WORKSHOP 1: CONGENITAL DEFECTS IN MULTICULTURAL URBAN POPULATIONS

CONVENERS: COMMUNITY GENETICS:

A.M. Plass (VU University Medical Centre, Amsterdam, the Netherlands)
M. Corel (EMGO-Institute, VU University Medical Centre, Amsterdam, the Netherlands)

Genetics and genomics are developing rapidly. The applications in diagnostics and treatment are more easily implemented than in preventive health care. Populations in big cities so far have had little profit from these rapid developments. Meanwhile their populations suffer from some specific genetic disorders and have specific reproductive health priorities for which interventions could be developed. Community genetics initiatives could help to solve some of the current inequalities in health. Perinatal mortality in Rotterdam is higher than elsewhere in the Netherlands. Preconceptional care may be a solution for some of the causes of mortality. Hemoglobinopathies are more frequent in minority ethnic groups that live in urban areas. Information campaigns need to be tailored and the attitude towards prenatal screening might need a specific approach. We discuss some community genetics initiatives as well as the challenges for the next decade.

POLICY IMPLICATIONS OF 3RD GENERATION IMMIGRANTS FOR NORTHRHINE-WESTPHALIA, GERMANY

H. Brand (Institute of Public Health Northrhine Westphalia, Bielefeld, Germany), E. Sievers

Introduction: Infant mortality reflects the health status of a population as well as the effectiveness of preventive care with a focus on maternal and child health especially for the migrant population. In 2004, Northrhine Westphalia (NRW) still had an infant mortality of 5.0‰, while the average in Germany meanwhile declined to 4.1‰. The question is, whether it is possible to define factors which may have contributed to this stagnation or regions with a special need for interventions.

At the moment there is no screening offered for haemoglobinopathies in NRW.

Methods: In depth analysis of the infant mortality by defining six district "clusters" by the proportion of the unemployed, migrant and aged population etc. An additional representative telephone interview (CATI) (N=1.800 plus 200 Migrants from Turkey)

Results: Regional data on infant mortality in NRW revealed a wide range of infant mortality within governmental districts and towns from 3.3 up to 8.5‰. The cluster with high levels of the indicators relevant to urban settings showed the highest infant mortality. They are concentrated in the area of the "Ruhrgebiet" – the old steal and coal area of NRW.

In newborns with foreign nationality the infant mortality assessed (11.1‰) was more than twice the rate compared in infants with German nationality (4.5‰). However, the variation attributable to different countries or regions of origin is considerable. In the migrant group the Turkish children are the biggest group. They have significant higher results (2000-2004): stillbirth (17,5‰ vs. 3,5‰), perinatal mortality (28‰ vs. 5,7‰), infant mortality (19,8‰ vs. 4,5‰).

Contrary, the results of the telephone interview show that the Turkish community seeks more information on health from the paediatrician, print media and relatives.

Conclusion: In the light of these findings a potential focus should be set on urban districts and towns for public health interventions. The proportion of the migrant population, ongoing immigration, and the mortality rate in infants with foreign nationality create the need for improved consideration in the conception of - and the access to - preventive measures in pregnancy and early childhood. Public Health Genomics issues - as prenatal screening for haemoglobinopathies among women from minority ethnic groups - should be considered on the political agenda and evaluated in the NRW setting by a Health Technology Assessment.

FIRST THINGS FIRST! A NEW COMMUNITY-BASED MODEL FOR PRECONCEPTION CARE

H.I.J. Wildschut (Erasmus University Medical Centre, Rotterdam, the Netherlands), J. Elsinga, J.A.M. Laudy, E.H. van Vliet-Lachotzki, P.H. Trienekens, E.A.P. Steegers

Introduction: Despite continuing efforts to improve antenatal care, the incidence of a number of adverse pregnancy outcomes including low birth weight, preterm delivery, and birth defects, has not gone down in recent years. Furthermore, maternal mortality does not decline substantially in developed countries such as the Netherlands. The most critical stages of embryonic development, i.e., 17-56 days after conception, largely take place before a woman is aware of her pregnancy. The first antenatal visit usually takes place after organogenesis and early placentation have been completed and, therefore, is too late to have a substantial impact on reproductive outcome. Hence, risk factors for adverse pregnancy outcome should be addressed before conception. The reduction of maternal and perinatal morbidity and mortality will therefore largely depend on enhancing and promoting preconception care. This can be achieved by primary preventive measures in the preconception period focusing on the timely assessment of modifiable risk factors. Moreover, in couples with an increased risk of genetic conditions in the offspring the preconception period offers more prospects for reproductive choice than the prenatal period.
Methods: Design: Protocol.
Results: In conjunction with the municipal Health Authority (GGD) a pilot study was initiated in three boroughs in Rotterdam to evaluate the successful implementation of preconception care among various ethnic groups. For this purpose, a campaign was launched locally to promote preconception care. The principle components of preconception care include (a) risk assessment, (b) information and advice on health promotion, (c) specific counselling and (d) intervention. Women or couples who are interested in the concept of preconception care are encouraged to visit the website (www.zwangerwijzer.nl) to fill out an electronic questionnaire with details about their health, lifestyle, past obstetric history, and family history of hereditary diseases. Each item of this checklist contains an explanation and, where indicated, recommendations for further action.
Conclusion: Apart from reproductive choice, the opportunity to address and reduce risk factors for adverse pregnancy outcome before conception has led many to believe that a shift from antenatal care to preconception care could be the most effective strategy to improve maternal and fetal outcome. In this context, the internet could play a major role in the dissemination of information that is relevant to a successful outcome of pregnancy.

THE MEASUREMENT OF ATTITUDES TOWARD PRENATAL SCREENING FOR HAEMOGLOBINOPATHIES AMONG WOMEN FROM MINORITY ETHNIC GROUPS: ARE TRADITIONAL INSTRUMENTS SUITABLE?

K. Brown (Institute of Psychiatry, King's college London, London, United Kingdom), E. Dormandy, T. Marteau

Introduction: Facilitating informed choice is seen as an important aim of many genetic screening programmes. Informed choice is based on the Western ethical principle of autonomy, whereby people are encouraged to act in line with their personal values and attitudes. Recent work in the UK has shown that pregnant women from minority ethnic groups are less likely than their white counterparts to make an informed choice about genetic screening tests, because they are less likely to act in line with their positive attitudes towards undergoing the tests.
This study investigates whether this finding represents a valid difference in rates of informed choice, or is a measurement flaw resulting from current measures of attitude being unsuitable for use with women from minority ethnic groups in the context of prenatal genetic screening.
Current measures of attitude may be unsuitable because they do not assess concepts relevant to the beliefs of the group in question, or because their response format is restrictive. French and Sutton (2005) suggested that affective attitude (how respondents feel about performing a behaviour) should be assessed in addition to instrumental attitude (cognitive appraisal of the extent to which performing a behaviour would be advantageous).
Methods: Design: Cross-sectional study. Measures: Instrumental and affective components of attitude were measured using closed-response (Likert scale) and belief elicitation methods. Subjective norm and perceived behavioural control were measured using standard instruments. Sociodemographic variables in-

cluding acculturation and religiosity were measured using situation-specific variations or shortened forms of standard instruments. Sample: 159 pregnant women who had been offered antenatal haemoglobinopathy screening were recruited from 24 general practices in two London boroughs. These boroughs are ethnically diverse, with approximately 50% of residents from minority ethnic groups. Participants completed the questionnaire by telephone or post.
Results: Responses to two methods of measuring instrumental and affective attitudes are presented, and differences between ethnic groups in these responses are highlighted. Acculturation and religiosity are presented as moderators of the link between ethnic group and attitude. Subjective norm and perceived behavioural control are proposed as potential mediators in the relationship between attitude and behaviour.
Conclusion: This study has implications for the measurement of attitudes towards genetic screening among ethnically diverse urban populations. Measuring informed choice using traditional instruments, which have not been developed for use with migrant populations, may give unreliable results. Further research investigating the predictive value of affective attitude on behavioural outcomes is necessary.

INFORMING THE MIGRANT POPULATION IN AMSTERDAM ABOUT THEIR ENLARGED RISK FOR HAEMOGLOBINOPATHIES

A.M. Plass (VU University Medical Centre, Amsterdam, the Netherlands), S. Weinreich, M. de Kinderen, M. Cornel

Introduction: In the Netherlands the migrant population is not well informed about their enlarged risk for haemoglobinopaties, even though more than 60 children are born with this disease yearly. It has been found that there is an under-representation of ethnic patients in clinical genetic centres. Moreover, the majority of the ethnic patients came to consult the genetic counsellor only after an affected child was born (v Elderen, 2004). Therefore, an initiative was developed to widely inform the Dutch migrant population in Amsterdam about their enlarged risk for haemoglobinopathies. People were invited to attend a so-called: "infotainment" meeting in which information was given in their native language through entertainment (a theatrical play), followed by a panel discussion and a (non-informative) music session. People were offered a free meal. This study examined the effectiveness of this patient-education programme.
Methods: Design: Pre-test Post-test design. Measures: Structured questionnaires on the basis of the Theory of Planned Behaviour (Ajzen, 1991) were developed in which not only attitude; social influence; perceived control and intention were measured using closed-response (5-point Likert scale), but also knowledge, familiarity with the disease, and stigma in addition to demographic variables. People were asked to fill out this questionnaire shortly before and after the information was given.
Sample: 80 people who attended one of these meeting filled out at least one of the questionnaires (19 Antilleans, 23 Surinamese, 7 Turkish, 3 Africans, 13 Moroccans, 4 Dutch en 11 of unknown nationality). 41 of them were aged under 45 (reproductive age), 58 filled out both questionnaires.
Results: Knowledge increased after the information had been given ($t(58)=-2.8$; $p=.007$). The overall attitude towards informing the public about their enlarged risk and towards DNA-carrier testing for haemoglobinpaties was very positive. The perception of control over the possibility to make use of this kind of testing increased in the so-called reproductive-age group ($t(30)=-2.1$; $p=.042$). Respondents did not feel stigmatised.
Conclusion: The patient education "infotainment" programme was successful: respondents were better informed afterwards and respondents aged under 45 (reproductive age) perceived more control over the possibility of making use of a test if they wished to. Moreover, participants regarded the information as important to know, and they did not worry about becoming stigmatised as a carrier of haemoglobinopathies.

