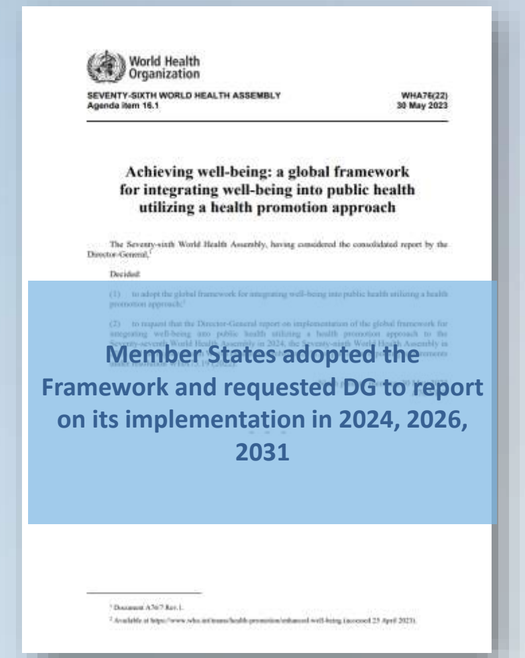
Further recalling the 2008 report of the Commission on Social Determinants of Health and the three overarching recommendations of the Commission: to improve daily living conditions, to tackle

[1] Document A75/10 Rev.1 (item 18.2, WHO's implementation framework for Billion 3).

Member States request the development of a Framework on achieving well-being

2023 World Health Assembly

Resolution WHA76(22) on the global well-being framework


World Health Organization

SEVENTY-SIXTH WORLD HEALTH ASSEMBLY
Agenda item 16.1

WHA76(22)
30 May 2023

Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach

The Seventy-sixth World Health Assembly, having considered the consolidated report by the Director-General,[1]

Decided:

(1) to adopt the global framework for integrating well-being into public health utilizing a health promotion approach;[2]

(2) to request that the Director-General report on implementation of the global framework for integrating well-being into public health utilizing a health promotion approach to the seventy-seventh World Health Assembly in 2024, the seventy-ninth World Health Assembly in

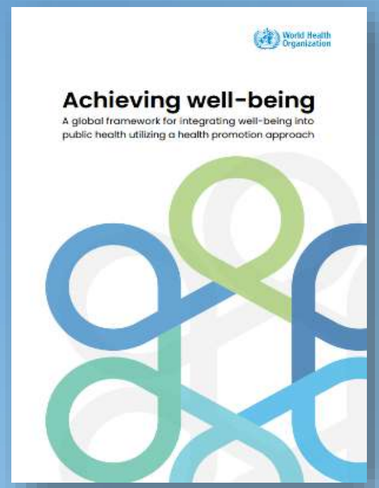
[1] Document A76/7 Rev.1.

[2] Available at https://www.who.int/teams/health-promotion/enhanced-well-being (accessed 25 April 2023).

Member States adopted the Framework and requested DG to report on its implementation in 2024, 2026, 2031

WHO MANDATE ON WELL-BEING

GLOBAL FRAMEWORK ON WELL-BEING





Vision

Societal well-being that enables all people to flourish and achieve their full physical and mental health potential throughout their lives and across generations.

Goal

To promote, strengthen and support Member States in their efforts to create sustainable well-being societies through transformative change, committed to achieving equitable health now and for future generations.

Strategic directions

1. Nurture planet Earth and its ecosystems
2. Design social protection and welfare systems based on equity, inclusion and solidarity
3. Design and support implementation for equitable economies..
4. Promote equitable universal health care coverage through PHC and, health promotion and preventive services
5. Promote equitable digital systems …free of commercial interest
6. Measuring and monitoring well-being

Agency and collective action:

Well-being agenda



Health Promotion pathways

- Good governance for health e.g., Health in all Policies
- Community empowerment and social mobilization
- Health literacy
- Healthy settings . Virtual settings

What this looks like in practice

EXAMPLES FROM COUNTRIES AND COMMUNITIES SERVE AS PRACTICAL ENTRY POINTS FOR HEALTH PROMOTION REFORM – LINKING GOVERNANCE, PARTICIPATION, EQUITY, SOCIAL CONNECTION AND WELL-BEING IN EVERYDAY LIFE.

ICELAND: WELL-BEING ECONOMY



1. **Integrate economic prosperity measures** that include well-being and quality of life, considering social, environmental, and economic factors.
2. **Prioritize collective well-being** for current and future generations, ensuring policies serve citizens.
3. **Define clear objectives** for public prosperity and embed them in planning and budgeting processes.
4. **Track progress** using indicators aligned with social and environmental goals.
5. **Implement fiscal policies** that advance social and environmental objectives across all population levels.

CANADA: QUALITY OF LIFE

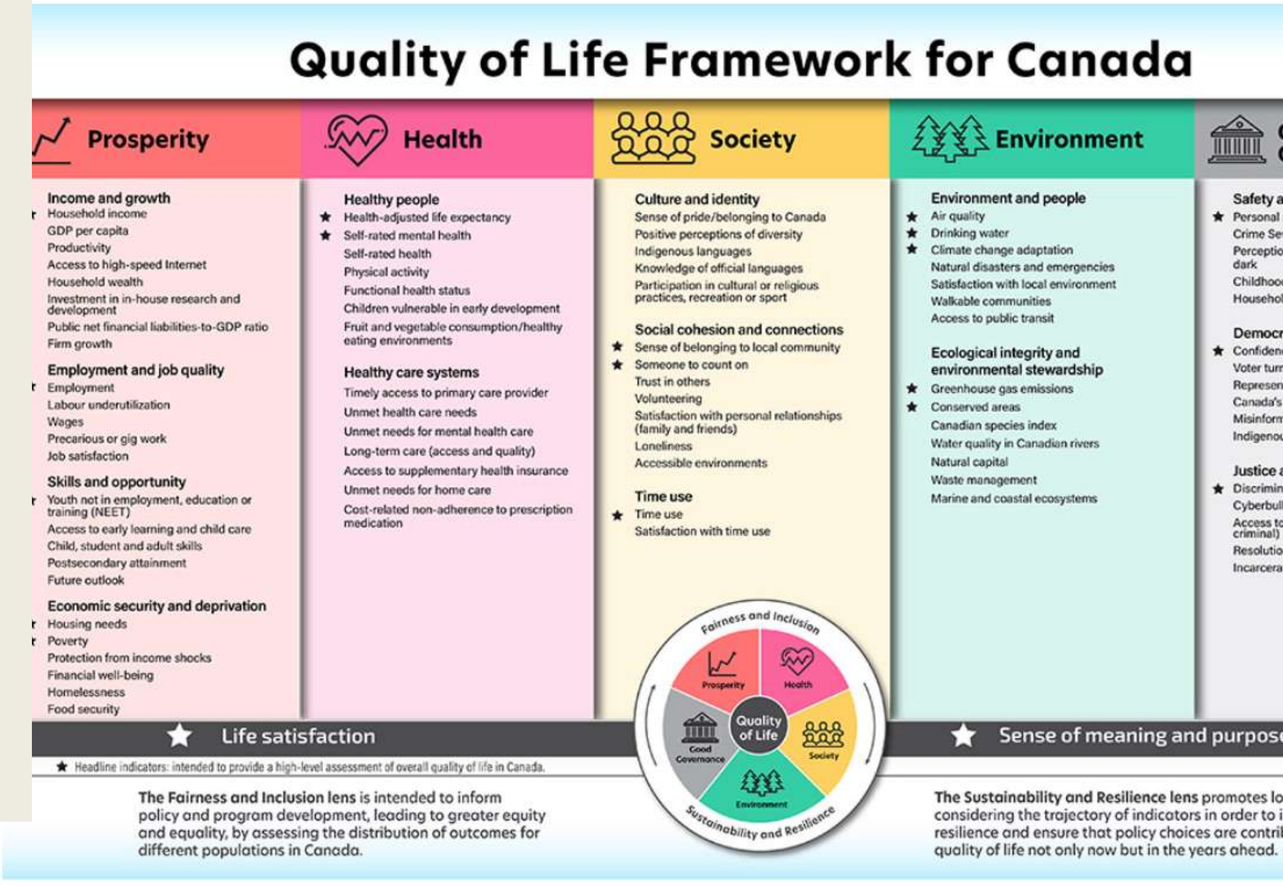
1. Collect data for eighty-four indicators, spread across five areas and two central indicators:

- Prosperity
- Health
- Society
- Environment
- Sound governance

2. The Framework includes two cross-cutting perspectives,

- equity and
- sustainability and resilience.

Infosheet: Quality of Life Framework for Canada



VERNIER (SWITZERLAND): NEIGHBORHOOD CONTRACT



- The objective is to enable the population to contribute to the improvement of their daily life and living environment.
- The municipal council votes each year on a budget allocation for the District Contracts.
- Citizens propose projects.

Contrats de Quartier de la Ville de Vernier | espace de concertation

SANTIAGO (CHILE): PARTICIPATORY BUDGETING



- Percentage of the Municipality budget is dedicated to initiatives led by the citizens.
- Citizens propose projects and through voting system the project are selected.
- Citizens benefit from a leverage of power and a portion of human and material resources to analyze the ideas and implement them.

FLANDERS (BELGIUM): SOLIDARITY NEIGHBORHOODS (QUARTIERS SOLIDAIRES)

- Create, reconnect, develop and maintain social ties to improve the quality of life and integration of the elderly in a locality or neighborhood.
- Helps to create the necessary conditions for everyone's well-being in their home and neighborhood, promoting safety, social connection, and informal care, alongside formal and integrated health services.



Bienvenue dans les «quartiers & villages solidaires» ! :: Quartiers Solidaires :: Pro Senectute Vaud :: Suisse

Ottawa at 40: what should we carry forward?

- **The principles endure.**
- **The context has changed.**
- **Conditions shaping health are interacting and reinforcing one another in new ways.**
- **The level of action must evolve.**

- **The opportunity now is to place health and well-being more firmly at the centre of how societies define and pursue progress.**

Thank You

for your time
and attention

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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Empty Chair SESSION

An empty chair is reserved for members of the audience who would like to converse and debate with our speakers.

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LUNCH

Ideas are better when shared — enjoy lunch and network

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Pitch Presentations

by the RGGPHA lab

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Catherine Grenier

PhD candidate - Stephan Van den Broucke

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Stephan Van den Broucke

Social identity and physical activity: Influence of multiple group identifications

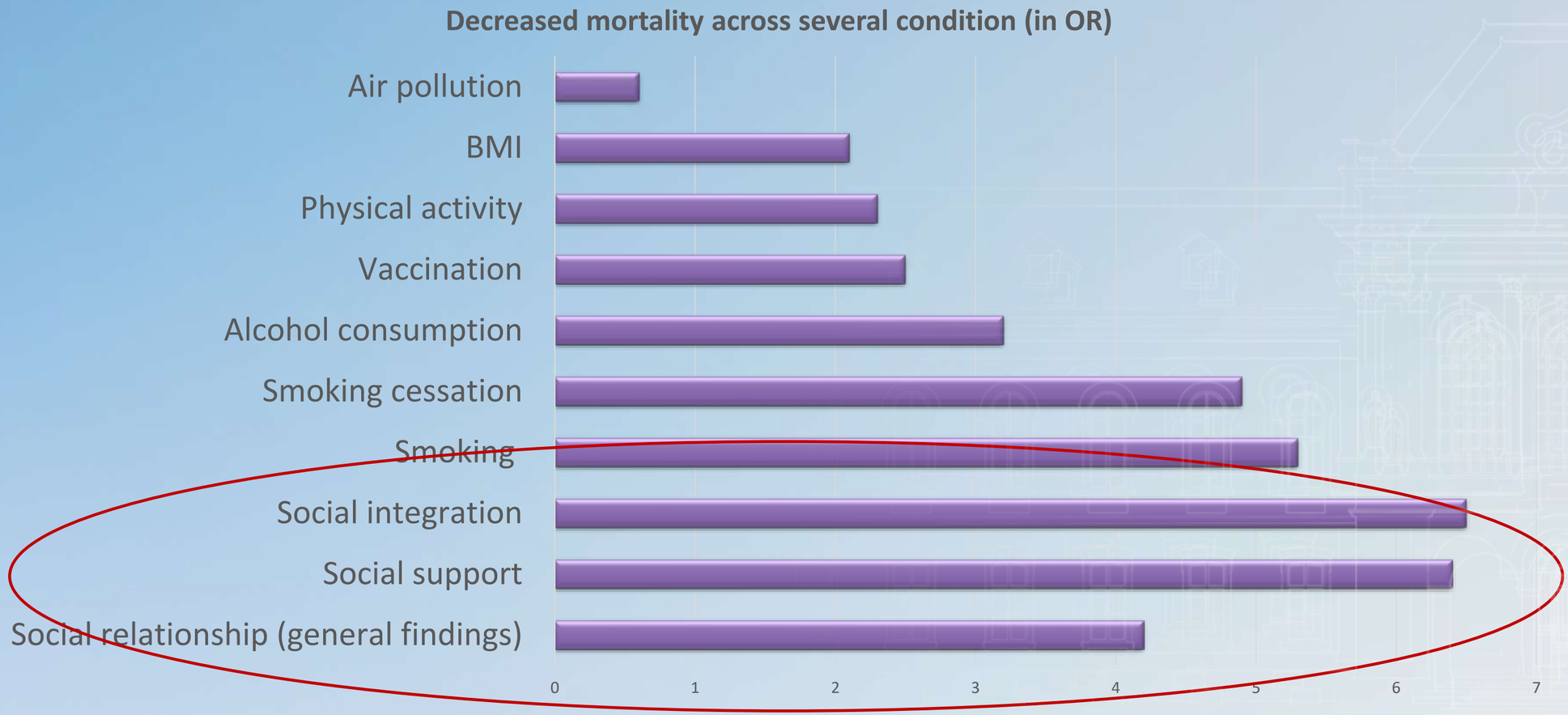
Catherine Grenier

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Stephan Van den Broucke

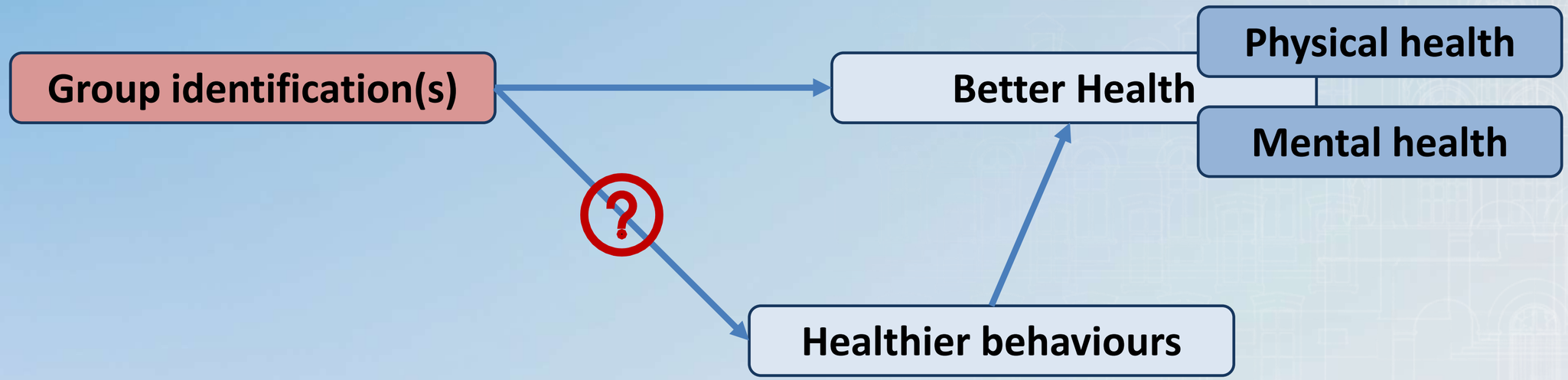
Introduction

Social connections and health (Hold-Lundstad et al., 2010;2015)



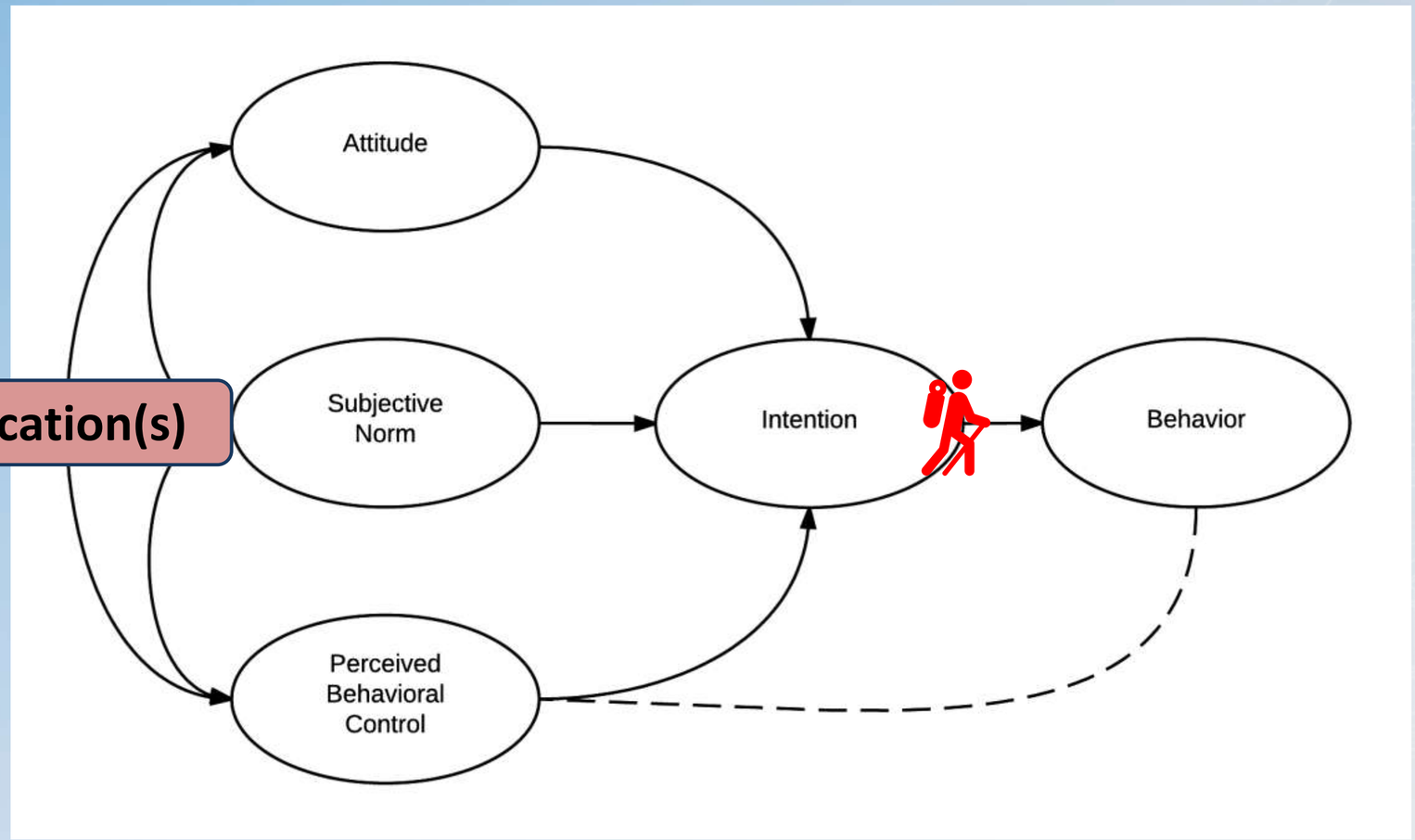
Introduction

Social cure (Jetten et al., 2012; Haslam et al., 2018, Sani et al., 2015)



Introduction

Theory of Planned Behaviour (Ajzen, 1991)



Group identification(s)

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Method

Participants

First year college student (N=346) in Psychology (33,2%), Law (11,2%), Pharmacy (10,2%), Sciences (9,9%)
Aged average = 18,73 (SD= 2,73)
295 women (75,3%) & 89 men (22,7%)

Procedure

Online questionnaire, using Qualtrics - Recruitment through social media & student mailing lists
IPSY ethics comity

Variable	Questionnaire	Example of item (French translation)
ID	SISI (Postmes et al., 2013)	I identify with my group
PA	(1 item)	Generally, how often do you do physical activity for at least 30 minutes ?
PA intentions	Based on Ajzen, 2006	I intend to do physical activity at least 6 times during the next 2 weeks
Attitudes	Based on Ajzen, 2006 (7 items)	For me, doing physical activity at least 6 times during the next 2 weeks would be: very bad - very good
S. Norms	Based on Ajzen, 2006 (2 items)	Most people that are important to me think that I should do physical activity…
PBC	Based on Ajzen, 2006 (5 items)	If I wanted, I could do physical activity…

Nous sommes constamment entourés de groupes dans notre quotidien qui peuvent être plus ou moins importants pour nous. Pour chacun des groupes ci-dessous, veuillez marquer votre degré d'accord avec la proposition suivante :

"Je m'identifie à mon groupe".

