Exchange Auditorium

11:00

Global Health: Emergency Humanitarian Assistance	
Session title	Emergency Humanitarian Assistance - Policy and Practice
Chair	Professor Bertrand Taithe

Dr Joanna Macrae, Department for International Development, UK

Bringing evidence into humanitarian practice

No abstract available

Exchange Auditorium

11:00

Global Health: Emergency Humanitarian Assistance	
Session title	Emergency Humanitarian Assistance - Policy and Practice
Chair	Professor Bertrand Taithe

Professor Tony Redmond, Professor of International Emergency Medicine, University of Manchester, UK

The professionalisation of the humanitarian space

No abstract available

Exchange Auditorium

11:00

Global Health: Emergency Humanitarian Assistance	
Session title	Emergency Humanitarian Assistance - Policy and Practice
Chair	Professor Bertrand Taithe

Dr Rony Brauman, Fondation Medecins Sans Frontieres, France

Emergency Humanitarian Assistance: Response or resilience?

No abstract available

Exchange Auditorium

11:00

Global Health: Emergency Humanitarian Assistance	
Session title	Emergency Humanitarian Assistance - Policy and Practice
Chair	Professor Bertrand Taithe

Ben Dempsey, Lead for Knowledge and Evidence, Humanitarian Leadership Academy, Save the Children

Whose humanitarianism counts? How localised humanitarianisms can shape future action

No abstract available

Thursday 6th March

Exchange Auditorium

14:00

Global Health: Emergency Humanitarian Assistance	
Session title	Planning and delivering health in humanitarian settings
Chair	Professor Tony Redmond

Mr David Nott, Consultant General and Vascular Surgeon at Imperial College Healthcare NHS Trust, UK

Surgical training for the austere environment

The surgical training in the austere environment is a course which is been set up and is running at the Royal College of surgeons of England for surgeons to be trained in all aspects of conflict and catastrophe which they may encounter on missions to areas of disaster such as earthquakes, tsunamis and areas of conflict. It is very much a hands-on course which demonstrates all the techniques required to manage patients with traumatic injuries in environments that are basic and without significant backup. The course is part of the training programme for the UK International Emergency Trauma Register (UKIETR) and also for other surgeons wishing to work with NGOs.

Exchange Auditorium

14:00

Global Health: Emergency Humanitarian Assistance	
Session title	Planning and delivering health in humanitarian settings
Chair	Professor Tony Redmond

Dr Amy Hughes, Clinical Lecturer in Emergency Response, University of Manchester, UK

The UKIETR response to Typhoon Haiyan, the Philippines

Typhoon Haiyan (aka Yolanda) was recorded as a Category 5 disaster by the United Nations, causing extensive destruction and casualties throughout its path on Friday 8th November. Contributing to the devastation was an associated storm surge that particularly affected the many remote islands off the northern tip of Cebu and the North West of Tacloban.

The death toll still remains uncertain, varying from an initial announcement that it was as high as 10,000 to current estimates of around 5-6000. Fatalities were particularly high in Tacloban. A significant feature was injuries caused by flying debris, including penetrating wounds, lacerations, and contusions with subsequent wound infection caused by delayed or absent treatment. There were also concerns about diarrhoeal disease secondary to contaminated water sources and poor sanitation. There followed an extensive international humanitarian response. The scale and complexity of the disaster created predictable logistical difficulties both within country and for international assistance, with particular difficulties in accessing and therefore delivering assistance to the smaller and more remote islands. On the 11th November, due to the scale of the emergency and its impact, the Philippine government formally welcomed international assistance to support its disaster response. In addition to the need for structural repair, there were requests for assistance with restoration of water and sanitation, agriculture, disease outbreak surveillance and support for the delivery of emergency health care. In response, The Department for International Development drew down from the UK International Emergency Trauma Register (UKIETR) to deploy a medical/surgical team with logistical in-country support from Save the Children/Merlin.

The UKIETR is a register of health professionals from which teams of specialist clinicians can be deployed all of whom are trained, governed, accountable and clinically competent to specifically meet the health needs, understand the humanitarian environment and as a result deliver high standards of clinical care in a country affected by a sudden-onset disaster, and help strengthen the international humanitarian response. The UKIETR is supported by The Department for International Development and hosted logistically by nongovernment organisations Save the Children/ Merlin.

Exchange Auditorium

14:00

Global Health: Emergency Humanitarian Assistance	
Session title	Planning and delivering health in humanitarian settings
Chair	Professor Tony Redmond

Dr Anisa Jafar, University of Manchester, UK

Co-authors: Fiona Lecky, Tony Redmond

Review of medical record-keeping by Foreign Medical Teams in Humanitarian crises delivers papers by home medical teams

Objectives: There is currently a global drive to create a universal medical record for use in disaster settings. In order to achieve this we need to understand what already happens and why. We sought to find out how and what medical records have been used by foreign medical teams during their response to humanitarian crises.

Methods: A systematic review of the literature was performed using synonyms of the AND-linked terms "humanitarian crisis", "medical record" and "foreign medical team". Databases searched included: Scopus, Web of Knowledge, PsychINFO, HMIC, Medline, EMBASE, Proquest, ASSIA, CINAHL and the FADE library.

Results: The results almost overwhelmingly demonstrated work published by local medical teams rather than foreign medical teams. A high proportion of papers were contributed by US, Japanese, Chinese and Turkish teams. In most cases where medical records were referred to, an "ad hoc" method was adopted and the fate of these records was often unclear. Some attempts at creating regional or national universal reporting have been documented.

Conclusion: Although the global focus is on foreign medical team recording, the bulk of what we can learn in the traditional literature is from local medical teams. Therefore the approach to universal record-keeping, if it is to achieve its ultimate aim of best serving the healthcare process of affected populations and to provide much-needed research data, must also encompass use by local teams.

Exchange Auditorium

14:00

Global Health: Emergency Humanitarian Assistance	
Session title	Planning and delivering health in humanitarian settings
Chair	Professor Tony Redmond

Mrs Frances Hill, Research Partners Manager, ELRHA, UK

Research and Realism: Effective Partnerships for Humanitarian Impact

With 'impact' now a criterion under which academics are assessed within the UK Research Excellence Framework, this represents a key driver for researchers and practitioners to work together. Research engagement with the humanitarian sector provides an ideal arena to demonstrate impact within a relatively short time period. From the research undertaken for the 'Rapid Research Response Secondment Programme', a programme funded by ELRHA (carried out by Engineers without Borders and the Universities of Nottingham, Edinburgh and London), it appears that academic stakeholders need more incentives to engage with practitioners. There are therefore mutual benefits to be derived from greater engagement between the two groups of stakeholders: academics learn from the field, get access to front line data sets, and see the reality of a humanitarian situation; practitioners have their work substantiated by rigorous evidence and research methods. Both are then able to share this dually informed knowledge and experience across both constituencies for the benefit of the humanitarian effort as a whole. With the rise of user/action-oriented research approaches, particularly relevant for measuring impact for socio-political and household level programmes, there is also considerable work to be done to work with HEIs to support the value of these approaches. Currently a mutual suspicion pervades around these approaches however, some research programmes have taken these approaches and adapted them to suit their levels of rigour. There is much talk about the value of collaboration and partnerships, but not so much about how to go about forming these collaborations, the tipping points, the challenges and areas of reciprocal benefit to each member of a collaboration. What this workshop aims to do is to bring about greater understanding and coherence on the factors that impact partnerships between academics and humanitarian practitioners by providing tools and insights to the partnership process. The aim is to provide a highly interactive space for participants to explore options they can take away and apply to collaborations they are either already engaged with or those that they are seeking to embark upon.

Exchange Auditorium

14:00

Global Health: Emergency Humanitarian Assistance	
Session title	Planning and delivering health in humanitarian settings
Chair	Professor Tony Redmond

Ms Aala El-Khani, PhD Researcher, University of Manchester

Co-authors: Professor Rachel Calam, Dr Fiona Ulph

An exploration of parenting needs in War and Refugee situations

Objective: The negative effects of wars and consequent displacement on children's psychosocial development and mental health are of great concern. Effective parenting is crucial to ensuring the safety and adjustment of children in insecure environments. Improving parenting has the potential to prevent child mental health difficulties and improve child safety and development. This study explored the parenting needs of families during war and refugee situations to investigate what it is that parents find most challenging, what they require assistance with and assistance may be best provided.

Method: This study was carried out with Syrian refugee parents residing both inside Syria in refugee tents and along the Turkish/Syrian border who have recently been displaced due to the current conflict in Syria. Eight semi-structured interviews and four focus groups were carried out with these families as well as two interviews with professional aid workers based inside the refugee camps. Data collection is complete and thematic analysis is being used to analyse the data and identify any emerging themes.

Results: Preliminary results show a great change in the parenting experience of families who are now facing significant environmental, child specific and parent specific challenges. Parents require assistance with helping their child with emotional expression, dealing with aggression and inappropriate behaviour caused by the turmoil and violence their children have witnessed. Parents are using coping mechanisms to remain strong for their children and hopeful for their future.

Conclusion: Parents are both in need of parent training and are motivated to engage in such training.

Exchange 1

11:00

Environmental Urban Health	
Session title	2014 HEALTHY-POLIS workshop:
Chairs	Professor John Thornes / Dr Clare Heaviside, Public Health England

Challenges and Opportunities for Urban Environmental Health and Sustainability

BACKGROUND

Densely populated urban areas are facing environmental health challenges including contamination of air, water and soil. Sprawling urban areas contribute to traffic congestion, with associated air pollution, noise and long commuting times affecting public health and productivity. Climate change is likely to aggravate certain health risks in cities by increasing the frequency and severity of extreme weather events, such as heatwaves and floods, and potentially contributing to air pollution episodes. On the other hand, climate change mitigation and adaptation policies can provide a range of health co-benefits associated with low carbon buildings, urban green spaces, active transport, and renewable energy generation.

Cities are complex systems that demand systems-based, interdisciplinary research methods involving epidemiologists, toxicologists, urban planners, environmental and public health scientists. Methodological innovation and standardisation of epidemiological, exposure and risk assessment methods across countries, are needed to address complex environmental health challenges in the context of climate change and sustainable development.

The new Healthy-Polis international consortium (www.healthy-polis.org) is organising its first annual workshop on “Challenges and Opportunities for Urban Environmental Health and Sustainability”, as part of the Urban Health 2014 conference in Manchester. This will be an opportunity for researchers and stakeholders working in this inter-disciplinary area (environmental public health, urban planning and transport, built environment, climate change adaptation and mitigation, air pollution and noise, and sustainable development) to share experiences, exchange views on the management of health risks in the urban environment, and identify opportunities for collaboration.

Thursday 6th March

PROGRAMME

11.00-11.05 Welcome and introduction
Dr Paul Cosford, Director for Health Protection and Medical Director, PHE

11.05-11.15 Introduction to Healthy-Polis international consortium
Dr Sotiris Vardoulakis, Air Pollution and Climate Change Group Leader, PHE

11.15-12.00 Session 1: Environmental Health Risks in Urban Areas
Chair: Professor Sir Andy Haines, London School of Hygiene and Tropical Medicine

11.15-11.30 Global health impacts of climate change
Dr Bettina Menne, WHO Europe

11.30-11.45 Infectious disease threats from global environmental change
Dr Jan Semenza, European Centre for Disease Prevention and Control

11.45-12.00 Built environment and health risks from air pollution
Dr Otto Hänninen, National Institute for Health and Welfare (THL), Finland

12.00-13.00 Lunch

12.30-13.00 [Healthy-Polis scientific advisory committee meeting]

13.00-14.00 Session 2: Case Studies (posters)
Chairs: Professor John Thornes / Dr Clare Heaviside, Public Health England

14.00-15.00 Session 3: Healthy Sustainable Cities
Chair: Professor Keith Dear, Duke Global Health Institute, China (TBC)

14.00-14.20 Public health impacts of greenhouse gas emissions reductions strategies in urban environments
Professor Paul Wilkinson, London School of Hygiene and Tropical Medicine

14.20-14.40 Integrated decision-making for sustainable housing, energy and wellbeing
Professor Michael Davies, UCL

14.40-15.00 An integrated decision-support framework for sustainable management of urban pollution
Professor Adisa Azapagic, University of Manchester

15.00-15.50 Panel Discussion

Professor Sir Andy Haines (LSHTM), Dr Bettina Menne (WHO Europe), Dr Ann Marie Connolly (PHE), Professor Michael Depledge (Exeter University), Dr Louise Newport (Department of Health), Professor Thomas Krafft (Maastricht University)

Questions:

Policy needs and priorities for future collaborative research?
Key indicators for urban environmental health and sustainability?
Key methods for integrated assessment of policies and interventions?
Capacity building and training needs?

15.50-16.00 Conclusions and Future Steps
Dr Sotiris Vardoulakis / Dr Bernd Eggen, Public Health England

Thursday 6th March

Exchange 2

11:00

Transdisciplinarity in Urban Health	
Session title	Planes, trains or automobiles? Why is the car the CHOSEN one?
Chair	Fiona Reynolds

Dr Anil Namdeo, Senior Lecturer in Transport and Sustainability, Newcastle University

Environmental Justice: Tale of two UK cities

Thursday 6th March

Exchange 2

11:00

Transdisciplinarity in Urban Health

Session title	Planes, trains or automobiles? Why is the car the CHOSEN one?
Chair	Fiona Reynolds

Eleanor Roaf, North West Regional Director, Sustrans

Sharing our streets: whose rights and whose responsibilities?

Thursday 6th March

Exchange 2

11:00

Transdisciplinarity in Urban Health

Session title	Planes, trains or automobiles? Why is the car the CHOSEN one?
Chair	Fiona Reynolds

Fiona Reynolds, Consultant in Public Health, Salford City Council

Carping from the Sidelines? The role of public health in improving transport

Exchange 2
12:40

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Professor Jutta Lindert

Dr Kelsey McDonald, Postdoc Fellow, Centre for Urban Epidemiology, Institute for Medical Informatics, Biometry and Epidemiology, University Clinics Essen, University of Duisburg-Essen
Co-authors: J Michael Oakes

Importance of policy-relevant, exchangeable comparison groups in observational neighborhood effects studies

Observational neighborhood effects studies often lack exchangeable populations between exposure groups, limiting identification of the independent effect of a neighborhood exposure on health. Furthermore, many observational studies model unrealistic changes in exposure, eg moving to a neighborhood with a substantially higher mean income. Both limit our ability to develop effective urban policies and interventions to improve health. We aim to demonstrate the value of employing propensity score matching (PSM) and adjacent quartile comparison groups to enhance causal inference in observational neighborhood effects studies. We create comparison groups where those in a lower socioeconomic status (SES) neighborhood quartile (Q) are matched only with those in the next higher Q. This improves exchangeability between groups, better approximates a real-world scenario where individuals would move to a somewhat better neighborhood and generates more realistic estimates for urban policy. We estimate the average effect of the treatment on the treated (ATT) moving from lower to next higher SES neighborhood Q on overweight/obesity, type 2 diabetes and smoking. Neighborhood SES is classified by census-tract level median household income (NH income) and percent with bachelor's degree or higher (NH education). Individual-level covariate and outcome data from the 2005, 2007, and 2009 California Health Interview Survey for San Francisco adults (n=2,515) was linked with census-tract level SES data from the 2006-2010 American Community Survey (n=194). We examined differences in the overlap of similar persons residing in non-adjacent neighborhood Qs and in the corresponding ATT results. Results suggest a significant difference in ATT when moving from the moderate-high to high NH education Q for overweight/obesity (-0.10, 95% CI -0.20 to -0.03) and smoking (-0.05, 95% CI -0.12 to -0.03), using exchangeable exposure groups. Analyses comparing Q2-Q4 neighborhood SES exposures to the lowest Q suggest reduced exchangeability of exposure groups. ATT results from these analyses differ somewhat from those comparing adjacent quartiles, with different estimates reaching statistical significance. However, as with the adjacent Q analyses, most estimates failed to reach statistical significance and those that did had a confidence interval near zero. Attention to exchangeability and realistic comparison groups enhance causal inference and provide more relevant information for urban policy makers. However, assumptions inherent to observational neighborhood effects studies still limit our ability to identify causal effects.

Exchange 2
12:40

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Professor Jutta Lindert

Mrs Hayley Teshome Tesfaye, Specialty Registrar Public Health, Mersey Deanery
Co-authors: Dr Jennie Day

Health Visiting Professionals - perceptions regarding barriers to health and wellbeing faced by European migrant families in Sefton

Background Since 2004, there has been an increase in the population of European migrant workers and their families living in Sefton. The number of births to non-UK mothers has also increased to over 9% of all Sefton births in 2010, doubled since 1995. In North Sefton, 13% of births are to non-UK mothers, to nearly a third of births in central Southport. The World Health Assembly (2008) emphasised the need for public health strategies to safeguard migrants' health, which is affected by wider determinants, requiring multi-sector action. Health Visitors are in a unique position in witnessing and mitigating inequalities and exclusion particularly among minority ethnic and lower socio-economic groups. Aim To explore the perceptions of Health Visiting professionals regarding barriers to health and wellbeing faced by European migrant families in Sefton and the common challenges Health Visiting professionals experience when providing services to this population. Design Qualitative study using in-depth interviews. Interviews were recorded, transcribed, analysed thematically and interpreted using a constructivist approach. Setting Sefton, Merseyside. Participants 8 Health Visiting professionals. Results The main themes that emerged highlighted barriers to health and wellbeing experienced by European Migrant families including: housing, isolation, language, culture, environment, education, access to agencies and services, health service access, knowledge and attitudes. Health Visitors reported that European migrant families had positive health and wellbeing, with high rates of immunisation and breast feeding. Health Visitors concerns about acculturation leading to migrant families' ill health were expressed. Health Visitors reported extreme poor housing and living conditions experienced by European migrants including damp, overcrowding, poor maintenance and unscrupulous landlords. Health Visitors routinely used interpreters and stressed the importance of this when communicating about cot death and domestic violence. They perceived a lack of use of interpreters by other services and health professionals as having a negative impact on migrants' health and wellbeing. Health Visitors perceived that migrant families were able to access GP services and some surgeries employed bilingual staff. It was expressed that some migrant families considered the NHS negatively, preferring to return to their home country for medical care. A&E services were perceived to be 'inappropriately' utilised due to lack of awareness of health systems, dissatisfaction with GP, parental concern, failure to prescribe antibiotics and transportation to GP out-of-hours services. However, it was highlighted that UK families probably used A&E as frequently and there is a lack of data to quantify the use of A&E by migrant families. Conclusions The wider determinants of health and barriers in accessing health, public and community services were perceived to have the greatest impact on health and wellbeing. It is possible that migrants' perspectives may contrast to those of Health Visitors. Further research is

Thursday 6th March

Exchange 2
12:40

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Professor Jutta Lindert

Dr Christina Fuller, Assistant Professor, Georgia State University School of Public Health
Co-authors: Dajun Dai, Christine Stauber, Deirdre Oakley, Erin Ruel

Socioeconomic and environmental predictors of nitrogen dioxide concentrations in Atlanta

Aims Traffic-related air pollution is a prevalent concern in cities and varies substantially by geography across urban areas. Low-income neighborhoods may be more exposed than wealthier areas due to siting of homes near high traffic areas. Our aim is to examine within and between neighborhood variation in nitrogen dioxide (NO2), a marker of traffic-related air pollution, and to identify spatial and socioeconomic predictors of NO2 concentrations within census tracts of differing poverty levels in Atlanta, GA, USA. Design and Setting We selected four census tracts for monitoring according to the percent of the population living below the United States federal poverty line: <20%, 20-30%, 30-40% and >40%. We divided each census tract into high and low exposure areas to increase exposure contrast. High exposure areas were defined as a 200 m buffer around roadways with >10,000 vehicles per day. We overlaid each tract with a 50m x 50m grid and randomly selected 30 grids from each tract: 10 locations in high exposure areas and 20 locations in low exposure areas. In October 2012 we collected two-week integrated samples of NO2 at each location using Ogawa passive badges and additionally in a subset of the full sample in July 2013. Results We collected data at 117 locations in October 2012 and the NO2 concentration (mean ± SD) was 11 ± 3 ppb. NO2 followed a trend with the lowest mean NO2 concentration (9 ± 2 ppb) measured in the lowest poverty tract and the highest (12 ± 2 ppb) in the highest poverty tract. High traffic areas had significantly higher NO2 than low traffic areas within the <20% poverty and >40% poverty tracts. A subset of 29 sites was resampled in July 2013 and NO2 concentrations were on average 47% lower (5.8 ppb) than in the fall. Preliminary multivariate models identify poverty level, distance to interstate highway, and average daily traffic as significant predictors of NO2. There is a significant interaction between poverty and distance to interstate highway. Conclusions Our results are consistent with past studies showing higher levels of traffic-related air pollution in locations close major roadways, which often are high poverty areas. However, there is an indication that in addition to proximity to traffic sources there may be an independent effect of socioeconomic condition (% poverty). Further analyses will elucidate this relationship more fully.

Exchange 2
12:40

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Professor Jutta Lindert

Mrs Maria Donovan, Specialist Community Public Health Nurse, School Nursing, Sirona Care and Health

The use of digital technology in order to promote young people holding their own health records, and thus take responsibility for their own health

Objective: To explore the use of digital technology in order to promote young people holding their own health records, and thus take responsibility for their own health. Methods: An experiential study based on a school based sexual health clinic. In order to explore the pros and cons of using digital technology in sexual health I have I have spoken to 20 young people(aged 14-18)and 6 colleagues involving semi-structured interviews in Bath and North East Somerset. Results Within the Sexual Health Clinic I noticed that the young people of who came to see me were storing their own health information on their pads or smart phones (all the young people have I Pads as a school learning tool in this school). This was in the form of showing me photos of their contraception pill when asking them what pill they were on. This led me to explore the great potential of digital technology enabling young people to take care of their own health. In order to formulate pros and cons of using this technology in a more structured way I questioned both young people and colleagues. I found that the young people were keen on using the technology on their own terms and in their own chosen way but expressed concern regarding enforced structure and confidentiality. For the young people that I questioned confidentiality was paramount. Some young people were unsure that parents would not resist searching for health records if they had knowledge of this service. Colleagues expressed that they thought that the idea was a good one, engaging with young people in their chosen mode of communication, they all thought that digital technology appears to be the future and that young people should be engaged early on in their lives with their own health and health records. The message would start in school but it would be a message for life. There were concerns from colleagues regarding confidentiality, security and medico-legal implications. Honesty and accuracy of the young people had implications on reliability of the records for some colleagues. Conclusions: An experiential exploration of the pros and cons of using Smart technology in the sexual health clinic demonstrates a starting point for understanding the potential of changing the way health records are held for young people. Young people have been found to be self directed and motivated in using Smart technology. By looking at the issues of young people holding their own records in the sexual health this can lead to a discussion on young people holding all their own health records.

Exchange 2

14:00

Tobacco Control	
Session title	From Global to Local: Exploring strategies for reducing the demand for and supply of illicit tobacco through a case study of the North of England Tackling Illicit Tobacco for Better Health Programme
Chair	Andrea Crossfield

Andrea Crossfield, Chief Executive, Tobacco Free Futures

Michael Gilmore, HMRC Catherine Taylor

Regional Programme Co-ordinator, Fresh

From Global to Local: Exploring strategies for reducing the demand for and supply of illicit tobacco through a case study of the North of England Tackling Illicit Tobacco for Better Health Programme

No abstract available

Exchange 3

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Dr Amanda Peet, Project Manager, The Christie NHS FT

Lets be clear - get it checked

The service aim is to promote awareness and early diagnosis of cancer. The pilot covers 3 specific cancers; breast, bowel and lung. The main objectives are to recruit and train a network of volunteers who then promote cancer awareness messages in their communities, targeting those at high risk and the hard to reach. Main aims: - Improve cancer survival across Manchester, Tameside and Glossop and so reduce cancer mortality. - Improve proportion of early stage tumours (i.e tumours with no spread beyond the first site) at time of diagnosis across the network, targeting more deprived areas, over 50's and more vulnerable groups. - Decrease the proportion of late stage tumours at time of diagnosis. The pilot is designed to raise public awareness of potential cancer symptoms in groups which are least cancer aware in the community and to promote early presentation to primary care and so rapid referral to diagnostic and treatment services in the specialist setting. Historically services have been designed universally and people are then shoe-horned into them. This is designed with the target audience in the most disadvantaged communities, and it is working! Funded by Macmillan Cancer Support and managed by The Christie NHS FT the key elements of the pilot and are held by the NHS and so set the strategic objectives. However, the service is delivered locally and in a responsive way. This pilot provides the opportunity to experiment a new type of strategic planning which has set aside traditional barriers in favour of a more holistic and imaginative, person-centered approach. To deliver this effectively the model has a grass-roots framework and is continuing to produce exciting developments, working in partnership with local NHS, city council and third parties. Recruiting local people as volunteers has unlocked access to people from deprived communities and/or experiencing poor levels of health, who don’t feel comfortable or confident using NHS or mainstream services. The local knowledge and real understanding of the volunteers recruited has helped to find a way of accessing local community members that we have found difficult to work with in the past. For instance, in designing materials and approaches the service can truly consider the needs of ethnic minorities with the help of volunteers and people from the target group. The service actively seeks to reach people who have little contact with services in the poorest areas with the lowest life expectancy. This is done across a variety of settings from Labour Clubs to Mosques. For example, residents associations, football clubs, libraries, shops, clinics, pharmamcies, hospitals, cafes, community centres, faith groups. In essence, the service goes to where the people are and in settings where people feel comfortable. Volunteers meet people who don’t initially want to think about the sensitive and potentially frightening issue of cancer and may ignore signs and symptoms and put off any changes that may lead to early diagnosis. Taking this to where people are really works. It has been identified as an environment in which people were and are more willing to discuss their concerns about cancer. At an older people’s event a lady told a volunteer that her nipple was very tender and sore and it hurt her when she took her bra off but that she was too frightened to go to her GP. One lady said she had

a pain in her side but that she didn't like to bother the doctor. Both ladies were encouraged to visit their GP and to regularly check for any other signs and symptoms. One lady was undergoing treatment for breast cancer and said she had too much going on to be bothered with doing her bowel screening. Without telling the lady that she must the volunteer talked to her about how she found out she had breast cancer and as the conversation continued if she had gone earlier she may have not needed a mastectomy and then as if by magic, just through reflective dialogue with the volunteer and some self reviewing of her situation, plus some reinforcement from the volunteers on the benefits of early detection, the lady decided for herself that she should do the kit. This way there is more motivation, because it is something she has decided to do rather than be told. Volunteers also promote the messages during their daily routine. Chatting at the school gates, in the shopping precinct and on the bus. One volunteer walked with a neighbour to the health centre whilst she made an appointment to see her GP about her breathlessness, that previously she had put down to her asthma but after talking to the volunteer she did identify that it was not the same and had lasted for some time. As well as cancer other issues have been raised, such as hypertension and diabetes. This led to additional training for the volunteers to help succeed in getting at risk people into the health system for treatment and people at significant risk of health problems. Volunteers have encouraged people to register with a GP in some instances. Already the pilot is proving to be a key tool in addressing health inequality in targeting people who have been previously hard to reach and in recruiting people with little or no qualifications from areas with high levels of unemployment. Local people may not have been through formal education, they may have spent lives bringing up families or caring for relatives. This service has already provided 6 volunteers with a route to employment in health and social care. 2 taking up posts in the NHS as a direct result from the experience from working as a community cancer awareness volunteer. Others from regaining confidence after circumstances left them unemployed. One volunteer has enrolled on an adult education course and another has been able to switch careers improving their own health and wellbeing. As well as the pilot providing a springboard for employment and as a skills escalator, the scheme has improved people's mental health. Many of the volunteers recruited from deprived areas and disadvantaged situations have reported and increase in self esteem and confidence. A reason to get up in the morning! Valuing their kids, family and life more! Having a sense of worth and feeling needed! Feeling so good to really help people! Ultimately this model is a key tool in addressing health inequality in two ways, by recruiting people with little or no experience from deprived communities and improving opportunities and supporting people in the deprived communities in understanding the benefits of early detection and healthy lifestyles, both effective in helping people take steps to better health: The flexibility of the service really helps make it sustainable. To help make it more sustainable it takes into account different age ranges, different cultures, different languages and individual opinions and priorities. The service finds ways to develop relationships with communities and individuals and building their trust before they can effectively undertake work on raising awareness. Reports already show it is worthwhile due to the personalisation of the approach. It is responsive to what people feel. Their particular needs, experiences and concerns are taken into account rather than providing the same campaign and health promotion materials. Each person is different and volunteers are trained to start where the individual is at - what will make a difference in being empowered to do it. Whether that be breast self examination, talking to friends and relatives about the benefits to early diagnosis, finding easy ways to change appointments, keeping check during screening intervals and above all reporting any changes to their GP quickly. The service is funded for 3 years and is into the final year. By year two, a cohort of volunteers and 2 co-

ordinators delivered over 7000 cancer awareness interventions across Manchester, Tameside and Glossop. People that have already participated have gained knowledge on the facts and myths surrounding cancer, have become more aware of the signs and symptoms and what to do if they notice any changes and feel more confident to talk to others about cancer. The real value is the added value from this pilot service. The role of the volunteer encompasses much more than raising public awareness and promoting earlier presentation. Living and working locally, being known at neighborhood level, volunteers have the knowledge and experience of the community they serve. It also means they have a real understanding of what it is like where they live and are deployed where they know the networks and community leaders. The role also involves signposting and encouraging access to NHS and non NHS health improvement services and screening programmes. Volunteers have reported that their own family and neighbours have not responded to invitations to be screened and despite posters being displayed in towns have still not ranked their appointments as a priority in their lives. Additionally volunteers have identified local services and ways of meeting individual health needs that sometimes have not required drawing on expensive services within the NHS. It compliments some mainstream services that w e have in the city. Services provided by city council on a neighbourhood basis, primary care and local NHS. Whilst talking to people about the signs and symptoms of specific cancers the volunteers come across people with behaviours that are known to cause ill health which provides scope for the service to further develop, incorporating motivational techniques around behaviour change and lifestyle. This is where the service has further potential to reduce health inequalities. Volunteers are the crucial link between health professionals and the community translating cancer awareness messages into actions that take into account of individual circumstances and help people develop a greater sense of control. They boost people's motivation to check for signs and symptoms and act promptly. There is evidence that engaging people in this way in talking about cancer has squashed people's fear of cancer being incurable and the fear that all lumps are cancer. Awareness has increased on the advantages of treating early and the flexibility and ethos is having a universal appeal as partners are keen to see this continue. The service co-ordinators are part of a new public health workforce supporting other government initiatives like Health Trainers and Lifestyle services. The volunteers do reflect our local community and if seen to be acquiring transferable skills and being successful in getting a career in local NHS, this sends out a symbolic message to residents of Manchester, Tameside and Glossop, that there are jobs in health and social care for them too. Over all this new service is already being perceived as positive with high level of enthusiasm and engagement. Working more cohesively together it is building bridges between services and delivering a service without duplication recognising each others skills and knowledge. The experience so far has been enriched by the people we meet and has made a real difference to people's lives and hopefully is saving lives across all boundaries.