ATTITUDES AND INTENTIONS OF PRIMARY HEALTH CARE PROVIDERS ON STIMULATING SCREENING FOR HAEMOGLOBINOPATHIES IN ETHNIC HIGH-RISK GROUPS IN THE NETHERLANDS

A.M. Plass (VU University Medical Centre, Amsterdam, the Netherlands), S. Weinreich, M. de Kinderen, M. Cornel

Introduction: In the Netherlands no national guideline on haemoglobinopathy-screening for ethnic minorities exists, even though more than 60 children are born with this disease yearly. There are sufficient clinical centres for diagnosis and treatment of haemoglobinopathies, but carrier screening is performed very seldom. The public is not widely informed about the latter possibility. Therefore, several initiatives have been taken in order to inform the public about the possibility of carrier screening for haemoglobinopathies. However, in accordance with the Dutch gatekeeper care-system, in order to get a test one has to consult the GP or midwife first. The aim of this study was to explore how GP's and midwives would react to patients' requests for a haemoglobinopathy-carrier test solely on the basis of ethnic background.

Methods: Design: Cross-sectional study. Measures: shorts structured questionnaires based on of the Theory of Planned Behaviour (Ajzen, 1991) in which attitude; social influence; perceived control, intention and past and present behaviour were measured using closed-response (7-point Likert scale) were sent by mail. In addition behaviour regarding ethnic anaemic patients was measured, and demographic variables (percentage of ethnic patients in the practices and profession (midwife or GP)). All questions, accept for attitude, were measured by one-single item. Sample: 150 GPs and 24 midwives filled out the questionnaire (response rate was 38%)

Results: Both GPs and midwives were positive about initiatives to inform migrants about their increased risk for haemoglobinopathies. Those who indicated that they had a large number of migrant patients in their practice felt more in control over referral for DNA-carrier testing ($t(145)=-3.0$; $p=.003$). Also they referred patients more often solely on the basis of ethnicity for a haemoglobinopathy carrier test than those who indicated seeing fewer migrant patients ($t(146)=-2.7$; $p=.007$). However, referral solely on the basis of ethnicity was rare ($M=3.8$). Midwives more often referred anaemic ethnic patients for DNA-carrier testing compared to GPs ($t(160)=-2.3$; $p=.019$). Both GPs and midwives were neutral in their intention to refer patients solely on the basis of ethnicity for a DNA-carrier test for haemoglobinopaties in the future. This was mainly explained by their perception of their colleagues' behaviour ($R2=.44$).

Conclusion: Even though the GP's and midwives clearly approved of patient-education programmes informing the Dutch migrant population about carrier screening for haemoglobinopathies, they did not intend to advise these patients to get tested. Ethnicity was not perceived as a risk factor in itself.

WORKSHOP 2: CULTURE & HEALTH; ETHNIC DIFFERENCES IN HEALTH

CONVENERS:

H. Bonink, E. van der Veen (The Netherlands Organisation for Health Research and Development (ZonMw), The Hague, the Netherlands)

Chair: C. Braakman (De Gelderse Roos, Expert Centre Phoenix, Renkum, the Netherlands)

A six-year Dutch research programme searching for explanations for ethnic differences in health and health care brought new knowledge on the ethnic differences, the reasons for these differences and the ways to reduce them. In this workshop we will show how new knowledge on ethnic differences from epidemiological and clinical research can be used to improve practise in the areas of prevention of diabetes and heart disease, during pregnancy, in the primary health care and in mental health care.

DIABETES MELLITUS AND CARDIOVASCULAR DISEASE IN 35-60 YEAR OLD SOUTH ASIAN SURINAMESE, AFRICAN SURINAMESE AND ETHNIC DUTCH MEN AND WOMEN: THE SUNSET STUDY

I.G. van Valkengoed (Academic Medical Centre, Amsterdam, the Netherlands)

The prevalence of diabetes mellitus is higher among the South Asian Surinamese and African Surinamese than among the ethnic Dutch population and current guidelines inadequately address differences in the risk profile between these ethnic groups.

The higher prevalence of diabetes mellitus, in combination with a high prevalence of other risk factors, only partly accounts for the increased prevalence of cardiovascular disease in the Surinamese population.

ACCULTURATION AND PROBLEM BEHAVIOUR IN IMMIGRANT YOUTH IN THE NETHERLANDS

G.W.J.M. Stevens (University Utrecht, Utrecht, the Netherlands)

Internalizing and externalizing problems of 819 4-18-year-old Moroccan immigrant children were compared to those of 2,227 Dutch native and 833 Turkish immigrant children. Parent, teacher and self-reports were obtained, using the CBCL, TRF and YSR. Moroccan immigrant parents reported as many problems for their children as Dutch parents but less problems than Turkish immigrant parents. Teachers reported substantially more externalizing problems for Moroccan immigrant pupils than for Dutch and Turkish immigrant pupils. In contrast, Moroccan immigrant adolescents reported fewer problems than Dutch and Turkish immigrant adolescents. The results may reflect true differences in children's behaviour, perceptual biases, social desirability in answering patterns and differences in thresholds to report problem behaviours.

In addition, the relation between acculturation and problem behaviour in Moroccan immigrant adolescents was examined. Three classes of adolescents with similar patterns of acculturation were determined through latent class analysis. We found an integrated, separated and ambivalent class. Girls with an ambivalent acculturation pattern showed more problems on several YSR and CBCL problem scales. The relation can be partly explained by the high amount of conflicts between parents and their ambivalently acculturated daughters. For boys, no associations were found. Our findings emphasize that gender and parent-child conflict should be taken into account to understand the complex relation between acculturation and problem behaviour.

ETHNIC DIFFERENCES IN MATERNAL MORBIDITY IN THE NETHERLANDS: AN ANTHROPOLOGICAL STUDY OF PATIENT PERSPECTIVES

A.J.M. Richters (Leiden University Medical Centre, Leiden, the Netherlands), M.M.D.J. Jonkers, J. Zwart, J. van Roosmalen

Migrant women of non-Western minority groups in the Netherlands experience more serious complications during pregnancy and delivery than indigenous Dutch women. This finding results from a two year running countrywide registration study of maternal mortality and serious maternal morbidity in the Netherlands (2004-2006). The supplementary qualitative study is aimed at answering the question, which factors may contribute to the overrepresentation of migrant women in the population registered with serious maternal morbidity. This study runs from December 2005 to September 2006. The goal is to interview

50 women with various ethnic backgrounds who are registered as having experienced serious complications during pregnancy and delivery. Interview topics include the perspective of the women on the origin and course of the complication, their help-seeking behaviour, their presentation of complaints, and their experiences with the health care received. The content of each woman's story will be compared with the medical story as registered in her patient file. The analysis of the various findings will try to identify factors, which may have increased the risk of a complication and/or have aggravated the course of the complication. Some results of the study will be presented.

ETHNIC DIFFERENCES IN HEALTH CARE UTILISATION

E. Uiters (Deparment of Justice, The Hague, the Netherlands)

Differences in health care utilisation between ethnic minorities and the indigenous population have been reported frequently. An adequate use of health care services is an important precondition for health. Therefore, it is important to examine whether ethnic differences in utilisation are an indication of problems in accessibility of health care services, or whether they reflect differences in need. In this presentation I will focus at the nature of ethnic differences in health care utilisation by examining differences in patterns of health care utilisation.

WORKSHOP 3: URBAN HEALTH RESEARCH:METHODOLOGIES (i.g. multilevel analysis monitoring)

CONVENERS:
E.J.C. van Ameijden (Municipal Health Service Utrecht, Utrecht, the Netherlands)
F. van Lenthe (Erasmus Unniversity Medical Centre, Rotterdam, the Netherlands)

MONITORING HEALTH IN THE CITY: METHODS AND INDICATORS

E.J.C. van Ameijden (Municipal Health Service Utrecht, Utrecht, the Netherlands), J. Toet, K. Haks, E.S. Quak, D. Meerkerk, B. Carlier

Urban Health is a broad research area. A brief description may be that it concerns public health research specific for urbanized areas. In most cities reside a relatively large number of disadvantaged and marginalized inhabitants who have an increased risk of poor health. Whereas diseases are not specific for cities, (especially environmental) determinants can be. These circumstances warrant specific methods and indicators in urbanized areas. The presentation will provide a limited overview of issues, with some examples of recent studies in Utrecht.
There are a number of general methodological considerations, e.g.: the concepts of urbanicity and urbanization are not consistently operationalised and often lack detail; due to migration and infrastructure changes, cities and suburbs continuously change; and suburbs are often defined according to administrative boundaries. Further, health status, health differences between subpopulations, determinants of health, and effectivity of interventions, can all vary according to the level of urbanization, between and within cities, and over time (interaction effects). As a result, statistical analyses require relatively complex techniques to deal with (interactions between) individual versus ecological level covariates, spatial distribution, migration, and time.
Study of Urban Health requires different types of research. For monitoring, the use of multiple methods and data sources helps to obtain a reliable and useful insight. This can include analyses of registrations (e.g. population registers, mortality, health care), health surveys in the general population and in specific marginalized groups, and for in-depth information qualitative studies can be used (ethnography). Methodological studies remain needed, as risk groups (e.g. ethnic minorities, homeless persons) are often hard to contact and instruments have to be socio-culturally sensitive and valid. Monitoring of policy and implemented interventions also offers important information. To guide community-based interventions, participatory research methods are available. Apart from monitoring, other relevant research is targeted at determinants of health, and innovation, implementation and cost-effectiveness of interventions.
The choice for appropriate indicators for health and its determinants can, amongst others, be made on the basis of the following: policy interest and impact, socio-cultural sensitivity and validity, and comparability (time and other places). Themes to be covered are manifold, e.g. well-being, health, disabilities, lifestyle, environment, and availability and use of preventive and care interventions. Indicators showing interaction effects are of interest as the underlying mechanisms may reveal factors that can be intervened. Finally, perceived wants and needs for information and assistance is worthwhile to monitor given a community approach towards prevention and care; we found that combining a population survey with stakeholder interviews is an efficient and valid method to set general policy priorities.

