THE INTERNATIONAL SOCIETY FOR URBAN HEALTH

4th International Conference on Urban Health

October 26 – 28, 2005

The Westin Harbour Castle
Toronto, Ontario Canada

The 4th International Conference on Urban Health is hosted by:

CENTRE FOR RESEARCH ON INNER CITY HEALTH
St. Michael's Hospital

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4th International Conference on Urban Health

October 26 – 28, 2005
Toronto, Ontario, Canada
Full Conference Program

PROGRAM

Wednesday, October 26, 2005

9:00 am – 7:00 pm **Registration/Information Desk Open**

Location: Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

12:00 pm – 4:00 pm **Pre-Conference Workshops**

Please refer to the Pre-Conference Workshops section for time and location

1:00 pm – 4:00 pm **Tours of Local Community Organizations**

Location: Please assemble in the Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

5:00 pm – 7:00 pm **Poster Session I and Welcome Reception**

Location: Metro East/Metro Centre Ballroom – Conference Centre, Second Level

Entertainment: Red Spirit Singers & Dancers

Opening Reception Speakers:

Patricia O'Campo, (Conference Chair), Centre for Research on Inner City Health, St. Michael's Hospital
David Vlahov, International Society for Urban Health
Rick Blickstead, Wellesley Central Health
Arthur Slutsky, St. Michael's Hospital
Honourable Carolyn Bennett, Minister of State, Public Health, Government of Canada

PROGRAM

Thursday, October 27, 2005

7:30 am – 5:00 pm **Registration/Information Desk Open**

Location: Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

7:30 am – 8:45 am **Poster Session II and Continental Breakfast**

Location: Metro East Ballroom – Conference Centre, Second Level

9:00 am – 10:15 am **Welcome Address & Plenary Session**

Location: Convention Level, Metro Centre Ballroom

Opening Remarks: *Patricia O'Campo, (Conference Chair), Centre for Research on Inner City Health, St. Michael's Hospital*

Guest Speakers: *Robb Travers, Ontario HIV Treatment Network*
Bill Downe, BMO Financial Group

Keynote Address: *Gro Harlem Brundtland, Former Director General, World Health Organization*

10:15 am – 10:30 am **Refreshment Break**

Location: Metro East Ballroom – Conference Centre, Second Level

10:30 am – 12:00 pm **Breakout Session 1**

A. Community Stream

Location: Metro Centre Ballroom – Conference Centre, Second Level

Moderator: *Sean Rourke*

HIV and Marginalized Populations

I. Women Under Arrest Striving for Health Rights
Renata Luz

II. A Community Based Participatory Approach to Developing an HIV Prevention for Severely Mentally Ill Latinas
Sana Loue

III. Community Empowerment Through Collaborative Research: The Sisters, Mothers, Daughters & Aunties Project to Promote Equitable Access to Future HIV Vaccines for Black Women in Canada
Charmaine Williams

IV. Committee for Accessible AIDS Treatment
Lynn Muir

B. Community Stream

Location: Pier 3, Convention Level, Hotel

Moderator: *Robb Travers*

Community-Based Participatory Research: Barriers and Facilitators

I. A Survey of Community Based Research (CBR) in Canada: From Barriers to Solutions
Sarah Flicker

II. Transgender People and Access to Care
Jake Pyne, Yasmeen Persad

III. VIVA Intervention Working Group Sustaining an Urban Community-Based Participatory Research Program Through a National Influenza Vaccine Shortage
Micaela Coady, Sarah Sisco

IV. Harnessing Media to Achieve Social Justice in Urban Communities
Katerina Cizek

C. Academic Stream

Location: Pier 2, Convention Level, Hotel

Moderator: *Ahmed Bayoumi*

Conceptualizing and Measuring Social Justice

I. Health Inequity in a Network Society: A Conceptual Framework
Roxana Salehi

II. Modeling Black-White Preterm Birth Disparity: Ecologic and Multilevel Models
Lynne Messer

III. Maternal & Child Health Neighborhood Context: The Selection and Construction of Area-level Variables
Jessica Burke

IV. Exploring Ideological Barriers to Addressing Health Inequalities at the Local Level
Patricia Collins

D. Academic Stream

Location: Bay, Conference Centre, Street Level

Moderator: *Patricia O'Campo*

High-Risk Youth

I. The Neighborhood Identification and Engagement Process: A Mixed Methodological Approach for Exploring Urban Youth Violence
Michael Yonas

II. The Emergency Department: Is it an Appropriate Venue for an Intervention Program to Reduce Youth Violence
Carolyn Snider

III. Risky Alcohol Use and Daily Cannabis Use Differ Between Low Educated Dutch Adolescents Living in and Outside the City of Amsterdam: A Result of Differences in Pleasure-Seeking Behaviour?
Ineke Stolte

IV. Environmental Influences on Youth Gambling: Is the Deck Stacked?
Jason Gilliland

E. Invited Panel: Urban Income Inequality and Health

Location: Metro West Ballroom – Conference Centre, Second Level

Moderator: *Elizabeth Gyorfi-Dyke*

Panelists: *James Dunn, Nancy Ross, Nazeem Muhajarine*

Title: Urban Income Inequality and Health

10:30 am – 12:00 pm Tours of Local Community Organizations

Location: Please assemble in the Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