Exchange 3
11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Beatrice Amponsah on behalf of Mr Eric Afram Danso, Greater Accra Regional Coordinator, Better Ghana Management Services Limited

Social Behavior Change In Communication Sanitation

Introduction Increased morbidity and mortality are inevitable consequences of the poor water and sanitation conditions in Ghana, especially in urban Ghana. The World Health Organization (WHO) estimates that 90 per cent of all global diarrhoea cases can be attributed to inadequate sanitation and hygiene and unclean water. Nearly 1 out of 4 households (23%) in Ghana practice open defecation or have no toilet facility, and whilst this is more pronounced in rural areas (35%) than urban areas (10%), it is a practice that is more common among the poor and also those with relatively lower levels of education.1 Social behavior change communication in sanitation will focus on encouraging and facilitating community based health promoting behaviors. It will seek to promote community ownership of sanitation and hygiene issues as well as enable the community to foster healthy decision making. The selected coastal plains in Ghana (Elmina, Cape Coast, Ga South, Ga West and Ga Central) have a population of about 1.0 million and are among the poorest communities in the country. The primary occupation, of the inhabitants includes fishing, subsistence farming, petty trading and artisanal activities. The major causes of mortality are HIV/AIDS, lower respiratory infections, diarrhoeal diseases, tuberculosis and malaria. The average life expectancy at birth for males and females is 52 years and 55 years respectively.2 The percentage of the population with sustainable access to improved drinking water sources is 49% in rural and 85% in urban regions, and the percentage of population with sustainable access to improved sanitation is 48% in rural and 19% in urban areas.3 Overcrowding, lack of clean water, insufficient and poorly maintained latrines, as well as poor hygiene practices facilitate the spread of infections and other diseases within the coastal catchment communities. This concept paper seeks to specifically delve into issues of individual households and the reasons behind poor usage and/or unavailability of toilets and water in these households. It will also explore incorporating social behaviour change communication activities into school curricula to encourage children's participation; (children as sanitation change agents) Executive Summary This concept paper outlines intervention strategies that will involve Community Stakeholders in education and behavioural change along selected coastal plains of Ghana as well as the main landing sites along the Volta Lake. Ample water, good hygiene practices, and appropriate sanitation facilities are crucial in reducing the incidence and prevalence of disease and infection. Most urban and rural communities are in need of greatly improved water and hygiene resources.

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Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Dr Mariel Droomers, Senior Researcher, Department Public Health, University of Amsterdam
Co-authors: Birthe Jongeneel-Grimen, Jan Willem Bruggink, Anton Kunst, Karien Stronks

General health effects of area-based interventions in Dutch deprived neighbourhoods. Should we invest in the neighborhood or its residents?

Aim: We report on the evaluation of the impact on perceived general health of area-based initiatives targeting problems with employment, education, housing and the residential environment, social cohesion, and safety. We compared the general health impact of area-based initiatives that focused on the improvement of the district environment with area-based interventions that mainly invested in the socioeconomic circumstances of its inhabitants. Method: We employed a quasi-experimental design to compare the development of perceived general health in the target districts with control districts. We performed time-series analysis of measurements over a prolonged period before and after the implementation of the area-based initiatives, i.e. from 2004 till mid 2008 and from mid 2008 till 2011. We fitted generalized general mixed models to assess the rate of change in good general health per half year. Results: Perceived general health did slightly improve between 2004 and 2008, but slightly deteriorated since mid 2008 - the start of the interventions - in both the target districts, though not statistically significant, and control areas. However, the general health in the deprived districts that invested more in the district environment was stable from mid 2008 onwards, while the health in those districts that invested mostly in the social position of individual residents statistically significantly deteriorated from 78% till 65% of the residents reporting good general health. Conclusion: Overall, the area-based initiatives that intended to ameliorate the living and social circumstances of residents of severely deprived districts did not seem to have incurred a more positive trend in good general health compared with control areas. Targeted investments in the district environment, however, seemed to have been able to safeguard the district population from a steep deterioration of their general health since mid 2008 - the onset of the economic crisis in the Netherlands - that was observed among inhabitants of districts that chose to invest in the social position of individual residents.

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Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Dr Anyansina Ayanlade, Researcher, OAU Ife

Health impacts of Oil production and other environmental change in the Niger Delta regions of Nigeria

The study aim at assessing the human health impacts of oil production and other environmental change in oil producing region of Nigeria. Since the beginning of oil exploration and other industrial activities in the Niger Delta of Nigeria, the environment has changed significantly over the years, with its impacts on human health in the region. Surprisingly, little research has been conducted in term of assessing oil production impacts health, the rate of occurrence and types impacts. One of the reasons for this may be due to the lack of accurate data and poor security which is militating against research work and appropriate decision making in respect of environmental problems in the region. This study therefore used remote sensing, non-remote sensing data, and social survey data. The major research questions prompted the collection of social data are: What are the health impacts of environmental change on the people of the Niger delta? Thus, impacts of oil exploration activities around Tsekelewu community are examined. The results show that the factor responsible for environmental degradation with its impacts on human health Tsekelewu has been the construction of artificial canals by oil companies. The canal linked these regions to the sea providing a regular inflow of seawater consequently destroyed freshwater mangroves. The results show that the impacts of oil exploration in this region have led to the destruction of large number of mangrove ecosystem and health effects on urban/rural dwellers. Majority of people in this region depend on rivers for drinking and domestic uses. Many sources of water have been contaminated by salty water which is neither good for drinking nor for domestic purposes. During field visits to determine health effects of environmental change in Tsekelewu. The majority of participants in focus group discussions and questionnaire complained of diarrheal infections, skin irritation and stomach-ache are the major health problem resulting from drinking brackish waters sometimes polluted by oil. The results show that about 98% of people perceived that stomach-ache is one of the effects of drinking contaminated water. Proportion of 97% for diarrheal infections, 82% for skin irritation and 52% for dry throat imply that local people in Tsekelewu familiar with of multiple effects of water pollution around them. The results showed that stomach-ache, diarrheal infections and skin irritation are the major environmental health effects from the perspective of the people living in the community. The study demonstrates that oil production has caused unforeseen environmental and health problems in Tsekelewu including death of freshwater mangroves forests. Therefore, findings from this research offer an inimitable opportunity for developing a multi-disciplinary approach to the appraisal, management and control of environmental change in the region.

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Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Mr Joseph Yeboah, Assistant Lecturer, Kwame Nkrumah University of Science and Technology

Co-authors: Daniel Buor

An Evaluation of Intervention Measures to Health Problems of Mining Impacted Communities: A study of Anglogold Ashanti's Operations in Obuasi, Ghana

This paper assesses the impact of intervention measures implemented by Anglogold Ashanti Company Limited in addressing health problems of their operations on the people of Obuasi and its surrounding communities. The simple random technique, supported by purposive procedure, was used to select a total of 300 respondents from five communities in the Obuasi Municipality for questionnaire administration, with 20 respondents sampled from the mining (Anglogold Ashanti), health and environmental sectors for formal interview. Biostatistics from health centres in the area were also collected. Data collected were analyzed using both qualitative and quantitative methods. The research revealed prevalence of diseases such as skin diseases, diarrhoea, upper respiratory infections and malaria, having resulted from land degradation and pollution of water and air from mining operations in the area. Other nutrition deficiency related diseases such as anaemia and hypertension have been associated with surface mining's severe impact on food production. Anglogold Ashanti Company has implemented measures such as reviewing operation methods, re-afforestation, provision of alternative sources of drinking water and health facilities as well as health education programmes in the communities. The impact of intervention measures has been positive. Evidently, hospital records showed a steady decline in malaria, skin diseases, diarrhoea and respiratory infections between 2007 and 2010. It was established that accessibility to health care reduces mortality rates. Despite a significant decrease in mortality rates by 51% between 2007 and 2010 mortality rates in the area are still high, with mining related diseases constituting over 30% of cause-of-deaths. It is recommended that safety and health education programmes be well structured and intensified. It has also been recommended that the mining company provide free health insurance packages to low income populations in the communities to ensure easy accessibility to health care.

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Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Abstract Presentations
Chair	Dr Amanda Peet

Ms Laura Nolan, Student, Princeton University

Co-authors: Ramnath Subbaraman, Tejal Shitole, Shrutika Shitole, Kiran Sawant, Mahesh Nanarkar, Anita Patil-Deshmukh, David E. Bloom

Burden of water poverty in a non-notified slum in urban India: Levels, determinants and implications

Slum dwelling in developing countries is associated with a lack of access to a variety of public services. In India, non-notified slums, which are not recognized by the government, are particularly poorly served. Many non-notified slums are barred from accessing municipal water supplies, and as a result, these communities create informal distribution systems, which are often very expensive for residents. While the WHO recommends consumption of a minimum of 50 liters per capita per day, we define 'water poverty' as per capita per day consumption of less than 20 liters - a water consumption level associated with, according to the WHO, 'very high' health risk. Study participants live in a non-notified slum in east Mumbai with a population of approximately 12,000 people. Following a listing of all households in the community, a representative sample of households was selected using a random number generator and individuals were selected for interview using a Kish table. Five hundred and twenty one interviews were conducted. Over 42 percent of residents use fewer than 20 liters of water per day and almost 85 percent use less than the WHO recommended 50 liters. Residents pay, on average, 180 rupees per 1,000 liters of water, which dwarfs the standard municipal charge in Mumbai of 3.24 rupees (US dollars 0.04) per 1,000 liters. In logistic regression models, the most important predictor of water poverty is cost, which alone explains almost 20 percent of the variation in water poverty among residents. Households paying between 100-199 rupees as compared to less than 100 rupees per 1,000 liters experienced 6 times the odds of water poverty. In a multivariate regression framework, cost of water, number of times water is obtained, and more people in the household are all jointly significantly associated with water poverty, even controlling for household income. Almost two-thirds of all residents report negative effects associated with obtaining water (such as being late to or missing work). Almost a third of the sample reported having to go a distance with carrying containers to fetch water. Of residents with young children (N=435), over 75 percent report that time spent getting water resulted in their being late for school, missing school, or losing time studying, among other negative impacts. In sum, insufficient water consumption is high in this non-notified slum and cost is heavily implicated in this severe lack of access. Results presented here are likely underestimates, however, because our measure of cost does not include the purchase of vessels for storage or the time cost of water collection. Not only does insufficient water consumption have severe health implications, but time and stress associated with obtaining water may be associated with lower productivity among adults and difficulty with school-going among children. Water poverty in urban India has implications for both public health and human development more broadly.

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World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Annie Smith

Dr Vikas Desai, Technical Director, Urban Health and Climate Resilience Centre (UHCRC)
Co-authors: Dr. Hemant Desai, Dr. Kalpesh I. Khatri, Dr. K.G.Vaishnav

Vector Born Disease Monitoring and Evaluation System towards Climate Change Resilience - Surat Municipal Corporation case study

Surat a historical and industrialized city is the 12th rapidly growing city of India. City is located on is spreaded in 326.515 sq.km with 44,61,026 total Population (2011), located on west coast of India on Arabian sea coast, river Tapti flows almost across the city. Almost zero unemployment city have hosted migrants from almost all states of country with 86% increase in population in last decade (2001-2011) Geo physical and socio demographic environment of the city is conducive to vector breeding and vector born infections. City has experienced regular floods and since 1914 total 23 floods are on record. In fifties Filariasis and in nineties Malaria including Falciparum malaria was a major public health challenge for the city. Post flood reemergence of plague (1994) and leptospirosis (2006 and 2013) is the add on public health challenge. Struggle to manage such series of public health challenges has resulted in to a metamorphosed urban governance and system including health system in the city. Today health administration and vector born disease surveillance and management system is a model in the country with several successes on its credit. Surat city Health including vector born disease control is managed by local self government as per the national program guidelines added by need based local initiatives. In the city there is three tier vector born disease case management system in public sector, this includes home based, urban primary health centre and referral institution complemented by private health sector. Regular vector and case surveillance is done by a battalion of 600 health workers with regular fix day, fix site, 15 days cycle of home visits. 41 Urban primary health centers diagnose and treat the cases as well as refer the cases as per national program guidelines. Severe complicated cases are managed at referral centers. Fever case surveillance is active (house to house) and passive (UPHCs, referral hospitals as well as 200 private institutions and dispensaries). Daily surveillance report is submitted to the zone office as well as head quarter in a prescribed format. This reporting is recently strengthened by IT support (UrSMS) which facilitates direct reporting in software and evidence based action on the same day. UrSMS has saved time as well as resources. SOP is operationalized to control clustering of cases and vector. Vector search is a part of fix day, fix site regular home visit under active surveillance. This includes identification, removal, family awareness as well as legal action for chronic intra domestic breeding sites and non-compliance. There is a special squad for construction site activity. Records of disease and vector surveillance are systematically preserved since fifties. With the recognition of Impending threat of climate change on urban health a retrospective analysis is documented. With consideration of long term upcoming need a research, training, documentation and network center

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World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Annie Smith

Mr. Chandrashekhar on behalf of Miss Bornali Dutta, Research Scholar, International Institute for Population Sciences

Pre hospital care and outcome of road traffic accident victims at a Level-I, urban, trauma centre in Mumbai

In a populous city like Mumbai, which lacks an organized pre-hospital emergency medical services (EMS) system, there exists an informal network through which traffic accident victims arrive at the trauma centre. The study describes the pre-hospital care received by the accident victim. This was a prospective hospital based study of road traffic crash victims carried out at a Level-I, urban, trauma centre in Mumbai between December 2012 and May 2013. After informed consent to participate in the study, patients/ attendants were interviewed for the study. Patients brought dead were excluded from the study. The injured road traffic accident victim in Mumbai usually is rescued by the police contrary to popular belief. Almost immediately after rescue, the victim begins transport to the hospital. No one waits for the EMS ambulance to arrive, as there is none. Almost two thirds of the patients were transferred from other medical health facilities. A taxi followed by auto rickshaw is the most popular substitute for the ambulance. The accident victims were transported to Level- 1 trauma centre with and without EMS. EMS is not uniformly distributed to all the injured patients, and many get transported directly without field triage or stabilization. In Mumbai basic life support consists of basic life support, oxygen support and advanced life support for few patients. Currently, as a result of not having an EMS system, pre-hospital care is a citizen responsibility using societal networks. It is easy to eliminate this system and shift the responsibility to the state.

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World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Annie Smith

Annie Smith on behalf of Dr Maya Peled, Director of Evaluation, McCreary Centre Society

Co-authors: Annie Smith, Duncan Stewart, Stephanie Martin, and Ange Cullen

Barriers and bridges: Youths' access to needed mental health services

INTRODUCTION & AIM: Adolescence is associated with the onset of various mental health problems (Moretti & Peled, 2004), yet young people often experience a number of barriers to accessing needed mental health services (McCreary Centre Society, 2013). The aim of this study was to investigate youths' reasons for not accessing needed mental health services, and to get their thoughts on how to better support young people in connecting to services and in fostering their positive mental health. METHODS: The study involved a mixed-methods design of self-report surveys and youth focus groups. Quantitative data was collected from 29,832 students (51% female) in public schools across British Columbia, Canada who completed McCreary's 2013 Adolescent Health Survey. Youth ranged in age from 12-19 (M = 15.0). Survey questions tapped a range of behaviours and functioning, including reasons for not accessing needed mental health services in the past year. Variables were derived from measures previously validated with adolescents. SPSS Complex Samples was used to analyze the data which was based on a cluster-stratified random sample drawn to be representative of students in the province. Qualitative focus-group information was collected from 70 young people between the ages of 15 and 25. All had experienced mental health challenges before the age of 19, and many had ongoing mental health concerns. Focus groups took place at a range of sites, located in both urban and rural areas across British Columbia. RESULTS & CONCLUSIONS: Most youth who completed a survey reported that their mental health was good or excellent (87% males vs. 76% females), as opposed to fair or poor. However, both males and females rated their mental health lower than their physical health. Eleven percent (17% females vs. 5% males) reported not accessing mental health services in the past year when they had thought they needed them. Among these students, the most common reasons included not wanting their parents to know, hoping the problem would go away, feeling fearful of what they would be told, and not knowing where to go. Focus group participants discussed similar barriers. They concluded that although young people may be reluctant to access needed services, receiving support to do so is key to ensuring that their problems do not worsen and that they get the help they need. Their suggestions included greater advertisement of supports available in each community; providing youth with more information about what to expect if they do access services; having a worker available to help young people navigate the mental health system; and ensuring continuity of care when youth are transferred from one service to another. Further, findings highlighted the importance of meeting youth where they are at and giving them a voice in their treatment planning in order to foster positive mental health among young people.

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World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Annie Smith

Annie Smith and Ann Alexander on behalf of Dr Maya Peled, Director of Evaluation, McCreary Centre Society

Co-authors: Ann Alexander, Tim Agg, and Annie Smith

Reducing violence and risk among gang-involved youth

INTRODUCTION & AIM: British Columbia (BC) has ranked among the highest provinces in Canada for youth gang involvement, and this involvement commonly takes place in urban areas such as Vancouver. Gang-involved youth, compared to their peers who are not gang-involved, tend to exhibit higher rates of risky behaviour, including criminal activity and substance use (Peled & Smith, 2010). Certain protective factors have been identified that predict reduced risk of gang involvement among vulnerable youth. One such factor is the expectation of having a job in five years (Peled & Smith, 2010). Based on empirical evidence, a program was developed in Vancouver, BC which provided youth (ages 15-18) at risk of gang-involvement with meaningful job placements in the community. The program involved a 10-week job placement, one-to-one support and supervision, and employer mentoring. The goals were to reduce participants' risk of future gang involvement and violence; to increase their ability to function in work and community environments; and to enhance their future job prospects. An independent evaluation of the program was recently completed. The aim of this presentation is to share the final evaluation findings and to discuss their implications. METHODS: Youth completed a survey at intake (n=59), midway through the program (n=32), and at discharge (n=21). The surveys assessed behaviours and functioning, and the degree to which the program contributed to improvements in youths' lives. Employers (n=22) also completed a survey canvassing their satisfaction with the program and their perceptions of the impact of the program. RESULTS & CONCLUSION: At intake, participants reported high rates of criminal activity and other risk behaviours. By discharge, most reported reduced criminal activity (67%), gang involvement (63%), and substance use (71%) because of their involvement in the program. Most also reported improved self-esteem (95%), overall mood (79%), hope for their future (71%), anger-management skills (67%), and connection to their community (73%). Additionally, most indicated improvements in various work-related skills. Employers also witnessed improvements in skills and psychosocial functioning among the youth at their site. Further, 70% of youth felt they had found their career path because of their involvement in the program. Several youth continued working at their job site after completing the program, which gave them additional support in pursuing their career path. The evaluation demonstrated that the program was meeting its goals. The findings suggest that providing at-risk youth with meaningful job opportunities, coupled with appropriate mentorship, can reduce the risk of gang involvement and violence and can increase their likelihood of pursuing their career path and staying on a healthy trajectory.

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World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Annie Smith

Dr Pip Fisher, GP and clinical lecturer, University of Manchester

Co-authors: Dr Enam Haque

Think global, act local: How students can improve the health of immigrant urban communities

Aims Medical students arrive at university keen to make a difference. Many dream of working overseas and of helping the disadvantaged. Not all will be able to afford electives abroad or take time out of their career to work in humanitarian aid. Rather than allowing their initial interest to dwindle, we developed a teaching programme to channel their enthusiasm towards improving the health of immigrant communities living in the UK. Method A 4 week student selected module was developed using a hub and spoke model. Students attended weekly teaching in the university (the hub) and went out to general practices serving ethnic minority populations around Manchester (the spokes). They observed consultations, including those conducted through interpreters or by bilingual clinicians, and carried out relevant audits in the practices, with debriefing and support centrally. Teaching included how to do an audit, diseases affecting immigrant communities, the UK asylum system, barriers to accessing care, using interpreters and how norms and values affect care that patients expect and that professionals offer. Students were required to write an academic report, create an educational resource for patients and to present their work to their peers. Results This module has now run twice. On each occasion it was one of the most popular topics. Using names as a very crude measure, at least half of the applicants themselves came from families who had migrated to the UK in recent generations. Topics audited so far have included: Hepatitis C testing in patients from Pakistan; HIV testing in patients from Africa; Blood pressure control in black Africans; Haemoglobinopathy screening; Ethnicity and consultation length; Vaccination of family contacts of patients with Hep B; MMR vaccination of new immigrants; Travel advice for the Haaj Evaluation Feedback from students and practices revealed high levels of satisfaction with the module, including positive comments on both the topic area and the model of delivery: “An eye-opener towards a different population that we may have to deal with later.” “My friends seemed quite jealous that I was receiving such excellent teaching about immigrant health and global health issues.” “a topic not taught on the medical programme -feel like I have a slight edge on other people on my course because of it.” Twelve (out of 16) students have presented their work at the RCGP annual conference. Discussion In the UK today one in 8 adults were born overseas (Office for National Statistics, 2012) and one in 4 medical students are of an ethnicity other than white British (Higher education Standards Authority, 2013). Teaching in medical school needs to acknowledge this diversity and address the challenges it poses This model allows students to learn the value of a public health perspective in making a real difference to patient care.

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Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Miss Robynne Sutcliffe, Research Assistant, Centre for Urban Epidemiology Institute for Medical Informatics, Biometry and Epidemiology University Hospital Essen
Co-authors: Ester Orban, Lukas Zimmermann, Kelsey McDonald, Susanne Moebus

The German Energiewende and Health: Impacts of energy and resource policy strategies on health

Background: Global conditions are driving urban energy and environmental policy making throughout the world. The German Energiewende aims at the transition towards a safe supply of renewable energies and the conservation of energy resources. This is intended by promoting sustainable electricity generation (wind, solar, biomass), energy efficiency improvements to housing and sustainable transport (biofuels, electric vehicles). The Energiewende should enhance urban health not only by reducing greenhouse gas emissions but also by promoting positive changes in urban planning and governance. Aim: Aim here is to analyse the current state of affairs, interactions and possible trade-offs between new energy and resource policy strategies and environmental health. Within the scope of a literature review, the purpose is to identify policy and research knowledge gaps and to suggest possible strategies to promote urban and environmental health. Methods: A structural model helped to narrow down specific topics and to conceptualise links between the Energiewende, the environment and health. A comprehensive literature search was conducted within policy documents and scientific databases with English and German language selections. A predefined selection strategy was used by two reviewers to identify relevant publications which were then assigned to specified topics. This research was initiated/funded by the German Federal Environment Agency. Results: Of >7,800 publications identified, 72 publications (21 scientific studies, 19 reviews, 32 reports) were reviewed. Overall, the Energiewende and its corresponding policy strategies are discussed frequently at local, state and federal levels in Germany, especially in terms of environmental issues. However, explicit connections to health outcomes are difficult to identify. The majority of identified publications are mainly based on Life Cycle Assessments; health is only indirectly included. Publications by health authorities rarely address possible health effects of renewable energy measures. Preliminary studies suggest possible connections between health and the Energiewende via the built environment (mould/dampness), wind energy (noise/infrasound) and fine particulate matter. The development of adequate recycling techniques, the potential use of nanotechnologies, as well as current smart energy grid and smart city urban developments were detected as important future topics. Conclusion: The possible impacts of the Energiewende and its corresponding policy strategies on the environment, society and overall health have not been fully examined yet. There is an urgent need for cooperation with the health sector. A Health Impact Assessment (HIA) with its community empowerment approach can be a suitable instrument for evaluation and participation. Using HIA in urban environments provides opportunities to optimise energy and resource policy activities that maximise health benefits and minimise adverse health effects.

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Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Professor Ted Schrecker, Professor of Global Health Policy, Durham University

Mapping epidemiological worlds: A new frontier for studying metropolitan health

The authors of a recent article on health and urban planning (Rydin et al., 2012) observe that 'rich and poor people live in very different epidemiological worlds, even within the same city'. Although the authors do not elaborate upon or theorize this point, it is more than a statement of the obvious and can provide the basis for important methodological advances in studying social determinants of health in metropolitan areas, in at least four respects. First, it avoids the conceptually problematic distinction between compositional and contextual factors in studies of place and health. Second, it recognizes the complexity of everyday exposures and vulnerabilities not only spatially but temporally, as the effects of these accumulate over the life course. Third, and relatedly, the concept invites inquiry from multiple disciplinary perspectives into how and why some people have far more control than others over their epidemiological worlds. Fourth, and perhaps most importantly, it offers an alternative to epidemiologists' focus on controlling for all variables but one. Since health is influenced by a complex set of real-world exposures and vulnerabilities that occur simultaneously or sequentially, and the entire range of those exposures is likely to vary across socioeconomic gradients, achieving meaningful reductions in health disparities against a background of widening economic inequalities and (in many cases) intensifying spatial segregation is likely to require initiatives that act on multiple influences on social determinants of health, across multiple policy domains. The methodology of mapping epidemiological worlds, literally and metaphorically, is distinctively appropriate to this challenge. References Rydin Y, Bleahu A, Davies M, Dávila JD, Friel S, De Grandis G et al. Shaping cities for health: complexity and the planning of urban environments in the 21st century. The Lancet 2012;379:2079-108.