ADVANTAGES AND DRAWBACKS OF CLUSTER-RECOGNITION APPROACHES, MULTILEVEL MODELS, AND SPATIAL MODELS IN THE INVESTIGATION OF NEIGHBORHOOD EFFECTS ON MENTAL DISORDERS

B. Chaix (INSERM UMR-S U707, Paris, france), J. Merlo

The multilevel approach used in most studies of neighborhood effects on health may often fail to provide optimal epidemiological information, since it does not incorporate any notion of space. We compared the advantages and drawbacks of cluster-recognition approaches, multilevel models, and hierarchical geostatistical models to gain insight into the spatial distribution of outcomes. We also endeavored to measure contextual factors in more local areas than administrative neighborhoods. Data on all 89,285 individuals ages 40–69 in Malmö, Sweden, 2001, geolocated at their exact residence, were used to investigate (i)

mental disorders due to psychoactive substances and (ii) neurotic disorders. The spatial scan statistic indicated the existence of a large cluster of disease in the north of Malmö for the two disorders. However, the method of Bayesian Detection of Clusters and Discontinuities showed that disorders due to the consumption of psychoactive substances were more clustered in space than neurotic disorders. We then used multilevel models to compare the magnitude of neighborhood variations of the two mental health outcomes. Hierarchical geostatistical models, however, provided information on not only the magnitude but the scale of neighborhood variations, indicating that substance-related disorders varied in space on a much larger scale than that of administrative neighborhoods. The prevalence of disorders increased with neighborhood deprivation, but far stronger associations were observed when using indicators measured in circular areas of smaller size than administrative neighborhoods. The prevalence of disorders due to psychoactive substances increased independently with neighborhood deprivation and neighborhood social disorder. In many neighborhood studies, viewing space in a continuous way may yield more complete information on the spatial distribution of health outcomes.

DESIGNING OF AN INSTRUMENT TO MEASURE OBJECTIVE HEALTH-RELATED CHARACTERISTICS OF THE NEIGHBOURHOOD

M. Huisman (Erasmus University Medical Centre, Rotterdam, the Netherlands), F. van Lenthe, C. Kamphuis, K. Giskes, H. Brug, J.P. Mackenbach

Scientific interest in the effect of neighbourhoods on health has been growing in the last years. More recently, researchers have broadened their horizon to incorporate objective measures of neighbourhood characteristics in addition to self-reported (subjective) information. Existing registries however, do not always provide the most relevant information, and for a number of characteristics no data are available. This has resulted in the development of several 'neighbourhood assessment instruments'.

The Dutch longitudinal GLOBE study has gathered a great amount of subjective neighbourhood information in order to investigate neighbourhood inequalities in health. To complement these data we set out to develop a 'neighbourhood assessment instrument' for social and physical characteristics of neighbourhoods that may influence the health of residents. Our focus was on characteristics that have been implicated in influencing health-related behaviours such as smoking, alcohol consumption, fruit & vegetable intake and physical activity.

It is the purpose of this presentation to describe the development of a Dutch 'neighbourhood assessment instrument'. We constructed a first draft of the assessment tool, which included neighbourhood characteristics that were derived from scientific literature on 1) environmental determinants of health-related behaviour, and 2) already existing assessment instruments for specific neighbourhood characteristics. This draft was pre-tested by a group of researchers to assess user-friendliness and clarity. Subsequently, the inter-relater reliability was tested of the instrument in a slightly adjusted form in the city of Rotterdam. Finally, the instrument was used to gather data on characteristics of fourteen neighbourhoods of high and low status in the city of Eindhoven – again in a slightly improved format.

During the data gathering round in Eindhoven the inter-rater reliability of most items of the instrument proved to be adequate. In subsequent phases we will assign 'scores' to each of the neighbourhoods on the basis of the available data. The associations of these scores will be correlated with the prevalence of health-related behaviours, which can be calculated from the GLOBE data.

WORKSHOP 4: ALCOHOL AND URBAN HEALTH: CHALLENGES AND OPPORTUNITIES FOR LOCAL POLICY

CONVENER:

W. van den Brink (Academic Medical Centre University of Amsterdam, Amsterdam, the Netherlands)

Traditionally the city is identified with drug problems and related public nuisance issues such as acquisitive crime and homelessness. In this symposium we look at the role of alcohol as a potential harmful drug for the individual user and the urban community. Alcohol abuse by urban youngsters is a well-known problem and questions have been raised regarding the role of opening hours, age restrictions and the density of alcohol outlets in certain neighbourhoods. In addition, alcohol intoxication and alcohol related problems seem to constitute a serious problem in urban setting and these problems are also translated in a large number of alcohol related visits to emergency wards. Finally, alcohol problems are important in the continuation of the chronic situation of many homeless people in the city. These and other issues and the opportunities for local interventions are discussed in this symposium.

PREVALENCE AND DETERMINANTS OF RISKY ALCOHOL USE AMONG ADOLESCENTS OF DIFFERENT ETHNIC BACKGROUND: DO DETERMINANTS OF FREQUENT ALCOHOL USE DIFFER FROM THOSE OF BINGE DRINKING?

I.C. Stolte (Municipal Health Service Amsterdam, Amsterdam, the Netherlands), A.C.M. Diepenmaat, M.F. van der Wal

Risky use of alcohol among adolescents, such as frequent drinking and binge drinking, is known to be associated with considerable social harm and disease burden. Risk factors for the various types of risky use might be different. Moreover, they might differ among ethnic groups. Goal of this study was to describe the prevalence of frequent alcohol use and binge drinking among adolescents of different ethnic background. Additionally, we investigated whether determinants of frequent alcohol use and binge drinking differ.

Methods: A survey was conducted among 4370 students of intermediate vocational schools in Amsterdam. Self-reported information about alcohol use, socio-demographics, agression (BDHI) and depression (CESD) was collected using a questionnaire. We defined a four-categorical outcome variable for the various types of alcohol use (no alcohol use (ref); recent drinking (at least once in the previous month); frequent alcohol use (daily drinking or 3-6 times a week > 3 glasses of alcohol); binge drinking (drinking > 10 glasses of alcohol per event, not more than 3 times a week). Analyses were conducted using multinomial logistic regression. In case of low prevalence analyses were descriptive.

Results: The prevalence of recent alcohol use (62.4%), frequent alcohol use (18.0%) and binge drinking (7.5%) was highest among students of Dutch ethnic background, and lowest among students of Turkish (resp. 19.2%, 0.7%, 1.7%) and Moroccan ethnic background (resp. 6.7%, 0.3%, 1.5%).

Multinomial logistic regression was only done for students of Dutch ethnic background due to the low prevalence among the other ethnic groups. Independent determinants of binge drinking were male gender, having an additional paid job and higher level of aggressive symptoms. Independent determinants of frequent alcohol use were male gender, having an additional paid job, higher level of depressive symptoms, and higher level of aggressive symptoms.

Interestingly, almost all students of Moroccan ethnic background who engage in frequent alcohol use reported elevated depressive (90%) and agressive (87.5%) symptoms.

Conclusion: Frequent alcohol use and binge drinking are especially a problem among male students of Dutch ethnic background. Interestingly, a higher level of depressive symptoms is associated with frequent alcohol use but not with binge drinking, indicating that prevention of the two types of drinking needs a different approach. Furthermore, the few students of Moroccan ethnic background who report frequent use of alcohol appear to have multiple problems.

ALCOHOL OUTLET DENSITY AND THE INCIDENCE OF DRUNKEN DRIVING AND VIOLENT ASSAULTS

A. Treno (Prevention Research Centre, Berkeley, California, United States of America)

While the relationship between alcohol outlet densities and problem outcomes, most notably, traffic crashes and assaultive violence, has been clearly established in the research literature, the social mechanisms underlying these relationships is not known. This presentation summarizes what is currently known in this area, outlines some unresolved conceptual issues, and suggests a number of lines for future research in this area grounded in "social selection" and "social influence" perspectives.