Choisissez l'option qui vous semble convenir le mieux. Vous pouvez nuancer votre choix en utilisant les niveaux intermédiaires. Si un groupe ne vous concerne pas, veuillez noter "non applicable".

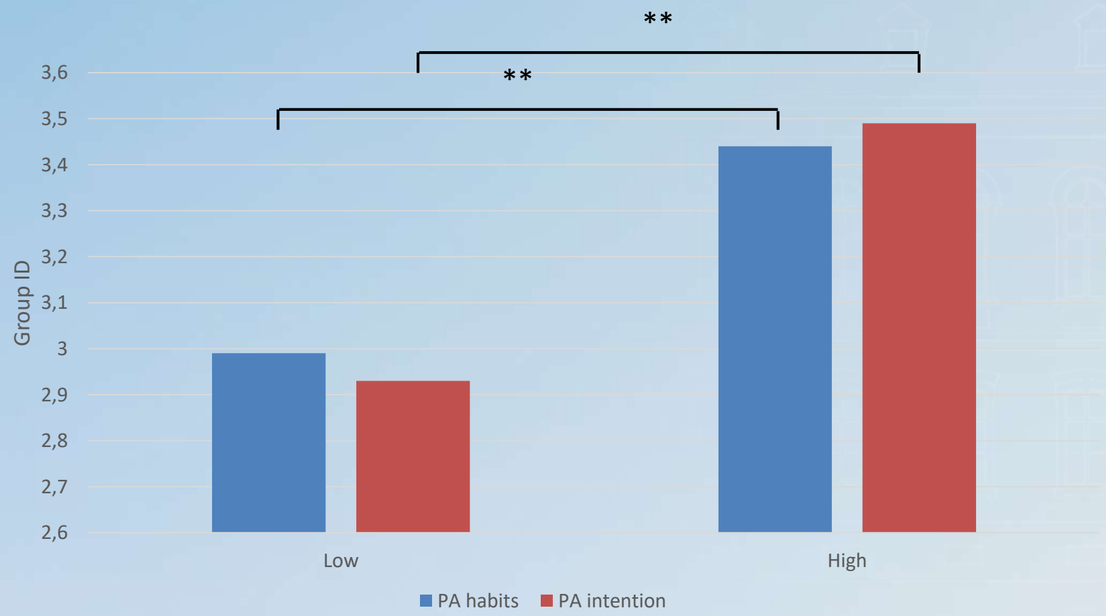
	(1) Tout à fait en désaccord	(2)	(3)	(4)	(5)	(6)	(7) Tout à fait d'accord	Non applicable
Famille	○	○	○	○	○	○	○	○
Amis de la faculté	○	○	○	○	○	○	○	○
Amis de sorties (cercle, régionale, autres)	○	○	○	○	○	○	○	○
Cokoteurs	○	○	○	○	○	○	○	○
Amis d'enfance ou du quartier	○	○	○	○	○	○	○	○
Club de sport	○	○	○	○	○	○	○	○
Mouvement de jeunesse	○	○	○	○	○	○	○	○
Groupe d'activité artistique (musique, dessin, etc.)	○	○	○	○	○	○	○	○
Autre :	○	○	○	○	○	○	○	○

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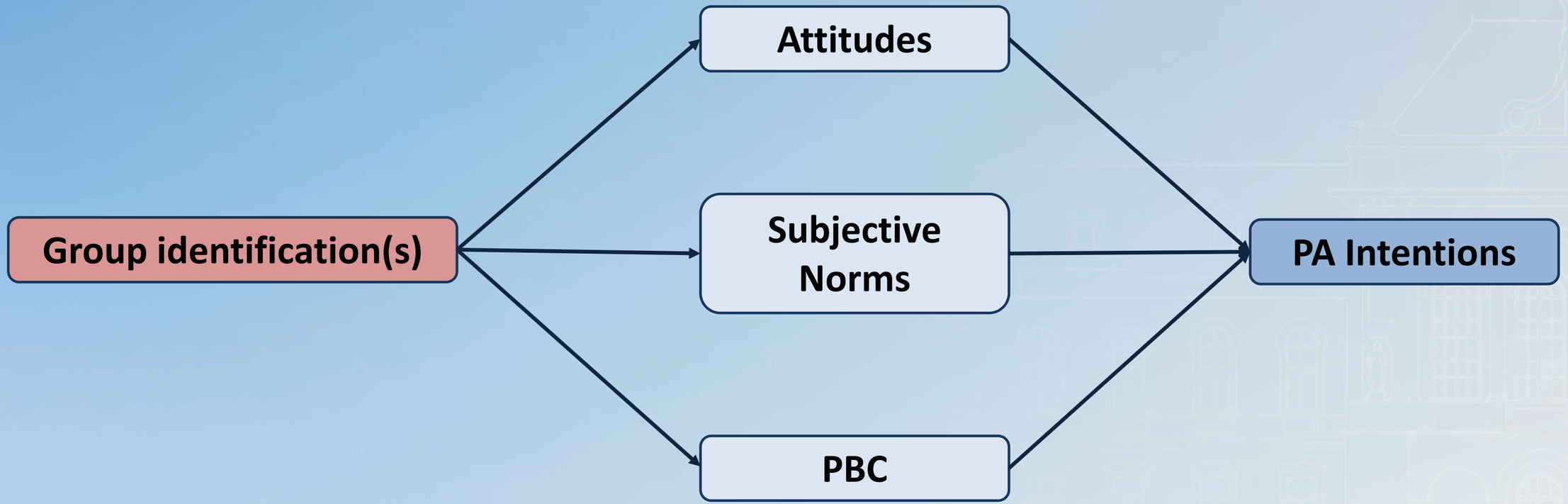
Results

Higher physical activity link to more group identifications

Mean number of group ID by low VS high PA habits and intention



Results


Group identification(s)
Attitudes
Subjective Norms
PBC
PA Intentions

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Conclusion

Multiple group identifications seem to have a positive relationship with AP, mediated by attitudes, norms, PBC in favour of AP.

Research

Further researches could explore how specific group norms and multiple group identifications would (or not) influence general subjective norms.

Health promotion

Interesting perspective for health promotion: considering multiple group identifications as a health determinant

Thank You

for your time and attention

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Jyoshma Dsouza

PhD - Stephan Van den Broucke

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Cancer Prevention Through Translational Research and Education :

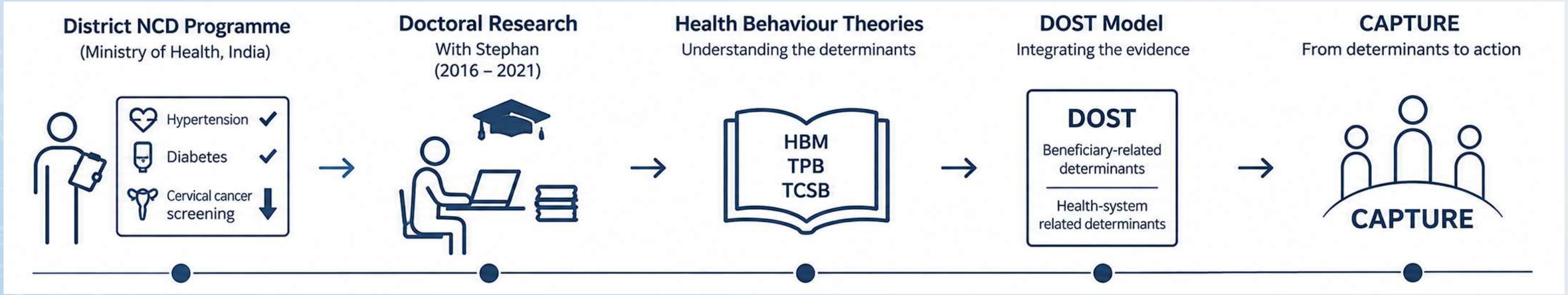
Translating behavioral science into community-based cancer prevention.

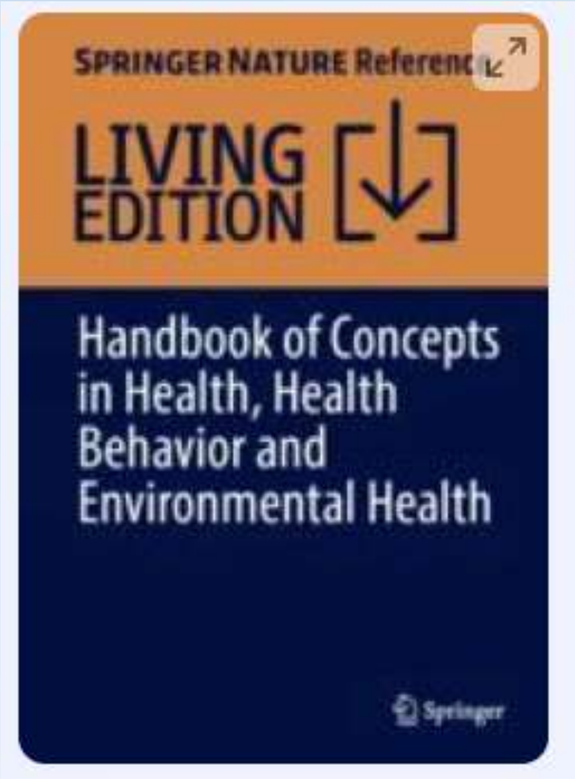
Dr Jyoshma Dsouza MPH PhD FHEA CHES®

University of Luxembourg

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Stephan Van den Broucke

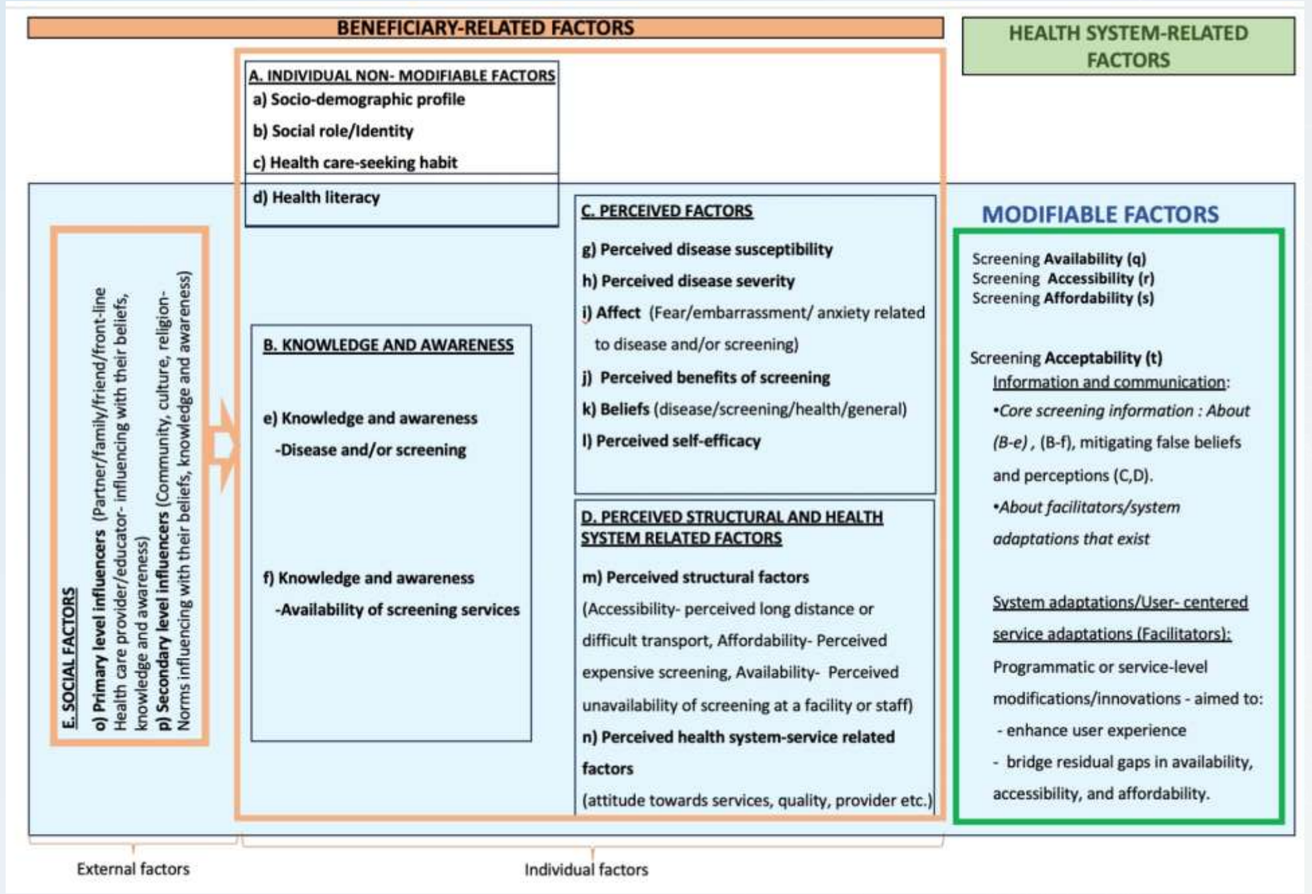

District NCD Programme
(Ministry of Health, India)
Hypertension
Diabetes
Cervical cancer screening
Doctoral Research
With Stephan
(2016 – 2021)
Health Behaviour Theories
Understanding the determinants
HBM
TPB
TCSB
DOST Model
Integrating the evidence
DOST
Beneficiary-related determinants
Health-system related determinants
CAPTURE
From determinants to action
CAPTURE



Book Chapter : Dsouza JP, 2026

"Health Behavior theories and Promotion for Cervical Cancer Screening Uptake.", *Handbook of concepts in Health, Health behaviour and Environmental Health*

The Determinants Of Screening upTake (DOST) model



Dsouza JP & Van den Broucke S 2025

Archives of Public Health

CAPTURE

EXPERTS AND ADVISORS



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PROF. STEPHAN VAN DEN BROUCKE

Full Professor (Professeur ordinaire)

UC Louvain, Belgium

INDIAN CANCER SOCIETY

RISE AGAINST CANCER

ಭಲಾಯ್ಕೆ ಆಯೋಗ್ Permannur

ಸ್ತ್ರೀ ಸಂಘಟನ್ Permannur

ST SEBASTIAN CHURCH PERMANNUR

ಪ್ರೇರಣಾ ಮಹಿಳಾ ಸ್ವಸಹಾಯ ಸಂಘಗಳ ಒಕ್ಕೂ
ಪ್ರಜ್ಞಾ ಸಲಹಾ ಕೇಂದ್ರ ಕಂಕನಾಡಿ-ಮಂಗಳೂ

CAPTURE









INDIAN CANCER SOCIETY

RISE AGAINST CANCER

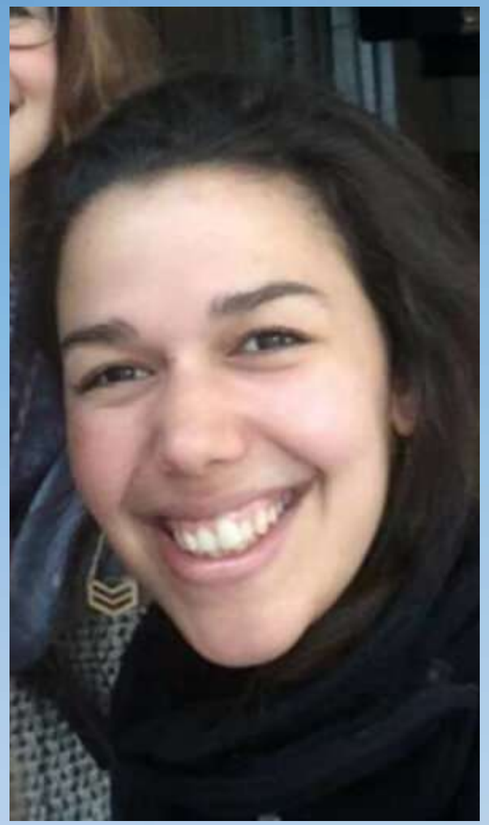
captureindia.project@gmail.com

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Thank You

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Sarah Fakroune

PhD candidate - Stephan Van den Broucke

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Psychosocial determinants of sleep health among university students

Sarah Fakroune, PhD Candidate
Under the supervision of Charles M. Morin, PhD
Stephan Van den Broucke, PhD

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https://storyset.com/home Home illustrations by Storyset

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Students are at risk of sleep difficulties

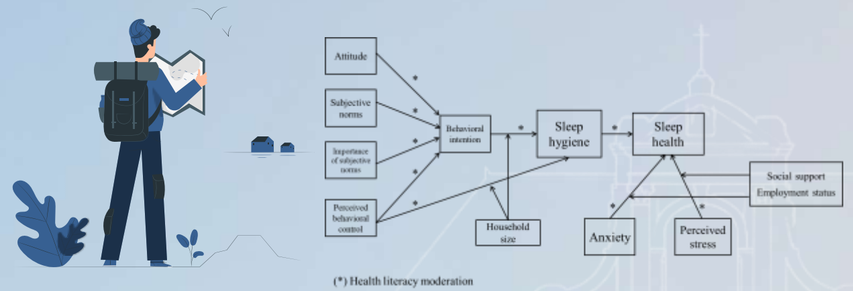


Prevent sleep difficulties by promoting sleep health
(Buysse, 2014; Ottawa Charter, 1986)



But which determinants to target to develop individual skills?