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Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Professor Valery Gafarov, Head of Laboratory, Collaborative laboratory of cardiovascular diseases epidemiology SB RAMS; FSBI Institute of Internal Medicine SB RAMS

Co-authors: Dmitriy Panov, Elena Gromova, Igor Gagulin, Almira Gafarova

Job stress is predictor of 16-th years risk of cardiovascular diseases in female population aged 25-64 years in Russia (based on WHO epidemiological program "MONICA-psychosocial")

Objective: To study the influence of job stress on relative risk of an arterial hypertension (AH), myocardial infarction (MI) and stroke in female population aged of 25-64 years in Russia over 16 years of follow-up. Methods: Under the third screening of the WHO "MONICA-psychosocial" program (MOPSY) random representative sample of women aged 25-64 years (n=870) were surveyed in Novosibirsk. Questionnaire based on Karasek's job demands-control model proposed by MOPSY protocol was used to estimate levels of job stress. From 1995 to 2010 women were followed for the incidence of AH MI and stroke with using “Myocardial Infarction Registry” data. Cox regression model was used for relative risk assessment (HR) of AH, MI and stroke. Results: The prevalence of high job stress level in women aged 25-64 years was 31.6%. HR of AH over 16 years of follow-up in women with high job stress was 1.39-fold higher (95.0%CI:1.08-1.78, p=0.01) compared to those with lower levels of job stress. HR of MI was 3.22-fold higher (95.0%CI:1.15-9.04, p<0.05), HR of stroke was 1.96-fold higher (95.0%CI:1.01-3.79, p<0.05) in women with high job stress. There were tendencies of increasing AH, MI and stroke rates in married women experienced stress at work compared to unmarried, divorced and widowed with the same stress level. AH significantly higher developed in women with university (2=8.23 df=1 p<0.01), college (2=3.98 df=1 p<0.05) and high school education (2=5.29 df=1 p<0.05) having job stress compared to those with elementary school education and stress at work. With regard to occupational class higher AH rates was found for ‘physical workers’ with job stress compared to pensioners without it (2=5.47 df=1 p<0.05) and AH rates were tend to be higher in ‘managers’ experienced stress at work (2=3.24 df=1 p=0.07). There were tendencies of increasing MI rates in ‘engineers’, but it was more likely in ‘physical workers’ with stress at work for stroke. Conclusions: There is high prevalence of stress at work in female population aged 25-64 years ant high job stress level is 31.6% in Russia. Women with high job stress have significantly higher hazard ratio of AH, stroke and MI over 16-th years of follow-up. Rates of AH MI and stroke development were more likely in married women with middle and high educational level and high job stress in professional class ‘managers’ and ‘physical workers’.

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Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Mrs Beatrice Scholtes, Researcher, Department of International Health, University of Maastricht

Co-authors: K Förster, P Schröder-Bäck, M MacKay, J Vincenten, H Brand

Mapping inter-sectoral cooperation for injury prevention: experiences using the organigraph methodology

Background: Although resulting injuries are managed by the health sector, effective prevention of injury requires inter-sectoral collaboration with organisations and actors across the spectrum of governance, at the local, regional, national and European levels. Identifying these actors and understanding the complexity of collaboration required can be difficult and time-consuming. A practical tool, that provides a way to explore and describe both the existing and necessary relationships between actors for effective implementation of an intervention, could facilitate programme/policy management and increase the likelihood of success. In this study we further developed and tested the practical application of the organigraph methodology using examples from child injury prevention. Methods: Mintzberg and van der Heyden developed the organigraphs methodology to depict how organisations actually work. The practical application of this method was developed further by the authors to explore how interventions in child safety are developed, implemented and enforced across the local, regional, national and EU levels. This included the mandated responsibilities of actors involved in the process and their inter-relationships. Professionals working in child safety in 25 European countries were asked to draw organigraphs for a programme or policy in one of the following four child injury domains: road safety, water safety, home safety or intentional injury prevention. In addition, an EU Brussels based NGO mapped EU level governance of child safety. Results: The resulting organigraphs show great diversity in governance across the participating countries, but consistently illustrate the trans-disciplinarity of child injury prevention interventions. Analysis of all 25 organigraphs produced a list of relevant sectors for child injury prevention interventions for each of the four domains, separately and combined. In addition, participants reported that the process of drawing improved their understanding of their own work and encouraged them to engage with other stakeholders in the field. Conclusions: The organigraphs depict the complex and multi-sectoral nature of child injury prevention in practice. The results highlight the breadth of governance for child injury prevention, both vertically, from the local to international level and horizontally, across sectors. The organigraph methodology provides a useful tool for professionals to appreciate the trans-disciplinarity of child injury prevention; plan, implement and evaluate their activities; and to foster collaborations among relevant stakeholders in the field. This study focuses on child injury prevention but the methodology could also be applied to other policy fields.

Exchange 3

14:00

Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Alvaro Valera Sosa

Shaping Healthier Neighborhoods, a Non-communicable Disease Prevention Strategy for Cities and People

No abstract available

Exchange 3

14:00

Transdisciplinarity in Urban Health

Session title	ABSTRACT PRESENTATIONS
Chair	Professor Ted Schrecker

Ms Annie Smith, Executive Director, McCreary Centre Society, and Duncan Stewart

Co-authors: Brynn Warren, Ange Cullen

The Vancouver 2010 Legacy: The effects of the 2010 Winter Olympic Games on the health of BC youth

INTRODUCTION: Vancouver, British Columbia hosted the 2010 Winter Olympic Games. BC youth who completed the 2008 and 2013 BC Adolescent Health Surveys (BC AHS) were asked about the effects that the Olympics had on them. AIMS: To identify the effects that preparations for the 2010 Games already had on different populations of urban youth in 2008, and the long-term effects on youth three years following the event. DESIGN: Over 29,000 public school students from Grades 7-12 completed the fourth BC AHS in 2008, and a similar number completed the most recent BC AHS in the spring of 2013. The BC AHS is a paper-and-pencil survey that asks youth about their health, and included a measure of how the 2010 Olympic Games has affected young people. RESULTS: When the BC AHS was administered in 2008, 9% of youth reported that they were already more active as a result of the upcoming Olympics, 6% had more sports opportunities and 6% had more job prospects. Younger youth were more likely to have become more physically active, while older youth reported having more job prospects as a result of preparation for the Games. Two years before the event, it was the youth who were already active and involved in sports who were reporting positive effects from the lead-up to the games. In contrast, some groups of vulnerable youth (such as those with experience of homelessness) reported that the Olympics was leading to fewer housing options, and taking away from their services. These results will be updated with information from the 2013 BC AHS, when youth were asked about what effects the 2010 Winter Olympics actually had on them Correlations between the effect of the game and health indicators such as positive physical and mental health, involvement in community activities, involvement in informal and organised sports, and injury prevention (such as sports helmet use) will be explored. CONCLUSION: Monitoring the effect of a large scale sporting event such as the Olympics can identify youth who are more likely to experience the event positively or negatively, and can identify how this experience correlates with health promotion and health risk behaviours.

Exchange 4

11:00

Urban Health Metrics/ GHIFT

Session title	Global Health Indicator Framework Toolkit (GHIFT) Collaborative
Chair	Professor Richard Rothenberg

Professor Richard Rothenberg, Regents' Professor, School of Public Health, Georgia State University, USA

Introducing GHIFT: Background, Objectives, and Opportunities

No abstract available

Dr Arpana Verma, Director, Manchester Urban Collaboration on Health

MUCH in GHIFT

No abstract available

Dr Michael Donmall, Director, National Drug Evidence Centre, Institute of Population Health, University of Manchester, UK

ViewIt: A Tool for the Visualization of Urban Health Data

No abstract available

Professor Hua Fu, Deputy Dean of School of Public Health, Director of department of preventative medicine, Fudan University, China

GHIFT: Perspectives from Shanghai, China

No abstract available

Dr Megumi Kano, Technical Officer, WHO Kobe Centre, Japan

WHO Kobe Centre and its Promotion of Urban Health Metrics Development

No abstract available

Exchange 4
12:40

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	Redressing health inequality: Impact of the research findings
Chair	Professor David Vlahov

Professor Fatemeh Rabiee, Professor of Public Health Promotion, Birmingham City University

Redressing health inequality: Impact of the research findings

This interactive workshop is based on three case studies from Birmingham, UK and Saudi Arabia. It begins with a short presentation of each study, highlighting various issues of inequalities then will focus on the impact and outcome of the findings in terms of how they have influenced health policy, health and social care provision for the research communities.

Participants will have a chance to explore the role of advocacy and skills required to partnership working with the policy makers and other stakeholders in helping them to translate the findings into action with a real impact on people's health and wellbeing.

1. Understanding Mental Health and Experience of Accessing Services in African and African Caribbean Users & Carers in Birmingham-UK

Introduction: Numerous reports have identified shortcomings in mental health services that have contributed to the poor quality of care and treatment provided for many black people. The geopolitical situation of the last decade, and an influx of refugees and asylum seekers from African countries, has added to the challenge of psychiatric service provision in UK.

Aim: This study aimed to examine the extent to which statutory and voluntary mental health services in Birmingham-UK, are meeting the needs of members of a range of Black African and African Caribbean communities. This was achieved through exploring understanding of mental health and experience of accessing mental health services amongst the target groups.

Methods: The study was based on the interpretative paradigm (Giorgi, 2003); focusing on how people attach meanings to social reality that influence their actions. Qualitative data was collected through 9 focus groups and 4 individual in depth interviews. Using a purposive sampling strategy, 25 service users and 24 carers were recruited; interviews recorded, transcribed and analysed using Krueger's framework (2000) & Rabiee's guidelines (2004).

Findings: Participants understood mental illness as a social problem linked with material and social deprivation, racism, a triggering trauma and an inappropriate treatment response. Loss was a recurrent theme across different focus groups. At least 20 people mentioned loss in their accounts of their experience of mental illness; although the nature of loss varied from losing a loved one to loss of home, identity or social status amongst different participants. Lack of respect and understanding in relation to religious and spiritual beliefs, was a cross cutting theme highlighted by participants. The findings highlight the link between the erosion of family and social support systems and mental illness particularly among participants from Somali and Congolese refugee and asylum seekers.

Conclusion & Recommendations: The findings provide new challenges for redressing health inequalities, and argue that to improve mental health, the social inequalities of "people's unequal lives" needs to be understood and confronted. Engaging users and carers in care pathway, acknowledging users' health beliefs and the importance of spirituality in healing, provision of alternative interventions and working closely with voluntary organisations and spiritual leaders are recommended for improving clinical outcomes and patient -centred care. This is essential for patient-centred, quality care, together with the provision of equitable psychiatric services particularly in relation to the process of sectioning, provision of talk therapy, and ensuring continuity of care. The presentation will highlight the policy and practice impact and outcome of the research findings.

2. Impact of the "Gym for Free Scheme" on Health and Wellbeing of Residents in Ladywood Constituency, Birmingham, UK

This paper presents the process, impact and outcome of an innovative award winning joint health Policy project "Gym for Free Scheme" between the Local Authority and one of the Primary Health Care Trust in Birmingham. The evaluation aspect of the scheme explores its effectiveness in relation to access, utilization, perceived health benefits and wellbeing of the target population and its sustainability in prevention & management of obesity within the first 6 months.

Methods of data collection were survey using a validated questionnaire, and focus group interviews using a semi structured interview schedule. 257 participants of the scheme were recruited for survey and 17 informants for 3 focus group interviews. Quantitative data entered into the SPSS package, and analysed using both descriptive and inferential data analysis. Focus group interviews were recorded and transcribed, and then analysed using Krueger's framework (2000), and Rabies's guidelines (2004).

Findings suggest that the scheme has been successful in increasing the uptake particularly amongst the most economically disadvantage group. There was a marked difference between the use of leisure facility before and after the introduction of the scheme ($p<0.05$), and particularly in relation to the frequency of use (25% versus 64%). The scheme had multiple benefits including physical, mental and emotional. It also promoted lifestyle changes and social networking such as: eating more fruit and vegetables (68% versus 41%), less fatty and sugary food (43% versus55%), less binge drinking (26%) finding friends and support group. One third of participants reported 3-7 kg weight loss. Other benefits mentions were: increased energy levels (47%), increased fitness level/ stamina (40%), muscle gain (37%), increased confidence (35%), stress relief (30%), loss of body fat (27%), less visits to General Practitioners (8%), and reduction in using antidepressant medication (10%).

In conclusion the scheme has taken a step towards addressing heath inequality and widening participation. Also it motivated people to alter their eating patterns, lose weight, and had a positive impact on users' health and wellbeing within the first 6 months. The presentation will highlight the health policy impact and outcome of our research findings. It also will highlight the policy and practice impact and outcome of the research findings.

3. Lifestyle and migration effects on Cardiovascular Diseases in an urban population in Saudi Arabia

Thursday 6th March

Introduction: Cardiovascular Diseases (CVDs) are leading causes of death worldwide; over 80% of the deaths from CVDs occur in low-and middle income countries (WHO, 2008). Saudi Arabia has high prevalence of many cardiovascular risk factors (CVRFs), including: tobacco use, physical inactivity, hypertension; diabetes mellitus (DM), overweight and obesity. The potential effects of immigration on heart health received attention in recent years; although more than one third of SA employees are expatriates, no study has yet investigated its impact on heart health.

Aim: This study aims at assessing the prevalence of cardiovascular risk (CVR) for the employees of a Saudi University and their families; evaluating the impact of migration on lifestyle behaviours and heart health of expatriate population; and developing a framework for health promotion intervention.

Design, setting and participants: A cross-sectional survey using WHO StepWise tools is used to collect data from 4500 employees and their families above 18 years old and non pregnant women.

Results: Two third of the participants were Saudi. Significantly higher proportion of Non-Saudi were employed (66% vs 50%), married (93% vs 74%), had university education or higher degree (79% vs 50%), had higher abdomen obesity (50% vs.35%) and were overweight or obese (78% vs 69%). Also they had significantly higher CVRFs: hypertension (34% vs 23%), and Hyperlipidemia (58% vs 50%) respectively. Using the Framingham scale, significantly higher proportion of Non-Saudi had low CVR risk (68.5% vs 53%), lower proportion intermediate risk (18.3% vs 35.7%), but more high risk score (13.2% vs11.4%) respectively. Preliminary analysis of the lifestyle changes of the migration community will be presented. Health promotion and policy implications of the findings in relation to urban health, migrant community and engaging the public in looking after their health will be discussed. The presentation will also highlight the impact of our research findings on practice.

Exchange 4

14:00

Urban Health Metrics/ GHIFT	
Session title	Urban Health Index
Chair	Dr Megumi Kano

Professor Richard Rothenberg, Regents' Professor, School of Public Health, Georgia State University, Editor of the Annals of Epidemiology

An Urban Health Index

No abstract available

Dr Scott Weaver, Director, Data and Research Services, School of Public Health, Georgia State University

Application of the Urban Health Index to Studying Geospatial Health Inequalities in Japan

No abstract available

Mr Martin Bortz, Doctoral Candidate, Institute of Public Health, Medical School University of Heidelberg, Germany

Applying the Urban Health Index to Rio de Janeiro, Brazil

No abstract available

Dr Dajun Dai, Assistant Professor in Geography (GIS), Department of Geosciences, Georgia State University

Applying the Urban Health Index to Shanghai, China

No abstract available

Exchange 5

11:00

Drug Users: Outcomes, Evidence and Policy	
Session title	Drug treatment and outcomes
Chair	Professor Jutta Lindert

Dr David Best, Associate Professor of Addiction Studies, Monash University and Turning Point

Demand modelling and outcome monitoring in drug treatment

No abstract available

Dr Andrew Jones, Research Fellow, National Drug Evidence Centre

Drug Treatment Outcomes

No abstract available

Exchange 5
11:00

Drug Users: Outcomes, Evidence and Policy	
Session title	Drug treatment and outcomes
Chair	Professor Jutta Lindert

Ms Sinead O Reilly, Health Advisor, GOAL, Ireland

Co-authors: Katherine Owen, Geraldine McCrossan, Emily Robertson

Innovation behaviour change interventions for reducing substance abuse in 8 - 24 years in Freetown, Sierra Leone

Background: Cited as one of the most serious challenges of the 21st Century , Non-Communicable Diseases (NCDs) are responsible for over 60% of all deaths worldwide, killing 36 million people every year. If current trends continue, the largest increases in NCD deaths will occur in Africa. Sierra Leone, challenged by some of the worst health indicators in the world and a weak health care infrastructure, is ill-equipped to deal with an increasing disease burden caused by NCDs. In 2009 the Ministry of Health and Sanitation (MoHS) reported a high prevalence of risk factors for NCDs among the adult population: 26% use tobacco, 17% use alcohol and around 90% consume inadequate diets and live sedentary lifestyles . Aim: In 2011 GOAL designed a two-year programme aimed at reducing NCDs and other negative impacts of substance use (tobacco, alcohol, illicit drugs) among children and youth (aged 8-24 years) in slum and disadvantaged areas of Freetown, Sierra Leone Design: The interventions aimed at generating a scientific research base for understanding substance use among children and youth living on the streets and piloting approaches to promoting healthy life choices; and building the capacity of the public health sector to apply best practices in the control of NCDs. Results: To develop a scientific research base two population-based cross-sectional surveys using a two-stage cluster random sampling design interviewed 805 8-24 year olds living on the streets in 27 city sections in Freetown. The results confirmed the high levels of tobacco, alcohol and marijuana use; as an escape from the difficulties of living on the street; and the strong influence of the peer group as a driver for use. Based on these findings GOAL designed a behaviour change programme ‘Fight Drugs’ aimed to increase the access children and youth had to high quality, information on drugs by engaging them in exciting, interactive and highly experiential ways. In turn, Fight Drugs sought to challenge the stigma children and young people living on the street face due to low awareness, discrimination, and misplaced fear within their communities. By 2013 there was a 29% reduction in the number of 8-14years old who had ever used drugs and 30% reduction in those who used drugs in the month prior to the survey. Among 15-24years old there was a 20% reduction in those who had ever used drugs and 30% reduction in those who used in the 30 days prior to the survey. Conclusions; The success of this programmes was that the behaviour interventions were designed based on evidence and that also targeted influencing groups. The scientific evidence base was used to advocate for a national strategy and successful launch the first Sierra Leone NCD national strategy in September 2013. At the conference GOAL will present the in full the interventions and the results on working with influencing groups in behaviour change.

Exchange 5
12:40

A Perspective from Fresh Minds

Chair Nazmus Khan and Nicolas Savage

Hassan Ahmad, Student, University of Manchester

Co-authors: Dr Vinay Bothra

Let's BASHH it out. Are the BASHH guidelines for HIV testing in secondary care in Greater Manchester effective?

The objective of this study is to examine the HIV testing protocol enforced in the 4 big hospitals trusts in the Greater Manchester region, (MRI, Salford Royal, Wythenshawe and North Manchester General) and determine whether the BASHH guidelines have been effective in promoting an increased HIV test uptake. This will be done by collecting quantitative raw data to see whether there has been any significant change in the uptake in testing since the guidelines have been introduced. The project will also look at the current barriers and facilitators facing the medical teams at these sites and recommendations will be provided (if improvement is required) taking evidence from a literature search as to how to improve the service. This is of particular importance as both Manchester and Salford currently have the 2nd and 3rd highest HIV prevalence rates outside of London.

Exchange 5
12:40

A Perspective from Fresh Minds

Chair Nazmus Khan and Nicolas Savage

Mehfuz Patel, Student, University of Manchester

Co-authors: Vinay Bothra

Promoting HIV testing in Primary Care: A Manchester Perspective

As part of a Personal Excellence Path (PEP) this project will explore the the possibility of expanding HIV testing throughout Primary Care in the Manchester area. In the UK there are an estimated 96,000 people living with HIV, of these 24% of these are unaware of their infection - not only are they unable to gain the benefit of early diagnosis and HAART they are potentially putting their partners and risk of HIV. Manchester with a prevalence of 5.66/1000 has the second highest prevalence of HIV outside of London and thus is an area 'high prevalence' and as per the CMO and HPA it is recommended that there are increased levels of testing in these areas. This paper will explore if Manchester is achieving the recommended testing levels, by analysing data collected from GP practises in the area on the extent of testing any strength and gaps will be identified allowing exploration of what barriers exist in testing and what recommendations can be put forward to overcome these barriers and then promote higher rates of HIV testing - ensuring that these recommendations are tailored to Manchester and the needs of its population and healthcare providers.

Exchange 5

12:40

A Perspective from Fresh Minds

Chair Nazmus Khan and Nicolas Savage

Dr Aneela Rahman, Associate Professor, Liaquat University of Medical & Health Sciences, Jamshoro, Sindh, Pakistan

Co-author: Dr Khalida Naz Memon

Author Request: Abstract Not Permitted

Exchange 5
12:40

A Perspective from Fresh Minds

Chair Nazmus Khan and Nicolas Savage

Nicolas Savage, Student, University of Manchester

Protection for prisoners protects the community

The subject of sexual relations between prisoners does not attract much in the way of public health resource or political interest. Prisoner healthcare is often seen to be at odds with the security needs of the penal system or populist 'punishment' rhetoric from elected officials. However, once released former prisoners pose a serious healthcare risk to the entire community. Inmates who acquire sexually transmitted infections whilst in prison are more likely to spread these amongst the wider population. Thus prisoners are a key target for Public Health England in efforts to contain the burden of sexually transmitted diseases. Her Majesty's Chief Inspectorate of Prisons policy statement on prisoner health stipulates that 'barrier protection should be freely available to all prisoners'. Never the less, the availability and accessibility of condoms to the prison population remains patchy. Here in Greater Manchester we studied the different policies adopted by HMP Forest Bank, HMP Manchester, HMP Hindley, and HMP Buckley Hall in an attempt understand why condom provision is not universal as well as to identify best practices based on evidence.

Exchange 5

14:00

Drug Users: Outcomes, Evidence and Policy	
Session title	Drug use, risk and visualisation
Chair	Dr Andrew Jones

Dr Michael Donmall, Director, National Drug Evidence Centre

Visualising Social and Geographical Patterns of Problem Drug Use

No abstract available

Exchange 5
14:00

Drug Users: Outcomes, Evidence and Policy	
Session title	Drug use, risk and visualisation
Chair	Dr Andrew Jones

Dr Sabriyah Linton, Postdoctoral Fellow, Rollins School of Public Health, Georgia, USA

Co-authors: Carl A. Latkin, Jacky M. Jennings, Caitlin E. Kennedy, David D. Celentano, Gregory D. Kirk, Shruti H. Mehta

Urban redevelopment, injection drug use, and visible drug activity in Baltimore, Maryland, USA, during 2000-2010

Background: Baltimore, Maryland has among the highest prevalence of injection drug use in the US. At the community-level, injection drug use has been associated with physical decay, economic deprivation, and visible drug activity. Various urban redevelopment strategies have been implemented to revitalize declining neighborhood conditions. This study used a mixed-methods approach to evaluate the potential impact of urban redevelopment on injection drug use and visible drug activity in Baltimore. Methods: First, qualitative in-depth interviews were conducted with 25 participants enrolled in the AIDS Linked to the IntraVenous Experience (ALIVE) Study who reported residence in or near a neighborhood slated for redevelopment in East Baltimore. Interviews were analyzed using the constant comparison method. Second, individual-level data from 1818 ALIVE participants were linked to neighborhood data, and a cross-classified multilevel model was used to assess longitudinal associations between neighborhood residential rehabilitation (% of residential properties with maintenance investment >$5,000 USD) and injection drug use. Residential rehabilitation was lagged one visit. Third, a space-time scan statistic approach was used to identify clusters of visible drug activity (narcotic calls for service) using a discrete Poisson model. Results: In qualitative interviews, respondents described positive consequences of residential rehabilitation including reduced visible drug activity, improved mental health, and increased collective efficacy; residential relocation due to redevelopment was described as supporting drug cessation and recovery. However, drug activity was also described as being more hidden and displaced to other neighborhoods, and respondents reported other negative consequences related to housing, employment, and social capital. In quantitative analyses, longitudinal multilevel models demonstrated an inverse association between living in a neighborhood in the second or third category of residential rehabilitation and injection drug use (second category: adjusted odds ratio (AOR)= 0.77, 95% confidence interval (CI)=0.67, 0.87; third category: AOR=0.74, 95% CI= 0.61, 0.91). Space-time cluster analysis demonstrated a reduction of visible drug activity in East Baltimore and provided evidence for potential displacement of visible drug activity to North and Northeast Baltimore. Discussion: Urban redevelopment may reduce substance abuse and may also facilitate reductions in visible drug activity. Negative consequences related to housing, employment and social capital, however, may also result for some residents and communities. Future research should focus on identifying the specific mechanisms of these health and social consequences, both positive and negative, to better inform "Health in All Policies" approaches.

Exchange 5
14:00

Drug Users: Outcomes, Evidence and Policy	
Session title	Drug use, risk and visualisation
Chair	Dr Andrew Jones

Miss Adrienne Cheung, Student, University of British Columbia

Co-authors: Julian M Somers, Akm Moniruzzaman, Michelle Patterson, Jim Frankish, Michael Krausz, Anita Palepu

Substance Dependence and Health Service Use Among Homeless Adults with Mental Disorders in a Housing First Trial

Objective: To examine the relationship between substance dependence and health service use among adults who were homeless with mental disorders two years after randomization to a Housing First (HF) intervention or Treatment as Usual (no additional housing or support). Design: The Vancouver At Home study consists of two randomized controlled trials of HF interventions. Substance dependence was determined using the MINI 6.0 instrument. To assess health service use, we examined the number of emergency department (ED) visits and the number of hospital admissions based on administrative data for 6 urban hospitals. Negative binomial regression modeling was used to examine the independent association between substance dependence and health service use, adjusting for HF intervention, age, gender, ethnicity, education, length of lifetime homelessness, mental disorders, chronic health conditions, and other variables that were selected a priori to be potentially associated with health service utilization. Setting: Participants were recruited through referrals from community agencies including shelters, drop-in centres, homeless outreach teams, mental health teams, inpatient hospital wards, and criminal justice programs in Vancouver, British Columbia, Canada. Participants: 497 homeless adults with mental disorders were recruited, of whom 58% (N=288) met criteria for substance dependence. We included 381 participants in our analyses who had at least one year of follow-up and had a personal health number that could be linked to comprehensive administrative data from all regional hospitals. Of this group, 59% (N=223) met criteria for substance dependence. Results: We found no independent association between substance dependence and health service use in the form of ED visits and hospital admissions (IRR=0.85; 95% CI: 0.62-1.17 and IRR=1.21; 95% CI: 0.83-1.77, respectively). The most responsible diagnosis for hospital admission was one of schizoaffective disorder, schizophrenia-related disorder, or bipolar affective disorder in 48% (N=263) of hospital admissions. Fifteen percent (N=84) of hospital admissions were attributable to substance use. Conclusions: Substance dependence was not independently associated with health service use in homeless adults with mental disorders participating in a HF trial. Hospital admissions among this cohort were driven by severe mental disorder diagnoses.

Exchange 6
11:00

Tobacco Control	
Session title	Tobacco Control, Young People and Social Media
Chair	Professor Waleska Caiffa

Dr Luca Sala, Director of Veterinary Public Health Service, Director of the Department of Prevention, ASL Biella

Health promotion in tobacco control use in young people

No abstract available

Hadas Altwarg, Deputy Chief Executive, Tobacco Free Futures

Smoke & Mirrors - Taking a Stand against the Tobacco Industry

No abstract available

Exchange 6
12:40

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Abstract Presentations
Chair	Professor Paula Martins

Professor Paula Martins on behalf of Mr Matheus Melzer, Master Student, Federal University of São Paulo
Co-authors: Matheus Ribeiro Theodósio Fernandes Melzer, Isabella Mastrangi Magrini, Paula Andrea Martins

Maternal abdominal obesity and female gender are associated with abdominal obesity in children living in an urban area.

Background: Abdominal obesity in children has been associated with cardiometabolic risk factors, individual and environmental characteristics. Aim: To assess the association of dietary and socioeconomic factors, sedentary behaviors and maternal nutritional status with abdominal obesity in children living in an urban area. Design: Cross-sectional design with household-based survey. Setting: The urban area of Santos City in Brazil. Participants: A sample of 357 mothers and their biological children aged 3-10 years residents of 36 randomly selected census tracts. Methodology: Two interviews were conducted by health professionals previously trained by the Nutritional Environment Assessment 'AMBNUT' research group for data collection which included socioeconomic and physical activity questionnaires, anthropometric measures (weight, height, waist circumference, skinfolds) and two 24h recall, one on each visit. Assessment of children's abdominal obesity was made by waist circumference measurement, in the midway between the hip bone and their lowest rib. For classification it was used the cut-off points proposed by Taylor et al. (2000) which uses the 80 percentile of waist circumference and a model for the multiple logistic regression was adjusted for analysis using the SPSS version 18 software. Consent forms were collected before the first visit. Households which mothers had gone through bariatric surgery, had cancer, AIDS or were pregnant were not interviewed. Results: It was found that 30.5% of children had abdominal obesity. Univariate analysis showed significantly associations ($p < 0.05$) were found with children's body mass index (BMI) for age equal or higher than 1 z-score, maternal abdominal obesity by waist circumference above 80cm, maternal total fat above 32 percent, maternal overweight classified by the World Health Organization cutoff points for BMI, higher socioeconomic status classified according to their purchasing power by the Brazilian Association of Survey Companies, household car possession and higher protein intake. In the multivariate regression model, it was included all variables with a p value < 0.2 in the univariate analysis, and for the adjusted model children's BMI for age (OR: 93.7 IC95% 39.3-223.3), female gender (OR: 4.1 IC95% 1.8-9.3) and maternal abdominal obesity (OR: 2.7 IC95% 1.2-6.0) were significantly associated, regardless of socioeconomic status, which lost its significance. Nor sedentary behaviors or other dietary factors showed significance in the analysis. Conclusions: Abdominal obesity in children seems to be more associated with maternal nutritional status, other indicators of their own nutritional status and female gender. More studies are needed for better understatement of the use of waist circumference on children. Nutritional education programs on urban areas should focus on working with both mother and children for a better outcome on children's health.