TACKLING ALCOHOL-RELATED VIOLENCE IN CITY CENTRES: THE EFFECT OF EMERGENCY MEDICINE AND POLICE INTERVENTION ON ALCOHOL-RELATED ASSAULTS

A.L. Warburton (University of Manchester, Manchester, United Kingdom), J.P. Shepherd

Background: An increasing problem in urban societies is the violence and disorder that occurs in and around pubs and clubs, on weekend nights and involving large numbers of young adults, who have consumed alcohol. Continued investment and expansion by the entertainment and alcohol industries, in British, European and other cities is resulting in greatly increased numbers and capacity and popularity of entertainment district bars and nightclubs and represents a significant public health problem.
Objectives: To identify correlates of city centre alcohol-related assault injury, in a European capital city, with particular reference to emergency department (ED) and police interventions and number and capacity of licensed premises.
Methods: Assaults resulting in ED treatment were studied using a three stage, longitudinal controlled intervention, during a three-year period of rapid expansion in the night time economy, when ED-initiated, targeted police interventions were delivered. A controlled ED intervention targeted at high-risk night-clubs was carried out. Main outcome measures included ED treatment after assault in licensed premises and the street.
Results: Targeted police intervention was associated with reductions in assaults in licensed premises but unexpected increases in street assault that correlated significantly with numbers and capacity of premises. Combined police/ED intervention was associated with a significantly greater reduction compared to police intervention alone (OR 0.6, 95%CI 0.37-0.97). Risk of assault was 50% greater in and around licensed premises in the city centre compared with those in the suburbs, although dispersion of violence to more licensed premises was not observed.
Conclusions: Capacity of licensed premises is a major predictor of assaults in the street in which they are clustered. Marked decreases in licensed premises assaults resulting from targeted policing were enhanced by ED intervention, but were associated with increases in street assault. City centre assault injury prevention can be achieved through police/ED interventions targeted at high risk licensed premises and control of small area licensed premise capacity. Source of support: Wales Office of Research and Development (WORD)

SUBSTANCE USE AMONG EMERGENCY ROOM PATIENTS IN THE NETHERLANDS

S. Vitale (IVO, Rotterdam, the Netherlands)

Both alcohol use and illicit drug use are associated with many health problems. Besides long-term adverse health effects, alcohol and illicit drug use directly influence health through injuries occuring as a result of all types of intentional and unintentional accidents, e.g. traffic accidents, workplace accidents, and falls. In the past 15 years the relationship between substance use and injuries has been studied more intensively. In order to clarify alcohol and illicit drug use within the emergency room population in the Netherlands data from three different hospitals in three different regions were studied, focusing on whether interventions for these substances should be region specific. Alcohol and illicit drug use were assessed using a self-report questionnaire filled in by the patients, and by combining self-report with staff judgement on alcohol and illicit drug use. Data on alcohol use (self-reported and staff judgement combined) resulted in prevalence rates of 4.9% to 18.2%. Patients positive for alcohol are more likely to be male, aged 48 to 58 years, more likely to be a frequent excessive drinker, and to have injuries as a result of violence. Patients positive for

illicit drugs are more likely to be male, aged 28 to 38 years, unemployed, and frequent excessive drinkers. Among men aged 18-35 years with a Dutch cultural background, some differences emerge regarding alcohol consumption between the various hospitals, but most variation exists in the case of illicit drug use. This confirms that the emergency room seems to provide an opportunity to initiate interventions regarding alcohol use and seems to suggest that this is independent of the region concerned. However, in the case of illicit drug use interventions seem to be more region specific.

SHELTER-BASED MANAGED ALCOHOL ADMINISTRATION TO CHRONICALLY HOMELESS PEOPLE ADDICTED TO ALCOHOL

T. Podymow (Inner City Health Project, University of Ottawa, Canada), J. Turnbull, D. Coyle, E. Yetisir and G. Wells

Background: People who are homeless and chronically alcoholic have increased health problems, use of emergency services and police contact, with a low likelihood of rehabilitation. Harm reduction is a policy to decrease the adverse consequences of substance use without requiring abstinence. The shelter-based Managed Alcohol Project (MAP) was created to deliver health care to homeless adults with alcoholism and to minimize harm; its effect upon consumption of alcohol and use of crisis services is described as proof of principle.

Methods: Subjects enrolled in MAP were dispensed alcohol on an hourly basis. Hospital charts were reviewed for all emergency department (ED) visits and admissions during the 3 years before and up to 2 years after program enrolment, and the police database was accessed for all encounters during the same periods. The results of blood tests were analyzed for trends. A questionnaire was administered to MAP participants and staff about alcohol use, health and activities of daily living before and during the program. Direct program costs were also recorded.

Results: Seventeen adults with an average age of 51 years and a mean duration of alcoholism of 35 years were enrolled in MAP for an average of 16 months. Their monthly mean group total of ED visits decreased from 13.5 to 8 ($p = 0.004$); police encounters, from 18.1 to 8.8 ($p = 0.018$). Changes in blood test findings were nonsignificant. All program participants reported less alcohol consumption during MAP, and subjects and staff alike reported improved hygiene, compliance with medical care and health.

Interpretation: A managed alcohol program for homeless people with chronic alcoholism can stabilize alcohol intake and significantly decrease ED visits and police encounters.

WORKSHOP 5: HEALTH CARE FOR ASYLUM SEEKERS AND ILLEGAL IMMIGRANTS: DEBATING PRACTICE AND ETHICS

This workshop is organised in cooperation with Pharos

MODERATORS:
N. Klazinga (Municipal Health Service Amsterdam, Amsterdam, the Netherlands)
K. Stronks (Academic Medical Centre, Amsterdam, the Netherlands)

E. Bloemen (Pharos Knowledge Centre, Utrecht, the Netherlands), M. van Berkum (Pharos Knowledge Centre, Utrecht, the Netherlands), Chauvin (INSERM Unit 707, Paris, France)

Health care for asylum seekers and illegal migrants is a topic of heated debate in many countries. International law, national legislation and varying perspectives on the right on health care determine how countries assure the access and quality of health care and, in many cases, struggle with determining the limits of services that should be provided for free. In this workshop, organized in cooperation with Pharos, a knowledge center on refugees and health in The Netherlands specialized in health care for migrant groups, a debate will be set up to explore the practice and ethics of health care for asylum seekers and illegal migrants in various countries.
The workshop will start with a presentation by Pharos on the situation in The Netherlands, describing the various care arrangements, the scope of services and the existing policy reports and parliamentary debates (i.e. report Smeets commission 2004) and recent initiatives to codify professional norms and ethics with respect to care delivery to asylum seekers and illegal migrants (Evert Bloemen, Monica van Berkum, Pharos, Utrecht)
A second presentation will be based on a study on out-of-status person's access to health care: a cross sectional-survey in 19 cities of 7 European countries. (Pierre Chaivin et al, INSERM, European Observatory of Medecins du Monde, Paris) abstract 134
The remaining part of the workshop will be a discussion with the participants exploring the practice and ethics in their respective constituencies (moderator Niek Klazinga, GGD Amsterdam); topics debated include the policies to guarantee access and quality of services, limitation of the services provided for free, interpretation of the norm "necessary care", professional codes, tensions between governmental policies and professional norms. The results of the workshop will form input for the Dutch policy debate on codifying professional norms on care for asylum seekers and illegal migrants.

OUT-OF STATUS PERSONS' ACCESS TO HEALTHCARE: A CROSS SECTIONAL SURVEY IN 19 CITIES OF 7 EUROPEAN COUNTRIES

P. Chauvin (INSERM Unit 707, Paris, France), I. Parizot, N. Drouot, N. Simonot, European Observatory of Medicins du Monde

Introduction: In 2005-2006, Médecins du Monde's European Observatory of Access to Healthcare conducted a survey on out-of-status persons' access to healthcare. The Observatory's objectives are to organise a collection of data, observe the laws' implementation conditions, and bear witness to inequalities in healthcare access. The main purpose is to obtain the same access to healthcare for illegal migrants in Europe as the rest of the population and prevent people suffering from serious illnesses that cannot be treated in their home countries from being expelled.
Methods: The questionnaires were administered from July 2005 to February 2006. A total of 835 individuals were surveyed in Belgium, Spain, France, Greece, Italy, Portugal and England. The questionnaires were administered by volunteers at MDM centres (mainly social workers or health professionals) or, in rarer cases, by personnel from partner organisations.
Results: People surveyed came from 85 different countries, according to each European country's own history of migratory flows. The time spent in the host country without a residence permit ranged between

1 month to 24 years (mean: 24 months). Out of the people surveyed, 78.3% could theoretically access to free healthcare. This figure concealed significant differences between the countries surveyed: Greece is an exception with only 6.9% of the people entitled to free healthcare. In Belgium, Italy and England, it was readily available in primary and/or secondary care and, to a lesser extent, in France where 10% of the population surveyed did not have access to it. Spain is where people were best informed of their entitlement to free healthcare (nearly 100%). In Italy and Portugal, one third of theoretical beneficiaries were unaware of their rights, and 40 and 45% in Belgium and France respectively. During their last health problems, 11.1% of the people were refused care by health professionals. For nearly half the people concerned, care had been delayed for one or another of the health problems encountered. The most frequent obstacles encountered in accessing healthcare concerned unawareness of the right to healthcare or of where to go to seek care, the cost of the treatments, the administrative difficulties, the fear of being denounced, the fear of discrimination, and the linguistic and cultural barriers.
Conclusion: Whether by law or by practice, exclusion of out-of-status people from healthcare seems to be very frequent in the cities and countries surveyed. This raises important issues both ethically and in a public health perspective in European urban populations.