And how can we identify them?



Test a structural equations model
Cross-sectional design (N=524)
(with the use of the Theory of Planned Behavior; Ajzen, 1985)

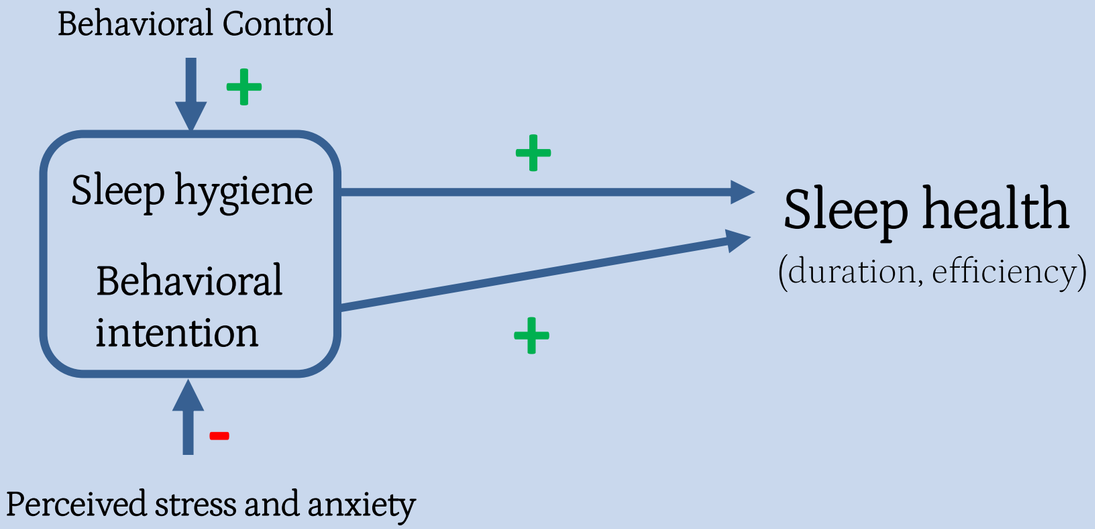


Evaluate the efficacy of a psychoeducational and behavioral intervention
RCT (N=82) 3 weeks, 3 sessions, 90 min each
(with the use of Behavior Change Techniques; Millie et al., 2011)

https://storyset.com/people People illustrations by Storyset

Cross-validation findings

Main determinants



On the agenda

Model needs to be refined, as the design was cross-sectional

Then, the intervention should be adapted in line with these results (focuses on targeting sleep regularity, timing and perceived stress, anxiety)

Understanding how to promote healthy sleep among students might involved better control over sleep hygiene, in line with intentions and mental health in favor

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Thank You

for your time and attention



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https://storyset.com/data Data illustrations by Storyset

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Ruth-Janet Koumba Maguena

PhD candidate - Stephan Van den Broucke

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MAKING HEALTH PROMOTION INTERVENTIONS WORK IN CONTEXT

Lessons from Comprehensive Sexuality Education interventions for young people in Gabon

Ruth-Janet KOUMBA MAGUENA

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Stephan Van den Broucke

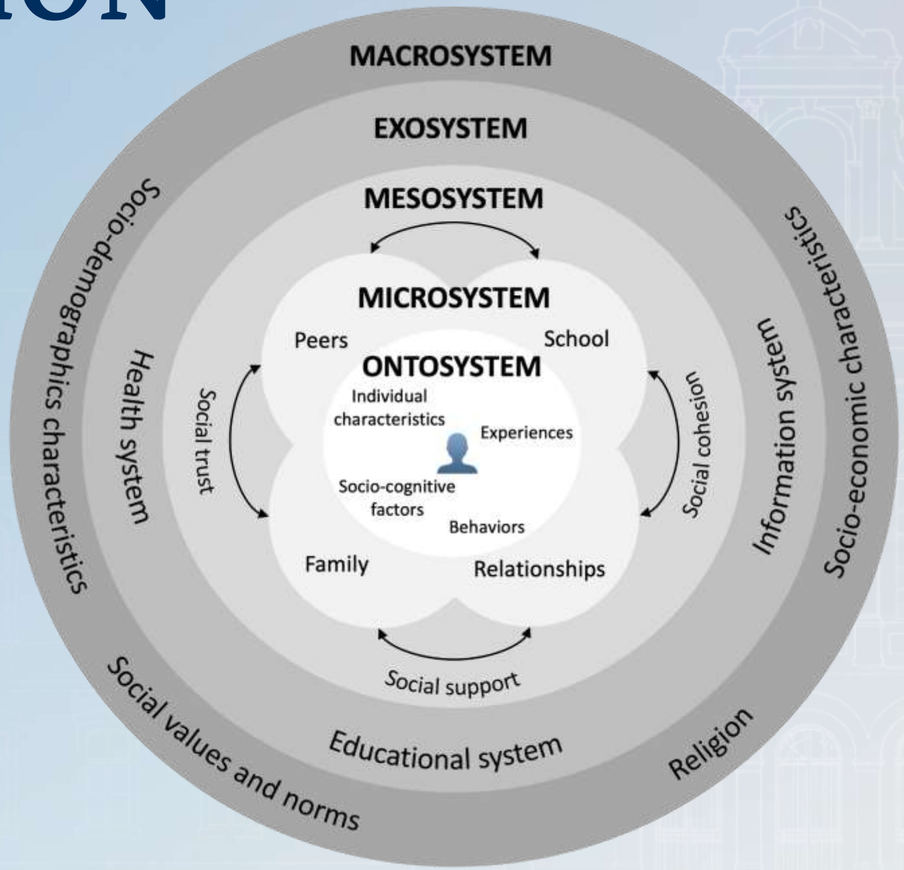
CSE AS A HEALTH PROMOTION INTERVENTION

Comprehensive Sexuality Education is a structured educational process addressing the cognitive, emotional, physical, and social dimensions of sexuality.[98]

International guidance (UNESCO)

↓

Locally developed programmes



Determinants of adolescent sexual behaviour in sub-Saharan Africa. Adapted from Koumba Maguena et al. (2025).

IMPLEMENTING CSE IN GABON

ENABLING FOUNDATIONS

- Strong policy recognition
- Active and multisectoral intervention landscape
- Committed and experienced actors
- Contextual expertise and adaptive practices

IMPLEMENTATION TENSIONS

- Fragmented coordination
- Limited and unpredictable resources
- Dependence on individuals and projects
- Weak institutional learning

CSE implementation takes place within a socially and morally sensitive environment.

WHAT DID WE LEARN ABOUT CSE IMPLEMENTATION IN GABON?

- **NEGOTIATE:** Translate principles into contextually legitimate practice
- **CONNECT:** Organize complementary responses to multidimensional determinants
- **CONVERT:** Turn policy commitments into mandates, resources and routines
- **ADAPT:** Adjust implementation while preserving its purpose
- **LEARN:** Preserve implementation knowledge across project cycles

Implementation is a process of translation across evidence, values, actors, institutions, and practice.

LESSONS FOR HEALTH PROMOTION INTERVENTIONS

- **CONTEXT IS ACTIVE:** It shapes legitimacy, feasibility, and implementation.
- **TRANSLATION IS COLLECTIVE:** Evidence is interpreted and negotiated across actors.
- **CAPACITY IS SYSTEMIC:** Implementation depends on relationships, resources, and institutional arrangements.
- **SUSTAINABILITY MEANS LEARNING:** Experience must be retained and transformed into collective capacity.

Effective health promotion interventions require evidence to become contextually legitimate and institutionally supported practice.

Thank You

for your time and attention

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1348 Louvain-la-Neuve
BELGIQUE

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Samer Al Hamwi

Masters Thesis with Stephan Van den Broucke

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

"Health Literacy as a Mediator of Healthcare Access Inequalities Among Refugees and Asylum Seekers in Wallonia, Belgium: A Cross-Sectional Study"

SAMER ALHAMWI

SYMPOSIUM IN HONOR OF
Stephan Van den Broucke

The Context

- **Universal healthcare system** in Belgium, BUT refugees face persistent barriers.
- **Consequences:** Inequalities for individuals AND additional costs for the system (ER visits, delayed diagnoses).
- **The Gap:** Structural barriers are well-documented, but Health Literacy (HL) as a mediator is underexplored.
- **Our Question:** Is HL the missing piece?

Methods

- **Design :** Cross-sectional quantitative study (N = 67).
- **Population :** Refugees & asylum seekers in Wallonia (Palestine, Syria, Iraq).
- **Instruments :**
  - HL: HLS-EU-Q12 (12 items, $\alpha = 0.964$).
  - Barriers: Likert-scale based on KCE dimensions ($\alpha = 0.740$).
- **Analysis :** ANOVA, Spearman correlations, Mediation analysis (Baron & Kenny + Sobel test).

Key Results

- **Low HL is prevalent :** 58.2% showed problematic/inadequate HL (vs. 13.5% general population).

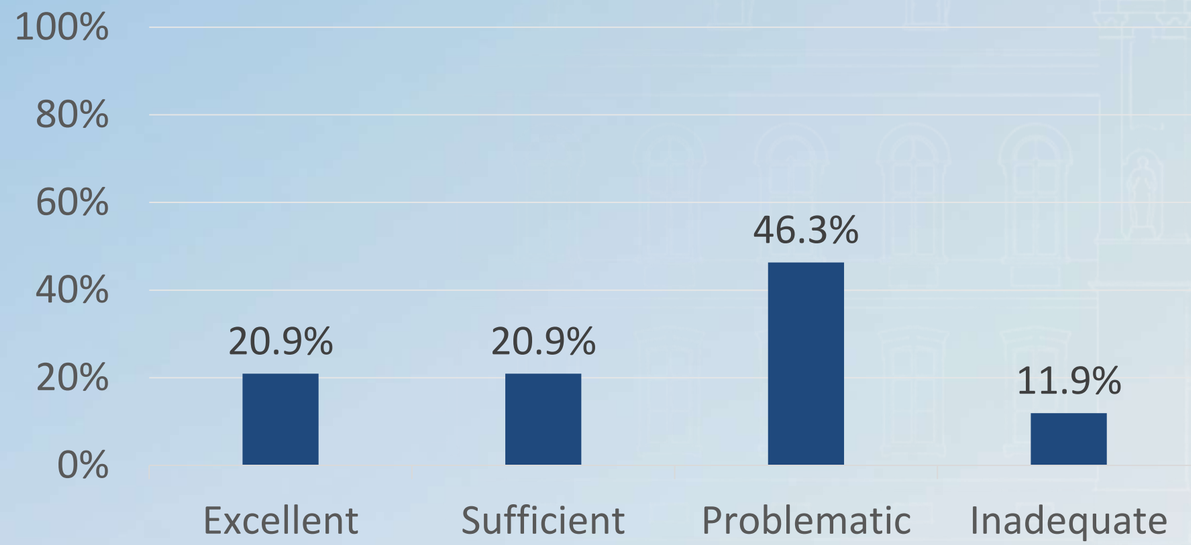


Figure : Distribution of Health Literacy (HL) levels among the study sample (N = 67).

Key Results

- **HL mediates access:** HL fully mediates the impact of language & admin status on barriers (Sobel $z = 4.42$, $p < 0.001$).
- **Language is key:** French proficiency ($\eta^2 = 0.784$) and education ($\eta^2 = 0.386$) are main predictors.
- **Support gap:** 59.7% dissatisfied with available support.

Conclusion & Implications

- **HL is not about blaming refugees, but empowering them AND improving the system.**
- **Pragmatic levers:** Targeted health education (multilingual workshops, peer support, simplified admin).
- **Prevent** human & economic costs for Belgian society.
- **HL as an integration indicator** (alongside language, employment).

Thank You

for your time and attention

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Manon Janssens de Varebeke

Masters Internship with Stephan Van den Broucke

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Patients' Perceptions of Organizational Health Literacy in Cancer Care

Celine Jeitani - Manon Janssens de Varebeke

Presented by Manon Janssens de Varebeke

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

"Is it the patient's job to understand? Or is it the Health Care Organization's job to be understandable?"

Health Literacy (HL)

= Patient's ability to access, understand, appraise, and apply health information to make health-related decisions and lead a healthy lifestyle (Sørensen et al., 2012)

Organizational Health Literacy (OHL)

= Health Care Organization's capacity to design, adapt, and deliver services to make healthcare accessible, understandable, and usable for all patients

(Bremer et al., 2021)

Rise in OHL in public health research and in Belgium

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How do cancer patients perceive their hospital's organizational health literacy practices, and how do those practices shape their experience of care?

1. Communication as the infrastructure of health literacy
2. Active agency in navigating healthcare
3. Relational safety as a condition of participation
4. Shared health literacy: the invisible support system
5. Invisible barriers and unseen patients
6. Institutional authority, trust & limits to participation

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Responsibility for Health Literacy still falls on the patients and families, not the institution.

1: Compensating for the system gaps

- Unclear communication and language barriers highlight the lack of fundamental OHL.
- Patients compensate through information-seeking behaviors and by turning to their social network and other healthcare members.

2: Relational resources to adapt

- Seeking information, interpretation, decision-making, management, and emotional support.
- Emotional support crucial resource for managing health

3: Unequal opportunities

- Information-seeking behaviors are influenced by HL levels and age.
- Social network availability, accessibility, experience, language, and communication

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Conclusion:
Reducing the burden on patients, where organizations can intervene

- ➔ Patients' information-seeking behavior to fill the communication gap: Clear and complete communication adapted to patients' Health Literacy competences and language levels
- ➔ Coping through relational resources: A system that ensures a safe, supportive, holistic, and appropriate environment, accessible to patients, to not rely on network
- ➔ Unequal compensation resources: Tackle structural, cognitive, emotional, inequality and unequal participation barriers to prevent exclusion

(Coleman et al., 2017; Farmanova et al., 2018; Pelizzari et al., 2025; Straßmayr et al., 2025)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Thank You

for your time
and attention

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Celine Jeitani

PhD candidate - Stephan Van den Broucke

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Stephan Van den Broucke

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When Organizational Health Literacy Meets Practice

Celine Jeitani

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

What does a health-literate organization look like?

Accessible, Understandable, Navigable, Equitable

Brach's 10 attributes

Structures & Policies

Patient Involvement

Workforce

Leadership



Vienna/V-HLO

Org-HLR

Communication & Information

Adaptability

Equity

Through Patients and Health Pros

PATIENTS

- **ACCESS**
  Empathy • availability • support
- **UNDERSTANDING**
  Clear communication • information
- **RELATIONSHIP**
  Trust • emotional safety • reliance on professionals

HEALTH PROs

- **COMMUNICATE**
  Explain • clarify • reduce jargon • teach-back
- **ADAPT**
  Language • culture • psychological/medical/social needs
- **SUPPORT & NAVIGATE**
  Follow-up • redirect • involve others • teamwork

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Organizational Standard

↓

Organizational Conditions





Assessing needs

Adapting jargon

Clarifying

Changing language

Teach-back

Using third parties

Redirecting

Intensive follow-up



Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

iPSY
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CAPACITY

Leadership
Governance
Accountability
Resource allocation
Workforce structures
Coordination
Policies
Organizational learning

EXPERIENCE



PRACTICE

Clear communication
Jargon adaptation
Teach-back
Empathy
Language adaptation
Information provision



Thank You

for your time
and attention

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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Session 3

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



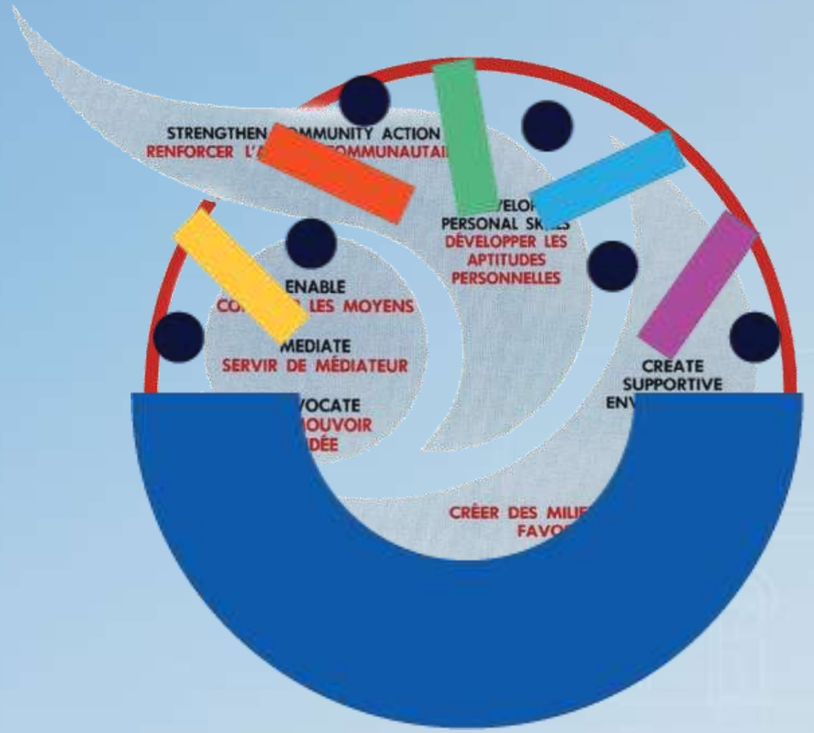
KEYNOTE Speaker

Evelyne de Leeuw

Chaire d'Excellence de Recherche du Canada Université de Montréal & Cities Institute
UNSW Sydney

SYMPOSIUM IN HONOR OF
Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Health (promotion) for all and everything