Exchange 6

12:40

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Abstract Presentations
Chair	Professor Paula Martins

Ewa Monteith-Hodge on behalf of Ms Ange Cullen, Research Assistant, McCreary Centre Society

Let's Get Moving: Insights on the Physical Activity of Youth in Urban Settings across British Columbia

INTRODUCTION: In British Columbia (BC), Canada and throughout the world, youth in urban settings are less likely than their peers in rural areas to meet national physical activity guidelines. In 2008, for example, it was found that 17% of youth in BC's urban areas participated in 20 minutes of physical activity daily during the past week, while 19% of students in rural areas met this achievement. Further, youth in urban areas were more likely than their peers in rural areas to have not exercised for this duration at all during the past week (9% vs. 7%). From a population health perspective, the importance of physical activity (for individuals and society collectively) warrants public health efforts. In particular, it is important to consider how urban settings can either help or hinder young people's ability to be physically active. AIM: Use findings from the 2013 BC Adolescent Health Survey (BC AHS) to understand both the degree to which physical activity plays a role in the lives of youth in BC's urban settings, and those supports that could further enable young people's physical activity. DESIGN: Conducted by the McCreary Centre Society, the BC AHS is a survey of students in public schools throughout the province. The survey consists of 130 questions covering demographics, physical and mental health, and health-related behaviours and experiences. The BC AHS was first issued in 1992; administered every five years, 2013 represented the survey's fifth cycle. The survey entails a random cluster-stratified design in which classrooms are randomly selected to participate, stratified by geography and by grade (7 through 12). PARTICIPANTS: The 2013 BC AHS was completed by 29,832 students age 12 to 19 years (51% female). RESULTS: With comparison to the 2008 BC AHS results, findings to be discussed include young people's modes of transportation to/from school, how often students participate in extracurricular sports or physical activities and achieve daily recommended levels of physical activity, the meaningfulness of these activities, and the reasons students are unable to participate in such activities. In addition, the experiences of students in urban settings are compared to their peers in rural settings, to show how urbanization might influence young people's ability to be physically active. CONCLUSION: In the context of healthy growth and development, physical activity can offer youth a multitude of positive and rewarding health outcomes. By examining the prevalence of physical inactivity and related experiences among urban BC youth, the BC Adolescent Health Survey provides valuable insight into the physical health needs and interests of young people, and where efforts addressing inactivity in BC's urban settings have been successful or are in need of further attention.

Exchange 6
12:40

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Abstract Presentations
Chair	Professor Paula Martins

Professor Claudia Oliveira, Professor, Federal University of Sao Joao del-rei

Early mortality in patients after hospitalization for diabetic care sensitive conditions primary in a middle city of Brazil: A worrying reality

Objectives:Hospitalizations related to diabetes mellitus (DM) and its complications are considered Ambulatory Care Sensitive Conditions (ACSC) and represent about 4.3% of hospital admissions. Previous studies have observed that re-hospitalizations for diabetes ranged from 20.2%- 23.1% and that adequate outpatient care significantly reduced the risk of new admission. In order to understand the reality of the healthcare system in the care of DM, a study is being conducted to monitor the course of the users and evaluate the impact of ACSC admissions for diabetic patients. Design: A prospective cohort study that included all diabetic patients older than 18 years , hospitalized in the period July-October, 2011 in Divinópolis , MG, Brazil, a city of 200,000 inhabitants and referral center for the region . After 18-24 months of discharged, we conducted the first visit of folow up. Data were collected containing sociodemographic , lifestyle, and food and medications, social support networks and quality of life, clinical and anthropometric examination, ECG and blood tests. Divinopolis has 17 teams of the Family Health Strategy (FHS) , which represents a population coverage of 27.5% . The Brazilian Health System is public and it is expected that the FHS would attend 100% of the population being the health system gateway. Results:92 patients were eligible for the study and 72 have already been approached by phone or home visit . Of these , 6.9% refused to participate after three contact attempts and 9.75 % were not changed or municipality. After about 20 months, there were 22 deaths, with a mortality rate of 30.6% in the study population. The mortality rate in patients 50-69 years was 36.4% and above 70 years was 43.5%. Approximately 20.4 % of patients had poor metabolic control, 18.2% had high blood pressure and 29.5% had signs of diabetic foot , 25% of patients were unable to walk to the nearest health Unit. In this study, diabetes contributed 126 years of potential life lost, which equates to an average of 10.5 years of life less per individual. All patients interviewed in this research were sent to the reference center, where they are receiving adequate care. Discussion: Around 50% of patients remained without adequate treatment after discharge. For those seeking health care , the costs of medication and maintaining a proper diet can also make it difficult for low-income patients benefit from health care. The percentage of complications observed in the study group points to a potential seriousness of the situation. Conclusion: Brazil advanced in building a comprehensive health system, but because of its complexity improve their quality and resolution is still a major challenge. Better preparation of teams and strengthening networks of care to diabetic patients involving all levels of care are mandatory. The partnership between health services and universities are a viable possibility for diagnosis and intervention in these scenarios.

Exchange 6

12:40

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Abstract Presentations
Chair	Professor Paula Martins

Dr Md. Mobarak Hossain Khan, Assistant Professor, University of Bielefeld Department of Public Health Medicine

Prevalence of diabetes and overweight/obesity and their association among general adults in Bangladesh

Abstract not available

Exchange 6

14:00

Policymaking and Political Leadership for action on urban health	
Session title	Integrated Health Policy; the case of Amsterdam, the Netherlands
Chair	Debbie Abrahams

Luuk Tubbing, Department of Public Health, Academic Medical Center, University of Amsterdam

The concept of Integrated Health Policy

Introduction: Integrated health policy (IHP) is considered a promising approach in dealing with wicked health problems. However, conceptual ambiguity and diversity among approaches is hampering further research and applications. We aimed to contribute to conceptual clarification as a first step towards operationalising IHP. Methods: In an online concept mapping procedure, we invited 237 Dutch experts from the fields of science, policy, and practice, 62 of whom generated statements on characteristics of IHP, specifically on the local level. Next, 100 experts were invited, 24 of whom sorted the statements into piles according to their perceived similarity and rated the statements on relevance and measurability. The data was analysed using concept mapping software. Results: The final concept map consisted of 97 statements, grouped into 11 clusters, and partitioned into five themes. The core themes were ‘integration’ and ‘health’, the first being about ‘policy coherence’ and ‘organising connections’, and the latter about ‘positioning health’ and ‘addressing determinants’. The more peripheral themes were ‘generic aspects’, ‘capacities’, and ‘goals and setting’, which respectively addressed general notions of integrated policy making, conditions for IHP and the variety in manifestations of IHP. Mean measurability ratings were low compared to relevance. Conclusion: Our concept map unified and organised a comprehensive range of aspects of IHP, appreciating the aspects' conceptual interconnectedness and the concept's complexity. Furthermore, it distinguished core and peripheral themes. While IHP can be considered as a hard to measure concept, our concept map provides a fruitful basis for further operationalization in future research, policy, and practice.

Exchange 6
14:00

Policymaking and Political Leadership for action on urban health	
Session title	Integrated Health Policy; the case of Amsterdam, the Netherlands
Chair	Debbie Abrahams

Kirsten Langeveld, Department of Public Health, Academic Medical Center, University of Amsterdam

The employment of a knowledge broker as a means to make health an integral part of the local policy: A case study in the city district of Amsterdam New West, The Netherlands

Introduction: In order to reduce health inequalities it is necessary to address determinants outside the health sector. Healthy public policy is considered a promising way of improving public health.There is not much known about how to transform current local policy into Healthy Public Policy (HPP). There is a gap between theory on HPP and actual development and implementation of this kind of policies. One of the barriers for making health an integral part of local policies is a lack of awareness and knowledge among civil servants of the way health is related to (issues that are central to) their own policy domain. Aim: We installed a knowledge broker to promote the integration of health issues in policies on the social determinants of health (SDH) at the local level. Methods: To increase awareness and knowledge we set the agenda for health among civil servants with the rainbow model of Dahlgren and Whitehead. We specified alternatives to current policy documents so that health became integrated in this policy documents. In the city district of Amsterdam New West, the Netherlands we studied several policy cases, like Poverty and Economy. We based our data collection on interviews, observations and policy documents. Results: Agenda setting of the knowledge broker: The rainbow model increased the awareness of the civil servants of the role their policy field played for health. As is expressed by the information the civil servant responsible for the policy on poverty sought on health and sent to the knowledge broker.Specifying alternatives of the knowledge broker: Integration of policy alternatives succeeded for a large part. For example our proposition to stress the vulnerable position of free lance workers was added to the Economic policy document. Conclusion: The employment of a knowledge broker by agenda setting of health (increasing awareness and knowledge of SDH among civil servants) and specifying alternatives to policy documents is a promising way to make health and integral part of local policy and in this way we aim to bridge the gap between theory on HPP and its practice.

Exchange 6
14:00

Policymaking and Political Leadership for action on urban health	
Session title	Integrated Health Policy; the case of Amsterdam, the Netherlands
Chair	Debbie Abrahams

Jennifer R. van den Broeke, Department of Public Health, Amsterdam Medical Center, University of Amsterdam

Professionals' experiences when working with people with complex needs and the program theory of a solution: a qualitative study

Introduction: Residents of deprived urban neighbourhoods are more likely to suffer from chronic diseases, overweight, and unhealthy lifestyles. They experience more problems with work, housing, income and child rearing. Irrespective of this higher burden of problems, the utilisation of care is higher than in non-deprived neighbourhoods. It is increasingly recognised that people with complex needs are worse off in a fragmented health and social care system, than people with common – single – needs. Therefore it is hypothesised that professionals should work in more 'integral' ways 1) to adequately address the complex needs, and 2) to reduce utilisation of care. In a pilot project in Amsterdam North, The Netherlands, an experiment is undertaken to integrate preventive-, social- and health care to offer integral support. To understand how to shape integral working, it is necessary to know what problems professionals experience when working with people with complex needs. Aim: In three deprived neighbourhoods in Amsterdam North, the Netherlands, we explored what problems professionals experience when working with people with complex needs, and we describe the pilot project's program theory to tackle these problems. Methods: In depths interviews with professionals working in the pilot neighbourhoods. Action research to develop a program theory. Interviews were recorded, transcribed, and analysed using framework analysis. Action research consisted of field observations at neighbourhood conferences and partnership meeting, interviews and conversations, and dialogue sessions with project coordinators for reflection upon and accentuating of the program theory. Results: Respondents (n=18) consisting of 5 social workers, 3 nurses, 2 psychologists, 2 physician assistants, 2 case managers, 2 physiotherapists, and 2 general practitioners, experience a variety of problems when supporting people with complex needs. These problems cluster around the following themes: 1) competencies (lack of competencies to coach patients and to act in a generalist manner to be able to oversee all social and medical needs), 2) multidisciplinary collaboration (practical problems in reaching other professionals for consulting and gearing activities to one another), and 3) organization (lack of support from the organizations they work for in supporting multidisciplinary collaboration). Conclusion The pilot project in Amsterdam North is primarily top down in nature. The aim is for professionals to develop new competencies that will enable them to work in a generalist, population health oriented, and coaching manner, which makes more adequate care and support to people from deprived neighbourhoods possible. To reach this aim action was undertaken to establish a partnership of social-, preventive- and care organizations. This helps the competing organizations to set a common goal leading to more support for professionals to collaborate. The partnership developed training for professionals and a protocol with the motto 'one client – one plan – one case manager'.

Exchange 6
14:00

Policymaking and Political Leadership for action on urban health	
Session title	Integrated Health Policy; the case of Amsterdam, the Netherlands
Chair	Debbie Abrahams

Arnoud P. Verhoeff, Department of Epidemiology & Health Promotion, Public Health Service Amsterdam, University of Amsterdam

Tackling the overweight epidemic: an integrated approach to reduce overweight and obesity among children in Amsterdam

Introduction: The prevalence of overweight and obesity among the youth in the city Amsterdam, the Netherlands, is around 8% higher than the national mean (23% and 15% respectively). Within the city the prevalence is higher among children living in deprived areas, and among migrant children coming from non-Western countries. Overweight is generally related to imbalance of energy intake and energy use, and is a complex phenomenon. To tackle the overweight epidemic, an integrated approach is necessary. Aim: The aim of the 'Amsterdam Approach Healthy Weight 2013-2033' is to reduce the incidence and prevalence of overweight among the youth on the long run. The prevalence of overweight among the youth in Amsterdam should at least be comparable with the prevalence at national level in the year 2033. Methods: The programme focusses on the prevention of overweight and obesity, and the reduction of overweight and obesity. Activities will be focussed on the settings school, environment (social and physical) and care. The activities will be accompanied by evaluation research in order to monitor the progress, to increase the effectiveness and to implement new scientific knowledge. Conclusion: An integrated approach to reduce the incidence and prevalence of overweight and obesity among youth seems to be the most promising. In the coming years, the approach in Amsterdam will give more scientific insight in the effectiveness of the approach.

Exchange 7

11:00

Citizens' Engagement / Engaging the public in looking after health	
Session title	A Tale of two cities - public engagement in London and Manchester
Chair	Dr Richard Fitton

Samantha Meikle, Director, London Connect

Patients accessing their own records and will they dance (YMCA)?

No abstract available

Dr Richard Fitton, GP

Manchester, patient and family centred health data, patient accessed records and the GMC response to doctor Harold Shipman mass murderer

No abstract available

Exchange 7
12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Shamin Talukder

Dr Clareci Cardoso and Marco Tulio Torres Barros, Professor, Universidade Federal de São João Del Rei

Co-authors: Paulo Rafael Fonseca Silva, Hector Yuri Souza Ferreira, Juliano Cleriston da Silva, Roniere Souza e Silva, Eduardo Dias Chula

Evaluation of pre-hospital delay in care to patient with a diagnosis of acute myocardial infarction in the central west of Minas Gerais State, Brazil

OBJECTIVE: To understand the line of clinical care of patients with Acute Myocardial Infarction (AMI) in the emergency services in Divinópolis-MG, Brazil. METHODS: prospective cohort study over a period of 10 weeks. Was conducted surveillance in five emergency services to identify patients with AMI diagnoses. Patients with confirmed diagnosis were interviewed at the time of hospitalization and information on the procedures performed, outcome and satisfaction were raised through medical records and interviews. We conducted descriptive and multivariate analysis using the method of classification and regression tree. RESULTS: 40 patients were diagnosed with AMI, and three died during the hospitalization. The results show a delay in seeking care for AMI treatment in 37.5% of patients investigated. The profiles of patients who arrive early in the emergence service are those with AMI with SUPRA ST and those who have done primary or rescue angioplasty. In relation to sociodemographic variables, age, education, number of people in residence and sex were important variables associated with time. The main treatments were primary angioplasty (17.5%) and fibrinolysis (37.5%). The door-to-balloon time was longer than 90 minutes in 85.7% of patients and door-to-needle longer than 30 minutes in 61.5% of patients. The satisfaction with the medical care received and delivered was 5.0 and 3.5 respectively on a scale CARDIOSATIS_Usuário and medical team (0-5).CONCLUSION: The time between onset of symptoms and the first assistance was higher than recommended (two hours) in 38% of patients. Less than 40% of patients had a door needle time of 30 minutes, which is less than the parameters established protocols to the treatment of AMI. Furthermore, only 14.3% of patients who underwent primary angioplasty had door-to-balloon time of less than 90 minutes as recommended by the American Heart Association. Complications of AMI are associated with their rapid evolution and the lack of symptoms in the population. Thus, it is important to know the time between the onset of symptoms to the first visit and the clinical status on admission, since these factors are associated with prognosis and treatment. These results point to the need to restructure the network of care to AMI in the region, creating protocols for standardization of procedures. On many occasions the patient comes to the emergency department on time, but it is not even underwent primary angioplasty with clinical indications for this procedure. Furthermore, it is essential to create an answering service mobile emergency in the region for the initial treatment of patients with AMI can be optimized.

Exchange 7
12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Shamin Talukder

Mr Cordero Tanner, Student, Georgia State University

There Is No Stress in Team: How Participation in Sports Provides an Alternative Therapy for the Mental Wellbeing of Urban Youth

This paper suggests using sports to impact the mental wellbeing of today's urban youth who are exposed to violence. Violence in urban communities ignites a stressful environment and negatively impacts the mental wellbeing of youth. Violence in urban communities ranges from weapon use, physical aggression, domestic violence, and gang-related activity. Through primary research and a review of literature, I have found evidence that exercise and sports have a positive effect on stress. Exercise increases overall health and an individual's sense of mental wellbeing. With proven evidence that exercise helps reduce stress, I argue that there is a need for sports in our urban youth population to relive stress. After interviewing a small sample size of people who were involved with sports at varying levels, findings show that sports provided an alternative to the traditional therapy model. Sports give inner city youth another way of coping with stress and reduce their exposure to violence in their communities. Economically urban communities do not have the same access to counseling and mental health facilities. The cultural norms around seeking out mental health services in urban communities are also different. In urban populations, individuals deal with mental problems on their own, often using drugs and alcohol to self-medicate. Using sports is an acceptable, inexpensive, multiple layer mechanism for dealing with stress and improving the mental wellbeing of youth.

Exchange 7
12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Shamin Talukder

Dr Shamim Talukder, Chief Executive Officer, Eminence

Co-authors: Dr Shams El Arifeen, Dr Peter Kim Streatfield, Shusmita Hossain Khan

Diabetes and Pre-Diabetes in Bangladesh: Updated Numbers based on the Bangladesh Demographic and Health Survey 2011

Background: Based on the IDF estimations in Bangladesh around one in eight adult Bangladeshis are either suffering from diabetes or prediabetes. In addition almost all small to medium scale population-based assessments in Bangladesh indicate an increasing trend of diabetes prevalence. Objectives: Based on the available evidence on rising prevalence of diabetes in the country, the Bangladesh demographic and health survey (BDHS) 2011 included testing for fasting blood glucose, for the first time. The objective of this inclusion was to determine national status of this future development challenge. Methods: Women and men age 35 and older in 7543 households were sampled for blood glucose level tested. Blood glucose was measured using the HemoCue 201+ blood glucose analyzer in capillary whole blood obtained from the middle or ring finger from adults after an overnight fast. WHO (2006) cut-off points for measuring fasting plasma glucose was used for defining diabetes and pre-diabetes status. Along with any reported case with proper documentation was also taken under consideration for determining the prevalence rate. Results: Overall, one in nine women and men age 35 and older has diabetes and one in every four is pre-diabetic. This translates into 5 million people with diabetes and 12 million people with pre-diabetes. These figures are projected to be 8 million and 19 million people respectively in 2025 if current prevalence rates remain. Although the rate of diabetes is higher in urban areas, the actual number of people with diabetes is higher in rural areas reflecting the greater rural population in Bangladesh. The rural-urban differences in the number of people with pre-diabetic conditions are even greater. Conclusion: This high rate and number of people living with diabetes and pre-diabetes is actually an indication of a upcoming development challenge in the country which needs urgent attention.

Exchange 7
12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Shamin Talukder

Ms Oluwaseyi Somefun, Student, University of Witwatersrand

Co-authors: Ibisomi Latifat

Determinants of Postnatal Care Non-utilization in Nigeria

Globally, there has been significant improvement in the maternal health outcomes of individuals (WHO, 2002). Despite this, maternal mortality remains an outstanding public health challenge (Aremu, 2011), as there is a large difference in the maternal mortality rate of the developing world and the developed world. Results from the logistic regression show that age, wealth status, occupation, birth order region, education, access, birth size, place of delivery and antenatal care are significantly associated with the non-use of postnatal care among women in Nigeria at the bivariate level. Since the bivariate analysis shows associations of variables without controlling for the confounding effects, multivariate analysis using logistic regression was applied in view of further examining the predicting variables. At the multivariate level, we found older women aged 35 and above to be significantly more likely not to utilize postnatal care services. This may be because younger women may have more modern attitudes towards health care than older women (Stephenson, Tsui, 2002) and also have the ability to respond to changes in health care (Kozier, Erb, 2008). Urban residence has been found to be significantly associated with postnatal care utilization in several studies (Raghupathy, 1996; Mekonnen & Mekonnen, 2002) but place of residence did not appear to have any influence on the non-utilization of postnatal care services among women in Nigeria. This contradicts results from a study by Adamu, (2011) in Nigeria which concluded that there was a significant association between place of residence and postnatal care utilization. Studies have documented that antenatal care visits usually have an influence on the utilization of postnatal care because women are expected to receive adequate counselling and advice which would inform them about the importance of postnatal health care utilization (Garenne et al., 1997). The results in this study show that women who reported receiving antenatal care had lesser odds of not utilizing postnatal care. This may be because these women may have been counselled on the importance of the uptake of PNC during their antenatal visits. Conclusion This study has examined the influence of environmental, predisposing, enabling, need and previous exposure to other healthcare services factors on non-utilization of postnatal care services in Nigeria. Therefore, knowledge on the differential factors that affect non- utilization of postnatal care will help in the development of focused intervention programmes to meet with the aim of improving postnatal care utilization among women in Nigeria. These interventions should particularly target poor women, older women and the less educated in Nigeria.

Exchange 7

14.00

Citizens' Engagement / Engaging the public in looking after health	
Session title	Exemplars of social and community health
Chair	Richard Fitton

Neil Wiliams, www.friends-of-glossop-station.co.uk volunteer and director Glossop railway station

No abstract available

David Jones, Editor, Glossop Chronicle

The Glossop Chronicle newspaper - Reporting healthy activities in the press

No abstract available

Richard Fitton, General Practitioner

The Glossop Chronicle newspaper - Reporting healthy activities in the press

No abstract available

Sean Wood

President, Glossop Rugby Club, arts teacher, band member and creator of green routes in cities

No abstract available

Greg Williams, Steve Colquhoun, Jamie Wright and Bruce Elliot, ICUH Programme Manager, Tackle it Programme Manager, Foundation of Light, Sunderland FC, and Programme Manager, Developing Informatics Skills and Capability (DISC)

Applying lessons from being Sunderland or Manchester United football supporters to social and physical health

No abstract available

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Mr Duminda Guruge and Dr Manuja Perera, Senior Lecturer in Health Promotion, Health Promotion Unit, Department of Biological Sciences, Faculty of Applied Sciences, Rajarata University of Sri Lanka

Co-author: Kalana Peris

Author's Request: Abstract Not Permitted

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Ms Annie Smith, Executive Director, McCreary Centre Society

Co-authors: Pat Bullen (University of Auckland), Stephanie Martin (McCreary Centre Society)

From North of 60 to the South Pacific: Promoting youth health across the globe through youth engagement

AIMS: A sustainable cross national program for engaging youth in health research outcomes to create positive change at the individual and community level. DESIGN: Based on the knowledge that engaging youth in the decisions that affect them has been shown to improve health outcomes (Smith et al 2009), McCreary Centre Society developed a program which offers youth the opportunity to respond to population level health survey data and develop projects to address health disparities in their local community. The model of engaging youth with health data is also currently being developed in the context of Aotearoa/New Zealand. Youth health data from the Youth 2000 survey series, a nationwide quantitative youth health survey last conducted in 2012, will be shared with communities of youth across the country. SETTING: Canada and New Zealand. Developed by McCreary Centre Society and used across Western Canada. The model is now being applied in New Zealand . RESULTS: Evaluation results from Canada show that engagement in such a program can reduce health risk behaviours such as substance use and criminal behavior, and can increase a number of protective factors including knowledge of youth health issues, improved community and school connectedness and improved mental health outcomes. The program has been adapted to meet the needs of different cultural groups and marginalized populations including Indigenous youth, homeless youth and youth in custody. It has also been successfully delivered in urban centres as ethnically diverse as Whitehorse (Yukon) and Vancouver (BC). The program won the Canadian Solicitor General's Award for Youth Leadership and Crime Prevention in 2009 for its Indigenous youth program. Evaluation results (Peled, et al 2009) showed disadvantaged Indigenous youth who participated in the program reported a reduction in substance use (92% of youth), self harm (100%), and suicidal thoughts (100%). Their involvement helped to increase their community connectedness (69% of youth), peer relationships (87%), and school connectedness (63%). Most (60%) also reported that their involvement helped to enhance their family relationships. Youth also reported improvements in their self-esteem (81%), sense of meaning in the activities they engage in (81%), and hope for their future (94%). CONCLUSION: This program can be adapted for use outside of North America and shows strong associations with improved health outcomes for youth. It can also be used to engage in global information sharing around community-based responses to youth health.

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Mr Tendayi Gondo, PhD Student, University of Venda

Co-authors: Aleina Mutazu

A 'step-wise logic' perspective on the impact of HIV and / AIDs infrastructure reform in Benishangul-Gumuz Regional State of Ethiopia

In the wake of the HIV and / AIDs pandemic, most African governments have embarked on a number of infrastructural reforms aimed at putting in place adequate mitigation mechanisms and sustaining the productivity of people living with HIV and / AIDs. The majority of such reforms however have remained un-appraised. This alone has tended to stifle our own thinking and understanding of the extent to which such infrastructural investments are making a difference. This analysis seeks to close the existing knowledge gap by evaluating the extent to which HIV and / AIDs infrastructure reforms have made a difference in health sector of Benishangul-Gumuz Regional State of Ethiopia. We first develop a ‘step wise logic’ model that is later employed to evaluate the impact of the reform. Data on facilities relating to HIV Counseling and Testing (HTC), Prevention of Mother to Child Transmission (PMTCT) and Antriritroviral Therapy (ART) services and visitor-ship statistics was obtained from the Health Bureau. Additional empirical evidence was obtained from a sample survey of health officials. Our analysis reveals that since 2002, significant improvements have been registered in the HIV and / AIDS infrastructure. Such investments have however not cascaded into improved mitigation efforts. The HIV and / AIDs infrastructure sector of the region can be dismissed as one of constrained capacity, usage and transformation.

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Dr Monica Swahn, Professor, Georgia State University

Co-authors: Jane B. Palmier, J.D., MPH, Rogers Kasirye M.A.

Illicit Drug use and its Psychosocial Correlates among Street Youth in the Slums of Kampala

Aims: Illicit drug use is recognized as a growing public health problem across cities world-wide and yet little is known about the prevalence and risk factors of drug use among youth in Cities across Sub-Saharan Africa and in Kampala, Uganda, specifically. The number of youth who live on the streets and in the slums of Kampala appears to be growing rapidly, but their overall mental health needs and use of illicit drugs have not been well documented which has hampered resource allocation and service implementation. As such we seek to determine the prevalence and correlates of illicit drug use in this vulnerable, urban population. Design: A cross-sectional, face-to face survey delivered by social workers and peer educators in May and June of 2011. Setting: 8 community drop-in centers operated by the Uganda Youth Development Link in Kampala, Uganda to serve vulnerable youth. Participants: Service-seeking attendees (N=457) at the community centers, ages 14 -24, were recruited to take part of the 30-minute survey. The participation rate was 91%. Results: Bivariate and multivariate logistic regression analyses were computed to determine associations between psychosocial correlates and illicit drug use in lifetime and in past month. Drug use included any drugs including marijuana (njaga or bangi), opium (njaye) or aviation fuel. Any drug use was reported by 33.3% of boys and 11.4% of girls. Moreover, past month drug use was reported by 24% of boys and 6% of girls. Several risk factors were significantly associated with past month drug use including past month drunkenness (OR=32.51;95%CI:13.71-77.06), parental neglect (OR=4.85;95%CI:2.59-9.07), being lonely (OR=3.60;95%CI:1.09-11.94), being an orphan with both parents deceased (OR=3.51;95%CI:1.65-7.47), expecting to die early (OR=3.02;95%CI:1.64-5.57), rape (OR=2.42;95%CI:1.32-4.44), being HIV positive (OR=2.60;95%CI:1.15-5.86), and being involved in traded sex (OR=2.25;95%CI:1.26-4.03). In multivariate analyses, only past month drunkenness and being an orphan remained statistically significantly associated with past month drug use. Conclusions: Given the dire circumstances of this vulnerable population, increased services and primary prevention efforts to address the risk factors for illicit drug use are urgently needed. Youth with concurrent heavy alcohol use, traumatic childhood and being an orphan, and who also has a disrupted social network appear to be particularly vulnerable to drug use and are also more likely to report being HIV positive. As such, these youth represent a high priority for both primary and secondary prevention services and strategies that address their broader health concerns as well as their specific drug use needs.