WORKSHOP 6: URBAN GREEN SPACE, HEALTH AND SOCIAL SAFETY

CONVENER:
R. Verheij (NIVEL, Utrecht, the Netherlands)
Co-chair: A. van den Berg (Wageningen University, Wageningen, the Netherlands)
March 2006 a Dutch newspaper reported: 'After the severe riots in the deprived Paris suburbs, autumn 2005, a French delegation of civil servants visited an equally deprived neighbourhood in the city of Rotterdam. However, they concluded that the situation in the Rotterdam neighbourhood was far from comparable to theirs. They said: "This neighbourhood has open, green spaces; this neighbourhood breathes".
This newspaper clipping shows that urban green space is important for people's health and well being. In spite of this, on many occasions, green space has to give in to building activities. In this workshop we will discuss recent scientific research on the effects of urban green space on people's health, well-being and social safety and the implications of this research.

GREEN SPACE, HEALTH AND FEELINGS OF SOCIAL SAFETY
J. Maas (NIVEL, Utrecht, the Netherlands)
People living in greener areas tend to perceive their perceived health as better than their counterparts living in less green areas (controlling for socio-economic and demographic spatial clustering). Whether such a positive relation will also be found when looking at peoples' feelings of social safety will be discussed on the basis of recent empirical research.

POSSIBLE MECHANISMS BEHIND THE RELATIONSHIP BETWEEN GREEN SPACE AND HEALTH, AND THEIR IMPLICATIONS
S. de Vries (Alterra, Wageningen, the Netherlands)
Within the Netherlands a relationship between the amount of nearby green space and perceived health has been established. However, it is not clear which mechanisms are responsible for this relationship. For example, is it air quality, stress reduction, or facilitation of physical activity? This presentation focuses on the implications of the different mechanisms for the optimal spatial planning, design and management of urban green for health purposes. These implications will also guide future research on the relative importance of the different mechanisms.

ARE ALLOTMENT GARDENERS HEALTHIER THAN THEIR NEIGHBOURS WITHOUT A GARDEN?
M. van Winsum-Westra (Wageningen University, Wageningen, the Netherlands), A. van den Berg
Allotment gardens are increasingly popular among residents of urban neighbourhoods with a lack of public and private greenery. In Amsterdam alone, there are over 30 of these garden complexes, with more than 6000 gardens. Health, restoration and well-being are among the most important reasons for renting an allotment garden. But is it really beneficial for people's health? We will present preliminary results of a survey in which we compared the health condition of allotment gardeners, their neighbours, and candidate allotment gardeners on waiting lists.

SAFE AND GREEN: CONCEPTIONS OF SOCIAL SAFETY, AND CONSEQUENCES FOR THE DESIGN OF URBAN NATURE
E. van Gemerden (Leiden University, Leiden, the Netherlands), H. Staats
Social safety can be improved by spatial design. But social safety is a complex, multidimensional issue, and designs that optimize certain conditions for social safety can produce rebound effects. Explaining social safety as basic trust in the social context, more than the absence of crime, we will give an overview of what designing for social safety implies, in particular for urban nature. We explore the relation between urban green space, coping with life's demands, and the evaluation of the quality of the social context.

WORKSHOP 7: PROMOTING SOCIAL INCLUSION AND TACKLING HEALTH INEQUALITIES - A EUROPEAN EXCHANGE OF GOOD PRACTICE

CONVENER:

I. Stegeman (EuroHealthNet, Brussels, Belgium)
I. Stegeman, H. Saad, L. Avedano, J.L. Drubigny, E.J.C van Ameijden

Introduction: Urban settings are enormously important when it comes to reducing health inequalities and promoting social inclusion. Health and social inequalities are highly concentrated in urban settings, especially in big cities. However the potential for tackling these problems resides mainly in cities, which benefit from a variety of social and health services.

Method: The workshop will look at actions undertaken at local, regional and European level to reduce health inequalities and social inclusion. The workshop will first set the context of health inequalities and social inclusion.

In a second part, the workshop will focus on the activities of various European networks that strive to improve the well-being of citizens by developing initiatives and programmes related to health and social cohesion.

Presentations will provide a zoom in urban settings and will encourage discussion on the transferability of good practices.

Results: Presenters will present the objectives, methods and results - or anticipated results of on-going activities.

Conclusions: The conclusions of the workshop will be disseminated widely via EuroHealthNet communication tools (website, a special issue of the newsletter and individual email) to relevant decision makers, professionals in the field and the press).

WORKSHOP 8: AGING IN URBAN ENVIRONMENTS IN THE US: FINDINGS FROM RACIAL AND ETHNIC SUBPOPULATIONS

CONVENER:

C.F. Mendes de Leon (Rush University Medical Centre, Chicago, United States of America)

The purpose of this workshop is to examine the role of neighbourhood environments in overall health and well being of older adults in the United States. Data will be presented from several large scales, epidemiologic studies in diverse racial subpopulations, including African-Americans, non-Hispanic Whites and Hispanics. The data cover several neighbourhood dimensions, including overall socio-economic milieu, the built environment, and neighbourhood social climate. The findings will be discussed in the context of a conceptual framework that specifies the role of social-structural variables in the development of adult-onset disease processes.

NEIGHBOURHOOD CONDITIONS, HEALTH AND WELL-BEING IN AN URBAN POPULATION OF OLDER BLACKS AND WHITES

C.F. Mendes de Leon (Rush University Medical Centre, Chicago, United States of America), K.A. Skarupski, J.L. Bienias, S.A. Everson-Rose, L.L. Barnes, D.A. Evans

Introduction. There is a growing appreciation for the potential importance of neighbourhood conditions for the overall health and well-being of older adults. Neighbourhood social conditions have often been characterized in terms of general socio-economic milieu, such as degree of poverty or social deprivation. The purpose of this study was to examine the association between general socio-economic milieu and physical and mental well being in a racially diverse population of older adults. We also examined the degree to which more specific social neighbourhood conditions, in particular social cohesion and social disorder, account for the association between socio-economic milieu and well-being.

Methods. We used cross-sectional data from a population-based study of community-dwelling black and white adults aged 65+ from Chicago (N=3,885). Mental well-being was measured using the Centres for Epidemiologic Studies-Depression scale (CESD) scale of depressive symptoms. Physical health was measured by a summary measure of three performance tests of physical function. Neighbourhood socio-economic milieu was assessed using U.S. Census Block Group indicators of socio-economic status (SES). Neighbourhood variables of social cohesion and disorder were based on block group-level aggregation of individual perceptions of these conditions. Multi-level models were used to test the association between neighbourhood SES, social cohesion and disorder and each outcome, adjusting for age, sex, and individual-level income and education.

Results. Neighbourhood SES was significantly associated with CESD scores (coefficient = -0.12; $p < .01$) and physical function scores (coefficient=0.43, $p<.001$), after adjusting for age, sex, and individual SES. Social cohesion and disorder accounted for 69% of the association of neighbourhood SES with CESD scores, and 21% of the association with physical function. Neighbourhood conditions tended to show weaker associations in black than in white neighbourhoods.

Conclusion. Neighbourhood social conditions are associated with depressive symptoms and physical function in older adults. Neighbourhood social cohesion and disorder seem to mediate the overall relationship between socio-economic milieu and these outcomes, especially depressive symptoms. The findings suggest that urban residential environments may affect physical and mental health in older adults.

SOCIAL INTERACTION AND INTERRACIAL UNEASE

K.A. Cagney (University of Chicago, Chicago, United States of America), C.R. Browning

Introduction: Evidence suggests that measures of neighbourhood social context (e.g., social network interaction and exchange, collective efficacy) have independent effects on health. We theorize that perceptions of interracial unease are yet another marker of community cohesiveness. We examine the extent to which neighbourhood-level perceptions of unease affect the health of individual residents. We hypothesize that these effects will be felt most greatly by older adults, given the likelihood of longer tenure and tether to

the community. We allow for interactions with race, believing that the effect of these neighbourhood social processes on health may vary across race group. We invoke theories of social organization and collective efficacy to separately examine the impact of neighbourhood structure (e.g., affluence) and process measures (e.g., unease).
Methods: We combine the Project on Human Development in Chicago Neighbourhoods-Community Survey, the Census (neighbourhood-level measures) with the Metropolitan Chicago Information Centre-Metro Survey (individual-level measures). We employ Hierarchical Modelling techniques.
Results: Consistent with previous research, we find that neighbourhood-level affluence has a positive effect on health (controlling for individual-level covariates and neighbourhood-level measures of social network interaction/exchange, residential stability, and age structure). Unease has a negative effect on health, and, for Whites only, attenuates the association between neighbourhood-level affluence and health.
Conclusion: Community climate has a role in the health of older adults. Neighbourhood-level receptiveness to social interaction and to racial integration may shape individual-level health and well-being. Social relationships between Blacks and Whites are typically investigated via individual-level interactions; neighbourhood-based explorations warrant further consideration.

SPATIAL DISTRIBUTION OF FOOD IN BLACK AND WHITE: NEW INSIGHTS ABOUT FOOD AVAILABILITY IN A SEGREGATED CITY

J.A. Kelley-Moore (University of Maryland, Baltimore, United States of America), J. Lloyd, J. Rennie Short

The availability of grocery stores in neighbourhoods is associated with better nutrient intake for residents and overall neighbourhood stability. However, much of the literature does not distinguish between types of grocery stores beyond classifying them as "chain" versus "non-chain". The purpose of this paper is to accurately assess actual food availability in Baltimore, Maryland, a residentially segregated city by race and social class.
Methods. We developed a heuristic to classify levels of food stores in neighbourhoods based on criteria such as size of store, hours of operation, and variety of products. Using ArcGIS mapping software, we defined the boundaries of the Baltimore neighbourhoods, and geocoded the food stores by level. We then added the GIS layers of socio-economic and racial composition of the neighbourhoods.
Results. The results of the spatial regression analysis indicate that poorer neighbourhoods are likely to have small, poorly-stocked food stores with limited hours. More affluent neighbourhoods tended to have more total food stores and a greater variety of types of store. Fresh meat, whole-grain breads, and fresh produce were available in a greater number of stores in White neighbourhoods than in Black neighbourhoods. There was an interaction between racial and socio-economic composition of a neighbourhood. Middle-class Black neighbourhoods were more likely to have better grocery stores than poor Black neighbourhoods, but were less likely to have the level of store found in economically equivalent White neighbourhoods. Indeed, the largest grocery stores (some open 24 hours) were only located in predominantly White neighbourhoods.
Conclusion. Classifying food stores by level helps elucidate the mechanisms of urban health inequality by indicating not just whether food is available, but what kind of food is available in neighbourhoods. This element of spatial inequality reflects the social construction of space, differential economic and political investment, and stereotypes regarding food preference by race and class.