Evelyne de Leeuw

CERC Une Seule Santé Urbaine

UNE SEULE SANTÉ URBAINE

ONE URBAN HEALTH

Canada Excellence Research Chairs
Chaires d'excellence en recherche du Canada

École de santé publique
Université de Montréal

CReSP
Centre de recherche en santé publique
Université de Montréal

UNSW
Cities Institute

Life 101: a complex of spheres





Geosphere

Hydrosphere

Atmosphere



Geosphere

Hydrosphere

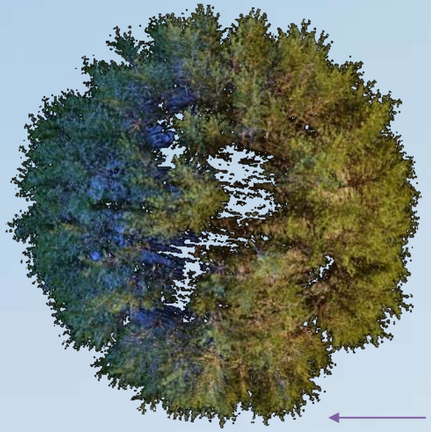
Atmosphere



Geosphere

Hydrosphere

Atmosphere



Biosphere



Geosphere

Hydrosphere

Atmosphere

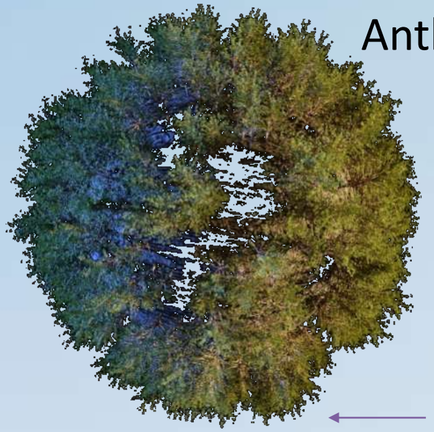
Biosphere



Geosphere

Hydrosphere

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Biosphere

Anthroposphere





Geosphere

Hydrosphere

Atmosphere



Biosphere

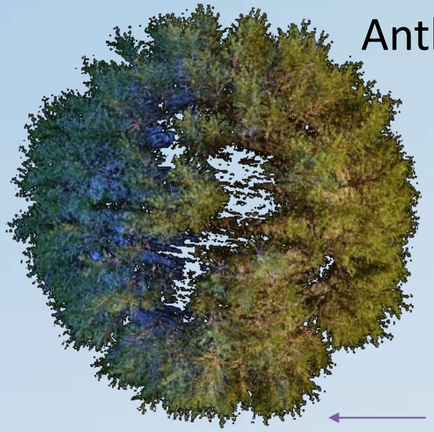
Anthroposphere



Geosphere

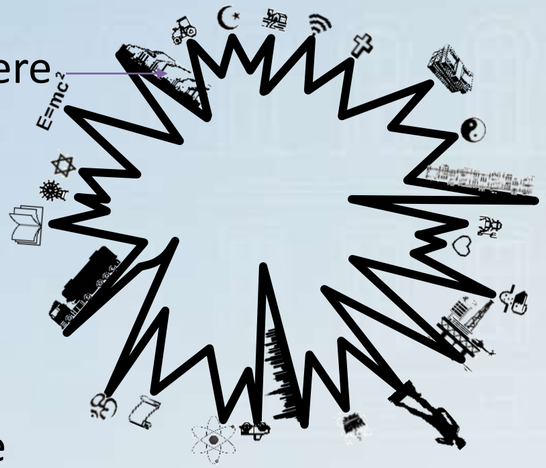
Hydrosphere

Atmosphere



Biosphere

Anthroposphere



Cosmology
Worldview



FRANCE

Olympic deadline
Paris races to clean up the Seine in time

By *Charlotte Lytton* PARIS

Riders of Paris's No7 Métro line have long enjoyed a scenic view as the track passes near Austerlitz station, set between the beautifully manicured Jardin des Plantes to one side, and the River Seine on the other. Recently, that view has been punctured by a circular behemoth: the Austerlitz storage basin – the size of 20 Olympic pools – built to save next summer's Games.

With a series of Paris 2024 competitions – and the opening ceremony – slated to take place in a river that has not allowed public swimming for a century, and heavy rains this summer scuppering several trial events due to excess bacteria in the water, the Seine being unsafe at the start of the Olympics in July is an ever-growing threat.

Yet the cavernous Austerlitz basin – a building site fringed by diggers and cranes – currently appears as the rest of the city's Seine clean-up plans: incomplete. The goal is to have what is essentially a giant rainwater holding tank, capable of storing up to 46m litres, ready by spring. Once the rainwater is collected, it will be transported via a tunnel beneath Austerlitz train station and the 350-year-old Pitié-Salpêtrière University hospital beside it, beneath the river, to a downstream treatment plant. When levels of *Escherichia coli* and intestinal enterococci meet the safety thresholds, it will be passed back into the Seine.

This €1.4bn ($1.47bn) project is now the great hope, organisers tell me, for the Games, the city and beyond; a vital step in preventing further pollution of the 780km waterway (the Seine sits at the confluence of the Marne and Oise rivers). Prior to the city's winning bid, there had long been concerns about how Paris's largely 19th-century sewer system could prevent urban runoff, where bad weather washes pollutants such as rubbish, pesticides and sediment into the water. But nobody foresaw the worst rains in 65 years hitting the city this July, forcing the cancellation of the Olympic triathlon and paratriathlon test events, and the Open Water Swimming World Cup.

This has been "an exceptional summer", said Pierre Rabadan, Paris's deputy mayor. While he is aware that "unexpected challenges" could strike again ahead of the opening ceremony on 26 July, organisers insist there is no plan B in place, nor will there be. Should another bout of heavy rain hit, forcing urban runoff-induced bacteria to rise above safe levels, "We can try to push the dates of competition one or two days to be able to bring back good quality of water," Rabadan suggested – though, given the practicalities of shifting Olympic events, this may seem optimistic.

There is a simple solution: to forget the river altogether, and use one of the city's many pools instead. But as well as it being an integral part of Parisian history immortalised in paintings and literature, making the Seine swimmable again has become a multibillion-euro promise too big to renege upon.

It was a fundamental part of the city's Olympic bid and of the election campaign of the city's mayor, Anne Hidalgo. Hers was the latest in a line of political promises dating back to Jacques Chirac, the former prime minister and president, who, in 1990, declared that, by 1993: "I will swim in the Seine in front of witnesses to prove [it] is a clean river."

'We believe the cities of the future will need to embrace nature in order to thrive'

1.4

Cost in billions of euros of a giant rainwater holding tank from which water will be cleaned and passed back into the River Seine

That next summer's Games are a century on from the last time Paris hosted the Olympics has further raised the stakes. They also promise major financial rewards: one study estimated that the Games could generate €10.7bn in economic benefits for France.

The biggest clean-up issue is wastewater – domestic and industrial – with 1.9m cubic metres discharged into the Seine in 2022. While this is 90% less than 20 years ago, it is still too much. Wastewater (both legal and illegal) is dumped to avoid saturating the sewage system and potentially causing it to flood, particularly when heavy rain hits.

Efforts are also under way to reconnect pipes in more than 20,000 homes to newer sewer networks under Paris – though the offer of a €6,000 grant per household yielded take-up of only around a quarter of eligible residents by March last year. These residences are still believed to be dumping wastewater directly into the river.

Until recently, boats moored within the city limits did the same, though after a council mandate in 2018 they, too, must connect to the sewer system (an estimated half have complied).

"It is a very big challenge," Prof Jean-Marie Mouchel, a hydrologist at the Sorbonne, said of the work ahead. Still, the period to enact this vision "is very short. The timescale for building new sewers, of modifying wastewater treatment plants normally is about 10 years. And the challenge was to make it in only five."

As temperatures rise, along with population density in cities, making urban waters swimmable is an ever more important goal. Rivers can provide essential relief, especially during summers, with city-dwellers hit far harder than rural counterparts, as paved surfaces and narrow streets absorb and trap heat.

A study published in Lancet Planetary Health earlier this year found that people in Paris are far more likely to die from extreme heat than those in 853 comparable European cities. In recent years, the likes of Zurich and Munich have successfully cleaned up their rivers, with Berlin and Amsterdam among those next in line – yet none matches Paris for the length of its river and population density.

Dan Angelescu, CEO of Fluidion, a water-monitoring company based in Paris and Los Angeles, described the city as "pioneering a global trend, and the Olympics, definitely, are a high-visibility opportunity to make a statement". There is "a lot of citizen pressure to have access to quality urban waters", he added, and bacterial monitoring sensors are part of the solution. "We believe the cities of the future will need to embrace nature to thrive, and will also need to embrace digital sensor technologies to be able to monitor fragile urban ecosystems and the safety of different water uses. No one wants to live in a gloomy city where the river is used exclusively as an urban sewage conduit or as a shipping route."

Wildlife would also benefit from a cleaner Seine. Mouchel notes that "in the 70s, there were only three fish species living in [the river]; now there are more than 30". But a 2020 paper by researchers at Université Paris-Saclay and the Sorbonne highlights that this would bring it to only around the same level as that of many centuries earlier.

"Before human intervention, the Seine River hosted 11 diadromous [fresh- and saltwater-dwelling] and at least 22 freshwater fish species," it said. "The fish community has changed since the medieval period due to overfishing, pollution, habitat destruction and the disruption of migration routes." Effective action is required, they add, "to strengthen the recovery and sustainability of migratory fish populations in the Seine".

Some Parisians are yet to be convinced by the clean-up: a 2021 poll found that 70% described the river in negative terms, with the smell and pollution ranking among the chief offences. Arnaud Montand, a boat captain who has lived on the Seine since 1998, said: "I find it funny – this idea to want to give back the river to the Parisians and the swimmers. I think there are better places for that."

He is concerned about the knock-on effect on the boat tour industry, which will have to cease in areas where post-Olympic swimming spots are created. Over time, he concedes that "the boats [have become] bigger and bigger" – but "I don't think the boats are the cause of pollution inside the Seine. Humans near rivers are the cause." On a Sunday morning, he said: "You see the leftovers from Saturday night, and plenty of it is in the water. It is not the boats creating all this garbage – it's the people."

70

The percentage of Parisians who describe the Seine in negative terms, with the smell and pollution topping the list of complaints

Along with small-scale detritus, every year, 360 tonnes of waste is pulled from the Seine, including old scooters, safes, motorbikes and TV sets. These objects are the modern replacement for its earliest forms of trash: human bodies, tossed into the water during wars between Catholics and Protestants in the 16th century.

London can relate to this. At least 200 tonnes of waste is hauled out of the Thames annually: swimming in the tidal Thames is "not an activity which the Port of London Authority encourages".

The UK is regularly ranked among the worst countries in Europe for river cleanliness, with more than 389,000 discharges of untreated sewage (amounting to 2.4m hours of pollution) in 2022. And swimmers have suffered in UK waters this summer. At least 57 fell ill after the World Triathlon Champion Series at Sunderland's Roker beach in August, where, three days before the event, readings for *E coli* colonies were 39 times higher than the month before. In September, Swim Serpentine (held at the Serpentine lake in Hyde Park, London) was nearly cancelled after blue-green algae, which can cause vomiting, nausea and allergic reactions, bloomed in the water.

If Paris succeeds in cleaning up the Seine, the work may become a blueprint for urban metropolises worldwide. As the deadline approaches, those involved are under no illusion about the scale of the task. "We still have to address the question of runoff," Mouchel said. "And to pray." *Observer*

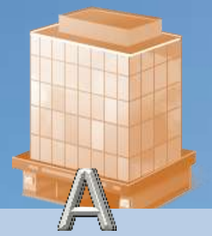
CHARLOTTE LYTTON IS A JOURNALIST BASED IN LONDON



Health is everyone and everywhere

- Known knowns etc.
- What and how?
- From anthropocentric to ecocentric…
- Literacy…: the capacity to listen


Air and pollution
Land and sea use
Climate change
Globalisation and industrialisation
Food systems
Infectious and zoonotic diseases
Non-communicable diseases
Biodiversity
Plant and soil health
Urban health
Waste and sanitation
Aquatic health
Antimicrobial resistance

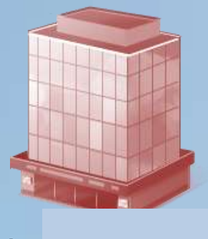


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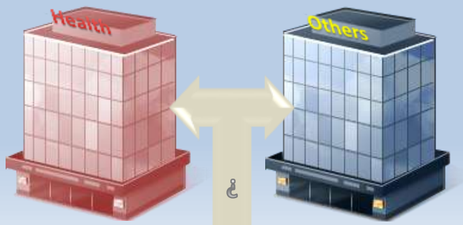
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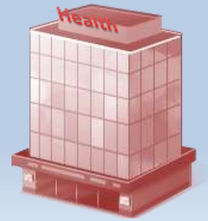


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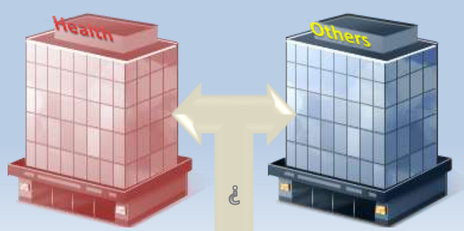


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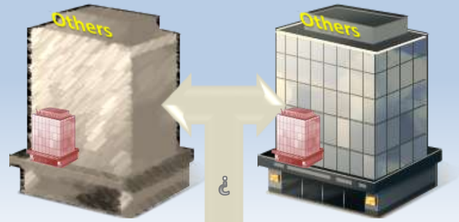




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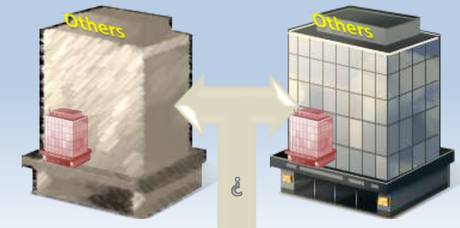














The challenge is to ‘synergise’

One Health



Healthy Cities



de Leeuw, E. (2021) One Health(y) Cities: Cities are pandemic ecosystems and that’s where the action ought to happen. *Cities & health*, *5*(sup1), S26-S31.

De Leeuw, E. (2022) One Urban Health. https://www.urbanet.info/one-urban-health/

One Health and Healthy Cities – two universes?

One Health



Healthy Cities



The Sustainable Development Goals:



(Healthy) Cities *are* SDGs:



A clean, safe, high quality physical environment (including housing quality).

Access to a wide variety of experiences and resources with the possibility of multiple contacts, inter-action and communication.

An ecosystem which is stable now and sustainable in the long term.

A diverse, vital and innovative city economy.

A strong, mutually supportive and non-exploitive community.

Encouragement of connectedness with the past, with the cultural and biological heritage and with other groups and individuals.

A high degree of public participation in and control over the decisions affecting one's life, health and well-being.

SUSTAINABLE DEVELOPMENT GOALS

A city form that is compatible with, and enhances the above parameters and behaviours.

The meeting of basic needs (food, water, shelter, income, safety, work) for all the city's people.

High health status (both high positive health status and low disease status).

An optimum level of appropriate public health and sick care services accessible to all.

A Science of Settlement:



Networks

Nature

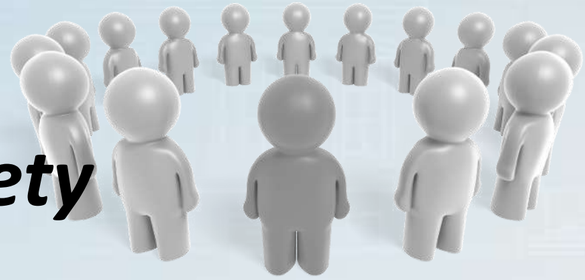




Anthropos



Shells



Society

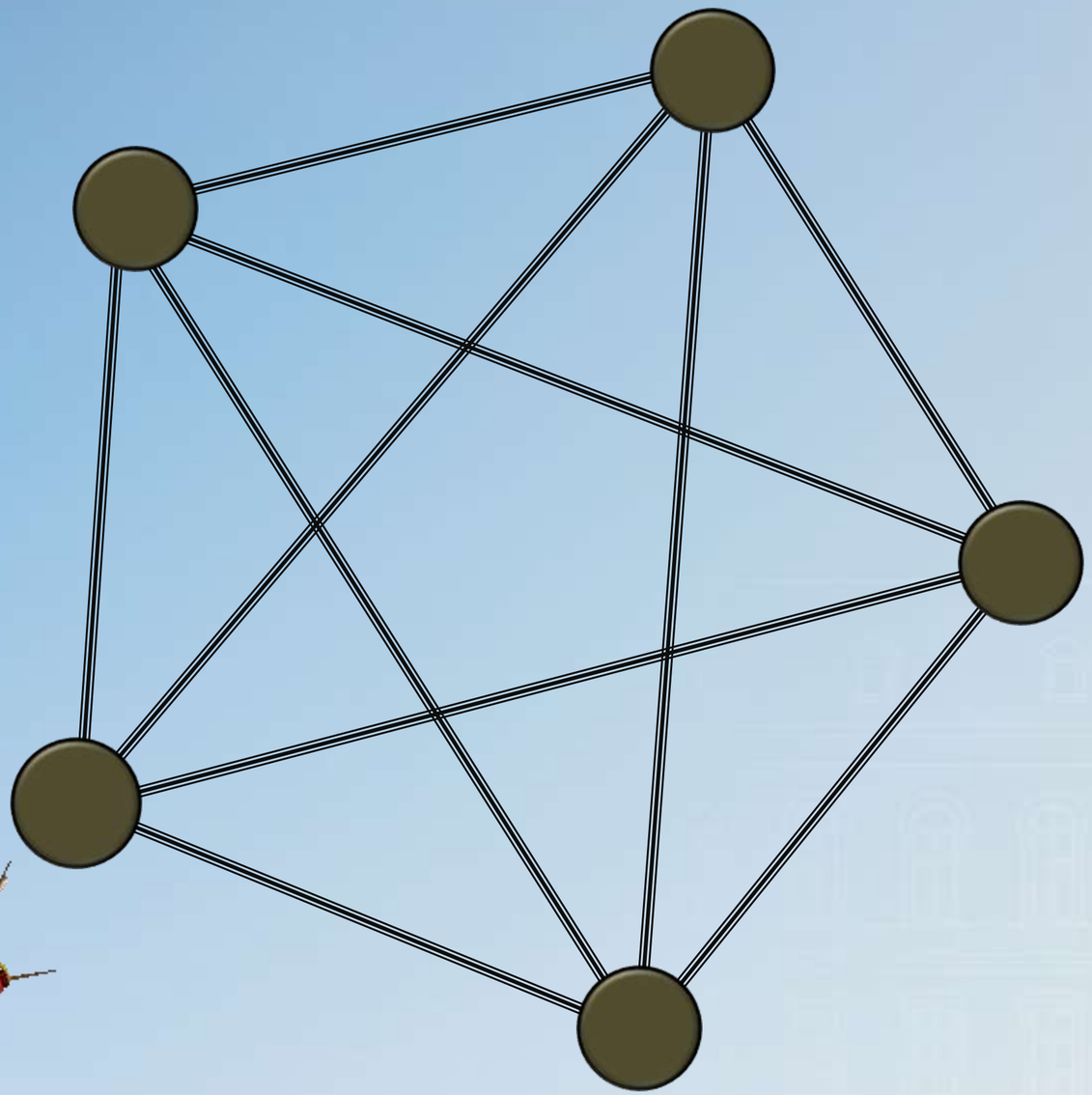
Doxiadis, C. A. (1970) Ekistics, the Science of Human Settlements: Ekistics starts with the premise that human settlements are susceptible of systematic investigation. Science, 170(3956), 393-404.