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Miss Ewa Monteith-Hodge, Youth Projects Coordinator, McCreary Centre Society

Co-authors: Ange Cullen, Stephanie Martin, and Brynn Warren

Health Disparities between Youth in Custody and those in Mainstream School

Abstract not available

Exchange 8

11:00

Health Promotion / Health Equity, Inequalities and Disparities	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Siddharth Agarwal

Mr Johan Osté, Policy Advisor, Municipal Health Service Amsterdam
Co-author: Tobias van Dijk

Health promotion campaign addressing GHB-overdose in nightlife settings

Background: Gamma hydroxybutyrate (GHB) is a relatively new recreational drug, but has become increasingly popular in the last decade. One of its most harmful toxic effects is loss of consciousness (passing out), or even coma in the case of a large overdose. As a consequence, in Amsterdam the Ambulance is needed four times weekly on average for mostly young people that passed out on GHB. These alarming figures led to the development of a health promotion campaign. Goal: to better inform GHB users in nightlife settings, in order to prevent passing out as a consequence of a GHB overdose. Method: The project started with a thorough analysis on the ambulance data. Subsequently focusgroups were held among stakeholders in the nightlife scene of Amsterdam: club owners, party organizers, security personnel, partygoers, and GHB-users. The focus groups revealed information about user-motives, characteristics of the setting of use, and the specific factors that are most likely to increase the risk of overdosing. This information served as input for the campaign and led to a strategy and finally to the development of our campaign. Intervention: The campaign consists of a website (www.outgaanisnooitok.nl) and flyer on which the user-tips are presented. To target the specific groups with our website and flyers, we used specific channels through which this audience communicates (community-sites, bloggers, event-pages). To lure the target audience to the website, and to raise awareness about the problem of overdosing, two different videos (video clip and a video documentary) were presented on the Internet that could be liked, shared and commented. These videos should stress the impact GHB overdosing can have on their scene. Results: Within five months time, the website has been visited by over 8.000 unique visitors. Most visitors of the website came from the Amsterdam area, over 4.000. The video clip was viewed nearly 2600 times and the video documentary attracted over 8.800 unique individuals. Despite its long running time of six minutes, the mean viewing time was almost four minutes. A link on the website directed visitors to a GHB use screening test. At the end of the first month of the campaign, the number of successfully completed tests had increased with fifty percent. Finally, we compared the number of GHB-related ambulance rides before and after the launch date. In contrast to a steady increase in the last four years, and taking fluctuations throughout the year into account, we found a slight decrease of GHB-related ambulance rides after the campaign launch date. Conclusions: The main goal of our campaign was to better inform GHB users in order to prevent passing out as a consequence of a GHB overdose. Our findings give us confidence in the success of our campaign. Although we cannot rule out other factors the number of GHB related incidents decreased. We deliberately did not use mass-media channels, but utilized specific communication channels. Hence, we are quite confident that our message was received by our target group. Moreover, a large number of party-organizers and club-owners participated, thus adding to the importance of our campaign. These stakeholders also provided access to a generally difficult to reach audience.

Exchange 8

12:40

Transdisciplinarity in Urban Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Chris Birt

Ms Katherine Conlon, Specialty Registrar Public Health, Bristol City Council / University of West of England

Co-author: Marcus Grant, Sarah Burgess.

A novel approach to improving understanding of public health concepts within the academic study of built environment professionals

Rationale An increasing proportion of the global burden of disease is attributable to non-communicable disease. With evidence that many spatial aspects of urban environments are key determinants of health and the increasing urbanization of populations, the time is ripe for public health and built environment professionals to realign. A robust evidence base linking a rise in non-communicable diseases with aspects of the built environment (transportation, housing, quality of urban realm) demands that built environment professionals play a greater role in supporting the health of urban populations. Setting A faculty responsible for educating undergraduate and post graduate students in a range of built environment professions at a university in the South West of England. Courses include architecture, planning, urban design, civil engineering and transport. Context Public Health functions in the UK have recently moved back to local governmental structures providing opportunities for realignment of efforts to improve the wider determinants of health through the built environment professions. Intervention / Methods Since 2010 the faculty has hosted a series of public health specialists immersed as ‘practitioners in residence’ to influence the teaching and curricula design of built environment education. They bring key public health knowledge, approaches, concepts and skills. Outputs Identification of educational needs, pedagogic materials, creation of an international network of professionals contributing public health understanding to the education of health and the built environment. Outcomes Proximate outcomes include a measure of whether built environment educators and students are better able to understand and articulate public health concepts, demonstrated through developments in curricula design and student course work. Reciprocation of knowledge and skills exchange to the public health profession. Measured by qualitative methodologies and analysed by thematic analysis. Distal outcomes, developed through practice and research, include a new pedagogic approach for embedding public health concepts within the undergraduate and post graduate study of built environment disciplines, enabling graduate professionals to better integrate health into their decision making.

Exchange 8

12:40

Transdisciplinarity in Urban Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Chris Birt

Mrs Annelies Acda, Policy Advisor, GGD Amsterdam

Fit 4 Work: linking health and employment

The four major cities of The Netherlands (Amsterdam, Rotterdam, The Hague and Utrecht) and Capelle aan de IJssel, another municipality, are working on a business case called Fit 4 Work. It is a collaborative experimental project between the four major cities in the Netherlands (Amsterdam, Rotterdam, The Hague, Utrecht, added with the municipality of Capelle), and the UWV (Dutch Employment Service). Fit 4 Work focuses on re-integration AND health improvement within a multi problem target group with a large distance from the labour market. Most people have proven psychiatric problems and have a low self percieved health. The project is a collaboration between municipal Social Welfare departments, the Dutch Employment Service and the municipal Public Health departments, all bringing their own expertise, ranging from introducing network partners, knowledge of research to taking the lead in the procurement process and financing the project. F4W is a randomised controlled experiment (700 in F4W and 700 in contol group, following "regular" client procedures) for four years. The F4W group will be supported by the re-integration companies that won the bid (two, in order to compare their respective working methods as well). The research, carried out by the Erasmus University of Rotterdam, will include results on the effects of this integrated health and re-integration approach on self perceived (mental) health, social participation and paid employment. At the end of the four years a social cost benefit analysis (“business case”) will be carried out. About half of the research population has now been submitted to the F4W experiment. The F4W course itself is led by the reintegration companies, but the clients are selected by the municipalities, in order to avoid "cherry picking", following an agreed set of criteria. Parties included on the working floor are mental health organisations, life style coaches, job coaches, and of course the case managers of the clients. Aim is to develop tailor made reintegration and health packages for the clients. In the long run the overall goals are for the clients to have a better perceived health and/or to have made the transition from unemployment to at least 12 hours of work a week. The costs are carefully monitored and used in the cost benefit analysis. Fit 4 Work is the first project in which the partners mentioned above are working together this closely. This process is interesting in itself and therefore a process evaluation is also part of the procedure. Different organisational cultures and the economic crisis have put a lot of pressure on this project. It has been a valuable lesson which will hopefully show good results for the clients when the final results are available.

Exchange 8

12:40

Transdisciplinarity in Urban Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Chris Birt

Whamid Al-Shabib

Author's Request: Abstract Not Permitted

Exchange 8

12:40

Transdisciplinarity in Urban Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Chris Birt

Miss Martina Behanova, PhD Student, Graduate School Kosice Institute for Society and Health, Safarik University, Kosice, Slovak Republic

Co-authors: Zuzana Katreniakova, Iveta Nagyova, Jitse P van Dijk, Sijmen A Reijneveld

The effect of urban neighbourhood unemployment on health-risk behaviours in urban elderly differs between Slovakia and the Netherlands

Background: Elderly people with health-risk behaviours (HRB) suffer more often from disability and chronic diseases. The aims of this study were to compare Slovakia and the Netherlands regarding differences in the prevalence of HRB by neighbourhood and individual deprivation, and to determine whether area differences could be explained by the socioeconomic position (SEP) of the residents. Methods: We obtained data on non-institutionalised residents aged 65 and above from the EU-FP7: EURO-URHIS 2 project from Slovak (N=665, response rate 44.0%) and Dutch cities (N=795, response rate 50.2%). HRBs included daily smoking, binge drinking, physical activity, consumption of fruits and vegetables and body mass index. The neighbourhood-unemployment rate was used as a measure of area deprivation. Education and household income with financial strain were used as measures of individual SEP. We employed multilevel logistic regression. Results: In Slovakia no HRB was associated with either neighbourhood unemployment or individual SEP. In the Netherlands elderly people from the least favourable neighbourhoods were more likely to be daily smokers (OR 2.32, 95%-CI 1.25; 4.30) and overweight (OR 1.84, 95%-CI 1.24; 2.75) than residents from the most favourable ones. For Dutch elderly people the gradients varied per HRB per individual-level SEP indicator. Individual SEP explained country differences in the association of area unemployment with smoking and lack of physical activity but not with overweight. Conclusion: Countries differed in the associations with HRB of both neighbourhood unemployment and individual SEP. SE factors at both levels should be considered when setting up health promotion activities in elderly.

Exchange 9

11:00

Policymaking and Political Leadership for action on urban health	
Session title	Austerity Policies: The rise of the food bank
Chair	Councillor Jane Black

Chris Mould, Chairman, The Trussell Trust

The dramatic growth of the Trussell Trust foodbank network: how a simple community project brought hidden hunger to the attention of the Nation

No abstract available

Patrick Shine, Shaftesbury Partnership

No abstract available

Eamonn O'Brien, Trustee, Manchester Central Food bank

No abstract available

Exchange 9

12:40

Policymaking and Political Leadership for action on urban health	
Session title	Abstract Presentations
Chair	Councillor Pat Karney

Professor Eileen O'Keefe, Emeritus Professor of Public Health, London Metropolitan University

Co-authors: Susan Bagwell, Simon Doff

Healthy urban governance in London's independent fast food sector: can we move up the supply chain?

We consider the applicability of the notion of 'healthy urban governance' focused on 'reduction in inequity in health and its determinants' (1) in relation to competence in London to address upstream determinants of obesity. This is explored against the background of: renewed interest in global cities as sites for intervention; the restructuring of the public health function in England, with devolution of authority and resources to local authorities and promotion at the national level of public health influence to corporate entities via 'responsibility deals'; the statutory responsibility of the Mayor of London to reduce inequalities in health; identification of obesity as a priority for public health at municipal level in London (2); the position of independent fast food outlets in deprived neighbourhoods (3,4). We take as starting point our current research devoted to study of the Healthy Catering Commitments programme to improve the nutritional status of meals offered by independent fast food outlets (5). The aim is to explore attempts to move upstream to address supply chain impact on the food environment available to consumers. The research involves qualitative research with independent fast food businesses and suppliers. Results have implications for application of the Greater London Authority's remit to encourage health promoting public procurement policies. Research partners include the Chartered Institute of Environmental Health and the Greater London Authority Food Board. 1. Burris S et al (2008) Emerging principles of healthy urban governance. Knowledge Network on Urban Settings Thematic Paper 5 WHO Centre For Health Development 2008 2. Freudenberg N, Libman K, O'Keefe E (2010) A Tale of Two ObesCities: the role of municipal governance in reducing childhood obesity in New York and London. Journal of Urban Health: Bulletin of the New York Academy of Medicine 3. Bagwell S (2013) 'Healthier Catering initiatives in London, UK: An effective tool for encouraging healthier consumption behaviour' Critical Public Health 4. Bagwell S (2011) 'The role of independent fast-food outlets in obesogenic environments: a case study of East London in the UK' Environment and Planning A 41, 2217-2236 5. Economic & Social Research Council ES/L002051/1 Supporting interventions for healthier catering: tools and resources for SMEs in the independent fast food sector.

Exchange 9

12:40

Policymaking and Political Leadership for action on urban health	
Session title	Abstract Presentations
Chair	Councillor Pat Karney

Ms Annette James, Head of children and Young People's Health Improvement, Liverpool City Council

Co-authors: Kerry Lloyd, Jane Corbett, Frank Hont

Liverpool Mayoral Action Group on Fairness and Tackling Poverty

Economic wellbeing is an important public health issue, as there is a strong association between wealth and health. People on low incomes are significantly more likely to experience poorer health outcomes compared to those on higher incomes. Liverpool has a long history of higher than average levels of unemployment, poverty and poor health, requiring radical action in order to transform the health and economic wellbeing of the city. The city has an elected Mayor who has set a number of priorities and has identified commissions and groups to drive these. One such group is the Mayoral Action Group on Fairness and Tackling Poverty. The group is chaired by an independent leader from a trade union background supported by a cabinet member. With a membership of elected members and council officers, including public health; the group have set principles drawn from experience, research and policy. Three tenets of working were agreed at the outset around the wider determinants of health and wellbeing, outcome measures were identified and grouped into what must be done, what should be done and what could be done. An initial dashboard was agreed and data identified to populate this. Early actions include ensuring no child in the city goes hungry, ensuring everyone has effective timely financial advice and minimising the impact of the 'bedroom tax'. The group builds on the work of Liverpool's Fairness Commission.

Exchange 9

12:40

Policymaking and Political Leadership for action on urban health	
Session title	Abstract Presentations
Chair	Councillor Pat Karney

Dr Alex Asakitikpi and A.S Ogbiye, Senior Lecturer & Head of Sociology Department, Monash South Africa

Co-author: D.O Omole

Urbanization, Industrialization and health risks in Nigeria

Abstract not available

Exchange 9

12:40

Policymaking and Political Leadership for action on urban health	
Session title	Abstract Presentations
Chair	Councillor Pat Karney

Dr Alex Asakitikpi, Senior Lecturer & Head of Sociology Department, Monash South Africa

Urban Governance, Waste Management and Health Risks in Southwestern Nigeria

This paper explores urban processes in southwestern Nigeria and how they have strong implications for diseases and other health outcomes in the country. The study comprised thirty-two in-depth interviews of men and women aged between 28 and 66 years (median age = 41); six focus group discussions and a comprehensive review of urban policies by state governments. In particular, the insights of Lawuyi's (2004, 2005) 'dynamics of urbanization from a ritualistic perspective' provides a useful construct to examine episodes of refuse (mis)management as a failure in understanding and simultaneously separating the profane from the sacred within a Durkheimian theoretical framework. We found a significant disconnect between urban governance and waste management in public spaces. Among urbanites, there is no clear distinction between the sacred and the profane and where they do, they are fused together to form one functional whole. For this reason, people do not respond to the environmental chaos that is characteristic of urban centers in Nigeria but rather live with it. We consider how this co-existence makes meaning within the socio-cultural context of the society and its implications on urban health in the country.

Exchange 9

14:00

Healthy Ageing	
Session title	Age-friendly cities and healthy cities: reshaping the urban environment
Chairs	Mr Alex Ross, Professor Chris Phillipson

Alex Ross, Director, WHO Kobe Centre

The WHO Perspective

No abstract available

Professor Chris Phillipson, Executive Director, Manchester Institute for Collaborative Research on Ageing

The Research Perspective

No abstract available

Paul McGarry, Senior Strategy Manager, Age-friendly Manchester team, Manchester City Council

The Local Authority Perspective

No abstract available

Exchange 10

11:00

Stratified Medicine, Biomarkers and Population Health

Session title	New opportunities in delivering better health to populations
Chair	Professor Aneela Atta Ur Rahman

Professor Martin Gibson, Honorary Professor/Consultant in Diabetes/Endocrinology: Imaging, Genomics and Proteomics Research Group

Linking integrated health records with Genomics – are our health services fit for the future?

No abstract available

Dr Caroline Sanders, Senior Lecturer in Medical Sociology, University of Manchester

Opportunities and barriers to the adoption of telehealth in UK healthcare

No abstract available

Dr Martin Yuille, Co-director of Centre for Integrated Genomic Medical Research (CIGMR) and Reader in Biobanking in the Centre for Integrated Genomic Medical Research at University of Manchester, UK

Joining up the pieces for stratified medicine and population health

No abstract available

Exchange 10

12:40

A Perspective from Fresh Minds

Chair	Dr Paula Whittaker

Mr Rayko Kalenderov, Student, University of Manchester

Osteoarthritis: pathogenesis and potential for treatment

Abstract not available

Exchange 10

12:40

A Perspective from Fresh Minds

Chair Dr Paula Whittaker

Miss Ai Ling Tan, Student, University of Manchester

Co-authors: Dr Pip Fisher, Dr Enam-ul Haque

Immunisation of household contacts of hepatitis B patients

Background: Hepatitis B, the most common type of hepatitis can be easily prevented by immunisation. Some patients do not present with any symptoms but others may face serious complications. It is therefore important to prevent this disease through screening and immunisation of contacts.

Aim: Guidelines worldwide state that all hepatitis B household contacts should be immunised [1, 2, 3]. The objective of the audit was to look at immunisation of hepatitis B household contacts in a multi ethnic GP surgery in Manchester.

Method: EMIS Web, the consultation software for the surgery was used to collect the data. A search for the household contacts for each hepatitis B patient was performed to determine if they had been immunised against Hepatits B. Patients who had been diagnosed in the past 1 month from time the audit was conducted were excluded. The audit standard was set at 70%. As the standard was not met in the first analysis, a patient information leaflet was created and it was recommended that all household contacts be sent a letter inviting them to come for vaccination. Six months later, the audit cycle was completed to determine the effect of the proposed intervention.

Results: Initially, there were 14 hepatitis B surface antigen positive patients with 26 household contacts. At the second round of the audit, there were 16 hepatitis B surface antigen positive patients with 31 household contacts. Between the first and second audit there was no change in the vaccination coverage of household contacts. 9/26 (35%) were known to be vaccinated or immune to hepatitis B initially, compared to 11/31 (35%) six months later.

Discussion: A possible explanation for the lack of effectiveness in intervention could be attributed to the lack of response of the contacts to the letters delivered to them. Given that the practice is comprised of a high population of patients whose primary language is not English, the written language might have proved to be a barrier. However, there was a lack of coding of language in EMIS to give evidence of this. In addition to this, there might have been a lack of follow-up of the non-respondents. Student audits are often left with the audit cycle incomplete. In the light of such a situation, this project aims to show the value of completing an audit cycle in order to educate the student on real world challenges faced in implementing change.

Exchange 10

12:40

A Perspective from Fresh Minds

Chair Dr Paula Whittaker

Miss Sophie Fox, Student, University of Manchester

Co-authors: Dr Pip Fisher, Dr Enam-ul Haque, Dr Syed Hassan, Dr Ahmed Choudhury

Health at the Hajj

Background: Each year, 25,000 British Muslims travel to Mecca for the Hajj, the world's largest mass gathering with over 3 million attendees. Various health risks are associated with the event related to overcrowding, resultant injuries and spread of infectious diseases. Since 2001, the meningitis ACWY vaccine has been a visa requirement for pilgrims, and this is the ideal time to give health advice. Aim: To investigate demographics of patients who have been on Hajj, and health advice given to them, at an urban GP Surgery. Methods: All meningitis ACWY vaccinated patients in the practice were identified and their records reviewed to determine whether specific health advice (based on literature review) had been given. Standard was set at 70%. Results: Currently, no published guidelines are available on this subject. 15 patients were identified: 10 males and 5 females, aged 11 to 64 years. They had four different first languages. This study found that patients may not be currently receiving adequate advice on managing health risks at the Hajj: 80% (12/15) patients were given general travel advice, but none received counselling specifically for the Hajj. The standard was therefore not achieved. No specific patient education materials, written or audio-visual, were available during the clinic appointment. Conclusions: More education is needed on this topic for healthcare staff as well as patients. A pre-Hajj consultation template and a specific educational leaflet have been designed, and will be implemented to ensure all patients receive sufficient information. We plan to re-audit after the next Hajj.

Exchange 10

12:40

A Perspective from Fresh Minds

Chair Dr Paula Whittaker

Miss Zainab Jawad, Student, University of Manchester

Co-authors: Sara Al-Hashimi, Manahil Rana, Farkhondeh Farrokhnia

Barriers to participation in the NHS Cervical Screening Programme (NHSCSP) in black and minority ethnic women

Aims: Anecdotal evidence suggests that participation in the NHS cervical screening programme (NHSCSP) is lower in women from black and minority ethnic (BME) backgrounds. A study was designed to investigate whether this was the case. Any cultural barriers that existed were identified, and remedied using an educational programme that was devised and implemented. Methods: Using a patient database of a large primary care provider in a culturally-diverse city suburb, a list of patients who were eligible for the NHSCSP was obtained. Patients who were overdue their cervical smear by more than 2 years were then identified from this list. Demographic data on these patients was then analysed. A paper questionnaire was distributed to BME patients to explore potential cultural barriers. A patient-focussed educational programme was then devised using the results of this survey. Results: BME patients were found to be less likely to participate in the NHSCSP. Reasons for this varied, but frequently cited barriers included religious beliefs, incorrect health beliefs ('cervical cancer doesn't affect people of my ethnic heritage') and lack of understanding of the procedure. The educational programme devised focussed on this issues, and feedback indicated high patient satisfaction and increased patient knowledge of the NHSCSP. Conclusions: It is well-established that cultural barriers exist which restrict the participation of BME patients in the NHSCSP. Our study correlates with this information and indicates that more needs to be done to address this issue. By delivering focussed education to patients, patient anxiety towards the NHSCSP can be decreased resulting in increased BME patient participation.

Exchange 10

12:40

A Perspective from Fresh Minds

Chair Dr Paula Whittaker

Mr Dean Hannay, Student, University of Manchester

Co-authors: Dr Avril Danczak, Dr Pip Fisher, Dr Enam Haque

Co ona mówi? (What is she saying?)

Background: 7.7% of UK residents have a non-English first language. This has implications for provision of health care. Lack of linguistic support may impair clinical care, increase risk to patients and decrease satisfaction with services. Most sources state that best practice is to provide trained interpreters. We evaluated the potential resource implications for our inner city practice of providing professional translators and double-appointments to our non-English speaking population. Methods: We firstly estimated demand for interpretation by searching the 6,000 records of all currently registered patients, excluding those who had self-reported their first language as 'English'. Secondly, we conducted a questionnaire on patients attending surgery over two mornings, looking at their preferred language. Outcomes: 7.7% of patients reported a first language other than English according to patient records, while 29% of the 76 patients in the waiting room reported a first language other than English, and 21% gave the impression of a low proficiency in spoken English. Discussion: The disparity in the results gleaned from the two different sources suggest that those less proficient in English may be more frequent attenders to our surgery. Analysis indicated that the practice would require roughly one extra full-time GP to satisfactorily meet the language needs of its population, yet practice remuneration takes no account of this. The practice is recommended to Read-code, in addition to first language and ethnicity, all patients' current level of spoken English. Further investigation is required to determine the priorities for lengthening appointments.

Exchange 10

14:00

Stratified Medicine, Biomarkers and Population Health	
Session title	Stratification of Medicines for the health of populations
Chair	Dr Mark Fidock

Dr Alasdair Gaw, Lead Specialist in Stratified Medicine- Technology Strategy Board

Delivering Stratified Medicine in the UK: A National Approach

No abstract available

Professor Munir Pirmohamed, David Weatherall Chair in Medicine, University of Liverpool

Pharmocogenetics: reducing harm

No abstract available

Raj Sharma, Scentific Director – Respiratory Products, GlaxoSmithKline

Population based real world clinical trials: the Salford Lung Study

No abstract available

Exchange 11

11:00

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Obesity, Physical Activity & Diet
Chair	Dr Peter Elton

Mr Fred Turok, Chairman of ukactive and Chair of the Department of Health Physical Activity Network

Turning the Tide of Inactivity

No abstract available

Professor Paul Gately, Professor of Exercise & Obesity, Leeds Metropolitan University & Chairman of the National Obesity Forum for Yorkshire and the Humber

Obesity – Time for focused action for those in need

No abstract available

Dr Claire Griffiths, Senior Lecturer in Physical Activity, Exercise and Health, Leeds Metropolitan University

Food outlets and childhood obesity – are takeaways to blame?

No abstract available

Exchange 11

12.40

Citizens' Engagement / Engaging the public in looking after health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Ogunleye Adetona Comfort Iyabo

Dr Ogunleye Adetona Comfort Iyabo, Lecturer, University of Cape Coast

Co-author: Fakomogbon, M

Fast Food industries and urban health in Kwara State, Nigeria

Fast food is a form of small-scale industry that refers to food that can be prepared and served very quickly. There is a direct relationship between fast food industries and urban development because fast food industries are of immense socio-economic values. For instance, it makes cooked food readily available for people and at the same time it creates employment. Fast food industries though contribute to urban development; some of the wastes generated pollute the environment (Schlosser, 2002). The bulk of these industries in the case of Ilorin metropolis are however located at the commercial core or the Central Business District for easy accessibility and attract customers in order to maximize profit. The implication of polluted environment on people's health as a result of the location of the fast food outlet cannot be over emphasized. There is therefore a need to highlight some of the health hazards or otherwise and suggest how best these fast food can contribute to urban development without necessarily jeopardizing people's health. This research examined; the variations, differences, and the environmental impacts of the location of these industries in Ilorin metropolis, Kwara State, Nigeria. Four major fast food shops of Mr. Biggs, Royals, Chicken Republic and Rush meal were selected based on high patronage. Questionnaires were administered on 300 customers purposively selected at the four fast food outlets. Percentage, frequency distribution, charts and even chi-square test statistical analyses were used to explain the findings. The analyses of the data revealed that though the fast food industries to some extent contributed to the development of Ilorin metropolis, their activities however lead to environmental pollutions such as land, water and air pollution of which the land pollution ranks the highest due to waste like nylon and plastic litter, unbreakable and disposable materials, spoilt food e.t.c. Government should therefore ensure that these fast food industries meet an acceptable level of hygiene.

Exchange 11

12.40

Citizens' Engagement / Engaging the public in looking after health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Ogunleye Adetona Comfort Iyabo

Laura Hastings, Dr Joseph N.Kandeh and Julie Mariama Sesay, Child Survival Programme Manager, Concern Worldwide / District Medical Officer, Western Area Ministry of Health & Sanitation / Community Development Team Leader, Concern Worldwide

Co-authors: Albert Yanguba, Christopher Purdy, Jennifer Weiss, Megan Christensen, Henry Perry, Rosemary Davis, Khadijatu Bakarr

Lessons learned from the implementation of a participatory, community based household

BACKGROUND Al Pikin fo Liv was launched in October 2011 in ten urban slum communities of Freetown, Sierra Leone in partnership with the Ministry of Health & Sanitation (MoHS), Western Area Urban District Health Management Team (DHMT), and Freetown City Council (FCC). The overall goal of the five-year project is to contribute to the reduction of maternal, infant and child morbidity and mortality among 36,436 children under the age of five and 37,327 women of reproductive age. To contribute to this goal, the project is emphasizing four core strategies including improved quality of Maternal, Newborn and Child Health (MNCH) care at the health facility level; increased household MNCH knowledge and practices; strengthened community and district capacity to plan, implement and monitor health activities; and improved national and district level MNCH policy environment. A key challenge in Sierra Leone is the lack of complete and accurate data on the health status of the population, especially in the urban context, where obtaining reliable local data is especially challenging due to the population's transient status and shifting geographical boundaries. This lack of data reduces the ability of the community, district and national health authorities to plan and respond effectively to health priorities. RESULTS Census Data Collection: To date, 20,141 households with pregnant women and /or children under five in eight communities have been identified by the census. This number is significantly different than national census estimates. In waterfront slums, the number of beneficiary households is lower than anticipated, while more beneficiary households are located on hillside slums. Part of the reason for this discrepancy may be due to differing definitions of 'resident'. The project census defined a slum resident as someone who has resided in the community for six months, whereas the national census counted anyone who spent the previous night in the community. Another reason for differing estimates of population figures is contested community boundaries. During the participatory mapping process, community leaders often drew boundaries that differed significantly from those defined by Government of Sierra Leone's 2004 Local Government Act which defined electoral wards and boundaries. When disagreement arose, Concern assessed whether the population in the disputed boundary area was counted within the PHU catchment area, and, if so, included them in the census.