NEIGHBOURHOOD VARIATION IN DISABILITY RATES AND LIVING ARRANGEMENTS OF OLDER HISPANICS IN URBAN NEIGHBOURHOODS IN THE UNITED STATES

K. Eschbach (University of Texas Medical Branch, Galveston, United States of America), K.S. Markides,

Background. Previous research has documented the existence of a higher rate of reported disability for older Mexican Americans compared to non-Hispanic whites of the same age. We investigate the relationship between neighbourhood environment and disability rates and living arrangements of Mexican Americans age 65 or older, and in comparison to other groups.
Data and methods. We use self-reported disability data from Census 2000 in two forms: First, aggregated

by age, sex, and poverty status at the Census tract level, and linked to characteristics describing the physical and built environment of the tract. Second, we use individual data from the 5% public-use microdata file, linked to contextual data at the level of the public-use microdata area. In the first case, we use Poisson-family regression to analyse tract-level determinants of disability and of the living arrangements of the disabled. In the second case, we use logistic regression models to analyse these determinants at a broader geographic level but with more information about the characteristics of individual subjects.
Results. Each one percent increase of Mexican American population share in a census tract is associated with 0.1 increase in the odds that an older Mexican American will report a disability. A 1% increase in the tract poverty rate is associated with a 0.7% increase in the odds of reporting a disability, adjusting for individual poverty status, demographic, and other contextual characteristics. Immigrant composition, and the prevalence of family households are associated with lower disability rates. Mexican Americans living in communities within 50 miles of the U.S.-Mexico border report significantly lower disability despite the high poverty and diminished access to health care in those areas. Other social and physical characteristics of tracts also influence reported disability rates for older Mexican Americans.
Conclusions. Disability rates are a function of neighbourhood as well as individual characteristics.

NEIGHBOURHOODS AS RISK REGULATORS IN THE HEALTH OF OLDER ADULTS

T.A. Glass (Johns Hopkins Bloomberg School of Public Health, Baltimore, United States of America), C.F. Mendes de Leon

Introduction: A growing but fractious literature has documented associations between various features of residential neighbourhoods and health outcomes in different populations. Initial findings suggest that neighbourhood "effects" are more difficult to detect in older adults. Also, controversy remains about what a neighbourhood is and whether neighbourhoods are causally related to health. Most studies have sought to estimate "independent" causal associations from observational data after adjustment for so-called "compositional effects" based on the aggregate characteristics of individual residents. These issues prompt a reassessment of basic questions about how neighbourhoods operate and how their role in the causal chain of health processes should be conceptualised.
Methods: This paper presents a theoretical overview and reassessment of basic issues in neighbourhood research as it relates to the study of health in older adults. We will also highlight some of the challenges in studying neighbourhood effects in different racial/ethnic subpopulations.
Results: We extend a previous analysis showing the potential utility of the concept of "risk regulator" to provide a solution to the question of whether neighbourhoods constitute causal factors (Glass and McAtee, Soc Sci Med, 2006). A conceptual model is presented which applies the concept of risk regulators to the study of urban neighbourhoods in late life.
Conclusion: The emphasis on separating "contextual" from "compositional" effects in the causal sense may have been misleading or misplaced. A more promising approach may be to study the ways in which features of the built, social and cultural environments operate indirectly to alter the spatial distribution of risk regimes that help explain differential patterns of health and well-being.

WORKSHOP 9: IMPROVING HEALTH OF MULTICULTURAL POPULATIONS

CONVENER:
A. Möllmann (Gesundheit Berlin E.V., Berlin, Germany)

GAP BETWEEN PATIENTS' NEEDS AND TREATMENT FOR MULTICULTURAL POPULATIONS IN EMERGENCY DEPARTMENTS

T. Borde (alice-Salomon-Fachhochschule Berlin, Berlin, Germany), T. Braun, I. Schwartau, M. David

Objectives: The function of emergency departments (ED) is defined as the treatment of patients with an emergency or in urgent need of medical care. International studies indicate an increasing utilisation of ED by ethnic minorities and other social disadvantaged groups for non-urgent conditions. There is an obvious gap between patients' needs and their utilisation patterns and the defined functions of ED. Our aim was to investigate into what extend psychosocial and psychosomatic problems are presented as somatic symptoms in ED.
Methods: The study was realised in four hospitals in Berlin, located in districts with a high migrant population and low SE. During the period of one month each, we held 815 standardised interviews and analysed 4930 ED records.
Results: Most patients self-rated the urgency of their consultation as high, although there was little correlation with the rating by physicians. Compared to the German population migrant women complained about more daily hassles, more headache, more general pain and more experienced violence. They attended the ED more frequently and tended to appear more often during the evening and night shift, as well as on week-ends. Migrants were less frequently hospitalised. In nearly 35% they were given a diagnosis that could imply psychosocial or psychosomatic disorders.
Conclusions: For migrants EDs seem to be an important source of care not only in the case of an emergency but also for psychosocial and psychosomatic problems. We propose that the definition of function, structures and competencies of the ED should be redefined to meet patients' needs. They should also provide psychosocial care in a multidisciplinary and multicultural setting.

CHANGING STRATEGY?

W. Gulis (Verein ZEBRA, Graz, Austria)

In the last ten to fifteen years, a lot of NGOs, professionals and experts have been engaged with the topic of Migration policy and questions of integration in different fields, areas and at different levels. Especially in the public health institutions and in organisations of the social welfare, a lot of serious and professional examination has happened.
However, in the broader field of health and welfare institutions, this discourse could not be implemented. As a result, the analysis of these "problems" got stuck in one of the main and most obvious problems between (health) institutions and migrants - identified by the access and the language problems between staff and clients.
Because of the small resources in public health areas and the discussions about privatisation and the heightening of efficiency, the persons in charge argue that there is no possible way to change structures and open the organisation for the needs of migrants.
So many providers of all kinds – NPOs and NGO and Selfbuilding organisations – have started to develop projects to minimize the identified problems. Interestingly, most of the projects are dealing with the deficits of the Migrants in trying to train them. ZEBRA, along with a lot of others, did so. As an Austrian NGO dealing with refugees and asylum seekers, ZEBRA developed projects with and for Migrants: offering training courses for Migrants as health educators and so on.
But the more projects from non-institutional organisations there are, the less will happen within the organisations. Neither on the main (access-) problem nor on the many other structural and political deficits. The management could use and decide between the external offers.
The focus, then, in our speech will be: ZEBRA has been changing its strategy in the last four Years. The

focus has changed from: "what kind of problems does Members of a minority group in the system make" to "which structural deficities has the Organisation to handle with these clients". Behind these change of paradigma, there is the assumption that the big issues for the future will be development of policy, structures (law, organisation, administration...) and management.
In short, we propose that it is necessary/essential to discuss and redefine the strategies and concepts with which instruments and on which levels a process can be run in a way that it is possible to change policy in a greater dimension.

INTERCULTURAL MEDIATION AT BELGIAN HOSPITALS

H. Verrept (University Antwerpen, Antwerpen, Belgium)

Our presentation reports on the work of intercultural mediators at Belgian hospitals. Since 1999, hospitals can apply for funding of intercultural mediators at the Federal Public Service of Public Health. The total budget amounts to 1.330.000 in 2005. About 50 intercultural mediators (totaling approx. 40 full time equivalents) are currently being financed. Together, they intervened 67.000 times to help overcome linguistic and cultural barriers at the hospitals. The aim of the intercultural mediation program is to provide equitable access to quality care to ethnic minority patients.
During our presentation, we will briefly discuss the results of two evaluation studies carried: the first one was a qualitative study on the effects of intercultural mediation on the quality of care, as it is perceived by health professionals, ethnic minority patients and intercultural mediators. The second study focused more on the problems associated with the introduction of the program at the hospitals and a number of quality issues of the work of the mediators (with special attention for the interpreting skills of the mediators). The approach used in the second study combined qualitative and quantitative research methods.
The results of both studies were used as a starting point for the development and implementation of a quality assurance and improvement program that has now been running for 3,5 years. The focus of the presentation will be on the structure and content of the quality assurance and improvement program, its strengths and weaknesses. Special attention will be given to the implications of our findings for the development of linguistically and culturally appropriate services at hospitals.

CAN ETHNIC HEALTH CARE ADVISORS BRIDGE THE GAP BETWEEN THE ETHNIC MINORITIES AND HEALTH CARE AND WELFARE SERVICES?