Sure, but practically?











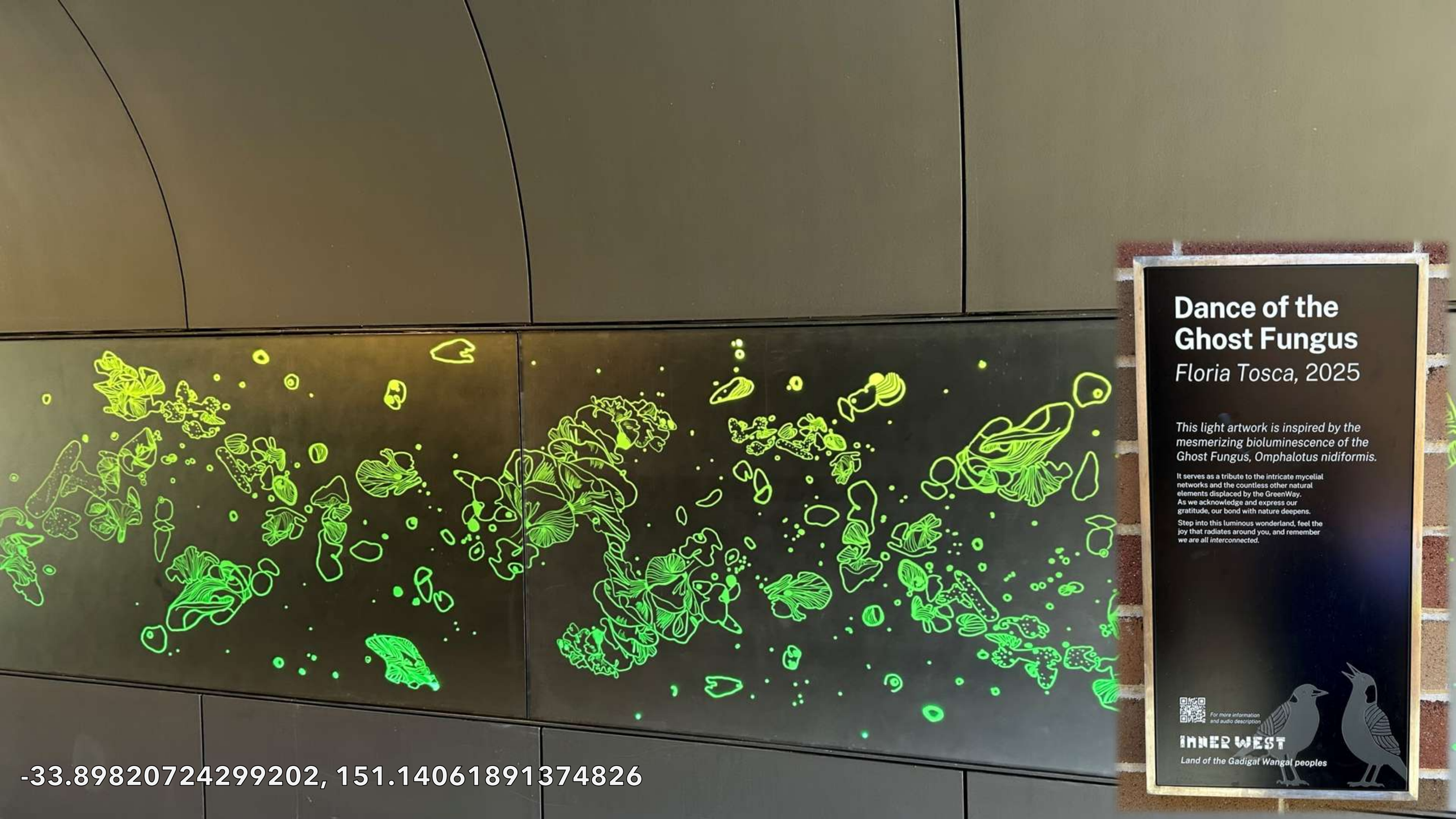




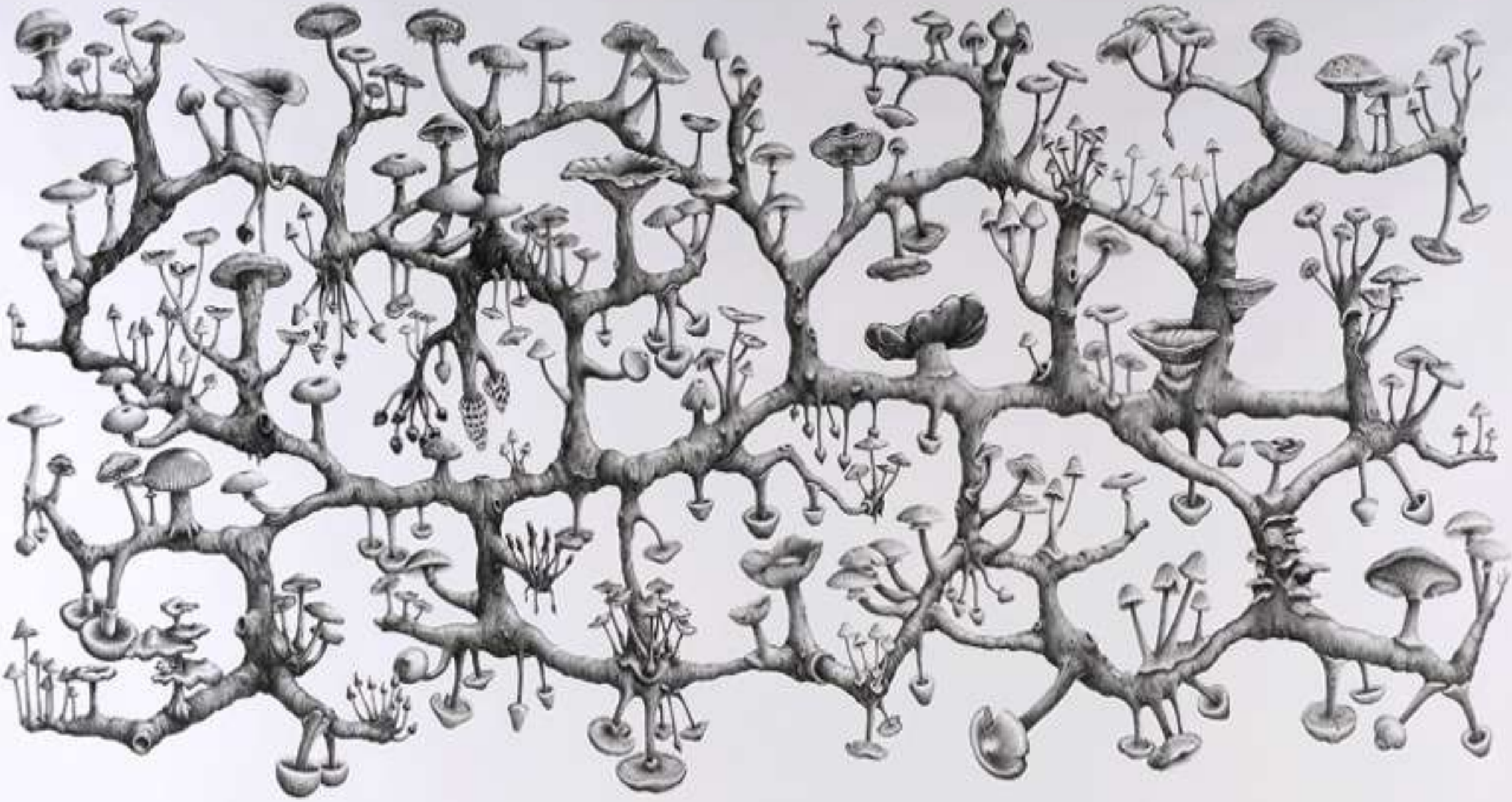








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Armillaria ostoyae - *de Sombere Honingzwam* – ***Honey Fungus***



The microbiome and the urban macrobiome



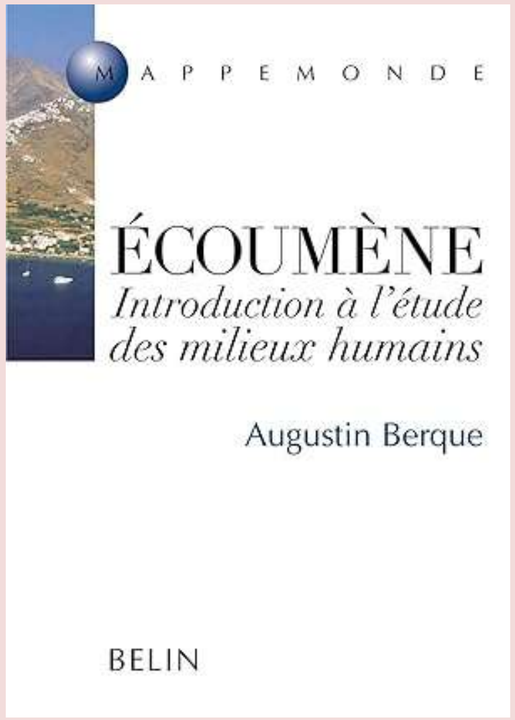
Joint Cosmologies



- Beyond nature and culture
- Ontologies, cosmologies and politics
- Animism, totemism, analogism, naturalism



Joint Cosmologies



- Beyond nature and culture
- Ontologies, cosmologies and politics
- Animism, totemism, analogism, naturalism
- ‘nature’ (‘scape’): an idea
- Augustin Berque (Japan)

landschap als zingeving

‘Concrescentie’

‘Country’

Kanien’keha:Ka
Gaawaadhi Gadudha



Zin

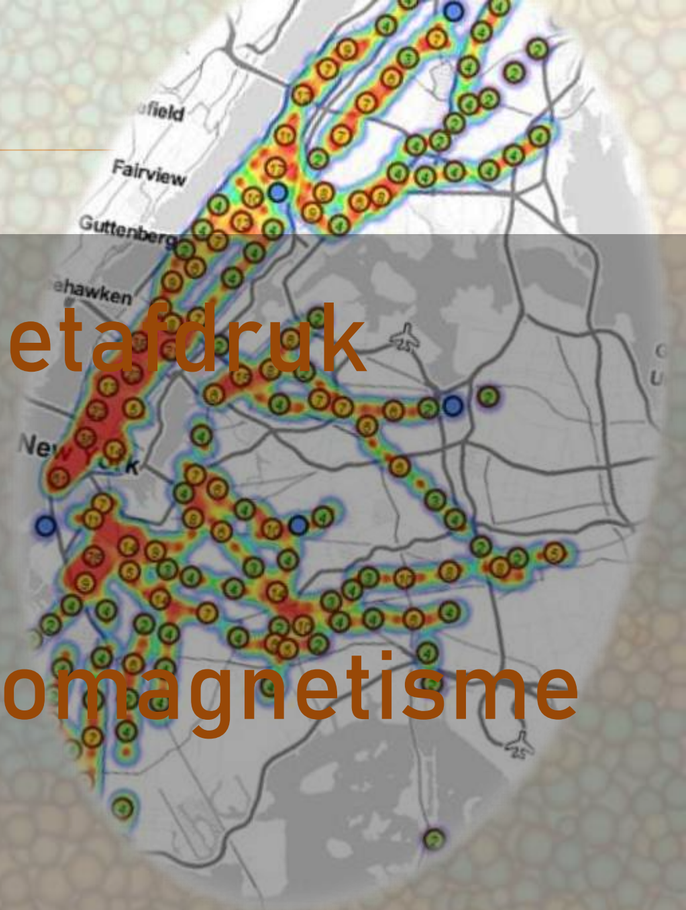
‘Zijn kunst en natuur heilzaam?’ (‘kunnen we kunst/natuur in een blikje stoppen?’)

1. Vind kunst met natuur (Helen McNicoll)
2. Laat AI de plantensoorten in het werk determineren
3. Plant een tuin met die soorten
4. Meet gedurende een jaar het electromagnetisme van die tuin
5. Laat AI die data omzetten in muziek
6. Speel de muziek voor verschillende patienten en condities
7. Meet de resultaten (*Galery, K., Djerroud, K., Chabot, J., Sekhon, H., Tannou, T., Gros, A., & Beauchet, O. (2025). Acceptability and effects on mental health of a music-based virtual reality intervention in geriatric outpatients: Results from a pilot randomized controlled trial. Frontiers in Virtual Reality, 6, 1608416*)
8. Herhaal (https://art.ageteq.ca/)

Helen McNicoll, *Sunny September*, 1913
Oil on canvas, 92 x 107.5 cm
Collection Pierre Lassonde

Zin

- Maak een 3D kaart van de stad en haar voetafdruk
- Voeg macrobioom genomics in!
- Meet patronen – mobiliteit, klimaat, electromagnetisme
- Voed dit aan een AI – LLM
- Laat AI verhalen ‘in de stijl van…’
- Luister



Helen McNicoll, *Sunny September*, 1913
Oil on canvas, 92 x 107.5 cm
Collection Pierre Lassonde

Some initial thoughts:

The Underground City, respiratory pandemics, and the unethical experiment



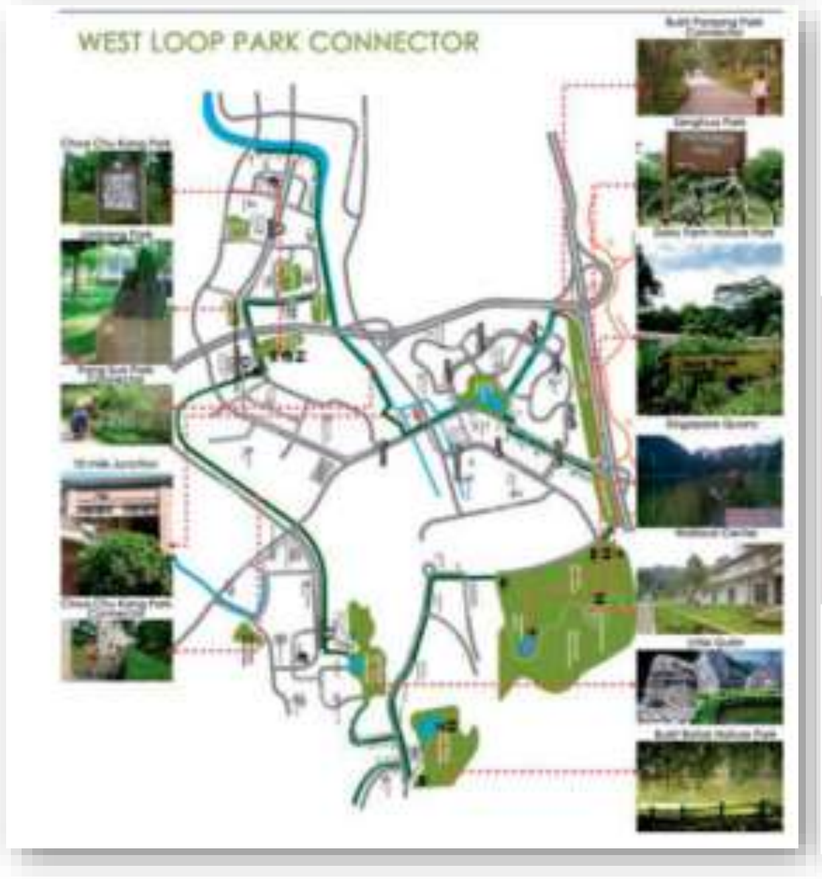


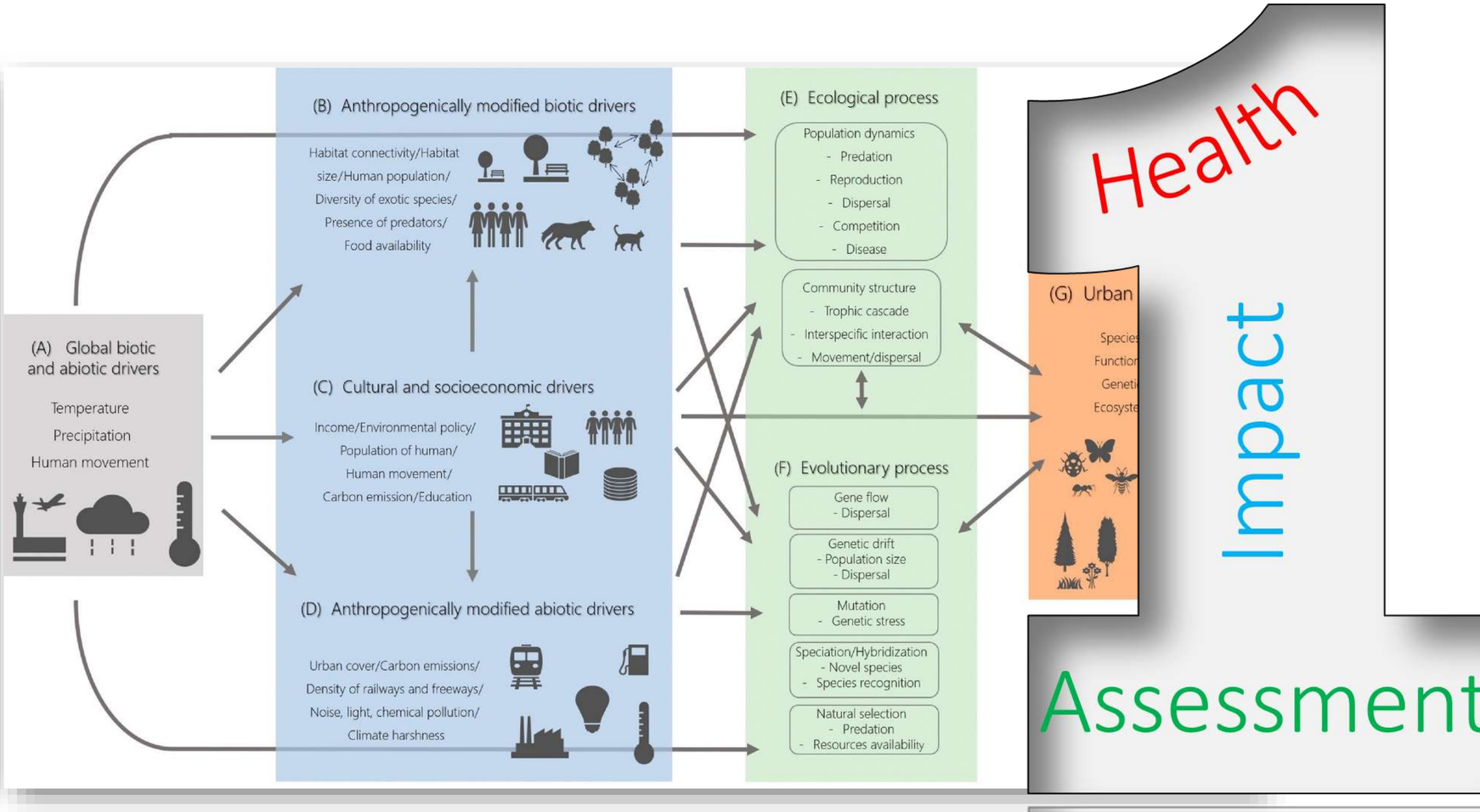




Some initial thoughts:

Green, blue health, nature-based solutions, and anthropocentrism





Uchida, K., Blakey, R. V., Burger, J. R., Cooper, D. S., Niesner, C. A., & Blumstein, D. T. (2021). Urban biodiversity and the importance of scale. *Trends in Ecology & Evolution*, *36*(2), 123-131.