Exchange 11

12.40

Citizens' Engagement / Engaging the public in looking after health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Ogunleye Adetona Comfort Iyabo

Professor Reima Suomi, Professor, University of Turku

Health support in social networks - a literature review

Aim With increased demand, and scarce resources to supply public health care, the mismatch between public health delivery and supply is increasing. In addition to the practice of turning activities to the private sector, the possibilities offered by social media should be taken into account and utilized. Through social media, patients and citizens can discuss health issues with their peers, and get information and social support, thus relieving pressures towards public health care delivery. In addition, social media opens up new channels for healthcare professionals to lead professional conversations both inside their professional reference groups as well as with the citizen. Our research question is: What is the state of art of research and academic knowledge on social media usage in health care. Design The study was conducted as a structured literature review (Fink, 2005) in spring 2013. The databases of ABI/INFORMGlobal, EBSCO and Web of Science were searched with keywords in three categories, containing entries such as health 2.0, health, medic, social media, patient and doctor. We set no time limits to the emergence of the articles, as social media is rather new phenomenon. Just entries in English-language academic journals (peer-review process) were included in the study. In the process of scanning through the material, well defined exclusion criteria were applied to decide, whether the articles studied belonged to the area of our interest defined by our research question. Results A total of 1698 articles were found in the original publications database search. After scanning them through and excluding non-relevant articles, and various duplicates, 101 articles were left for contents analysis. Conclusions The 101 articles left can be categorized into six groups: 1. Services and discussion groups for specific diseases. 2. Use of search engines 3. Hospitals adopting social media 4. Privacy issues 5. Inaccurate information 6. Reputation of medical professionalism. During this research appeared five essential articles, with high amount of citations. Further it was possible to figure out several research gaps and/or interesting topics to consider in the future. First is about business models of these social media services in health care. This area seems to be totally derelict so far. Reason for these can be the poorly known or unclear revenue logics for social media services on general level. Even the Facebook haven’t clearly proved how to get income from services, even we now that marketing possibilities have a big role in this process. After that comes the topic with the most central and potential user groups. Is the most productive communication going to be patient-to-patient, patient-to-physician, patient-to-hospitals or maybe physician-to-physician? Fink, A. (2005). Conducting Research Literature Reviews: From the Internet to Paper (2nd ed.): Thousand Oaks

Exchange 11

12.40

Citizens' Engagement / Engaging the public in looking after health	
Session title	ABSTRACT PRESENTATIONS
Chair	Dr Ogunleye Adetona Comfort Iyabo

Mrs Rashmi Shirhatti, City Coordinator, Plan India
Co-authors: Dr. Sainath Banerjee, Dr.Sneha Siddham

Building a social capital of Community based Health risk pooling system through Mahila Arogya Samiti (Women's health committee)

Introduction: Pune is the eighth largest metropolis in India, the second largest in the state of Maharashtra. There are 564 slums in Pune city of which 353 are declared and 211 are undeclared. With growing economic activity in Pune, the slum population has been increasing at a tremendous rate. This increase in the slum population has been exerting pressure on the city's infrastructure services. Plan India Health of the Urban Poor project aims to compliment the provisions of National Urban health Mission (NUHM) by developing a cadre of community based organisation (CB0) to sustain, cater and deliver the health services by strengthening the capacity through various mechanism and strategies. Formation of Mahila Arogya Samiti (MAS) is one of the key interventions of the HUP Pune city demonstration project. HUP Pune city program has strengthened 61 MAS throughout the project period. These MAS comprised of women's group of 8-15 member, willing to dedicate part of their routine schedule to organise and facilitate community level health services, generate community awareness, ensure community based monitoring of the MNCHN services and facilitate the promotion of health risk pooling mechanism. Aims: to assess the qualitative outcome of the formation of MAS in terms of improvement of community level health services as well as the component of women empowerment being a social capital. Participants: Each MAS covers 1000 slum population or 200-250 households. The women members are the local residents of the community participating in the monthly meeting as well as training on MNCHN components. Results: Out of the 61 MAS established, 25 MAS have initiated the health fund (risk pooling mechanism) within their group by contributing certain amount. More than 50% MAS have initiated the internal lending process for exclusively health purposes. This results in managing their maternal and child health needs. The loan amount was exclusively utilized for the health purpose. This gave them confidence of leading and resolving their own problems without any external support. MAS members participate in the Ward Coordination Committee meeting in presence of senior government officials and medical professionals, shown enormous character by raising their voices and local problems directly with the concerned authorities. Conclusions: The biggest achievement of the formation of MAS is the sustainability of the members without having monetary gain and incentives. Another aspect of learning from the MAS activity was the behavior change at the community. The MAS has not only mobilized their own households towards healthy behavior, they have also mobilized the community. The MAS acts as a peer group engaging the community women for healthy behavior change. The major learning of the formation of MAS is that gaining knowledge and few hands on skills with a need based external support can achieve the paramount shift in the confidence and healthy life of an individual.

Exchange 11

14:00

Lifestyle and Wellbeing: Obesity, Cancer and Diabetes	
Session title	Childhood Obesity: challenges and strategies
Chair	Dr Peter Elton

Mr Tam Fry, FRSA, Honorary Chairman Child Growth Foundation & Spokesman, National Obesity Forum

The first 1,000 days

No abstract available

Professor C. Fergus Lowe, Chief Executive, Food Dudes Health

The Food Dudes Programmes: A behaviour change approach to obesity prevention

No abstract available

Dr Mihela Erjavec, Senior Researcher, Food Dudes Health

The Food Dudes Dining Experience: Fruit and Veg are Supercool, Eat Them Home and School!

No abstract available

Charter 1
11:00

International Council for Science	
Session title	Healthy Urban Systems: Perspective on systems approaches in Urban Health Research
Chair	Professor Jo Ivey Boufford

Professor Tony Capon, Director, International Institute for Global Health, United Nations University, Malaysia

Professor Thomas Krafft, Chair of International Health, Maastricht University, Netherlands

Professor Gerard Salem, Chair of Urban Health, Université Paris Ouest Nanterre La Défense, France

Professor Yong-Guan Zhu, Professor of Environmental Science and Director-General, Institute of Urban Environment, Chinese Academy of Sciences

Dr Francoise Barten, President-elect, International Society of Urban Health

No abstract available

Charter 1

12:40

A Perspective from Fresh Minds

Chair Dr Francoise Barten

Miss Ayo Olomolaiye, Student, University of Manchester

Co-authors: Nikoletta Panagiotopolou, Mr C Philip Harris

A case report on the use of Anti-Mullerian Hormone as a diagnostic marker for Premature Ovarian Failure

A 22-year old white Caucasian woman presented to an infertility clinic with amenorrhoea in December 2012.This episode occurred whilst taking the combined oral contraception pill and thus she stopped taking it. In January 2013, she had an episode of unprotected sex for which she took the 'morning after pill'. Amenorrhoea further persisted until a spontaneous episode of per vagina (PV) bleeding in March 2013. Periods have since been regular. This is the only incident of amenorrhoea that this patient has experienced. Prior to this she has had regular periods since menarche. There is no other significant medical, surgical or family history. Clinical examination was unremarkable. She appeared generally well with no signs of hirsutism, acne or striae and her BMI is 19.3. Investigations Prolactin, free androgen index and autoimmune antibody screen were unremarkable and the patient's karyotype is 46, XX. Progesterone, oestrogen and luteinising hormone levels were unremarkable. Follicle stimulating hormone (FSH) was very high in the 3rd month of amenorrhoea (104 iu/ml) and also the 4th month (68 iu/ml)- this is consistent for a woman with premature ovarian failure (POF). Upon menstrual resumption, Anti-müllerian hormone (AMH) was measured at <0.6pmol/L- a result which is thought to reflect an extremely depleted follicular pool. Two months later AMH was repeated and had increased to 4.3pmol/L. Discussion A diagnosis of POF in this 22-year old was influenced by the results of FSH and AMH. FSH is known to be reliable whereas AMH is a new biomarker for ovarian function and reserve and hence its reliability is under much scrutiny. In females, AMH is secreted from ovarian follicles continuously from birth until the menopause and so AMH levels are deemed to reflect the size of the follicular pool (Bhide P, 2012). A woman's follicular pool is known to deplete with age-it is therefore contrary that AMH levels should dramatically increase like that seen in this patient. Various causes for the inconsistency of AMH levels are currently being explored. Recent literature has proposed that variations in the handling of AMH samples can lead to inaccurate results (Nelson, 2013). Other factors that may affect AMH results include the variability of the AMH assay itself; there are multiple types that are currently being analysed by a range of laboratories (Nelson, 2013). Current knowledge of AMH opens up exciting possibilities for its use in reproductive medicine. If accurate, it is possible that it could be used to assess a woman's fertility and perhaps predict menopause onset. This case study highlights the current unreliability of AMH, thus it should not yet be used in this manner. References Bhide P et al 2012. The role of anti-mullerian hormone as a predictor of ovarian function. The Obstetrician & Gynaecologisy, pp. 161-166. Nelson, S., 2013. Biomarkers of ovarian response: current and future applications. Fertility and Sterility, Volume 99, pp. 963-9.

Charter 1

12:40

A Perspective from Fresh Minds

Chair Dr Francoise Barten

Mr Charles Portas, Student, University of Manchester

Pharmacy flu vaccinations for the under 65 at risk; General practice and pharmacy perspectives

The flu vaccine programme has been extended in selected pharmacies to allow more convenient access for the 18-65's at risk. These groups are at higher risk of complications of flu and so a free flu vaccination is recommended. A survey has been done to elicit pharmacist and general practice views of the programme. This report draws together common themes, opinions and feedback of the programme in order to improve service with further possible expansion.

Charter 1

12:40

A Perspective from Fresh Minds

Chair Dr Francoise Barten

Mr Nazmus Khan, Student, University of Manchester

Co-author: Dr Paula Whittaker

Is exercise counselling an effective way to increase physical activity in people with type 2 diabetes?

The unprecedented incidence and prevalence of diabetes mellitus has reached epidemic proportions, making it one of our most challenging health problems worldwide. The most common form of diabetes mellitus is type 2 diabetes, accounting for around 90% of all cases. There is widespread evidence linking the benefits of exercise in the management of type 2 diabetes. Many studies have demonstrated that people with type 2 diabetes who exercise regularly develop better glycaemic control and suffer from fewer complications of the disease. However, research shows that promotion of exercise is often inadequate, with many individuals stating that they receive less support and education regarding physical activity compared with other therapeutic strategies in the management of their disease. Despite the notable advantages of exercise in the management of type 2 diabetes, adults with this condition are in fact less likely to carry out regular exercise than the general adult population. This systematic review will look at the effectiveness of exercise counselling as a way to increase physical activity in this population. Furthermore, it aims to demonstrate whether exercise counselling has a positive impact on glycaemic control in comparison with the current lifestyle advice and education readily provided. Finally, this review will discuss the cost-effectiveness of incorporating exercise counselling into the management plan for type 2 diabetics.

Charter 1

12:40

A Perspective from Fresh Minds

Chair Dr Francoise Barten

Miss Sadie Regmi, Student, University of Manchester

Co-authors: Thomas Callender, Ailie Knox, Anand Bhopal

What's in A Name? A quantitative analysis of the effect of the 'Neglected Tropical Diseases' umbrella on funding for research and development into 13

Background: The revival of the concept of ‘Neglected Tropical Diseases’ (NTDs) over the last decade has resulted in a surge of interest in conditions that previously were largely unheard of in high-income nations. As NTDs have grown in prominence, funding has increased considerably for the group. However, it is unclear whether this gain has been shared equitably amongst the constituent diseases. Consequently, we decided to analyze research and development (R&D) spend and markers of disease burden. With such information, researchers and policy makers can better evaluate the effects of grouping NTDs together to achieve greater recognition and engagement. Methods: We used G-finder reports to assess the overall change in R&D funding for 13 core NTDs as a whole, as well as the diseases individually, over the 2007-2011 period. Subsequently, we compared the estimated burden of each of the 13 diseases to changes in R&D funding over the 2007-2011 period. Findings: Overall R&D funding has increased by 70% for the 13 core NTDs. However, the gains have not been shared equitably across individual diseases: 37.1% of funding was directed towards the kinetoplastids (leishmaniasis, human African trypanosomiasis, and Chagas disease), which together represent 7.5% of combined disability adjusted life years (DALY) and 20% of deaths. The helminthiases (lymphatic filariasis, schistosomiasis, hookworm infection, ascariasis, and trichuriasis) with 87% of DALY and 75% of deaths, received only 18.5% of the funds disbursed. Interpretation: Changes in funding for diseases do not appear to be aligned to any objective criteria such as disease burden or attributed deaths. While use of a collective term to group the diseases has given the NTDs more moral, political and economic weight, the approach to tackling these diseases does not appear to be aligned with need. Funding: None. Conflicts of interest: We declare that we have no conflicts of interest.

Charter 1

12:40

A Perspective from Fresh Minds

Chair Dr Francoise Barten

Mr Khalil Secker, Student, University of Manchester

Different methods of preventing violence against sex workers through social empowerment: a systematic review

What studies already show: -Violence against sex workers is associated with reduced condom use and increased transmission of STIs, so preventing violence against sex workers is inseparable from tackling the spread of STIs amongst wider populations. -Some of the different methods are self-organised and stem internally from the sex worker community, whilst some have been initiated by external agencies. -Methods can be broadly separated into two categories: 1. Methods focusing internally on the sex-worker community e.g. social support, sharing names of abusive clients between sex workers etc. 2. Methods focusing externally on changing the attitudes of key groups and organisations in order to reduce stigma e.g. politicians, the police, religious institutions, boyfriends etc What my research will show: -Whilst in general sex workers seem to relish community support from other sex workers, the competitive nature of the job can sometimes encourage hostility and create a barrier. -Whether or not violence prevention is more successful when a structured approach with multiple methods is used, including type 1 methods (focusing internally) and type 2 methods (focusing externally). -An evaluation of the different methods of measuring violence. This is difficult because empowered sex workers are more likely to speak out and to report incidents of violence, so it may give the false impression that rates have increased.

Charter 1
14:00

Urban Mental Health	
Session title	Hidden Voices in the City
Chair	Dr Rebecca Farrington

Dr Rebecca Farrington, Clinical Lecturer Community Based Medical Education, University of Manchester

Healthcare for Vulnerable Migrants

No abstract available

Dr Jo Miller, Head Doctor, Freedom from Torture North West Centre and GP specialising in care of asylum seekers

Early Identification of Torture Survivors

No abstract available

Peggy Mulongo, Wellbeing Manager / Cross-Cultural Mental Health Practitioner, NESTAC Charity

No abstract available

Charter 2

11:00

Healthy Cities

Session title	Strengthening People - Centred health Systems and Public Health Capacity
Chairs	Professor Kevin Fenton, Dr Ann Marie Connelly

Professor Kevin Fenton, Director of Health and Wellbeing, Public Health England

No abstract available

Dr Ann Marie Connelly, Director of Health Equity and Impact, Public Health England

No abstract available

Charter 2	
11:00	
Healthy Cities	
Session title	Strengthening People - Centred health Systems and Public Health Capacity
Chairs	Professor Kevin Fenton, Dr Ann Marie Connelly

Dr Roger Harrison, Senior Lecturer, University of Manchester

Co-authors: Isla Gemmell, Judith Clegg & Katie Reed

Do we need to develop specific Urban Health competencies to educate public health professionals?

Introduction The Institute of Medicine recommended public health education to be competency based. Evidence linking competency frameworks to better outputs remains scarce (Paccaud 2011). Nevertheless, public health competency frameworks are an established tool, used to guide teaching curricula, workforce planning, and individuals' continuing professional education (Koo & Miner 2010). Urban Health research identified problems from relying on traditional approaches to public health and epidemiology (Rydin et al 2012). Urban environments present as complex, context-specific systems, with diverse groups and competing political priorities. An appropriately trained public health workforce is vital to help effectively meet the challenges of Urban Health. The study had three objectives: To identify specific public health competency frameworks for Urban Health; Identify individual competencies specific to Urban Health that have been incorporated into core / generic competency frameworks; Explore the potential benefits (and possible harms) from developing a set of competencies for public health professionals working in the discipline of Urban Health. Methods A search was carried out of electronic databases (PubMed/Ovid, Google Scholar), grey literature and of articles retrieved. Search terms were (Health* AND (Urban* OR City OR Cities OR Industrial) AND (Competenc*)). Individual competencies for the competency frameworks for public health (Assoc. of Schools of Public Health, MPH Core Competencies; the European Core Competencies for MPH Education), and the Part A exam curricula of the UK Faculty of Public Health were listed in an Excel spreasheet. Results The literature search did not identify any competency frameworks for Urban Health. The two core competency frameworks and the Part A curricula produced a list of 824 individual competencies. The electronic key word search did not identify any matched terms. Conclusion Competencies that distinguish Urban Health may have been overlooked in competency frameworks for public health in general. This questions the extent to which unique features of Urban Health were considered in existing frameworks. Evidence from health promotion supports making distinctions between Urban and Rural Health competencies (Shilton et al, 2003). Important questions include: what are the merits of developing a core competency framework for Urban Health, of mainstreaming key competencies that distinguish Urban Health from public health in general, and of maintaining the status quo? The latter runs the risk of sustaining a "mismatch of competencies to patient and population needs" (Frenk et al., 2010). Research examining the effectiveness of competency based education and workforce development on desirable outcomes is warranted too (Ogolla & Cioffi 2007). The International Society for Urban Health is in a prominent position to lead on this.

Charter 2

11:00

Healthy Cities

Session title	Strengthening People - Centred health Systems and Public Health Capacity
Chairs	Professor Kevin Fenton, Dr Ann Marie Connelly

Dr Russell Jones, Public Health Programme Manager, Glasgow Centre for Population Health

Evaluating the HIA of the 2014 Commonwealth Games

Background In 2008, a health impact assessment (HIA) was conducted on the Glasgow 2014 Commonwealth Games by Glasgow City Council working in partnership with the Glasgow Centre for Population Health, NHS Greater Glasgow and Clyde, and the MRC Social and Public Health Sciences Unit. The purpose was to inform the planning of the legacy for the Games and enable Glasgow to fulfil its responsibility as a European Healthy City, for which HIA was a core theme for Phase IV (2003-2008). Information was gathered through a variety of methods: - A scoping event with key decision-makers that identified potential impacts - Engagement with Glasgow's communities which allowed people to share their views through the Glasgow Household Survey, a bespoke questionnaire and interactive workshops - A review of the evidence on the impact of previous major sporting events Findings and recommendations were made under 13 key themes and further engagement with decision-makers responsible for the legacy of the Games has been ongoing. An evaluation is now underway exploring the extent to which recommendations have been implemented. Aims The aims of the evaluation are: - to assess whether recommendations have been incorporated into policy and planning for the Games and its legacy, and if so, how? - to develop an understanding of the facilitators and barriers to implementing recommendations, and - to inform future HIAs in terms of what has worked well and not so well. Methods The evaluation incorporates analysis of relevant documents and 30 to 40 in-depth interviews with key stakeholders involved in implementing the recommendations. Results Fieldwork is ongoing but preliminary results indicate that conducting the HIA has influenced both policy and practice. For example, the findings of the systematic review on the impacts of mega-sporting events on host cities indicated that holding such an event is not, in and of itself, sufficient to guarantee a positive legacy from the event. This led to the development of a Legacy Team within Glasgow City Council and a Legacy Manager within the Glasgow 2014 Organising Committee. The presentation will discuss in greater detail the HIA recommendations that were translated into policy and practice, as well as those that were not. Particular attention will be given as to the mechanisms behind such decisions, by describing the facilitators that eased implementation and the barriers that hindered it. The focus will be on lessons learned to assist those proposing to conduct HIAs in the future. Conclusions As the research is ongoing, it is not possible to draw definite conclusions. Nevertheless, preliminary findings seem to indicate that involving decision-makers early in the HIA process, aligning recommendations with policy priorities, continuing engagement with decision-makers and finding 'champions' all help to facilitate the implementation of HIA recommendations.

Charter 2
12:40

A Perspective from Fresh Minds

Chair Dr Will Welfare

Mr Andrew Steele, Student, University of Manchester

Co-authors: Sarah Mills, Gareth Mills

Access and Barriers to Dental and Medical Care in Homeless Adults.

AIM The recent increase in Scotland's homeless population makes characterising the nature of homeless persons' access to medical and dental services, and the barriers they encounter in accessing NHS services, is a vital part of increasing the accessibility of the NHS to this disenfranchised population. METHODS A mixed questionnaire, involving set questions and free text was designed for manual distribution, and verbally delivered to homeless persons living within the city centre of Edinburgh, Glasgow and Dundee. Of those approached, twenty agreed to participate in the study. RESULTS Overall access to all NHS services was poor, with homeless persons generally having greater difficulty in accessing dental care over medical care. Though 65% of respondents had dental problems, only fifteen percent of respondents were registered with a dentist. Only thirty percent knew how to access dental care if they needed it. With 65% of respondents also reporting medical problems, half of all respondents were registered with a GP, and 50% knew how to access a GP if they needed medical care. Though 25% of respondents had seen a dentist in the past year and 35% had seen a GP in the last year, 50% had never seen a dentist while 35% had never seen a GP. CONCLUSIONS This survey indicated that overall access to medical and dental care is lower among homeless persons than in the general population, and that homeless persons experience unique barriers to accessing healthcare. Access to medical care was more readily available than access to dental care.

Charter 2
12:40

A Perspective from Fresh Minds

Chair Dr Will Welfare

Miss Fatima Saeed and Taha Lodhi, Students, University of Manchester

Co-authors: Dr Helen Barrett

MMR Vaccination: A jab from the past?

Background: The measles, mumps and rubella vaccine (MMRV) is given to children at 1 and 4 years and has reduced incidence rates of these diseases to < 1%. In 1998 at a press conference, Andrew Wakefield suggested a link between autism and the MMR vaccine. Following this, national immunisation rates were estimated to have fallen from 92 to 80%. Despite multiple epidemiological studies dismissing any association; there has been a harmful public perception on vaccine safety amongst parents. Aim: To assess current MMRV uptake; review possible reasons for non-immunisation and ascertain the methods of recall used within the population aged 1 -18 registered at a GP in Manchester. Standard: MMRV should be >90% as found in the 'Greenbook' by the Department of Health. Method: A retrospective review, using Emis Web, identified patients (n=163) currently registered with the practice aged 1-18 years with no record of the MMR vaccine. This is a population with diverse ethnic backgrounds and a lot of temporary accommodation. A sample 20% (n=32) were selected and reviewed by alphabetised systematic selection. Variables included were age (years), length of time vaccine was overdue (years), reasons for decline and methods of recall. Results: In the practice, 21% (n=1394) of patients were aged 1-18. A total of 12% (n=163) were recorded as not vaccinated. In the 20% sampled (n=32), 6.25% (n=2) had had a recall sent out by the practice, in the form of mail. The average time since vaccination was due is 7.8 years (1- 18). No parental discussions were recorded. In 21.9% (n=7) of the sample population documentation discrepancies were noted. Conclusion: There is sub-optimal vaccination within the audited population (88% uptake) and lack of recall in the majority of cases. There are a significant (21.6%) number of patients with information lacking or unclear. The reasons for which are beyond the scope of this audit - however it could be related to pre-registration reasons (e.g. lack or loss of official documentation where immunisations have been commenced abroad, changes in Read coding, incorrect coding by previous practice etc.) None of the records assessed disclosed parental refusal based on and/or references to the Wakefield report. Recommendations: Based on the results, standards and implementations already undertaken, the following are suggested: 1. Health care professionals should aim to actively tackle immunisations within consultations. It is more likely to be effective. 2. Some patients attended too infrequently for [1] to be implemented. These should be flagged as vulnerable and recall forms such as calls, email and mail attempted and documented. Review date: March 2014 - September 2014.

Charter 2
12:40

A Perspective from Fresh Minds

Chair Dr Will Welfare

Miss Esra Elsaigh, Student, University of Manchester

Dermatological Emergencies in the Intensive Care Unit

Dermatological emergencies are rare but potentially life threatening conditions. Early identification, hospitilisation and the appropriate management is critical to reducing morbidity and mortality when facing these conditions. Poly-pharmacy and co-morbidities make identifying serious drug reactions like stevens-johnson syndrome and toxic epidermal necrolysis difficult. The multiple possible causes of prodromal symptoms and rashes make it essential to be aware of rocky mountain spotted fever as a differential diagnosis. Toxic shock syndrome may become fatal in a matter of hours. The skin is the most commonly affected organ in graft-versus-host disease, the most common complication after an allogenic haemotopoietic stem cell transplant, and requires aggressive therapy in patients who are already immunocompromised. Dermatological emergencies present with vague symptoms and are rarely seen making it difficult for a physician to make a diagnosis, however it is paramount to keep the following conditions as a differential diagnosis as early intervention is life-saving. This review aims to shed light and provide a framework for physicians on the diagnosis and management of dermatological emergencies.

Charter 2
12:40

A Perspective from Fresh Minds

Chair Dr Will Welfare

Mr Muhamad Rozaimi Mohamad Rashid, Students, University of Manchester

An Audit of Minor Surgery in Primary Care

Aim: Since the introduction of the new GP contract by NHS on April 2004; provided under additional service of the practice or as a directed enhanced service (DES), minor surgery in primary care has shown to be very popular with patients in urban areas. It is not just cost effective but also time saving to both patient and secondary health care centers. Hence this audit aims to attain maximum standard of minor surgery in primary care by analyzing the aspects of: 1) Correct Clinical Diagnosis corresponding to Histological Diagnosis 2) Patient Information and Consent 3) Post-operative Complications 4) Patient Satisfaction throughout the care. Methodology: The audit ascertains patients' details from Hawthorn Medical Centre EMIS database. All patients included in the audit have had minor surgery performed between 23rd November 2012 and 19th March 2013. A sample size of 21 minor surgery procedures; 15 excisions, 1 incision, 1 aspiration, 1 injection, and 3 cauterize, were recorded and analyzed. Result: The number of correct clinical diagnosis made that is corresponding to histological diagnosis is 10/19 cases which is equivalent to 52.6% of accuracy. Patient informed consent and information recorded in the database are achieved in all cases. No patient with post-operative complications. All patients were given satisfaction questionnaire and the information is being kept anonymous by the Practice Manager for further improvements. Conclusion: The clinical diagnosis made corresponding to histological diagnosis is under the 100% standard. Patient consent, no post-operative complications, and patient satisfaction met the standard by 100%. Recommendations include all biopsy samples must be sent for histological analysis to avoid misdiagnosis as clinical assessment is not always accurate. A more systematic approach should be developed in handling histology results to prevent error. Automatic computer alert should be introduced to ensure all biopsy results are recorded and actioned.

Charter 2

14:00

Healthy Cities

Session title	Urban Health Transitions: Weaving wellbeing through the life course
Chair	Professor Mark Dooris

Professor Mark Dooris, Director of Healthy Settings Unit, University of Central Lancashire

No abstract available

Charter 2

14:00

Healthy Cities	
Session title	Urban Health Transitions: Weaving wellbeing through the life course
Chair	Professor Mark Dooris

Miss Anne Sophie Dube, Student, Université de Montréal - École de santé publique

Co-authors: Gosselin C, Paquin S, Pelletier A, Goudreau S, Drouin L, Gauvin, L.

Grassroots Projects aimed at Sustainable Mobility and Population Perceptions of the Need for Improvements in Neighborhood Built Environment

A growing body of research suggests that individual car usage, instead of active transportation (walking and cycling) has negative health (e.g., obesity) and environmental consequences (e.g., pollution). These changes in transportation modes have fueled intervention efforts to render built environments more conducive to active transportation. Research has focused on how to mobilize urban planners, engineers, and municipal workers. Little is known about the breadth and foci of grassroots projects conducted by community groups and how the foci of these grassroots project coincide with population perceptions of the need for improvements to built environment. We aimed to: 1) enumerate grassroots projects aimed at improving neighborhood built environments to support active transportation that are currently up and running in Montreal Canada, 2) describe the environmental targets of projects, and 3) examine the association between the presence of grassroots projects in neighborhoods and population perceptions of the need for built environment improvements in their neighborhood. We performed a census of grassroots projects aimed at built environments that were carried out by community groups in Montreal, Canada between January 1 2006 and November 1 2010. We linked these data with other data from a population-based internet survey of Montreal residents (n=2002, 46% female) conducted in the spring 2012. This survey questions addressed the extent to which respondents perceived their neighborhood environment to require improvements. We linked the previous data sets together and with objective indicators of the built environment. We identified 135 community organizations who ran 183 projects aimed at built environments.Overall, 27 were aimed at improving accessibility to services and amenities (e.g., implementing public markets); 95 at sensitization or improving active or public transportation options (e.g., adding bicycle racks; elaborating mobility plans); 84 at improving road safety e.g., traffic calming measures); 46 at improving road safety (e.g., improving lighting and road signaling); 69 at beautification and greening of neighborhoods including urban agriculture projects; 7 at protecting and promoting natural environments (e.g., waterfront, forests, nature conservatories). Projects were concentrated in more urbanized areas with greater social deprivation. A higher number of projects in the neighborhood was associated with a greater likelihood of the population perceiving that many dimensions of their neighborhood built environment required major improvements. Associations remained statistically significant after controlling for mixed land-use and proportion of intersections with injured pedestrians or cyclists. We conclude that greater community mobilization coincides with population perceptions of the status of the built environment. Financial support from the Montreal Public Health Department and LG's Applied Public Health Chair.