A.E. Hesselink (Municipal Health Service Amsterdam, Amsterdam, the Netherlands), A.P. Verhoeff, K. Stronks

Introduction: Empirical studies indicate limited access and a lower quality of care in health care and welfare services for ethnic minorities compared to the ethnic Dutch population, resulting in worse health outcomes. This deprivation is partly caused by problems ethnic minorities have with the Dutch language and their lack of knowledge on the Dutch health care and welfare system. In answer to this problem local steering groups in four districts of Amsterdam developed Information Centres on Health Care and Welfare and employed ethnic health care advisors. The main task of the health care advisors is to provide information on health and welfare issues to individuals or groups.
Methods: The implementation of the ethnic health care advisors is evaluated using a process evaluation. Information is gathered using reports, attending meetings of local steering groups, and by semi-structured interviews with people (in)directly involved in the implementation of the health care advisors. In addition, all individual and group contacts of the health care advisors are registered and analyzed.
Results: The ethnicity of the health care advisors, eleven in total, correspond to the main migrant groups in the district, e.g. Moroccan (5), Turkish (3), Surinamese (2) and Ghaneese (1). The focus and activities of the health care advisors varied between districts. In a period of two years, 1932 individual consultations took place with 1529 different inhabitants and 387 group educational sessions. Individual consultations were less successful while their was no fitting back-office to refer too and the ability of the target group to act independently was low. Group education was only successful in the Moroccan and Turkish population. In addition, in all districts the implementation was hampered by lack of ongoing commitment of parties involved (e.g. health care and welfare providers, migrant organizations) and lack of integration in existing

health care and welfare facilities. Although all Information Centres were closed after two years, two districts decided to extend the contracts of the health care advisors. Their focus is restricted in organizing group educations given by health care and welfare providers.
Discussion: Although only two districts decided to continue a part of the project, many inhabitants were reached which, at least for these inhabitants, bridged a part of the gap between migrants and professionals. Still the project was less successful than expected on forehand, which was manly caused by the lack of integration in the health care and de welfare system and low commitment from the involved parties. The underlying problem seems to be the questions; 'who is the owner of the problem, the district policy or the health care and welfare services'. In addition, how can all parties together organise an integrated system for employing and feeding the ethnic health care advisers / the bridges?

WORKSHOP 10: URBAN HEALTH CARE

CONVENER:
A. Verhoeff (Municipal Health Service Amsterdam, Amsterdam, the Netherlands)

ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH INEQUITY IN URBAN SETTINGS? THE ROLE OF SETTINGS BASED APPROACHES IN ENHANCING PARTICIPATORY GOVERNANCE

F.J.M.H. Barten (radboud University Nijmegen, Nijmegen, the Netherlands)

Within the coming two decades the world's urban population will increase rapidly, particulary in low- and middle- income countries where around 95% of this rapid growth is to take place and large parts of the population is living in slums. At the same time, there are fundamental changes in the world social, economic, political context. The nature of urban development will therefore have an important impact on global health and health equity. Important regional differences exist also in terms of resources and capacity to address the problems. Participation has been considered as crucial to social transformation and is a key-tenet of integrated settings-based approaches such as healthy cities. Although the relevance of participation has been recognized by many agencies, in practice it has been more difficult to achieve. This paper reviews the experience of a range of approaches to equitable urban health development by several multilateral and local organizations in enhancing participatory governance. While the urban growth rates in some cases equal those of the towns in 19th century Europe, some critical differences exist such as the fact that this rapid urbanization has not been accompanied by a similar growth in employment and production activities.

Also, the role of the state and the public services has been weakened in a context of increased integration of the global economy. The paper argues therefore that the main challenge to address the social determinants of health inequity in urban settings probably lies at national and global level and demands increased social control to enhance the democratic accountability of centralized global institutions. Global social movements have a critical role to play in this process.

PARENT AND CHILD CENTRES IN AMSTERDAM

A. Kesler (Municipal Health Service Amsterdam, Amsterdam, the Netherlands), A.M.M. Woudenberg

Every year about 10.000 children are born in Amsterdam; more than half of them belong to an ethnic minority. Almost a hundred years ago the Municipal Health Service Amsterdam (GGD) started setting up infant welfare centres, which deliver a standard package of youth health care for free- including vaccinations, nutritional an hygiene advice etc – for all infants and preschool children. Almost all Amsterdam's children under the age of 4 go to such a centre. Because of the considerable welfare- and health problems, a wide variety of other services have been set up in the last years, especially meant to support parents of small children. They all have different funding, are under different governmental influence and tend to work on their own. Parents frequently don't know where to go anymore. To make the services more "streamlined" and increase their accessibility we decided to set up Parent en Child Centres (PCCs), accommodating the standard preventive healthcare for infants and small children, but also include midwifery, maternity care, support in raising children and activities to encourage children's development.

HOME DELIVERIES IN AN URBAN POPULATION OF WESTERN NEPAL- A QUESTIONNAIRE SURVEY OF REASONS, CHILDBIRTH AND NEWBORN CARE PRACTICES.

T. Sreeramareddy (Maniapl college of Medical Sciences, Pokhara, Nepal), H. Joshi, V. Sreekumaran, S. Giri, N. Chuni

Background: About 98% of newborn deaths occur in developing countries, where most newborns die at home. In Nepal, approximately, 90% of births occur at home. Information about reasons for choosing home deliveries, childbirth and newborn care practices in urban areas of Nepal is lacking and such information will be useful for policy makers.

Methods: A cross-sectional survey was conducted during January-February, 2006 in Pokhara city, western Nepal. Two trained health workers interviewed the mothers of the infants attending immunisation clinics who were born at home using a semi-structured questionnaire.
Results: A total of 240 mothers were interviewed. Planned home deliveries were 140 (58.3%) and 100 (41.7%) were unplanned. Skilled attendance at birth was low (6.2%) and 38 (15.8%) mothers gave birth alone. Only 46 (16.2%) women had used clean home delivery kit and 92 (38.3%) birth attendants had washed their hands. The umbilical cord was cut after expulsion of placenta in 154 (64.2%) births and cord was cut with a new/boiled blade in 217 (90.4%) births. Mustard oil was applied to cord in 53 (22.1%) deliveries. Birth place was heated throughout the birth in 88 (64.2%) deliveries. Only 100 (45.8%) newborns were wrapped within 10 minutes and 233 (97.1%) were wrapped within 30 minutes. Majority (93.75%) of the newborns were given a bath after birth. Mustard oil massage of the newborn was a common practice (144, 60%). Sixteen (10.8%) mothers had discarded colostrums. Prelacteals were given to 37(15.2%) newborns. Initiation rates of breast feeding were 57.9% within one hour and 85.4% within 24 hours. Main reasons for choosing home deliveries were preference (25.7%), ease and convenience (21.4%) for planned whereas precipitate labour (51%), lack of transportation (18%) and lack of escort during labor (11%) for unplanned.
Conclusion: High risk home-based childbirth and newborn care practices are common in urban population. Community-based interventions are required to improve skilled attendance and hygiene during delivery. The high risk traditional newborn care practices like delayed wrapping, bathing, mustard oil massage, prelacteal feeding and discarding colostrums need to be addressed by community-based health education programmes.

CONSTRAINTS AND BARRIERS TO WOMEN'S TREATMENT SEEKING BEHAVIOUR IN RESPONSE TO OBSTETRIC EMERGENCIES: THE CASE OF NAIROBI INFORMAL SETTLEMENTS, KENYA

K. Ziraba (African Population and Health research center, Nairobi, Kenya), J.C. Fotso, B. Kabwe, N. Madise, T. Saliku

Over 500,000 women mainly from developing countries are estimated to die each year from pregnancy-related complications. Many deliveries take place outside of a health facility, yet most of the major causes of maternal death require emergency professional care. There is need to understand what the barriers to emergency care utilization are in order to inform service delivery improvement.
Objectives: The overall aim of this paper is to provide an understanding of the delays and barriers to emergency obstetric care utilization among poor migrant residents of Nairobi city slums. Specifically, we intend to:
* Examine women's treatment seeking behaviour in response to obstetric emergencies; and
* Investigate barriers to the utilization of emergency obstetric care.
Design: The data are from the Maternal Health study which is being conducted by the African Population and Health Research Centre (APHRC) in collaboration with the World Bank. The project is nested within the Nairobi Urban Health and Demographic Surveillance System. The study uses the three-delay framework (delay in deciding to seek care, delay in reaching the appropriate care, and delay in receiving treatment once at health facility). We collected cross-sectional data on socio-demographic characteristics, health seeking behaviour, expenditure, and perception of quality of health care and also assessed performance of maternity facilities.
Preliminary Results: About 67% of women had complications during their last pregnancy. Complications classified as severe by the respondent occurred in 60% of cases. Overall 54% of the interviewed women sought assistance for severe complications. Two-thirds of the facilities have means of transporting women to another facility in case of obstetric emergency however none had a printed referral form. Perceived and actual access and quality of care, maternal education and social economic status are associated with use of emergency obstetric care.
Conclusion: Women in slums of Nairobi have limited access and utilization of emergency obstetric care even when faced with a life threatening complication.

WORKSHOP 11: DOCTORS FOR HOMELESS

CONVENER:

R.A.L. van Laere (Municipal Health Service Amsterdam, Amsterdam, the Netherlands)

Statement: we need doctors for homeless to improve social medical care for underserved people in rich countries, comparable with doctors without borders (MSF) in poor countries.
Mission: Doctors for homeless aim to improve the social and medical condition of people with none or insufficient social and medical basic needs provided.
Objective: Doctors for homeless want to realize a platform to meet medical workers, to know how to provide and improve social medical care for the most under-served.
Methods: to provide a Workshop: to meet doctors for homeless, to know about Practise, Education, Research and Policy to improve social medical care for the homeless.
To meet… to present an overview of social medical care in practice, education, research and policymaking.
To know how…publications and guidelines, to stimulate practice, education, research and policy, to improve the social medical condition of the most under-served.
Optional method: visiting doctors for homeless, who will participate in the workshop, can be offered a late afternoon walking tour in the Amsterdam city centre red light district, for a walking presentation of the history of the development of the homeless population and Municipal Public Health response, guided by and together with doctors for homeless of the Dr.Valckenier-practice, for an informal exchange of knowledge and experience over diner.
Results: together we can bring more people home. We can stay close to the mission and keep it to the basics, just for what under-served people need us most.