Thank You

for your time
and attention

evelyne.de.leeuw@umontreal.ca

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



KEYNOTE Speaker

Susie Sykes

College of Health and Life Sciences, London South Bank University

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

iPSY

UCLouvain

Health Literacy: An Evolving Conversation for Health Promotion

Professor Susie Sykes

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

Health Literacy

"the capacity of individuals to obtain, interpret, and understand basic health information and services and the competence to use such information and services in ways which enhance health" 1

1995

"the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health" 2

1998

"Health literacy is linked to literacy and entails people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course." 3

2012

"representing the personal knowledge and competencies that accumulate through daily activities, social interactions and across generations. Personal knowledge and competencies are mediated by the organizational structures and availability of resources that enable people to access, understand, appraise, and use information and services in ways that promote and maintain good health and well-being for themselves and those around them."4

2021

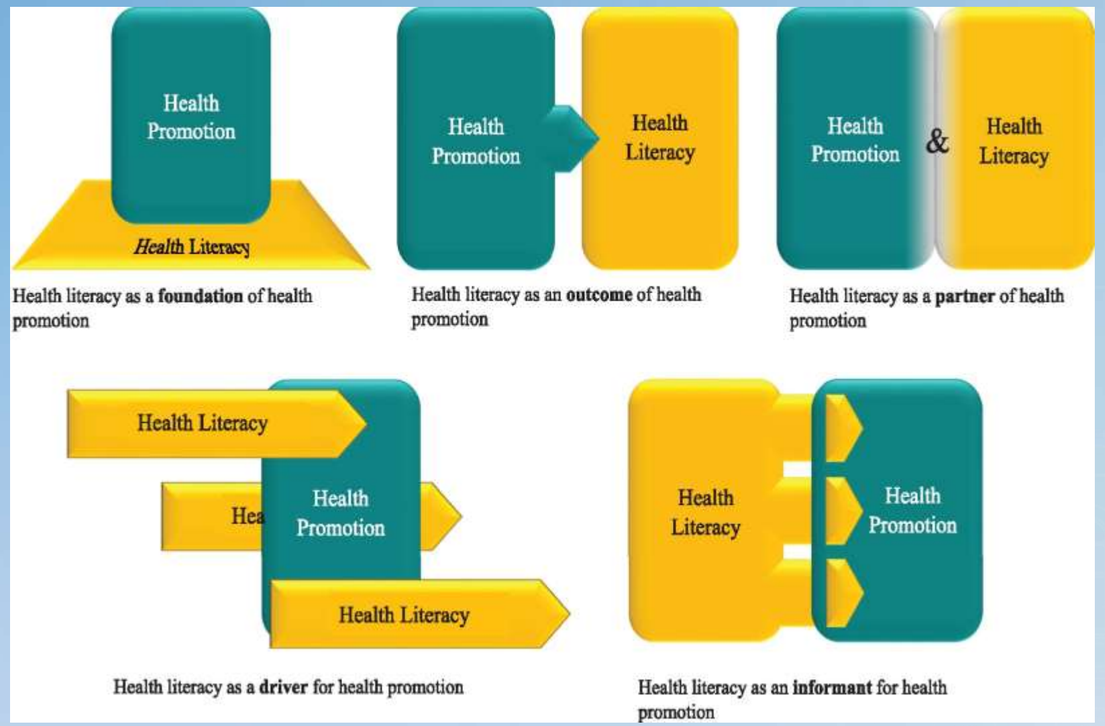
"Health literacy, as a specific literacy, encompasses any type of knowledge, attitude, practice and skill attributes that is needed for everyone to obtain, maintain and promote health in all situations during lifespan for own and others." 5

2026

Mapping the conversation.



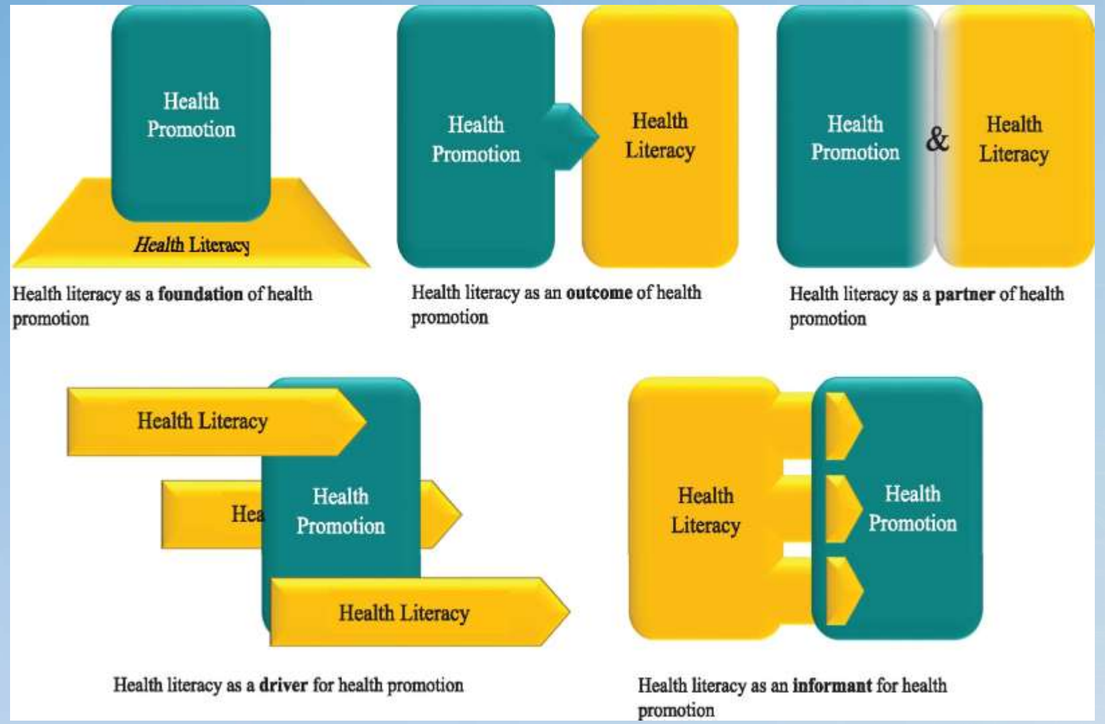
Articulating the relationship.



Gugglberger (2019)

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

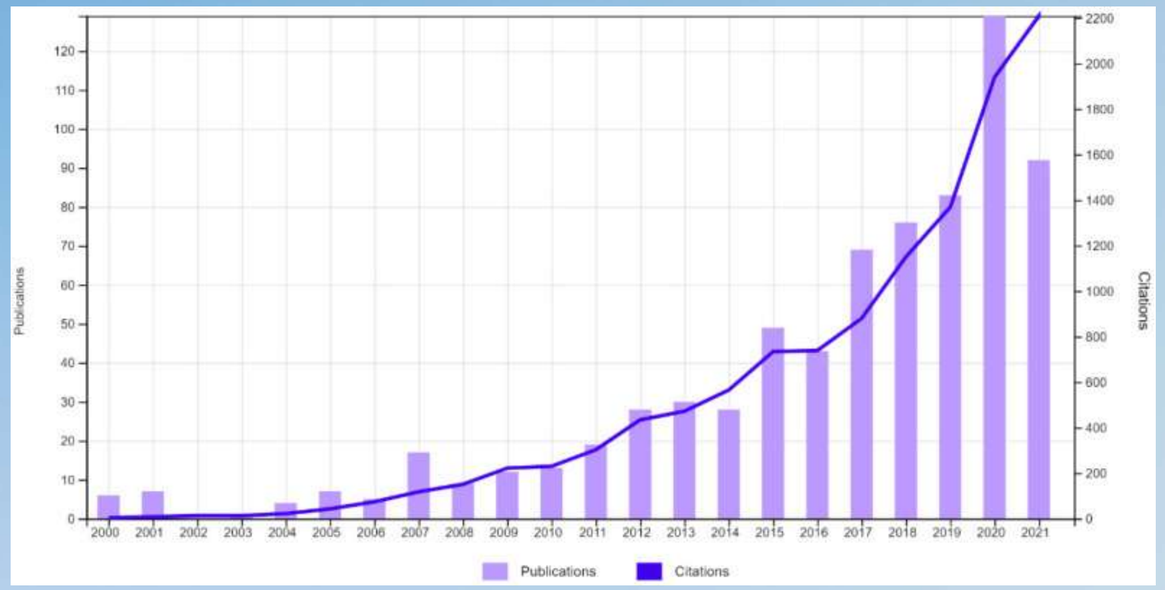
Articulating the relationship.





Gugglberger (2019)

Health Literacy



- 14,893 + publications
- Dedicated journals
- 162+ measurement tools (Tavousi et al 2022)
- 17-country international survey
- National policy and WHO policy infrastructure

7. Selva-Pareja, L., et al, (2022)

The enduring nature of health literacy

- Social movement theory?
- Measurement?

The enduring nature of health literacy

- Social movement theory?
- Measurement?

- Centering the information environment

- Centering epistemic agency

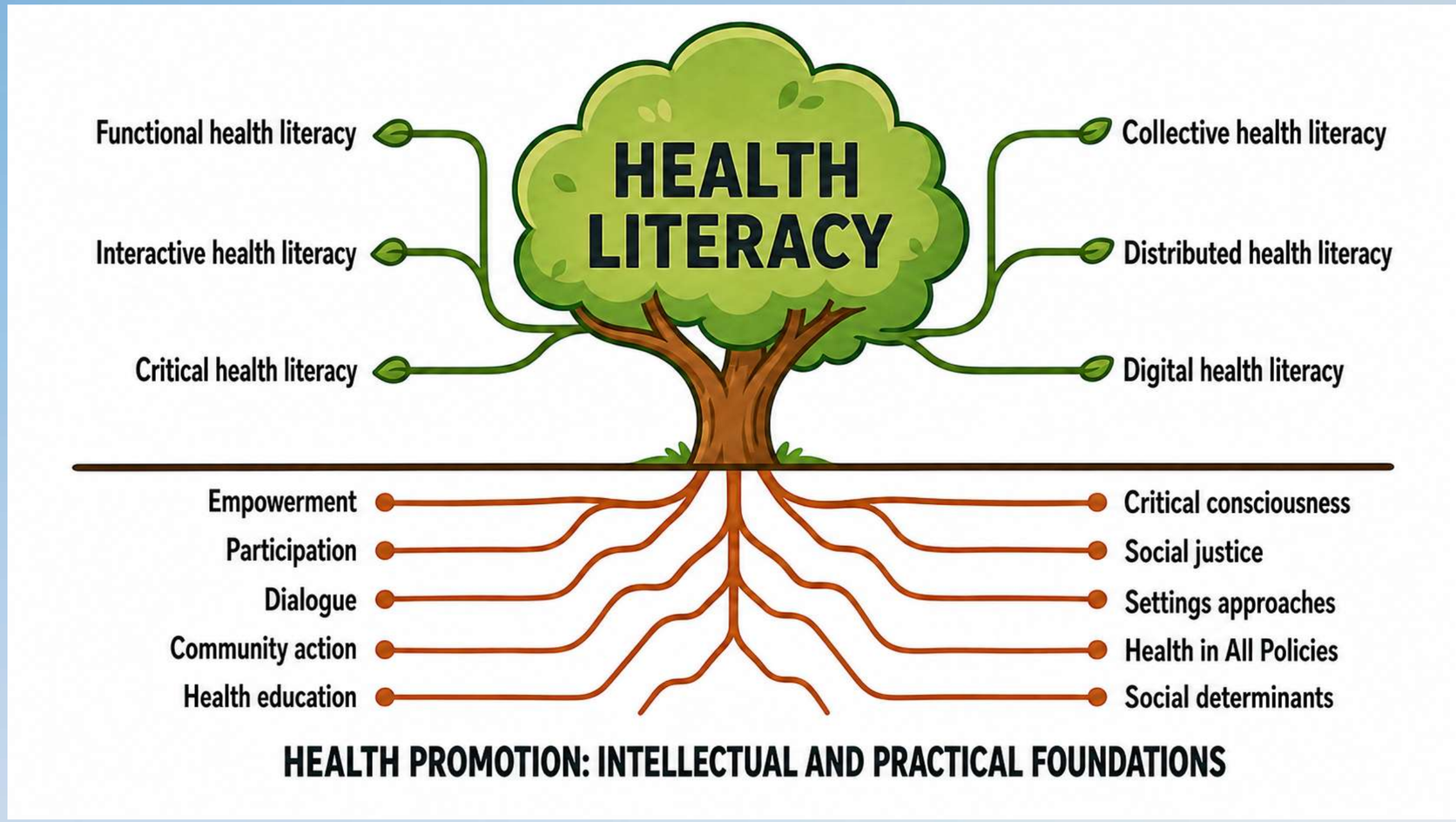
The enduring nature of health literacy

- Social movement theory?
- Measurement?

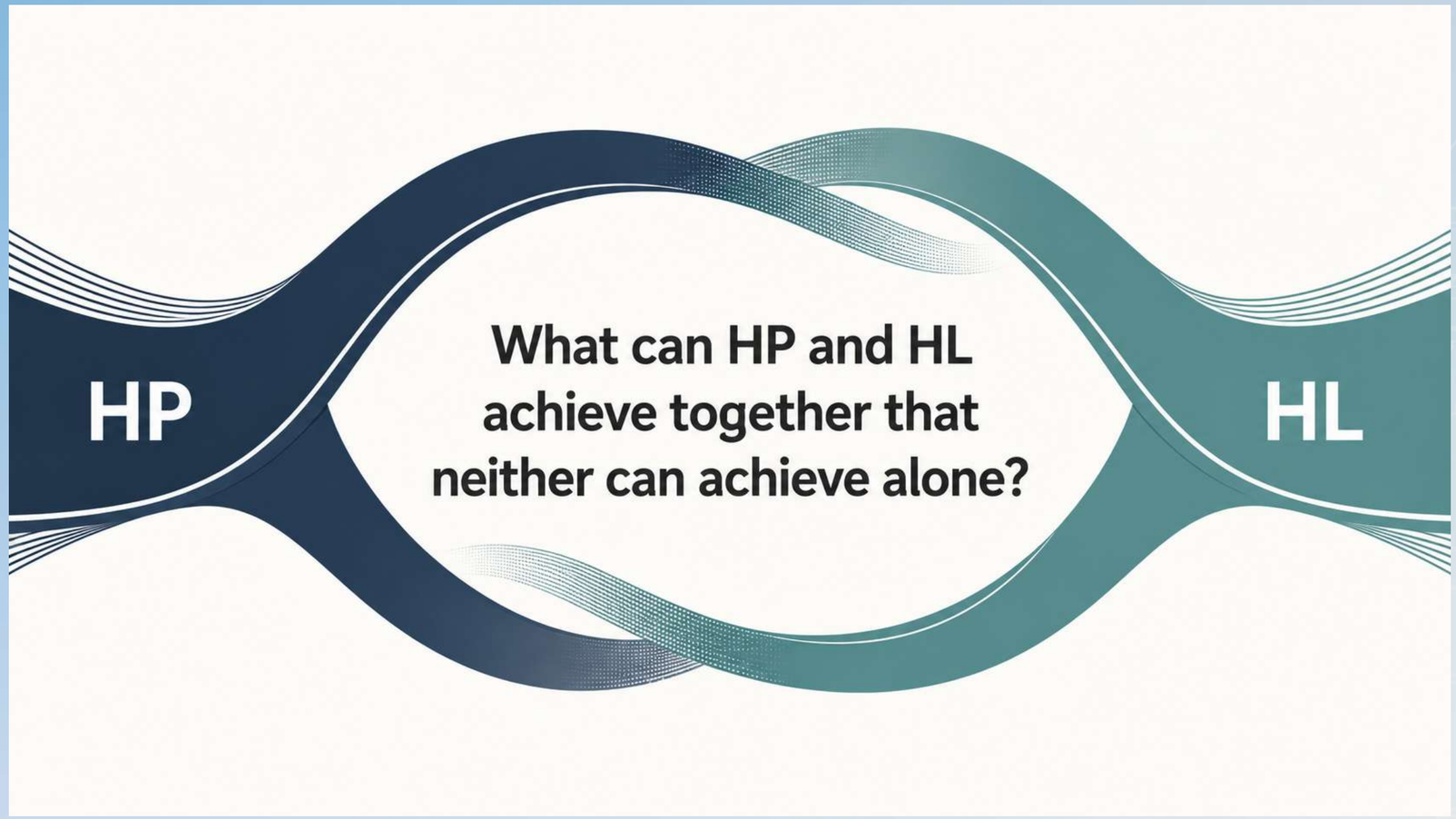
- Centering the information environment
- Centering epistemic agency

- A shared language across professions and disciplines

Remembering foundations.



Reframing the conversation.



Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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Thank You

for your time
and attention

sykess@lsbu.ac.uk

BREAK

We will be back in 15 mins

SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Closing Words

Isabelle Roskam

*IPSY Research Institute **President**, Professor - UCLouvain/PSY/IPSY*

SYMPOSIUM IN HONOR OF

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Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

IPSY

UCLouvain

Closing Words



Stefan Agrigoroaei

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Celine Jeitani

PhD candidate of Stephan Van den Broucke



SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

M-POHL

Action Network on **M**easuring **P**opulation and **O**rganizational **H**ealth **L**iteracy of WHO-Europe

A message from the M-POHL Team to Stephan van den Broucke

"Bridging Behavioural Science, Health Promotion and Health Literady to Improve Health Outcomes" Symposium, 11th September 2026

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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Closing Words



Stefan Agrigoroaei

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PhD candidate of Stephan Van den Broucke



SYMPOSIUM IN HONOR OF

Stephan Van den Broucke

Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes



Legacy Presentation by the Guest of Honor

Stephan Van den Broucke

P rofessor E meritus

UCLouvain/PSY/IPSY

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Stephan Van den Broucke

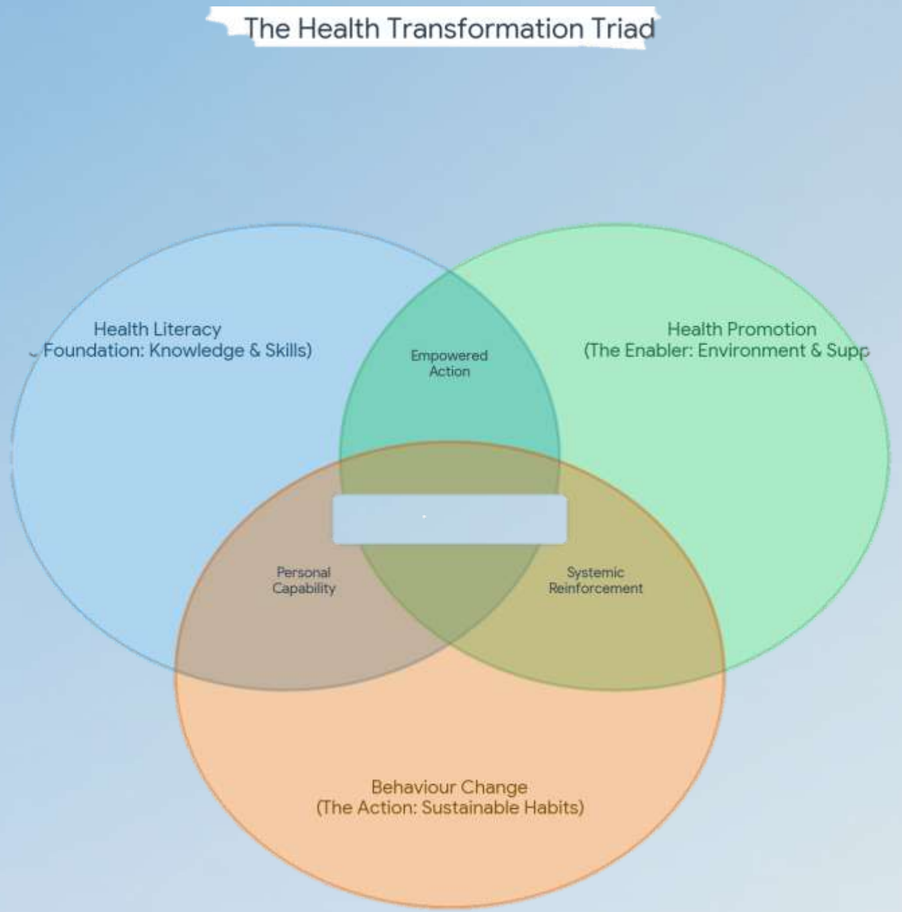
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Looking back to move forward: A critical reflection on the role of behavioural science in health promotion and health literacy

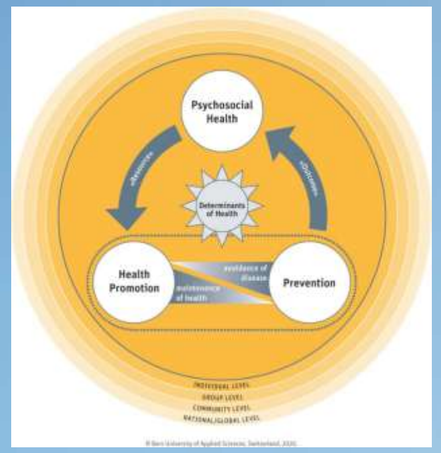
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Health promotion, health literacy and behaviour change



Health promotion and public health



- Health Promotion is firmly **rooted in public health**

  considered variably as a “part”, as a “specialised area of practice”, an “essential operation” or a “core function” of public health

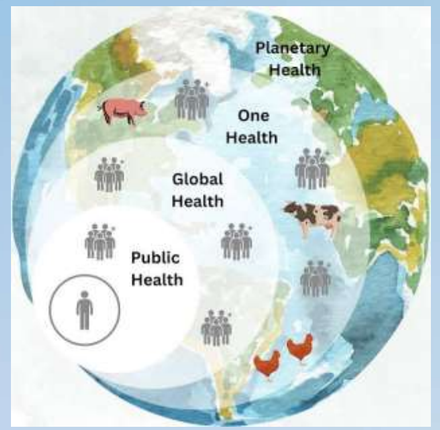
- Departure from traditional approaches to public health, due to a **unique value system**
  - launched in 1986 as a **response to specific health needs** in countries with a high standard of living
  - opposed to the **“benevolent paternalism”** that characterizes traditional public health thinking
  - much more focused on the values of **empowerment**, **equity** and **participation**
    - Inspired by a ***salutogenic*** conceptualisation of health (Antonovsky, 1996)
    - seeks to create a dynamic and ***participatory*** engagement with individuals and communities to enable them to take control of the determinants of their own health
    - revived the ***traditions of social medicine*** by paying particular attention to those who suffer from disproportionate health problems



Development of Health Promotion in the past 40 years



IUHPE
UIPES



- The **practice** of health promotion has considerably developed since the Ottawa Charter
  - expansion of the workforce
  - wide range of health promotion activities
  - proliferation of HP training programmes & course materials
  - established structures and institutions
- Health promotion is being **mainstreamed** into modern public health

firmly embedded in core competency and accreditation systems for Public Health

(e.g., Essential Public Health Operations, WHO Coalition of Partners, ASPHER's APHEA Accreditation System)

- **Paradigm changes** *within* health promotion
  - **One Health** recognizing the reciprocal feedback between human and animal health in shared ecosystems
  - **Planetary Health** emphasizing the interconnection between human civilization and the natural systems that support it

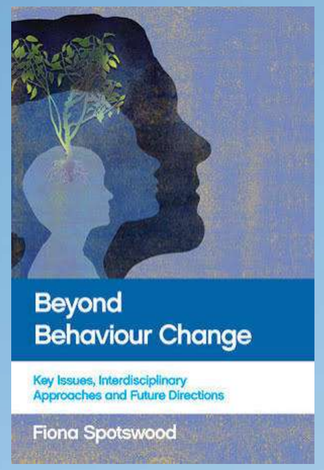
The place of Behavioural Science in Health Promotion





- Health promotion as a key component of public health is rooted in the **recognition of lifestyle factors** as leading causes of the burden of disease in contemporary society
  - Recognition that changing people's behaviour requires **more than "just informing** them of risks"
  - Theoretical **models** such as *Health Belief Model*, *Protection Motivation Theory* or *Theory of Planned Behaviour* highlight the importance of
    - anticipated outcomes of behaviors and their probability
    - perceived severity of outcomes
    - perceived effectiveness of preventive actions
    - perceived control / self-effectiveness
    - perceived norms
    - compensatory beliefs
    - …

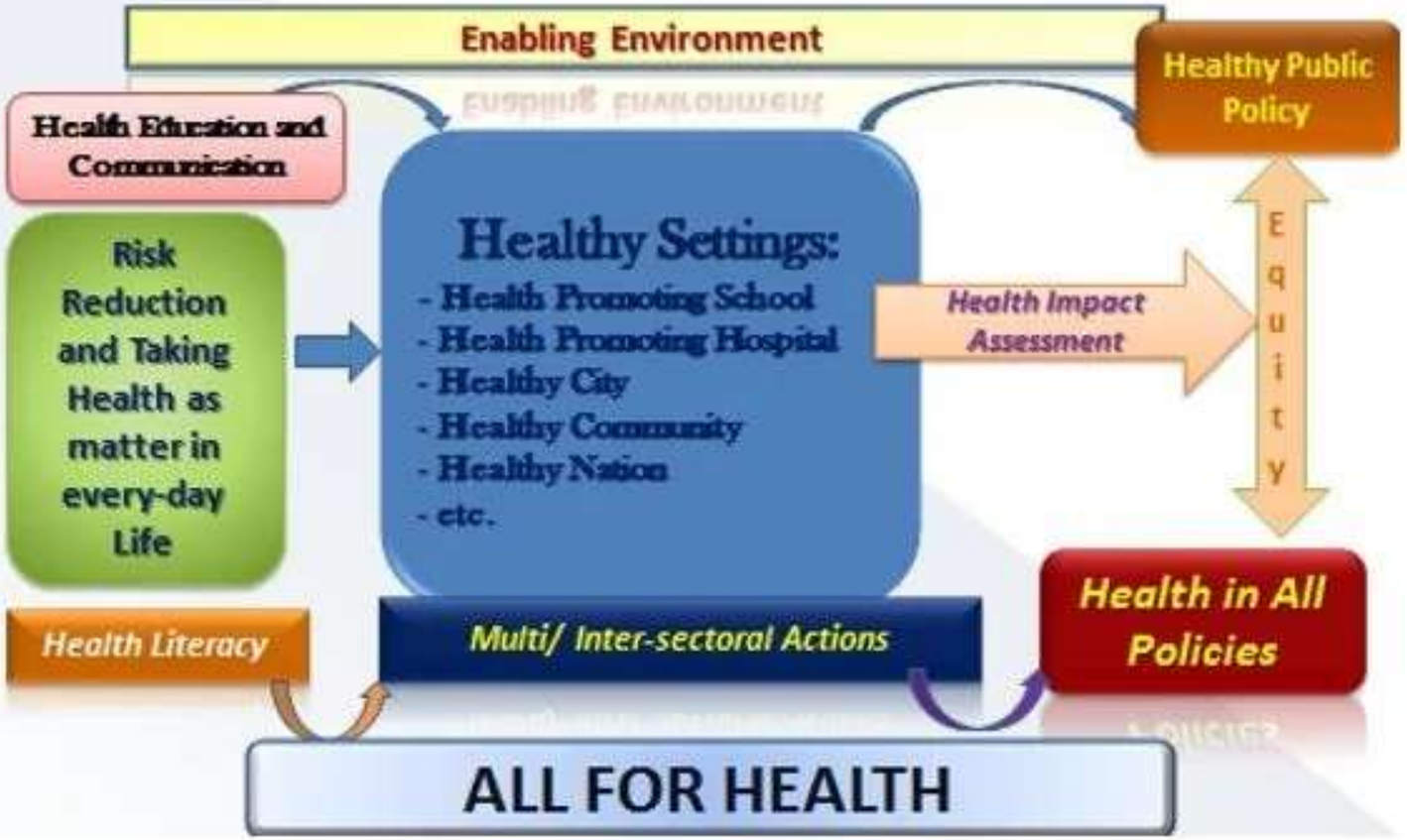
Beyond individual behaviour change





- Health promotion has **distanced** itself from a narrow focus on **individual behaviour** change
  - Broadened the scope from educating individuals to addressing the **environmental, social** and **political** factors that determine health
  - A narrow focus on health behaviour criticised for
    - not sufficiently accounting for the role of the **social and cultural context**
    - not sufficiently **empowering** people and thereby increases health inequalities
- **Epistemological reduction**
  - "**Behavioural intervention**" is often considered a synonym for information delivery, public education, or communication campaigns
  - **Behavioural expertise** is brought in at the tail end of projects simply to refine slogans or design brochures

Framework for Health Promotion Actions



"Health for All & All for Health"

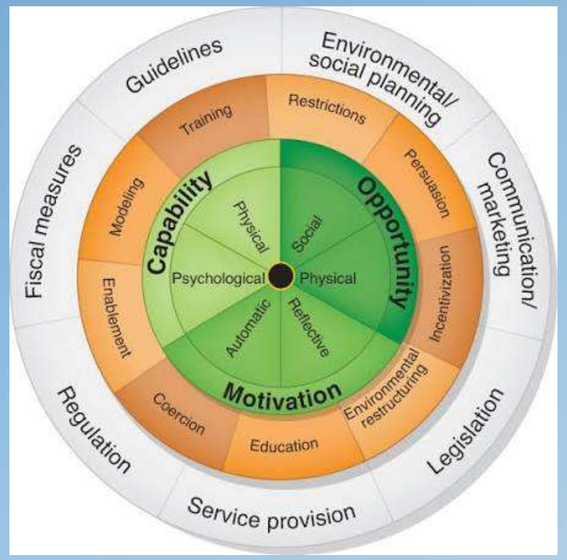


Dismissal of behaviour change ?

- Why health promotion should not abandon behavioural science
  - Behavior remains a critical determinant of health
    - Social determinants **do not have a direct effect** on health, but moderate the exposure to conditions that do have an effect, including lifestyle
    - Behavioural science helps to identify the ***emotional, cognitive*** and ***interpersonal factors*** that mediate or moderate the interactions between the social and environmental context and poor or good health
  - Abandoning the concept of behaviour change would imply missing out on new developments and insights from behavioral research
    - Refined models of health behaviour deriving from the expectancy-value paradigm
    - Notions and techniques that help bridge the gap between intentions and behaviour (like **goal achievement planning** or **nudging**)
  - Behavior change principles can also be used to achieve structural change when applied to influencing decisions 'midstream' or 'upstream' interventions

Van Den Broucke (2014). Health Promotion International, 29(4), 597-600.

Integrating behaviour change in a comprehensive approach to promoting health



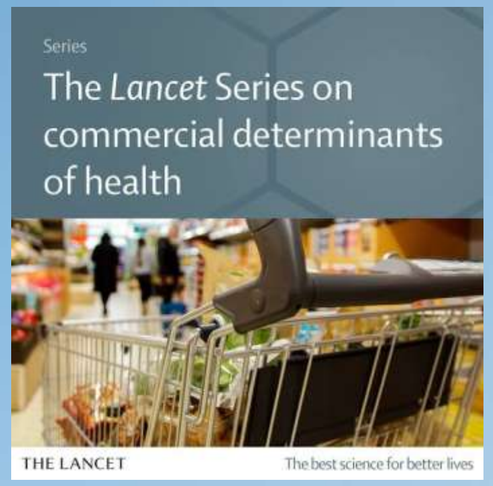


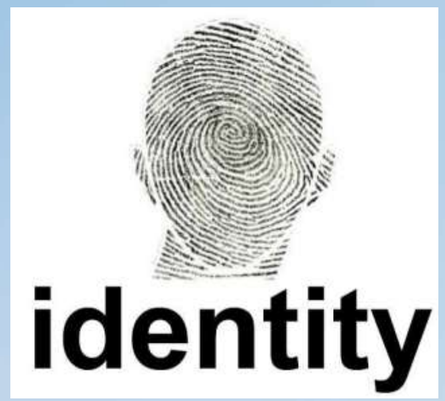
- Address the **information-giving fallacy**
  - Behaviour is an interaction of **capability**, **opportunity**, and **motivation** (Michie et al., 2011)

    > Health information campaigns only target reflective motivation and psychological capability, while ignoring physical and social opportunities and automatic motivation

  - Structural poverty, climate anxiety, and socio-economic stress **deplete the mental bandwidth** that is required to process complex health data
- Understand **how information processing works** in the age of social media and AI
  - ***Flattening of authority***: Social media feeds place evidence based institutionally endorsed info (e.g., from Health Ministries or WHO) alongside unverified peer anecdotes in the same visual hierarchy.
  - ***Algorithmic bias toward arousal***: AI models elevate emotionally charged health misinformation because it drives platform engagement
  - ***Cognitive "choke points"****:* Hyper-saturation of data drives individuals to bypass rational (system 2) information processing, and rely on system 1 "shortcuts"

Integrating behaviour change in a comprehensive approach to promoting health





- Address the commercial ecosystem and choice architecture
  - Commercial actors structure the **choice environments** to make unhealthy consumption the default, lowest-friction choice
  - Corporate actors **use precise behavioral insights** to encourage overconsumption, while public health counter-measures often rely on simple informational warning
  - Micro-targeting digital ads based on data analytics **exploit individual emotional vulnerabilities** and **cognitive biases**
- Acknowledge the role of Social Identity
  - ***Belief as identity:*** Health and environmental behaviors (e.g., vaccine uptake, dietary choices, energy consumption) are used as markers of group belonging
  - ***"Tribal" verification:*** Citizens evaluate new health recommendations based on whether they align with their social group's values, rather than their objective scientific merit.
  - ***In-group social proof:*** Micro-influencers and peers replace traditional centralized institutional figures as trusted sources of safety validation

An expanded psychological toolkit for Health Promotion





- **“Behavioural insights”**: rebooting the contribution of behavioural science as a driver of systemic health policy making
- Requires input from
  - **Cognitive Psychology**: Design information systems that fit human memory constraints and mental models
    - **Identify non-scientific intuitive concepts** held by the population regarding health risks and systemic trust.
    - Train citizens to **recognize common logical fallacies** and manipulation techniques before they encounter health misinformation
  - **Motivational Psychology**:
    - Move away from fear tactics
    - Design public health interventions that support autonomy (choice), competence (capability), and relatedness (connection)
  - **Social Psychology**: Utilize peer dynamics, social proof, and collective efficacy
    - Frame public health to complement, rather than conflict with, an individual's core social group values
    - Partner with trusted local voices and peer networks
  - **Environmental Psychology**: Adjust choice architecture to create healthy defaults in everyday settings

Can Behavioural Insights help to address Planetary Health?