Charter 2

14:00

Healthy Cities	
Session title	Urban Health Transitions: Weaving wellbeing through the life course
Chair	Professor Mark Dooris

Professor Pablo Fernandez de Arroyabe, Professor, University of Cantabria - Geography Department

Urban health and meteorological indicators

Physical and psychological wellbeing is a permanent objective for each citizen around the world. It is well known that the development of urban health studies requires a holistic approach in which demographic, social, cultural, economic and environmental factors be considered among many others. Environmental health is a branch of public health that looks at how natural and built environments may affect human health. An urban area is probably the most artificial environment that we can find in contrast to natural ones where biophysical processes follow natural laws. One of the physical variables that affects directly and indirectly peoples´ health in cities is the air. Atmosphere, in many cases polluted, is always there influencing daily human activities in urban areas. Physical atmospheric conditions are extremely relevant in relation to human health in all cities around the world. Atmosphere is undoubtedly the factor that crosses boundaries. The aim of this proposal is to show how meteorological factors are related to urban and global health through their anomalous variability and through climate change processes. Heat waves, floods, ultraviolet radiation, dry conditions, winds, shade and sun buildings exposure, positive or negative ions indoors or the light-darkness cycle are extraordinary relevant to our health. Considering this biometeorological approach to urban health give us the chance to mitigate weather and climate impacts on health. Based on empirical results, scientific community of biometeorologists who study these relationships have been able to develop Health Warning Systems (HWS) based on meteorological forecasting at urban scale. Some biometeorological indexes have been able to relate the physical properties of air masses to impacts on morbidity and mortality in the USA (Kalkstein, L,) (Sheridan, S.). Other authors have shown how the variation of the partial amount of oxygen on the atmosphere produces hypoxia and hyperoxia conditions in cities that, in extreme situations, can generate massive health crisis in specific groups of diseases (CIE 10) such as respiratory and circulatory illnesses. Some meteorological processes have been linked to the spreading of some infectious diseases such as influenza what make this issue extremely relevant in urban areas. In conclusion, meteorological variables are linked to human health in urban environments and they can be easily expressed through indicators but in few cases they have been incorporated to urban health studies. Moreover, some meteorological indexes can be used to anticipate impacts on morbidity and mortality and they should also be considered in urban planning documents in order to avoid or mitigate human health impacts and induce environmental comfort in cities around the world.

Charter 2

14:00

Healthy Cities

Session title	Urban Health Transitions: Weaving wellbeing through the life course
Chair	Professor Mark Dooris

Dr Stephanie Steels, Lecturer in Social Work

Developing Urban Health Indicators for Low Income Countries: Vietnam, a Case Study

No abstract available

Miss Ewa Monteith Hodge, Youth Projects Coordinator, McCreary Centre Society

Co-authors: Brynn Warren, Maya Peled, and Annie Smith

From the Courtroom to the Community: Informing Trans-Disciplinarity and Best Practices in the Support of Youth with FASD

INTRODUCTION Fetal Alcohol Spectrum Disorder (FASD) is associated with various cognitive impairments which increase the likelihood of victimization, being easily influenced by peers, and engaging in criminal activity. Youth with FASD are disproportionately represented in the criminal justice system, and face intervention challenges in custody and community settings. Therefore, it is critical to gain a better understanding of the needs of youth with FASD and associated cognitive impairments. This understanding can inform trans-disciplinary best practices to support this group of youth and make a lasting positive impact on their lives. DESIGN This study involved a mixed-methods approach of surveys and interviews to capture both quantitative and qualitative information. AIM The aim was to gain a better understanding of the needs of youth with FASD who are involved in the justice system, and the types of supports that may help them to successfully transition to adulthood. SETTING AND PARTICIPANTS Youth were surveyed in custody centres across British Columbia, Canada (n=114), as well as in alternative-to-custody programs (261 youth completed a survey at intake). RESULTS AND CONCLUSIONS In both groups, youth with FASD demonstrated more challenges than their peers without FASD, including higher rates of substance use and a greater likelihood of having sold illicit substances in the past six months. However, some protective factors were identified that predicted more positive outcomes among youth with FASD, including having supportive relationships with adults. For example, youth with FASD in custody who reported that an adult at the centre cared about them were more likely to anticipate not entering a custody centre again in the future, compared to their peers with FASD who did not feel that an adult at the centre cared about them. Qualitative information collected from youth with FASD and their service providers was consistent with the quantitative survey data. It also highlighted the importance of providing ongoing individualized support to youth with FASD as they enter adulthood. The presentation will further discuss effective ways of supporting youth with FASD to reduce their risk of continued involvement in the criminal justice system and to increase their likelihood of experiencing healthy outcomes.

Charter 3
11:00

Urban Planning and Architecture	
Session title	Health and Urban Planning
Chair	Professor Chris Webster

Professor Anne Ellaway, Lead for Neighbourhoods and Health Programme, University of Glasgow, UK

No abstract available

Ms Jenny Donovan, Prinicipal of Inclusive Design, Melbourne, Australia

Designing to Heal: the role of urban design in cultivating hope and community recovery after disasters and conflicts

No abstract available

Charter 3
12:40

Transdisciplinarity in urban health	
Session title	Arts, quality of life and urban health
Chair	Dr Simon Bell

Dr Simon Bell, Senior Research Fellow, OPENspace

Quality of life simulator

No abstract available

Charter 3

14:00

Urban Planning and Architecture

Session title	PRISMAPPRAISAL: A stakeholder-led Integrated Impact Assessment for viable urban development planning
Chair	Professor Roderick Lawrence

Mr Daniel Black, Director, Daniel Black & Associates, Bristol, UK

Mr Marcus Grant, Deputy Director of WHO Collaborating Centre for Healthy Urban Environments

PRISMAPPRAISAL: A stakeholder-led Integrated Impact Assessment for viable urban development planning

Evidence demonstrates increasing costs attributable to non-communicable disease, causal links between urban environment and the wider determinants of health, and that existing methods of development and plan appraisal are insufficient to address these issues. The lack of integration of health into methods such as Environmental Impact Assessment and Sustainability Appraisal is now well known and formal HIA has no capacity to support the development of better planning solutions. There remains a stark disconnect between theoretical assessment and viable delivery. A new approach, PRISM APPRAISAL, developed from successful action research, offers important lessons for the basis of an emergent solution. This innovative partnership between the WHO Centre for Healthy Urban Environments at the University West of England and multi-disciplinary consultancy, db+a, offers a service in an action learning paradigm, for the first time on a repeat basis; optimized for local authority spatial plans, large-scale development applications and neighbourhood planning. Public Health functions in England have moved back to local government giving better opportunities for tackling the wider determinants of health. The Government's 'Red-Tape Challenge', National Planning Policy Framework and National Housing Standards Review are removing substantial guidance and rigid assessment methods, leaving a vacuum in quality assurance, resulting in a need for new, robust and proven qualitative appraisal methods. Since 2000, the WHO Centre at UWE have been refining an approach within a stream of live plan-making and development projects. In 2012, db+a and UWE were commissioned by South Gloucestershire Council to carry out a PRISM APPRAISAL for the urban extension of north Bristol (5,700 units, 50ha employment land). Outputs show: agreed health objectives, group and individual grading of plan performance against objectives, and agreed actions. This activity led to funding from the UK's Technology Strategy Board to develop an online system tailored specifically to streamline this process. Outcomes are: clear demonstration, to volume developers in particular, of stakeholder demand for 'comprehensive development'; highlighting of details of barriers to health in planning proposals; and crucially the opportunity to consider and plan issues holistically rather than symptomatically. Many challenges remain unanswered, but developers are now taking a more proactive role in developing an area masterplan in partnership with local authority. This paper will assess this innovative approach to healthy development planning; to discuss strengths, limitations and lessons learned; recommending potential courses of action to improve and make the technique more widely available.

Cobden 1
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate change and urban insecurities I
Chair	Dr David Dodman

Umamaheshwaran Rajasekar (presenting), Gopalkrishna Bhat, Anup Karanth, Taru

Support systems and tools for urban health management

In India, marginalization of the poor and unhygienic living conditions along natural drainage/river banks have created an environment for the transmission of water and vector borne diseases resulting in frequent epidemic outbreaks. To face this challenge, the Government of India has initiated programs for systemic service level interventions targeting public health improvement. While these programs address some of the needs, they suffer from lack of manpower, data quality and analysis. The Asian Cities Climate Change Resilience Network (ACCCRN) is a privately funded program aim to build urban climate change resilience. This paper highlights key health interventions explored within this program and their impacts: Urban Service Monitoring (UrSMS): Surat Municipal Corporation (SMC) health workers collected door to door disease prevalence data using paper logs. This data was aggregated on a weekly basis to generate zone level statistics for action. The time lag between data collection and response was at times more than a week. To overcome this problem UrSMS was designed and implemented (PC and mobile) to facilitate near real-time data collection and analysis to trigger warnings. Currently, UrSMS helps Surat municipality to monitor water quality and disease prevalence across the city. More than 400 primary health centres, clinics and doctors feed data into the system on a daily basis. It has helped reduce time between disease reporting and response from a week to less than a day, therefore helping SMC to prevent disease outbreaks. Disease Surveillance system (DSS): Indore, a medical hub for Western Madhya Pradesh, faces problems of water logging and vector-borne disease outbreaks during monsoons. Currently, disease monitoring is implemented by the state health department on a weekly basis and problems of water logging are addressed by the Indore Municipal Corporation. Coordination and information sharing between health and municipal departments is limited to taking location-specific action. To overcome this problem a mobile phone based DSS was developed and tested during the 2013 monsoon. This system helped in collecting disease prevalence and water logging information in tandem. Health and municipal administrators can now visualize water logging and disease incidences as maps and reports, remotely, on a near real-time basis, helping them make informed decisions. Medi-Help Line: The Indore medical hub is surrounded by tribal population groups with limited access to health information and facilities. These groups often try to access medical facilities of neighbouring cities, unaware of government/civil society's health facilities and schemes in the area. Medi-Help has helped to improve access to these health schemes. The system is currently operated by the Sahayata (NGO) and is supporting the peri-urban population of Indore. These interventions are based on the general paradigm that changes in climate and inaccessibility of basic services severely impact health outcomes, and that therefore contextualized tools and systems for integrated monitoring are a prime necessity.

Cobden 1
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate change and urban insecurities I
Chair	Dr David Dodman

Dang Thu Phuong, Challenge to Change

Climate Change and Health burdens on the most vulnerable populations in Vietnam

Today, almost 30% of the Vietnamese population lives in cities, and it is estimated to reach 45% (40 million) by 2020. There are currently 753 urban areas, with Hanoi, Ho Chi Minh City, Hai Phong, da Nang, Hue, and Can Tho being the main centres. The rapid, often unplanned, urbanization in the country can outpace the ability of the government to build essential infrastructure and services and improve the living quality in cities. This has resulted in a range of negative social consequences including a growing gap in terms of access to quality and affordable health services, a lack of employment opportunities, high levels of pollution and worsening sanitary conditions. Each of these factors increases the risk of diseases and more generally an increase in inequities. In addition, cities in Vietnam are already experiencing climate change impacts such as increasing temperatures, more incidences of river flooding, destructive storms and typhoons, and saline intrusion. Challenge to Change (CtC), a British NGO supports vulnerable communities in rural and urban contexts in Vietnam to adapt to those dynamics partly triggered by climate change. CtC has been implementing community-based adaptation initiatives under the Asian Cities Climate Change Resilience Network since 2009. Among its activities have been Hazards, Vulnerability, Capacity Assessments and Household Surveys in the cities of Can Tho, Quy Nhon and Da Nang. In these assessments, health risks among vulnerable groups including children, poor women and men working in informal sector, elderly people and poor migrants have come particularly to the fore. Various approaches have been used to identify and arrive at pathways to mitigate diseases and vulnerability. The paper will focus specifically on the question of how urbanisation dynamics have exacerbated ill health and livelihood insecurity among the most vulnerable groups. Based on research in specific urban settings, evidence based interventions at national and local levels are being developed with the objective to assist vulnerable population groups in developing adaptive capacities in order to mitigate to health and climate change risks.

Cobden 1
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate change and urban insecurities I
Chair	Dr David Dodman

Rais Akhtar

Climate Change and Urban Health in India: Examples from Delhi

Climate change represents a range of environmental hazards and will affect populations where the current burden of climate-sensitive disease is high - such as the urban poor in India. It is not the rapid development, size and density of cities that are the main determinants of health vulnerability but, rather, the unplanned urban expansion and increased populations, particularly migrants from rural areas in hazardous zones,i.e. flood plains. The overall population density of Delhi increased from 9340 persons per sq.km in 2001 to 11,297 in 2011, which is highest in the country. A recent survey on a situational analysis of young child in India reveals that about 52 percent of Delhi,s population lives in slums with inadequate provision of basic services particularly water and sanitation. The scientific evidence, although limited for low income populations including slum dwellers, indicates that current weather extremes have significant impacts on human health, particularly the impacts of heat waves, heavy precipitation and floods events. The methods for assessing the risks of climate change are undergoing development and there is a need to shift the focus from global and regional to local studies. Sectoral approaches to climate change impact assessments often ignore the effects on health.The paper asserts that frequent outbreaks of dengue in Delhi in comparison to other metropolitan areas is the outcome of urban heat island resulting from the mean temperature warming trends in Delhi and the National Capital Region after 1990. . Besides,Delhi is one of the most polluted metropolitan cities in the country, with registered vehicles of 74,38155 in 2011-12, out of which 62.45% are diesel based motor vehicles. According to statistics maximum number of deaths occurred in Delhi due to cancer(13.56% of total deaths) during 2011.At the same time dengue and malaria are on rise. Hence there is total absence of epidemiological transition in Delhi as the urban regions equally suffers both from rising vector borne and chronic (lifestyle) diseases. There is a need to better describe the risks to health as well as improve the effectiveness of public health interventions. Improving the resilience of Delhi to climate change also requires improvements in the urban infrastructure including housing, access to health care ,and safe drinking water, sanitation and hygiene and such improvements may not be achieved quickly enough in India to avoid an increased burden of disease due to climate change and urban pollution. The analysis of data shows that no more than 4 percent of the total population of the capital city in Delhi is accessible to 24 hours water supply. The data analysis shows that dengue, malaria, cancer and cardiovascular diseases are on rise in urban areas. Based on an analysis of data on population density, lack of health care facilities and other amenities, and high population of aged population, the author has identified north eastern and northwestern Delhi more vulnerable to climate change than other regions. Climate change will exacerbate the human health problems if adaptation methods are not incorporated in sectoral planning with focus on infrastructure development, health care facilities and access to sanitation and safe drinking water. Keywords: climate change, dengue, malaria, cancer, urban heat island, air pollution, Delhi, water supply, urban resilience

Cobden 1

12:40

Health Promotion / Health Equity, Inequalities and Disparities

Session title	Abstract Presentations
Chair	Gordon McCranahan

Mrs Claudia Costa, Researcher, University of Coimbra

Co-authors: Paula Santana, Adriana Loureiro, Ângela Freitas

Avoidable mortality and the geographic accessibility of healthcare in Portugal

Introduction: Portugal is the country in Europe with the most 'avoidable' deaths (i.e. premature deaths resulting from certain causes that should not have occurred given the availability of healthcare). Between 2006 and 2010, 12.7% of registered deaths were of avoidable causes. Aim: To identify the geography of 'avoidable' mortality, assessing the areas of relative risk, and the association with the geographic accessibility to the nearest hospital. Data and Methods: A transversal ecological study was used to analyse deaths by 'avoidable' causes (as listed by Nolte, 2004) that occurred between 2006 and 2010 in the municipalities of mainland Portugal. The hierarchical Bayesian model proposed by Besag, York & Mollié was used to calculate the smooth Standardized Mortality Ratio (sSMR), the statistical significance of the risk of dying and an ecological regression to enable the calculation of the relative risk associated to the geographical accessibility of the municipalities to the nearest hospital. This was obtained using network analysis methodology. The time accessibility of the statistical subsection was identified, weighted by its resident population, and then this information was aggregated in order to identify the weighted average travel time from the municipality. Results: The avoidable mortality amenable to healthcare presents a marked pattern with low scores in the north and higher scores in the south. However, there are some municipalities in the northern inland areas with scores above the national standard; the same is also found in the Lisbon Metropolitan Area (LMA). Over half the Portuguese population resides in municipalities with a sSMR above 100 (58.8%). Portuguese municipalities are, on average, 25 minutes away from a hospital. However, there are some rural municipalities in the interior of the country in which the majority of the population resides over 60 minutes away from a hospital. There is a significant association between avoidable mortality amenable to healthcare and geographic accessibility. For each additional minute required to travel to the nearest hospital, the risk of dying from an avoidable cause increases by 0.3% (IC95%: 1.002-1.006). This risk increases the greater the travel time. For someone living over 30 minutes away from a hospital, the risk is 13% greater (IC95%: 1.064-1.189). There is also a risk associated to the type of municipality as rural or moderately urban municipalities have a relative risk of 2% compared to urban areas (RR: 1.016; IC95%: 0.999-1.080). Conclusions: Urban areas with healthcare provision are at less risk of avoidable deaths amenable to healthcare. However, the Portuguese region that is most urbanized and has the most hospitals (LMA) has municipalities that go against this trend, suggesting that accessibility is not the only factor influencing the distribution of avoidable mortality amenable to healthcare.

Cobden 1

12:40

Health Promotion / Health Equity, Inequalities and Disparities

Session title	Abstract Presentations
Chair	Gordon McCranahan

Gordon McGranahan and Diana Mitlin

Overcoming obstacles to community-driven sanitary improvement in deprived urban neighbourhoods: lessons from practice

Sanitary improvement has historically been central to urban health improvement efforts. Low cost sanitation systems almost inevitably require some level of community management, and in deprived urban settlements there are good reasons for favouring community-led sanitary improvement. It has been argued that community-led sanitary improvement also faces serious challenges, including those of getting local residents to act collectively, getting the appropriate public agencies to co-produce the improvements, finding improvements that are acceptable and affordable at scale, and preventing institutional problems outside of the water and sanitation sector (such as tenure or landlord-tenant problems) from undermining improvement efforts. This paper will examine these sanitary challenges in selected cities where organizations of the urban poor are actively trying to step up their work on sanitary issues, and will consider they can best be addressed.

Cobden 1

12:40

Health Promotion / Health Equity, Inequalities and Disparities

Session title	Abstract Presentations
Chair	Gordon McCranahan

Dr Brynn Warren, Aboriginal Evaluation/Research Assistant, McCreary Centre Society

Co-authors: Stephanie Martin, Maya Peled, Annie Smith

Building Connections to Reduce Health Disparities: A profile of urban indigenous youth health in British Columbia

INTRODUCTION: In spite of recent awareness of indigenous rights in British Columbia (BC), Canada there remains extreme inequalities between the health of indigenous youth and non-indigenous youth. With the majority of indigenous youth now residing in urban centres, a complete picture of their health is paramount to ensure that communities, organizations and government agencies have the tools available to provide the supports needed to address health disparities within this growing population of young people. METHODS: Since 1992 the BC Adolescent Health Survey (BC AHS) has asked youth in urban and rural schools all across BC questions about their health promoting and health risk behaviours. In 2013 the BC AHS V was completed, with 29,832 youth across BC completing 130 survey questions about their physical and mental health, cultural connections, and feelings of belonging and safety in their communities. POPULATION: Over 3,000 youth identified as indigenous in the BC AHS V, with many living in urban areas. Using this data we can begin to build a clearer picture of the health of urban indigenous youth, including changes over the past fifteen years within the global context of ensuring health equity for increasingly urbanized indigenous peoples. RESULTS: Overall indigenous youth living in BC's urban centres reported being in good health, and there is decline in the rates of some risk behaviours including cigarette smoking. However the effects of colonization remain, reflected in the immense inequalities and challenges faced by indigenous youth including unacceptable rates of discrimination, violence, suicide attempts, and abuse. Increased urbanization may provide more access to services such as physical and mental health care, however many urban indigenous youth report feeling disconnected from their culture and traditions. Indigenous youth living in urban areas were less likely than those in more rural reserve areas to report feeling that they belong to their own ethnic or cultural group, participating in cultural activities, or speaking an indigenous language at home. Indigenous community members have identified connection to culture as a positive influence in the lives of indigenous youth, and past BC AHS data has suggested that cultural connection is a strong protective factor for indigenous youth, associated with positive health outcomes. CONCLUSION: With increasing numbers of indigenous peoples residing in urban settings, addressing urban indigenous youths' feelings of disconnection from indigenous culture may prove an essential step towards addressing the health disparities between indigenous and non-indigenous youth.

Cobden 1

12:40

Health Promotion / Health Equity, Inequalities and Disparities

Session title	Abstract Presentations
Chair	Gordon McCranahan

Mr Ricardo Almendra, Researcher, Universidade Coimbra

Co-authors: Paula Santana; João Vasconcelos; Adriana Loureiro; Angela Freitas; Elisabete Freire

Inequality and excess winter mortality due to diseases of the circulatory systems in Portugal

Portugal is the European country with the highest excess winter mortality (Eurowinter, 1997, Healy, 2003), though, as yet, this seasonal burden has not been systematically quantified or taken into account in the definition of public policy. Exposure to the cold may be partly explained by behavioural and socioeconomic factors, as the more fragile populations are the most vulnerable (Wilkinson and Armstrong, 2001). The aims of this study are to identify geographical clusters of municipalities with higher and lower Excess Winter Deaths (EWD) rate due to diseases of the circulatory system and to assess the socio-economic conditions that increase the risk of EWD in Portugal. Monthly deaths from diseases of the circulatory systems, (2002-2011) were standardized to 30 days with adjustments for leap years. To measure the winter seasonal burden, the EWD rate was calculated in accordance with Johnson and Griffiths (2003). The Moran's I spatial autocorrelation coefficient was used to test for dependencies between the EWD rates in Portuguese counties, and the Anselin's Local Moran statistic to identify significant local clusters. To assess the socio-economic conditions several variables were addressed: Proportion of purchasing power; Unemployment rate; Proportion of elderly; Aging ratio of buildings; Proportion of one person household with 65 years old or over. Between 2002 and 2011 there were 354,481 deaths due to diseases of the circulatory system, of which 40,000 were EWD. The EWD rate was 36.4 per 100,000 inhabitants, as the result of a 37% increase in mortality during the winter months. The spatial autocorrelation test (Moran's I) was 0.305 ($p<0.001$); the cluster of significant low EWD rates is formed by 10% of municipalities and the cluster of significant high EWD rates involved 7%. All the municipalities in the cluster of significant low EWD rates are urban while the cluster of high EWD rates is constitutes by rural counties. Although not all the variables can significantly explain the EWD rate pattern, the cluster with lower EWD rate has significant better results than the high EWD rate cluster in all tested variables ($p<0.001$). This study shows that vulnerability to cold is an important hazard in Portugal; the regions with higher EWD rate are more deprived areas, where neither the dwellings nor the people are adapted to winter weather conditions. Although the urban areas had significantly better results, the EWD rate is still very high and should be a concern to the authorities. A better knowledge of the impact of weather and climate on health, and the social vulnerability to cold may be essential for the establishment of adaptation and mitigation policies and strategies, as well as for health planning and the development of early warning systems.

Cobden 1
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate Change and Urban Insecurities II
Chair	Dr Alfredo Stein

Dr Jeremy Carter, University of Manchester

Climate change impacts and adaptation responses in Greater Manchester: connections to health and wellbeing

An ongoing University of Manchester research programme, focusing on Greater Manchester in North West England, is looking at extreme weather and climate change hazards, the vulnerability of receptors (including people and communities and critical infrastructure) to these hazards and options to reduce associated risks. Operating within this programme, research undertaken within the Climate Proof Cities project is focusing on the role of green infrastructure in reducing flood risk impacts in urban areas, which will include health and wellbeing impacts and the worsening of social inequalities in flood prone areas. Green infrastructure is a classic multifunctional climate change adaptation response, with benefits extending across socio-economic and biophysical agendas. Particular attention is being paid to the contribution of green infrastructure responses delivered at the landscape scale, and the governance approaches that can support their development and implementation. Here we find a spatial mismatch between the scale of green infrastructure resources with a role to play in reducing flood risk within Greater Manchester's urban centres and existing structures in place to plan and manage development and land use change across this area. This research raises an intriguing network of connections between the impacts of extreme weather and climate change on health and wellbeing, the role of green infrastructure adaptation responses and approaches for planning and governing urban areas.

Cobden 1
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate Change and Urban Insecurities II
Chair	Dr Alfredo Stein

Dr David Dodman and Donald Brown, IIED

The impact of the uncertain on the unknown: assessing the probable effects of climate change on urban health in low- and middle-income countries

While there is a widespread recognition that climate change will affect human health, the precise ways in which changes in climatic means and extremes will interact with a range of other variables to shape patterns of morbidity and premature mortality are poorly understood. This is particularly the case for urban areas in low- and middle-income countries, where there is already a widespread lack of data on these issues – meaning that little is known about the most serious current health burdens or the individuals and groups most affected, and still less about how changes in climate will shape these in the future. This paper reviews existing knowledge on how climate change will interact with other environmental changes in these towns and cities to intensify existing and to create new health burdens, with the aim of defining the parameters for future work in this area. Firstly, it reviews the overarching mechanisms by which global climate change is affecting, or is likely to affect, urban health. These include direct impacts (such as more frequent and/or intense heatwaves) and indirect impacts (such as the changes in water-borne diseases in a context of more frequent flooding), and the ways in which these affect different population groups (for example the very young or the elderly). Secondly, it takes a 'bottom up' approach by analysing local data from three African cities (Dar es Salaam (Tanzania), Ibadan (Nigeria), Mzuzu (Malawi)) to build a more accurate and detailed picture of life- and health-threatening risks for the residents of urban areas. The potential of climate change to affect these underlying drivers of health risks is then examined. The implications of this combined global and local assessment are highlighted for future epidemiological research and risk assessments, with a focus on generating the disaggregated data that is needed to assess differentials in health within and between urban populations.

Cobden 1
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Climate Change and Urban Insecurities II
Chair	Dr Alfredo Stein

Dr.Vikas K. Desai, Technical Director, Urban Health and Climate Resilience Centre (UHCRC)

Co-authors: Dr. Hemant S. Desai, Dr. Kalpesh Khatri, Dr. K.G. Vaishnav

Management of Post flood Re-emerging infections - Surat city experience

Surat city is one of the fastest growing city in India with total population of 48, 49,213 (2011 census). Surat is an industrialized city with heavy influence of in migration, approximately 40% population of the city is in slum and slum like area. Surat city has experienced 23 floods in last 100 years, last flood was in 2013. Even with these repeated devastations city is growing its economy with effective adaptation. Post 1994 plague epidemic outbreak Surat city has metamorphosed as a well governed city and clean city with several award winning urban development projects and initiatives to its credit. Surat city is located on west coast in southern part of Gujarat. Cases of Leptospirosis (Zoonotic infection) are regularly reported during monsoon only from rural area since 1994. Surat city have experienced two resurgent infections post flood period, Plague (1994) and Leptospirosis (2006 and 2013). Lessons learnt from 1994 episode were used for subsequent post flood public health interventions. Measure to manage Leptospirosis included a) development of early case detection protocol jointly by doctors of public and private hospitals b) declaration of leptospirosis as notifiable disease, c) laboratory confirmation support for suspected cases in public or private institutions at Leptospirosis Laboratory of Government Medical College, Surat. d) Active surveillance of fever cases e) chemo prophylaxis (Doxycycline) to fever cases. Based on 2006 experience in 2013 in Leptospirosis prone area a) rapid Post flood cleaning on priority b) early initiation of fever case surveillance and c) chemoprophylaxis to fever cases resulted in to lower morbidity and case fatality rate.