REFLECTIONS FROM THE STREETS: TWO DECADES OF CARING FOR HOMELESS PERSONS IN BOSTON

J. O'Connell (Harvard Medical School, Boston, United States of America)

The Boston Health Care for the Homeless Program (BHCHP) was created in 1985 with a mission of assuring quality health care to homeless men, women, and children in metropolitan Boston. The mandate from the local community was to develop a model of care that assured continuity, consistency, and availability of care that integrated medical and mental health care provided in shelters and on the streets with Boston's mainstream teaching hospitals and community health centers. BHCHP has evolved to serve 10,000 homeless persons each year in a network of care that includes not only daily hospital-based clinics at Boston Medical Center, Massachusetts General Hospital, and Lemuel Shattuck Hospital. Teams of physicians, nurse practitioners, physician assistants, nurses, and mental health clinicians venture out to provide direct care services at over 70 sites in the community, including adult and family shelters, soup kitchens an day programs, jails and detoxification centers, recovery programs and a variety of housing programs. All sites have shared a common electronic medical record since 1996. BHCHP operates a 90-bed medical respite care facility, the first in the nation, that provides 24-hour medical and nursing care for ill and injured persons who no longer need expensive acute care hospitalization but who are too sick to withstand the rigors of survival on the streets.

ADDRESSING THE HEALTHCARE NEEDS OF HOMELESS PEOPLE THROUGH INTER-PROFESSIONAL EDUCATION …OR HOW ON EARTH DID I GET MYSELF INTO THIS?

A. Jones (University of Oxford, Oxford, United Kingdom)

A brief story of how the frustrations of trying to work in an integrated fashion, in order to make a difference to homeless people's health and well-being, turned into a conviction that the only way to really make a difference was to learn more and to learn together with the other people engaged in the same struggle, and then of how that conviction turned into a real live educational initiative.

RESEARCH ON HOMELESSNESS AND HEALTH: A PERSONAL PERSPECTIVE

N. Wright (Substance Misuse HMP, Leeds, United Kingdom)

This section of the workshop will seek to give a personal account of the opportunities and barriers of conducting research amongst homeless populations. It will also provide an overview of the current evidence base for best practice working with homeless people drawing upon the speaker's paper written on this topic for the World Health Organisation Health Evidence Network.

A STREET MEDICINE NETWORK IN THE USA: PERSONAL EXPERIENCE OF THE FOUNDER OF OPERATION SAFETY NET

J. Withers (the Mercy Hospital of Pittsburgh, Pittsburgh, United States of America)

Operation Safety Net (founded in 1992), provides health care to the unsheltered (street) homeless population in Pittsburgh by walking teams of volunteer medical and formerly homeless outreach workers. A full time office coordinates care and case management of clients with a 24 hour a day "home care" service; including hospital consults, electronic records, social work and housing. Health Care students are key members of the team.

As a result of extensive networking and sharing of best practices, a network of "Street Medicine" programs in the USA and other countries has emerged. The second annual International Street Medicine Symposium will be held in California in Nov 2006 with participants from many US cities as well as Calcutta India, Santiago Chile, Toronto Canada and Amsterdam. The implications for care for the street homeless, the field of "Street Medicine" and role of social justice in our work will be discussed.

DOCTORS FOR HOMELESS AND CARE FOR THE POOR IN A RICH COUNTRY: A PERSONAL PERSPECTIVE

I.R.A.L. van Laere (Municipal Health Service Amsterdam, Amsterdam, the Netherlands)

Based on personal experience with outreach care for the poor in a rich country, over the last decade, this talk will discuss the need for an integral 'doctors for homeless' approach, based on lessons from practice, education and research, in order to be able to make policy and to appoint budget: to make the life of the poor in a rich country less terrible.

WORKSHOP 12: INFORMAL CARE GOVERNANCE: DEALING WITH TURBULENT REFORMS IN CARE AND WELFARE DERVICES

CONVENER:
L. Verplanke (University of Amsterdam, Amsterdam, the Netherlands)
W.G.J. Duyvendak (University of Amsterdam, Amsterdam, the Netherlands), E. H. Tonkens (University of Amsterdam, Amsterdam, the Netherlands), D. L. Willems (University of Amsterdam, Amsterdam, the Netherlands)

Informal care can be seen as a prime locus of daily struggles over the role of the state, civil society, professionals, the family and individual citizens/ patients in the context of revisions of the welfare state. In the area of informal care these changes are directly felt and dealt with. To borrow (and slightly turn) a phrase by the American sociologist Arlie Hochschild, informal care is 'a major shock absorber' of these changes in society. Changes in service provision, rights and responsibilities of citizens, the state, civil society, professionals and the community, are directly felt in the area of informal care. Big reforms as those going on in modern welfare states today are causing shocks that must be absorbed in informal care relations.

Today's welfare and care reforms consist of a strengthened turn to (the older idea of) community care, with a new stress on active citizenship. It is argued that for both ideological and economic reasons, the pillar of the new care and welfare order should be active citizens who take responsibility for each other's welfare in their community. They do so by performing all kinds of caring and governing tasks. Active citizens are both caring and steering citizens. This is developed against the background of older traditions, in which the state (and state related institutions) and the market were put forward as the dominant decors, and where citizens were constructed as patients, clients and passive (rights- receiving) citizens.

WORKSHOP 13: COMMUNITY BASED INTERVENTIONS:EXAMPLES OF GOOD PRACTICE IN TWO COUNTRIES

CONVENERS:
K. Stronks (Academic Medical Centre, Amsterdam, the Netherlands)
B.J.C. Middelkoop (Municipal Health Service, The Hague, the Netherlands)
R. Travers (St. Micheal's Hospital, Toronto, Canada)
J. Harting (Maastricht University, Maastricht, the Netherlands)

Introduction: In the area of health promotion, many interventions appear not to reach the groups most in need. Very often, these interventions seem not to be attuned to people with the greatest risk of health problems, like people in lower socio-economic groups and immigrant groups. It is often argued that participation of the community in the development and implementation of health promotion is a good way to increase its effectiveness and responsiveness, especially in inhabitants of deprived areas of large cities. Little is known, however, on the best way to develop such partnerships. The aim of this workshop is to obtain more insight into this issue by sharing expertise from two countries, i.e. Canada and the Netherlands, in this area. Special attention will be paid to the different ways in which the community and academic partners may collaborate in this process.
Examples of themes that will be discussed include:
- Community participation as an intrinsic goal or merely as a means in health promotion.
- What is a community (defined along geographical or ethnic lines? etc.)
- The influence of local / contextual factors on the effectiveness of community participation.
- What are the advantages of collaboration between community and academic partners? What are barriers and facilitating factors, and what are the implications for urban health and health promotion?

By presenting examples of less common approaches of community based partnerships, we hope the workshop will inspire the participants.
Content: This workshop will consist of three presentations (15 minutes each) and a general discussion (40 minutes).
In the first presentation, Dr. J. Harting (University of Maastricht, the Netherlands) will throw light on the principle of community participation in health promotion in a reflective way. Her presentation is entitled 'Participation revisited. A conceptual framework for the core principle of community based interventions'.
This presentation will be followed by two examples of good practice. Dr. R. Travers (Ontario HIV Treatment Network and the Centre for Research on Inner City Health, St. Michael's Hospital) will present perspectives and experiences from Toronto, Canada, entitled 'Collaboration Between Community and Academic Partners in Urban Health Research'.
Ms R.M.J. Corstjens (Municipal Health Service Amsterdam, the Netherlands), will give insight into her experience with a community-based intervention in Amsterdam, the Netherlands, entitled 'Healthy Lifestyle Westerpark: A participatory action research project on overweight among Turkish and Moroccan women in Amsterdam'.
These presentations will be followed by a general discussion. In this discussion, workshop participants will be challenged to reflect on the role of the community in collaboration with researchers in community-based interventions.

WORKSHOP 14: URBAN YOUTH POLICY AND YOUTH HEALTH CARE

CONVENER:
E.J. de Wilde (Municipal Health Service Rotterdam, Rotterdam, the Netherlands)
F. Öry (TNO Quality of Life, Leiden, the Netherlands), M. Kamphuis, E.J. de Wilde

Public Youth Health Care, in the Netherlands performed by school doctors and school nurses, can be a key player in (information about) relevant topics in today's youth policy in the large cities. Youth policy is a field in which several disciplines, services and institutes participate. For instance: educational services and schools, welfare, youth mental health care, local and national policy makers, and health care professionals need to collaborate in this matter.

The problems addressed in urban youth policy surpass the traditional field of youth health care: aggression and vandalism, youth prostitution, genital mutilation of girls, radicalism, intolerance towards gays, etcetera. Since youth health care professionals are the only medical professionals who see and examine practically all young people in a city at multiple occasions during their development, theoretically a superb opportunity exists to address these issues individually and to collect valuable empirical data for collective purposes.

A shift in perspective from the traditional (narrow) medical model towards a cultural, social model in youth health care needs to occur to occupy this position. The following questions will be dealt with during this workshop:

- What are the necessary changes in working frame of youth health care to become a key player in local youth policy?
- What new competences should be present in the training of medical professionals in this respect?
- What good practices and relevant technical and organizational developments are present and needed to facilitate this process?

This content is presented and discussed against the background of the legal and professional standards for youth health care.