- Traditional Health Promotion approach
  - Educational focus
    - Provide nutritional and carbon-footprint information via media campaigns, leaflets, ...
    - Putting eco-labels on food packaging
    - very little long-term impact on actual consumption habits
  - Standard structural focus:
    - Directing agricultural subsidies toward plant-based production or restricting high-emission food items
    - Effective, but consumers often reject the food, leading to waste or driving them to buy less sustainable options outside institutional settings

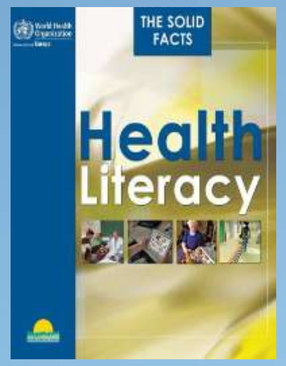


- Integrated behavioral approach

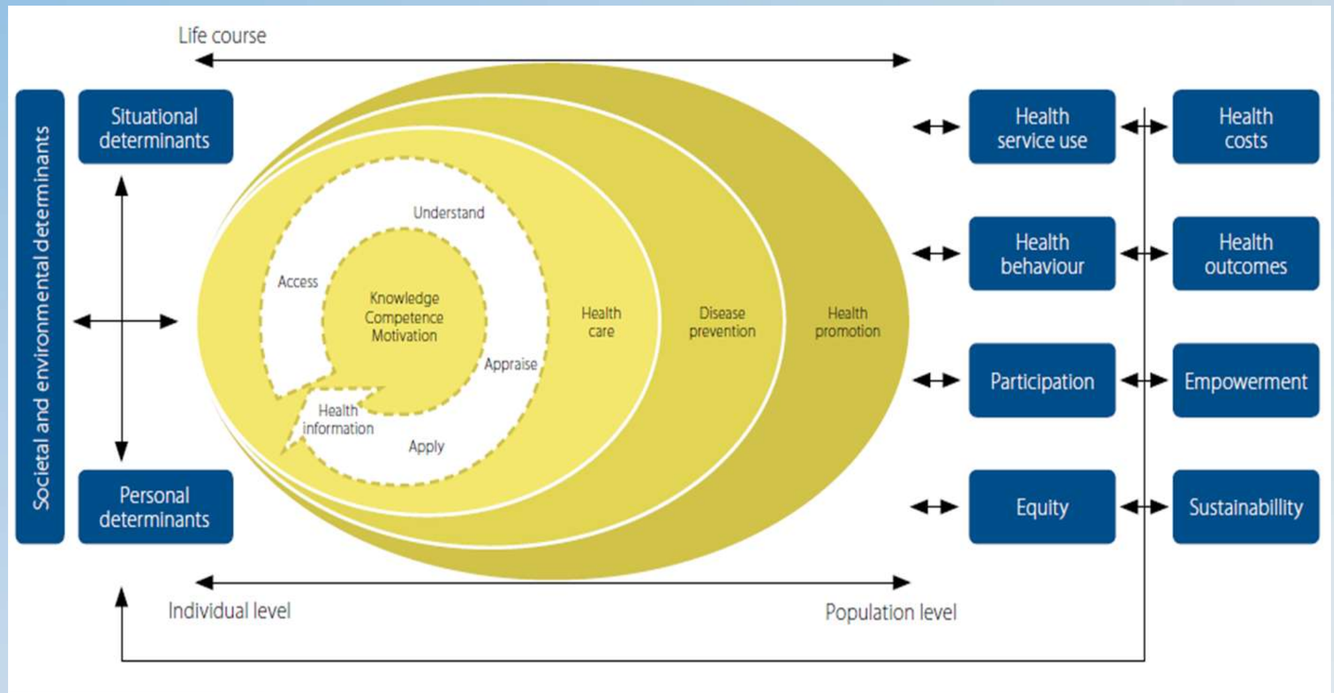
  uses behavioural economics to encourage eco-friendly habits and support policies that protect human and environmental health

  - **Social norms:** People often copy what others do; highlighting positive community actions increases public participation
  - **Identity-consistent framing:** Connecting environmental protection directly to personal and family health makes the abstract crisis feel urgent and relevant
  - **Self-efficacy:** Giving people clear, manageable steps boosts their confidence that individual actions actually matter
  - **Choice architecture:** Small, low-cost "nudges" (like default green energy options or plant-based canteen menus) make sustainable choices the easiest default

What about Health Literacy?



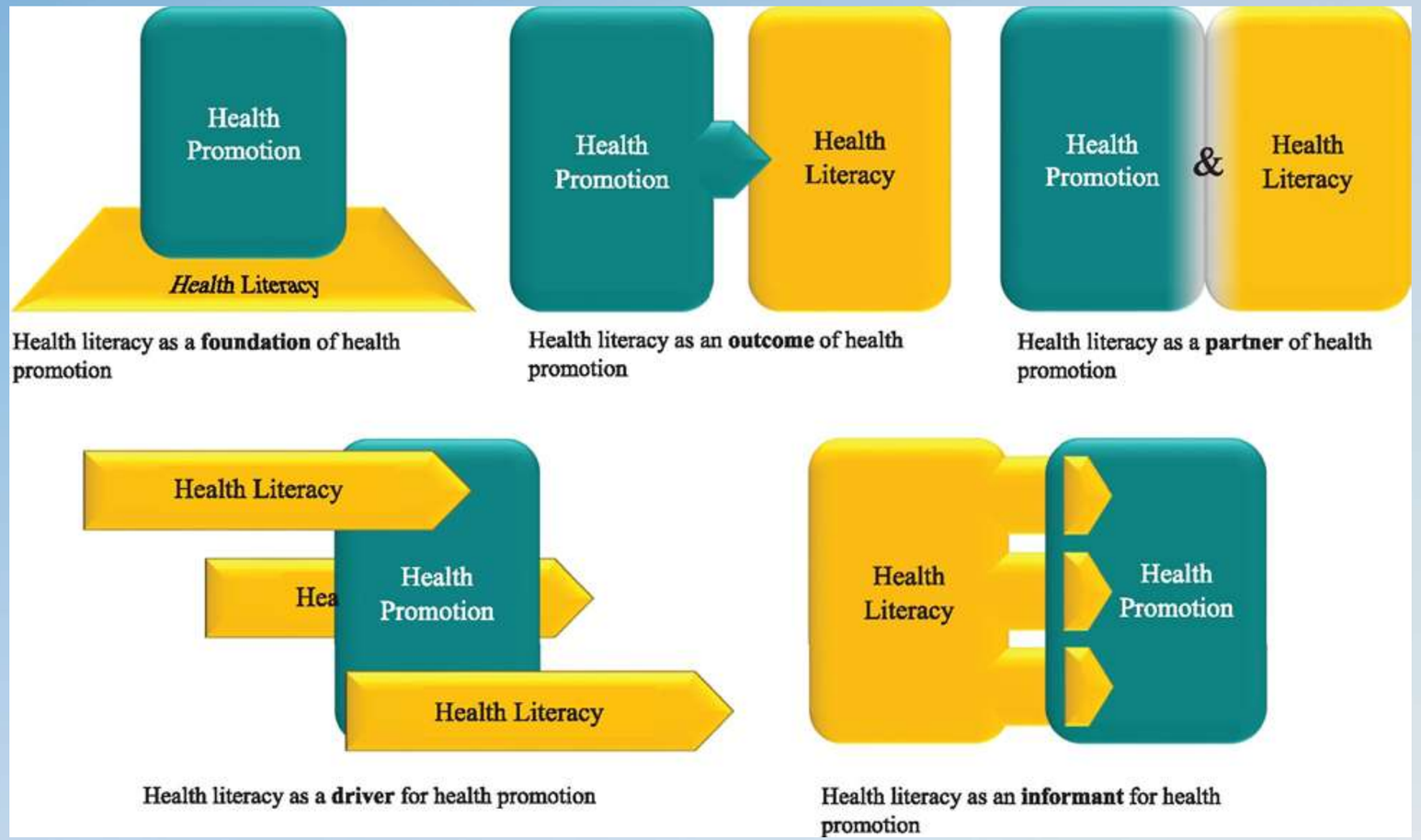
« A person's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course»



Sørensen, Van den Broucke, et al. (2012). BMC Public Health, 12(1), 80.

Health promotion and health literacy

Health promotion and health literacy have a multifaceted relationship



Gugglberger (2019). Health Promotion International, 34(5), 887-891.

Main criticism: Does HL shift the responsibility back to the patient or citizen?





Editorial

Why is health literacy failing so many?

Health literacy is vital to good health and wellbeing. It is fundamental to achieving the Sustainable Development Goals by 2030 and is a crucial tool to deliver universal health coverage. People need to know how to prevent disease and navigate health-care systems to ensure good health outcomes. However, many are not able to make healthy choices, even in countries with the strongest health systems. Why is this? Traditionally, health literacy has focused on an individual's ability to access, understand, appraise, and use information to maintain good health. Of course, such knowledge is important. But this approach neglects the societal and structural forces that shape our choices. In many parts of the world, health decisions occur within the family. The health of communities is often dictated by social and environmental factors outside the control of individuals. Research progress in these areas has been slow, and many health interventions still leave people behind. The result has been a health failure.

However, change is beginning to happen. Health literacy was recognised as a critical determinant of health in the WHO Shanghai Declaration in 2016, and has been recast as a collective practice of a community working to enable and build knowledge, rather than placing responsibility on the individual. A new WHO report on health literacy, published on Nov 6, advances this approach for non-communicable diseases, but its lessons apply across health care. The report calls for co-designed approaches, whereby the voices of users and of those who deliver interventions are incorporated into the design of the services. To deliver these services and make the health-care system more user friendly and accessible, front-line health and social workers must be better trained to engage and interact with the populations they serve. The report also calls for an integrative approach to develop health literacy interventions that involve a range of community-based organisations—not just medical centres—including schools, churches, sports groups, and workplaces. For example, health literacy programmes should be introduced in childhood and should be part of school curriculums. They should be designed and adapted to the needs of individual communities, through the involvement of local students and teachers. Ensuring health literacy must be a whole-of-society endeavour—at the individual, community, and national level—and work across sectors, not just health.

This approach is right, but the WHO report glosses over fundamental challenges to this vision of health literacy; in particular, the commercial determinants of health—ie, the corporate influence on health behaviours. The private sector sets research agendas, shapes narratives, and markets its products in ways that compromise health literacy, not only by misleading individuals, but also by fostering unhealthy communities and societies. The most egregious examples come from the manufacturers of tobacco, alcohol, and junk food. Over the past five decades, the tobacco industry has actively given false information and used its power to increase profits, regardless of the consequences to health. Health-care stakeholders have often struggled to amplify their voices over the messages of the private sector. Alongside this challenge is the rise of misinformation, particularly on social media. False information, spread regardless of the intent to mislead, can leave people in a state of epistemic helplessness. Even the most rational individual cannot make sensible, healthy decisions when bombarded with incorrect information. How can people, families, and communities know which sources of information to trust amid contradictory advice? How can WHO and other health stakeholders ensure that their information is the source that is amplified and used? How can health literacy be achieved in a world awash with false and misleading information?

We urgently need effective responses to these questions. Every person has a right to health. The ability to realise that right depends on everyone understanding their health, being able and empowered to make healthy choices, and being able to access effective interventions. Without understanding the ways that neglected communities learn, more people will be left behind. Most importantly, policy makers need to understand health literacy and how their decisions will impact different populations. A whole-of-society approach to health literacy is needed to remedy these issues. But it will be doomed to failure if it does not account for and address the fundamental drivers of what shapes our understanding of health and what makes our societies unhealthy in the first place—not least, the commercial determinants of health. ■ The Lancet

- Criticism of HL theory and practice
  - The concept and the way it is implemented represents an **individualistic, reductionist** approach
  - Neglects the broader **structural factors** that are important to address pressing public health concerns

    e.g., social inequities, commercial determinants of health
- Is this criticism legitimate?
  - ***Yes***, given the focus on functional health literacy that dominates much of the current HL practices

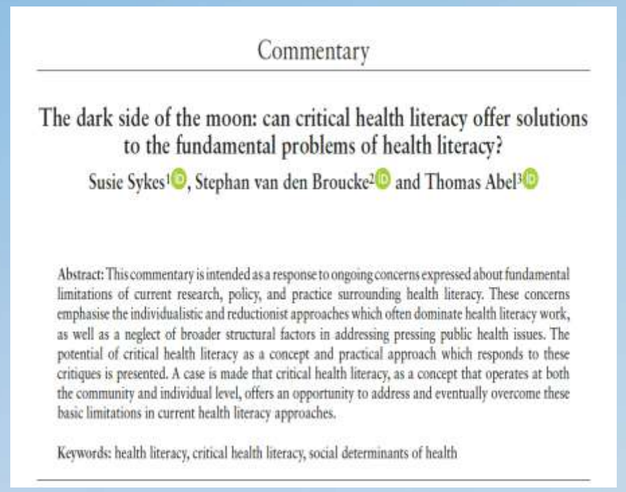
    Prioritises individual competencies to obtain, process and understand health information
  - ***No***, when HL is understood as a relational concept in which individually held competencies are mediated by the organizational structures

    e.g., *Organisational* and *Systems* Health Literacy

Addressing the Upstream Determinants of Health

- Root causes of health and health inequities are *upstream*
  - Managing health in an increasingly complex society implies making critical decisions

    e.g., choosing a health insurance, exert patient rights, make food choices in profit-driven markets, link health decisions to sustainability and climate change, …
  - Individuals (patients and citizens) need competencies to deal with challenges that **go beyond individual health choices**



Commentary

The dark side of the moon: can critical health literacy offer solutions to the fundamental problems of health literacy?

Susie Sykes[1], Stephan van den Broucke[2] and Thomas Abel[3]

Abstract: This commentary is intended as a response to ongoing concerns expressed about fundamental limitations of current research, policy, and practice surrounding health literacy. These concerns emphasise the individualistic and reductionist approaches which often dominate health literacy work, as well as a neglect of broader structural factors in addressing pressing public health issues. The potential of critical health literacy as a concept and practical approach which responds to these critiques is presented. A case is made that critical health literacy, as a concept that operates at both the community and individual level, offers an opportunity to address and eventually overcome these basic limitations in current health literacy approaches.

Keywords: health literacy, critical health literacy, social determinants of health

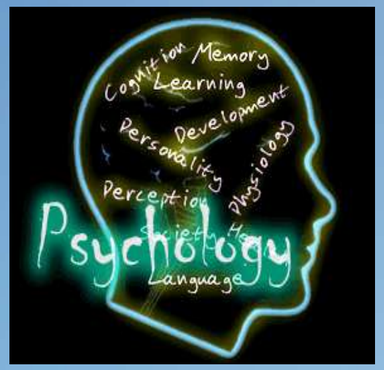
Sykes, Van den Broucke & Abel (2025) *Global Health Promotion*, 32 (3), 108-110.

- The notion of *critical health literacy*
  - Focuses on the competencies that are needed to recognise, reflect and act on the **social conditions and determinants** of health
  - Incorporates **critical reflection** on all factors and actors that are involved in the production and distribution of health
  - Involves a **commitment** to social justice and political action for change
  - Has the potential to align with **relational frameworks of HL** such as organisational and systemic health literacy



Why does health literacy influence health outcomes?

- The processes of finding, understanding, appraising and acting on health information are not well understood
- The causal pathways that link low HL to health behaviour and health outcomes are not clearly mapped out
  - some underlying psychological mechanisms and processes have been suggested
  - very little empirical research exists to date to support these mechanisms
    - only a handful of studies have directly investigated the mediating effects of social cognitive variables on the relationship between HL and health behaviors and outcomes
    - most of them focusing on a single mediator



Psychological processes underlying Health Literacy

- Cognitive processes
  - information processing

    study of the way in which information is acquired, represented, stored in memory and retrieved
  - risk assessment
  - decision making
- Motivational processes
  - expectancies and attitudes
  - social learning (observational learning, perceived norms, …)
  - perceived competence
  - metacognition and self-determination
- Emotional processes

Apply to

→ Accessing (health) information



Understanding information



→ Evaluating (appraising) information



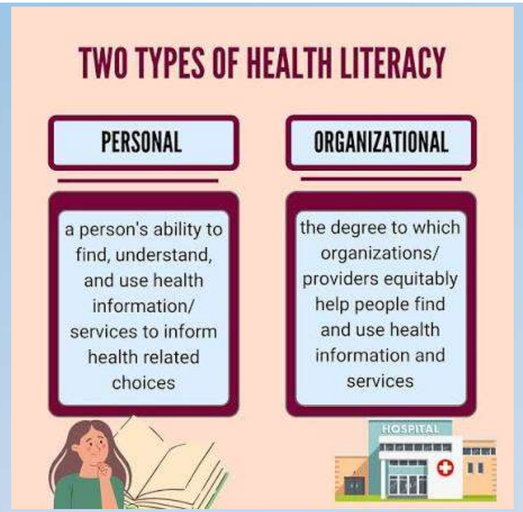
Applying (using) health information



→

Behavioural science applied to Organisational Health Literacy





- **Traditional** approach
  - Information focus

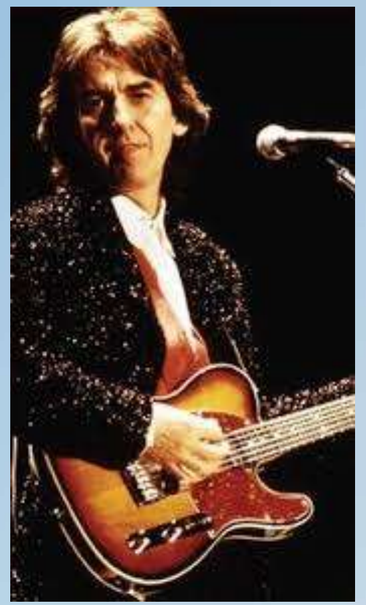
    Text simplification: rewrite patient intake documents, consent forms, and medical discharge leaflets into plain language
  - Standard structural focus:
    - **Reduce barriers**: Develop digital patient portals, put up better signs in clinics, …
    - **Caveat**: when patient are anxious, they suffer from cognitive overload, making it difficult to navigate these tools
- **Integrated** behavioral approach
  - Transform how health systems and workplaces empower people to find, understand, and use health information
    - **Beyond the individual**: move responsibility away from just the patient or employee, making the environment itself health-literate
    - Audit administrative processes to **eliminate repetitive forms**, protecting the patient's mental bandwidth.
    - Apply **behavioral design** to patient portals, using clear behavioral nudges in digital tools
    - **Train staff in communication** that builds patient confidence and autonomy



- While health promotion has distanced itself from a narrow focus on individual behaviour change to address the environmental, social and political factors that determine health, it should not abandon behavioural science altogether
- Behaviour change principles can be integrated in a comprehensive approach to promoting health, incorporating insights from cognitive, social and environmental psychology to achieve structural change at 'midstream' and 'upstream' level
- As a concept closely linked to health promotion, health literacy should not be reduced to individual, functional skills, yet understood as a relational concept in which individually held competencies are mediated by the organizational structures
- Psychological theory can help to unravel the role of cognitive motivational, social and emotional processes that define health literacy and their impact on health outcomes

“It's all in the mind.”

— George Harrison



Bridging Behavioural Science, Health Promotion and Health Literacy to Improve Health Outcomes

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LET'S CELEBRATE !

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