Cobden 2
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Urban Violence and Conflict: Exploring the response to urban violence
Chair	Dr Kirsten Howarth

Elena Lucci, Independent Consultant (via Skype)

Humanitarian action in contexts of urban violence

No abstract available

Cobden 2
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Urban Violence and Conflict: Exploring the response to urban violence
Chair	Dr Kirsten Howarth

Verena Brähler, University College London

Inequality of Security in Rio de Janeiro, Brazil

The persistently high levels of violent crime in Latin America have been reason for great concern for both citizens and politicians due to its socio-political and humanitarian implications. With a homicide rate of 12.6 per 100,000 inhabitants in 2010, Latin America is the only region in the world where the homicide rate is still increasing. In 2010, almost 100,000 people have been murdered in Mexico, Brazil, Colombia and Venezuela alone.

However, not all Latin Americans are affected by crime, violence and insecurity in the same way. There is good reason to believe that actual crime rates and perceptions of insecurity differ according to people's place of domicile and their socioeconomic profile.

Against this backdrop this research introduces the notion of Inequality of Security. As is well known, inequality undermines institutions and social cohesion, prevents economic growth from reducing poverty, transmits poverty between generations, wastes talent and is also a major determinant behind violence, crime and social unrest. In contrast to that, security is a universal human right and a highly valued societal good. It is crucial for human life and of inestimable value for our societies.

The aim of this research project was to measure Inequality of Security in the city of Rio de Janeiro, Brazil. It did so by designing a survey – with questions on social cohesion, crime talk and victimisation, day and night-time perceptions of safety, satisfaction with security and personal experiences with crime and violence – and applying this survey to 282 residents in the neighbourhoods of Vidigal, Novo Leblon, Botafogo, Tabuleiro, Complexo do Alemão and Santíssimo.

The collected data provides strong numerical support for the hypothesis that the Right to Security remains an unequally distributed human right and societal good. In light of the humanitarian consequences of the Inequality of Security, the research concludes that we need to remodel our understanding of democracy, citizenship and the legitimacy of the Latin American polity in light of the regeneration of violence and crime.

Cobden 2
11:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	Urban Violence and Conflict: Exploring the response to urban violence
Chair	Dr Kirsten Howarth

Dr Melanie Lombard, Global Urban Research Centre, University of Manchester

Exploring urban land conflict: A case study from provincial Mexico

In the context of increasing concern about urban violence and insecurity, land conflict has been seen as a critical factor. In an urbanising world, where more than 50 per cent of the global population now lives in urban areas, where and how people access land for shelter in cities has become one of the most pressing issues. In the urban informal settlements which house the majority of residents in global Southern cities, the effects of insecure tenure include forced eviction, displacement and resettlement. Insecurity of tenure has thus been identified as one of several increasingly serious threats to urban security and safety; and urban poor communities are most vulnerable to conflict and violence more generally. Peri-urban areas are often subject to intensive residential development, whether through formal or informal processes, and it has been suggested that land conflict is more likely to develop in these areas. This paper explores conflict related to land through a specific case of irregular settlement on the peri-urban fringe of Xalapa, a provincial city in Mexico, where contestations over land under informal development have led to disputes which periodically escalate into violent encounters between different groups of settlers as well as the state. Through an in-depth discussion of the case study, the paper aims to discuss the effects of land conflict on the tenure and living conditions of the urban poor, and to examine the specific characteristics and outcomes of land conflict, as well as responses from the various actors involved.

Cobden 2

12:40

World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Mr Philippe Gradidge

Mr Philippe Gradidge, Lecturer, University of the Witwatersrand

Co-authors: Nigel J. Crowther, Shane A. Norris, Lisa K. Micklesfield

Patterns, levels and correlates of physical activity in urban black Soweto women

Abstract not available

Cobden 2

12:40

World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Mr Philippe Gradidge

Dr Makoto Miwa, Research Associate, University of Manchester

Co-authors: Sophia Ananiadou, James Thomas, Alison O'Mara-Eves

Text mining supporting big data for systematic reviews

Systematic reviews and health technology assessments (HTAs) are increasingly relied upon to give comprehensive and unbiased evidence to inform policy and practice. As well as increasing in methodological breadth (e.g., the inclusion of qualitative research in Cochrane reviews), recent years have seen an increase in substantive and geographical breadth, with systematic review programmes commissioned by major agencies such as DFID, 3ie and AusAID. Systematic reviews have to find solutions to the challenges of big unstructured textual data, with significant time spent manually sifting through the many thousands of irrelevant hits retrieved from electronic databases in order to find relevant studies. One way of reducing labour in systematic reviews and HTAs is to utilise active learning methods with text mining, since this offers the potential of identifying relevant studies automatically during the sifting process, and excluding irrelevant studies without manual inspection. While active learning has been demonstrated to work well in clinical and technical areas, social scientific research is more challenging due to the presence of diverse contexts and terminology. To address this problem, we investigate how text mining methods with active learning can support public health systematic reviews beyond clinical settings. We examine systematic reviews in social scientific research domain and discover useful criteria and enhancements to address the data imbalance problem in that relevant studies are much fewer than irrelevant ones. We applied active learning with two criteria (certainty and uncertainty) and several enhancements to systematic reviews of social science (specifically, public health) research. The results show that the certainty criterion accelerates the identification of relevant studies from a large number of published studies, and weighting positive instances is promising to overcome the data imbalance problem in the data set and produce a high performance classifier that distinguishes relevant studies from irrelevant ones. We also show that unsupervised probabilistic modeling of studies can uncover the hidden topics underlying the studies without manual efforts, and thus boost the performance of active learning. The most promising criterion and weighting method are the same regardless of the review topic, and the unsupervised modelling is effective especially in challenging areas with complex topics. With these enhancements, we find that 95% of relevant studies are covered by checking less than 50% of the entire studies in the data set, and this result shows that active learning has a potential to greatly reduce the screening workload.

Cobden 2

12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Mr Philippe Gradidge

Dr Durgavasini Devanath, Emergency Medicine Trainee, Royal College of Surgeons, Ireland

Resource Rich Organisations for Chronic Conditions - Their Role in a Collaborative Approach to Disaster Management

Background : 2013 saw the United Nations Office for Disaster Risk Reduction focus its efforts on highlighting disabilities in disasters. WHO includes chronic conditions within the scope of 'disability'. There has been some research on chronic conditions in disasters, but not much on interagency collaborations and coordination with organisations (international / national / local) set up to serve specific target groups of chronic conditions and disability (cerebral palsy, dialysis, haemophiliacs etc). Aims : This paper aims to explore existing hospitals and organisations dealing with chronic conditions currently serving the Irish population on a daily basis, review their current programmes, data and pre-existing tools, that could be of assistance when planning, preparing & responding to a disaster. Method: Online search for oganisations serving the Irish population affected with various forms of chronic conditions & disabilities followed by a face to face / telephone interview reviewing their current programmes, data & pre-existing tools. A review of national programmes (and tools) set up in hospitals in Ireland serving populations of chronic conditions (Via Health Service Executive) Results: Extensive resources are available to be incorporated in every aspect of the disaster cycle: planning & preparedness, response, recovery & mitigation by the various organizations. Incorporating these available resources will be cost & time effecting, preventing duplication of efforts. Conclusion: With their well established relationships with the population they serve, these organisations have an abundance of data, programmes & tools that could serve in planning & preparedness, response, recovery & mitigation for a disaster. And many of these organisations are willing and open to the idea of collaboration & cooperation with the appropriate authorities / city councils / hospitals in developing new programmes & tools that could be of significant use in disaster planning, preparedness, response, recovery & mitigation especially in an urban setting. Similar to the Irish setting, these organisations around the globe should be treated as an asset in the (urban) health care setting of disaster management internationally.

Cobden 2

12:40

World Health

Session title	ABSTRACT PRESENTATIONS
Chair	Mr Philippe Gradidge

Dr Elizabeth Kimani-Murage, Associate Research Scientist, African Population and Health Research Center

Co-authors: Wekesah F, Schofield L, Mohamed S, Ettarh R, Mberu B, Egondi T, Kyobutungi C, Ezeh A

Experiences of vulnerability to food insecurity in urban slums in Nairobi, Kenya

Background: Food and nutrition security is critical for economic development due to the role of nutrition in healthy growth and human capital development. Slum residents, already grossly affected by chronic poverty, are highly vulnerable to shocks arising from political instability among others. This study describes the food security situation among slum residents in Nairobi, with a particular focus on vulnerability during security crisis, highlighting the case of 2007/2008 post-election crisis in Kenya which greatly affected slum settlements. Methods: The study was undertaken in two slums in Nairobi Kenya; Korogocho and Viwandani and was nested within the Nairobi Urban Health and Demographic Surveillance System (NUHDSS), a system that follows about 70,000 individuals within about 30,000 households in the two slums. The study used a triangulation of qualitative and quantitative data collection methods. The qualitative study, conducted in November 2010 involved ten focus group discussions with community members; and 12 key-informant interviews with opinion leaders. The quantitative data collection, involving questionnaires was done in three cross-sectional surveys between March 2011 and January 2012 and involved a pooled sample of 3210 households, randomly sampled from the NUHDSS. Food security was defined using the Household Food Insecurity Access (HFIA) criteria. Results: The study indicates high prevalence of food insecurity; 85% of the households were food insecure. While most of the households purchased raw food most of the time (87%), the other households consumed foods prepared on the streets (13%). The qualitative narratives highlighted household vulnerability to food insecurity as common-place but critical during times of crisis. Respondents indicated that residents in the slums generally eat for bare survival, with little concern for quality. The narratives described heightened vulnerability during the post-election violence in Kenya in late 2007 to early 2008. Food prices for stable food like maize flour doubled, and simultaneously household purchasing power was eroded due to worsening unemployment conditions. Both quantitatively and qualitatively, respondents indicated use of negative coping strategies to food insecurity such as reducing the number of meals, reducing food variety and quality, scavenging, and eating street foods. Conclusions: This study describes the deeply intertwined nature of chronic poverty and acute crisis in urban slum settings. Households are extremely vulnerable to food insecurity, particularly during periods of crisis, and frequently employ negative coping strategies. Effective response to address vulnerability to household food insecurity among the urban poor should focus on both the underlying vulnerabilities of households due to chronic poverty and the impacts of acute crises on these households.

Cobden 2

12:40

World Health	
Session title	ABSTRACT PRESENTATIONS
Chair	Mr Philippe Gradidge

Dr Rana Ejaz Ali Khan, Professor, The Islamia University of Bahawalpur, Pakistan

Co-authors: Sara Noreen

Quality of Prenatal-care in Bangladesh: An Empirical Evidence from BDHS

The provision of prenatal-care services along with quality reduces mortality and morbidity in mothers and newborns. Bangladesh has developed various strategies and policies for improvement in maternal and newborn health. The nation has committed to Millennium Development Goals (MDG) regarding maternal health but still the utilization of quality prenatal-care is lacking. In this paper an attempt has been done to examine the socioeconomic determinants of quality of prenatal-care utilization by the women in the age group of 15-49 years. Micro data having 22437 observations from Bangladesh Demographic Health Survey (BDHS) 2004 and 2007 has been used. Ordered logistic regression analysis is utilized to determine the association between quality of prenatal-care utilization and explanatory variables categorized into demographic, socioeconomic, health and regional characteristics. Quality of prenatal-care utilization is measured by simple additive index by taking six components of prenatal-care. The results have shown that age of woman enhances the probability of quality of prenatal-care utilization while age square decreases it. The number of died children and ratio of male to female children in the household negatively affects the likelihood of quality of prenatal-care utilization. Age at first marriage, woman's education, her partner's education and wealth index of the household raises the probability of quality of prenatal-care utilization. In the regional characteristics, urban locality of the household and large/ capital city enhance the likelihood of quality use of prenatal-care utilization. Divisions of Bangladesh have shown insignificant effect on quality of prenatal-care utilization which demonstrates that there exists no disparity among divisions in the perspective of quality of prenatal-care utilization by women.

Cobden 2
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	The ambivalence of urban humanitarianism II: Urban disaster response
Chair	Dr Tanja Müller

Dr Rony Brauman, HCRI & CRASH

Urban or rural humanitarianism, an irrelevant alternative?

How best can one help, where are the priorities, how are needs defined, who is in a (legitimate) position to do it? These are, among others, common operational questions humanitarian actors come up with. Drawing both on a comprehensive literature review and Médecins Sans Frontières' field experiences, this paper will question the relevance of the urban category for humanitarian actors, as it hardly presents common features or specificities.

Cobden 2
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	The ambivalence of urban humanitarianism II: Urban disaster response
Chair	Dr Tanja Müller

Graham Saunders, IFRC

Urban disaster response - fit for purpose?

No abstract available

Cobden 2
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	The ambivalence of urban humanitarianism II: Urban disaster response
Chair	Dr Tanja Müller

Samuel Carpenter, British Red Cross (via Skype)

Preparing for disaster in a complex urban system: The case of the Kathmandu Valley

The city is a growing centre of humanitarian concern. Yet, the humanitarian system is only beginning to understand the scale and, importantly, the complexity of the humanitarian challenge in urban areas. This paper examines the challenges and opportunities of disaster risk management and preparedness for response in a complex, dynamic and continually evolving urban system – the Kathmandu Valley. Methodologically, the paper draws on a review of the academic and practitioner literature and a series of 26 individual and group interviews with disaster management actors across Government, the International Red Cross and Red Crescent Movement, UN agencies, NGOs and affected communities. It is argued that complexity can be seen as a defining feature of urban disaster management, both in terms of urban areas and systems themselves and the rapidly evolving preparedness and response systems that serve them. To meet the challenge of preparing for disaster amidst urban complexity, the paper highlights that sensitive adoption of new approaches, partnerships and technologies is essential.

Cobden 2
14:00

Urban Risk and Humanitarian Response: Climate change and urban insecurities	
Session title	The ambivalence of urban humanitarianism II: Urban disaster response
Chair	Dr Tanja Müller

Dr Simon Reid-Henry, Queen Mary, University of London

The New Urban Humanitarianism: framing a humanitarian right to the city?

No abstract available

Cobden 3

11:00

Urban Risk and Humanitarian Response: Stress and The City

Session title	Stress and The City II
Chair	Professor Diana Mitlin

Professor Frances Lund and Laura Alfers, WIEGO

Crossing boundaries in the management of risk in urban informal workplaces: Research and action in Durban, South Africa

AIMS: This paper reports on a pilot project planned for 2014, known as “Safer, Healthier Warwick.” It has emerged out of four years of research on extending Occupational Health & Safety (OHS) to urban informal workers by the global action-research-policy network, WIEGO. WIEGO’s research on the mitigation of health and safety risks in urban informal workplaces (such as roadsides, waste dumps and homes) has established the need for trans-disciplinary work not only between health professionals, but also between the health disciplines and urban planners, and between the levels of governance through which these disciplines operate. To demonstrate this, the paper discusses each element of the planned project, and where appropriate provides a rationale for each of these elements by drawing on previous research on OHS conducted by WIEGO. SETTING: Warwick Junction is an informal trading area and transport hub located in the inner city of Durban, South Africa. Approximately 6000 visible informal traders, spread across 9 different markets, provide goods to about 460.000 commuters who pass through the site daily. Products sold include fresh fruit and vegetables, cooked food, clothes and traditional medicine. Traders are well organized, but still face a number of health and safety risks in their workplaces. These range from burns, to wounds from the use of sharp implements, flooding during heavy rainfall, and violent crime. The regulatory environment in the area does little to protect the workers from the risks and hazards they face at work, and often serves to create new hazards. For example, one significant risk traders experience is that of random, and sometimes violent, evictions from their workplace by the local authorities. DESIGN: The intention of Safer, Healthier Warwick is to implement a participatory risk management system throughout the Warwick Junction trading area. The intention is to establish risk management committees in each market who will be trained in basic risk assessment, the design of evacuation procedures and routes, the installation of appropriate signage, as well as platforms for dialogue and consultation between traders and concerned regulatory institutions. The project has been conceptualised as a participatory one which encourages ownership of the risk management process by informal worker organizations. Importantly, however, it also acknowledges that poorer workers, even when organized, are unlikely to be able to manage risk effectively without the support of the regulatory structures which control informal workplaces. The project plans to engage, aside from the worker organizations themselves, a number of other stakeholders including the local university’s Occupational & Environmental Health Unit, as well as different departments from within the local authority (city health, the fire department, and the climate change mitigation division). CONCLUSIONS: 1) the need to rethink the basis of city level environmental health, which ‘sees’ citizens, but not workers in the public spaces of the city; 2) the need to move away from the ‘self-regulation’ approach to risk management in informal workplaces and to acknowledge that poor workers need institutional support; and 3) that the changing world of work requires solutions which cross institutional and disciplinary boundaries.

Cobden 3

11:00

Urban Risk and Humanitarian Response: Stress and The City

Session title	Stress and The City II
Chair	Professor Diana Mitlin

Dr Selmin Jahan, Senior Assistant Coordinator, Eminence

Water and sanitation facilities for the urban poor

Background: Dhaka is a dynamic city and has attracted substantial industrial investments. This increased the tendency of making the city as the centre of every development activity resulting in growing problems like slums, poor housing, traffic congestion, water shortages, poor sanitation and drainage, increasing air pollution and poor urban governance which results in growing problems of law and order. In spite of having so many poor groups in urban infrastructure, unfortunately the country does not have a comprehensive policy on urban poverty and urbanization. Objectives: This study reflects a comprehensive look at socio economic condition of slum dwellers living in Dhaka city with an aim to understand how to provide better water and sanitation system for the slum dwellers. Methods: The study had followed cross sectional design to know the socio-economic status of the population of study areas. The design intended to understand the socio-economical aspect regarding different implicit and explicit issues around water and sanitation. Quantitative approach was used among main female member of the household (Generally that's the mother of the family and the wife of the household head) to get the brief outline of socio-economic status, present water, sanitation and waste management access and expected water, sanitation and waste management facility. Qualitative approach was used for the community people, ward commissioners and relevant officials. Results: Study found that maximum number of families from the study area have access to the drinking water supplied by WASA Among most of them don't have their own water source and the source is usually far from the dwelling place. This pipeline water source does not supply water for 24 hours. So, community people, usually women and children, have to spend much time waiting in long queues to get water, creating different types of social problems including violence. Practice of using safe drinking water was found very low. A high number of families of the study area were found to be using unhygienic latrines. Conclusion: Information reveals that there is urgent need to develop water infrastructure by coordinating among different responsible bodies. Social and land ownership situation demands that there should be an extensive long term social mobilization and advocacy program to ensure regular safe water supply in the communities through participatory approach. It is assumed that community participation will be at the expected level and long term positive impact can be achieved by ensuring that participation of the landowners. Most of the target slums want sanitation services and many of them are also willing to pay minimum charges within their limit for maintenance of water and sanitation services.

Cobden 3

11:00

Urban Risk and Humanitarian Response: Stress and The City

Session title	Stress and The City II
Chair	Professor Diana Mitlin

Dr Helen Elsey, Public Health Specialist Registrar, University of Leeds

Co-authors: Khanal, S., Sah, D., Manandhar, S., Shah, S., Devkota, S.,MacGuire, F. , King, R., Baral, S. Wallace, H.

Healthy Kitchens: Healthy Cities: A scoping review and qualitative study to identify interventions to improve urban slum kitchens

The kitchen, which in South Asia is often the hidden domain of women and children, is the epicentre of activities which can either enhance or undermine health. Within the context of rapid and uncontrolled urbanisation, the activities in the kitchen and the risks they may lead to are changing. Burning solid fuels in poorly ventilated homes leads to high levels of indoor air pollution resulting in 2 mil¬lion premature deaths per year, particularly women and children (WHO, 2009). In South Asia, burns are a significant cause of morbidity and mortality with women over 14 years and boys under 12 at most risk (Golshan et al, 2013). Kitchen activities and infrastructure are clearly a risk to lung health and burn injuries, however much of the evidence for effective interventions comes from rural areas with little understanding of the dynamics in urban slum areas. Aim: To identify and pilot holistic interventions in urban slum kitchens to improve health. Design: This study included a scoping review to identify interventions to address lung health and burn injuries and a qualitative study conducted with women in two slum areas in Kathmandu, Nepal. Semi structured interviews were conducted with 21 women. The women took photographs to explain their kitchen and home environment. Four workshops were held in the two slum areas using participatory techniques to understand kitchen-related risks and identify potential interventions. Results: An initial 142 studies were found through searching Web of Science, Global Health, Ovid Medline, PsycINFO, Cochrane and Campbell database, 3ie, and WHO Library Database (WHOLIS). The scoping review identified interventions to improve lung health and reduce burn injuries through changes to housing infrastructure, cook stoves, child care and home health education. The review highlighted that much of the evidence of effectiveness for these interventions comes from rural areas and few studies have been conducted among the urban poor. The qualitative interviews identified the challenges women face in keeping themselves and their children healthy when threatened by floods, lack of income to use cleaner fuels to reduce smoky living spaces, limited space to keep small children away from fires and poor access to clean water and sanitation. The women identified associations between seasonal conditions, the kitchen environment and resultant health conditions. They strongly recommended improvements to their cook stoves to address both lung health and burn injuries. Conclusions: Good health is continually threatened in urban slum environments. Women were well aware of risks to their own and their family's health but were often powerless to make even small improvements to their kitchens and home environments. There is increasing evidence that improved cook stoves and changes to housing structures can improve lung health and reduce burn injuries, however the evidence from interventions conducted in urban slum areas is still weak.

Cobden 3
12.30

Transdisciplinarity in urban health	
Session title	Transport and Travel for Cities of Today and Tomorrow
Chair	Dr Anil Namdeo

Nick Vaughan, Head of Planning and Solutions, Transport for Greater Manchester

No abstract available

Helen Ramsden, Head of Travel Solutions

No abstract available

Cobden 3
14:00

Urban Risk and Humanitarian Response: Stress and The City	
Session title	Stress and The City III
Chair	Dr Maura Duffy

Dr Rubina Jasani, University of Manchester

If I did not pray, the jinn would press me down even further: ethnic and cultural determinants of help seeking among ethnic minorities in Britain

Anthropological literature on mental illness speaks about the role of explanatory models of distress and wellbeing as being key in determining help seeking, as well as more generally in understanding issues of compliance and non-compliance and disengagement with services. Using such perspectives in relation to ethnicity and culture was the focus of a larger study from which this paper is derived. It draws on ethnographic evidence from the qualitative narratives collected for the larger study.

While services claim that ethnic minorities have cultural explanations of mental illness and hence don't seek help, our narratives show how these explanations in many cases are competing and contrasting and hence, no one model can explain the complex interplay between culture, illness explanations and help seeking. Ambiguity, both in relation to explanations of mental illness and cultural understandings of mental illness was identified as a key finding, however, religion, culture and cultural rituals were central to the stories of relief that patients and their carers told. This paper unpacks these contradictions and taps into the dynamic healing practices that the South Asian diasporic communities engage in.

Cobden 3
14:00

Urban Risk and Humanitarian Response: Stress and The City	
Session title	Stress and The City III
Chair	Dr Maura Duffy

Professor Jutta Lindert, Professor of Public Health, University of Emden

Abuse and Mental Health in seven urban cities in Europe

Abstract not available

Cobden 3
14:00

Urban Risk and Humanitarian Response: Stress and The City	
Session title	Stress and The City III
Chair	Dr Maura Duffy

Miss Anna Chiumento, NWDTC PhD Student, University of Liverpool
Co-authors: Atif Rahman, Mark van Ommeren

Addressing the mental health consequences of urban violence and conflict: adapting and testing a low-intensity intervention for common mental disorders in Peshawar, Pakistan

Adverse life events, including urban violence, conflict and emergencies are potent risk factors for common mental disorders such as depression and anxiety, including posttraumatic stress disorder. Low and middle income countries (LMIC) lack sufficient numbers of mental health professionals to provide care to those in need, with 'task shifting' the delivery of care to paraprofessionals central to addressing this mental health gap. Aims: To assess the feasibility and effectiveness of Problem Management Plus (PM+): an innovative low intensity, trans-diagnostic intervention designed for delivery by paraprofessionals which aims to provide support to adults exposed to adversity in LMIC. Setting: PM+ has been culturally adapted for pilot testing in Peshawar, Pakistan. Peshawar is a site of urban violence and conflict with sporadic insurgency activity. Access to healthcare coverage is partial, with access to evidence-based mental health care limited to specialist tertiary care centres. Design: PM+ is a brief 5 session intervention designed for implementation by paraprofessionals in LMIC. It combines evidence-based strategies of problem solving counselling with selected cognitive behavioural strategies including behavioural activation, in-vivo exposure, strengthening social support, stress management and coping statements. It aims to address both psychological problems such as stress, fear and feelings of helplessness, as well where possible practical problems such as livelihood and financial problems, and interpersonal conflict. Cultural adaptation of PM+ has involved a rapid community qualitative assessment, manual translation, and development of an apprenticeship training and supervision model. An adaptation framework has been created to document this process. The intervention is being tested through a pilot individual randomised control trial with adults exposed to adversity in one Union Council of Peshawar. Results: Community consultations indicate that common mental disorders are prevalent amongst a conflict-affected population in Peshawar. Stakeholder review of PM+ indicates that a trans-diagnostic stepped-care treatment approach deliver by paraprofessionals enables effective use of available primary care resources, increasing access to evidence-based mental health care. Preliminary evidence from intervention adaptation and counsellor training suggests that PM+ offers a culturally appropriate intervention that addresses both practical urban insecurities as well as the impact of violence, conflict and emergencies upon mental health. Conclusion: Trans-diagnostic evidence-based interventions developed for delivery by paraprofessionals offer an opportunity to scale-up mental health care to those in need. Testing interventions in the conflict-affected humanitarian settings in which they are to be delivered is an essential step to ensuring the ethical principle of 'do no harm' is met. Preliminary results from this study indicate that the PM+ intervention offers the potential to fill a gap in primary care management of common mental health disorders prevalent in humanitarian settings.

Cobden 3
14:00

Urban Risk and Humanitarian Response: Stress and The City	
Session title	Stress and The City III
Chair	Dr Maura Duffy

Ms Ester Orban, Researcher, Centre for Urban Epidemiology, Institute of Medical Informatics, Biometry and Epidemiology, University Clinics of Essen, University of Duisburg-Essen
Co-authors: Kelsey McDonald, Robynne Sutcliffe, Barbara Hoffmann, Kateryna Fuks, Noreen Pundt, Anja Viehmann, Susanne Moebus

Urban traffic noise and mental health: Current state of research and results from the Heinz Nixdorf Recall study

Background: Noise is an environmental concern, especially in urbanized areas, where the main source of noise is traffic. Large numbers of people are affected and WHO considers noise an important public health issue. Studies suggest exposure to traffic noise causes annoyance and stress and is associated with cardiovascular diseases such as hypertension and myocardial infarction. Less is known about the relationship between traffic noise and depression. Depression is the most common mental disorder and the leading cause of disability worldwide. The etiology of depression is multi-factorial, complex and not fully understood yet. Environmental, psychological, social and biological factors may be involved, most likely in interaction. Aim and Methods: Our aim was to review the literature dealing with noise and depression, summarize the current state of research and identify potential gaps. Further, we analyzed the association between road traffic noise and incident depressive symptoms using 5-year follow-up data from the ongoing population-based, prospective Heinz Nixdorf Recall (HNR) study. This cohort contains 4814 randomly selected participants, aged 45?75 years at baseline, from the highly urbanized Ruhr area. High depressive symptoms were defined with a score >=17 on the CES-D 15-item short form. Road traffic noise (isophones) was modeled per European Parliament and Council Directive 2002/49/EC. High noise exposure was defined as daily annual mean noise levels >55 db(A). Participants with baseline CES-D scores >=17 were excluded. Generalized linear regression was used to calculate relative risks and their 95%-confidence intervals (95%-CI), adjusting for age, comorbidities and socioeconomic status. Results: Previous studies failed to find a consistent relationship between environmental noise and mental health, likely due in part to different exposure and outcome definitions and methods. A clear need for additional research on noise and depression was identified. Of the 4365 included HNR participants, 266 had a CES-D score >=17 at follow-up. There was a tendency towards an increased risk of depressive symptoms in the high-noise exposed population (RR=1.31, 95%-CI 1.04-1.66, n=3819). This effect was more pronounced in men (RR=1.59, 95%-CI 1.08-2.34; n=1940) than in women (RR=1.18, 95%-CI 0.88-1.58; n=1879). The adjustment did not change the results. Conclusion: To date, there is little evidence of an effect of traffic noise on depression. Our results suggest that residential traffic noise exposure may increase the risk of developing depressive symptoms, particularly in men. Several potential pathways support the hypothesis that noise exposure may be related to depression. For instance, sleep disturbances, which may be caused by noise, has been shown to be associated with depression in previous studies. Thus, decreased quality of sleep represents one possible link between noise exposure and mental health, although other mechanisms are also possible.

Thursday 6th March