12:00 pm – 1:45 pm Luncheon

Location: Metro West Ballroom – Conference Centre, Second Level

12:30 pm – 1:45 pm Opening Remarks

Patricia O'Campo

Guest speakers: *Aileen Meagher, St. Michael's Hospital*
Honourable George Smitherman, Minister of Health and Long-Term Care, Province of Ontario
Bill Butt, BMO Nesbitt Burns

Featured speaker: *Loretta Jones, Healthy African American Families*

Featured Multi-media Presentation: *Katerina Cizek, National Film Board*

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B. Academic Stream

Location Metro Centre Ballroom – Conference Centre, Second Level

Moderator *Nathan Taback*

Global Urban Health

I. The Urban Environment From the Health Perspective: The Case of Belo Horizonte, Minas Gerais, Brazil
Waleska Caiaffa

II. Sexual Behaviors of Street Children in Lahore, Pakistan: The Risk of Survival
Susan Sherman

III. Reported Use of Violence Among Young Men in Dar es Salaam, Tanzania
Suzanne Maman

IV. Health Impact of the Mumbai Floods: A City Deluged
Anant Bhan

C. Academic Stream

Location Pier 2, Convention Level, Hotel

Moderator *Phil Deacon*

Homelessness and Housing

I. The Aging of the Homeless Population: Fourteen-Year Trends in San Francisco
Judith Hahn

II. The ESCSY Study Group, Risk Behaviours For Sexually Transmitted Infections (STIs) in Canadian Street Youth: Does Time Spent On The Street Matter?
Yemi Agboola

III. Access to Health Care For Homeless People With Serious Health Conditions in Toronto, Canada
Stephen Hwang

IV. Women Sleeping Rough: Health Outcomes after Five Years on the Streets of Boston, 2000–2004
James O'Connell

V. Homelessness Following Eviction in Amsterdam
Matty de Wit

D. Academic Stream

Location Bay, Conference Centre, Street Level

Moderator *Jeff Hoch*

Mental Health

I. Stressful Neighbourhoods and Depression: An Examination of 25 Metropolitan Areas in Canada
Flora Matheson

II. A Learning Collaborative to Improve Mental Health Service Use For Low-Income, Urban Youth
Mary Cavaleri

III. Affective Suffering in Older Women: Evidence of a Threshold Affect that Varies by Race/Ethnicity
Cecile Yancu

IV. Mental Illness as a Risk Factor For Poor Health, Substance Use, and Dependence Among Unmarried Urban Mothers
Nancy Reichman

V. Quality of Life Outcomes for Mental Health Care Clients Engaged in the Workman Theatre Project
Nicole Koziel

E. Academic Stream

Location Pier 3, Convention Level, Hotel

Moderator *Geri Lynn Peak*

Gender and Urban Health

I. Gender Differences in Depression Among Low Income Recent Immigrants in Canadian Urban Centres
Katherine Smith

II. Gender Issues and the Health of Disadvantaged Persons
Rhonda Love

III. Whither Gender in Urban Health?
Victoria Frye

IV. Housing Policy, Women, and Health in Canadian Cities
Toba Bryant

3:00 pm – 5:00 pm **Tours of Local Community Organizations**

Location Please assemble in the Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

PROGRAM

Friday, October 28, 2005

7:30 am – 2:00 pm **Registration/Information Desk Open**

Location Metropolitan Grand Ballroom Foyer – Conference Centre, Second Level

8:00 am – 9:00 am **Poster Session III and Continental Breakfast**

Location Metro East Ballroom – Conference Centre, Second Level

8:00 am – 9:00 am **Annual General Meeting of the International Society for Urban Health**

Location Bay, Conference Centre, Street Level

9:00 am – 10:30 am **Plenary Session**

Location Metro Centre Ballroom – Conference Centre, Second Level

Opening Remarks *Stephen Hwang, Centre for Research on Inner City Health, St. Michael's Hospital*

Guest Speakers *Maria Páez-Victor, Community-Based Research Consultant, Toronto*

Keynote Address *Richard Lessard, Montreal Regional Health and Social Services Board*
Attempting to Redress Health Inequalities in an Urban Setting: Public Health Interventions

Featured Speaker *Francisco Armada, Minister of Health and Social Development of Venezuela*

10:30 am – 10:45 am **Refreshment Break**

Location Metro East Ballroom – Conference Centre, Second Level

10:45 am - 12:15 pm **Breakout Session 4**

A. Community Stream

Location Pier 3, Convention Level, Hotel

Moderator *Oonagh Maley*

Innovative Youth Engagement

I. Toronto Teen Survey (TTS) Phase One: How Do We Meet the Specific Sexual Health Needs of Youth in Diverse Urban Environments?
Susan Flynn

II. Young People in Control; Doing It Safe. The Safe Sex Comedy
Juan Walter

III. Youth-Led Research: A Successful Model of Community-Based Participatory Action Research
Omar Guessous

IV. Queer Youth Speak: A Model for Developing Equitable Partnerships for Community-Based Research
Christine O'Rourke

V. A Community-Based Participatory Approach To Assess The Context Of Sexual Risk Taking In Urban, African-American Girls
Shani Peterson

B. Community Stream

Location Metro Centre Ballroom – Conference Centre, Second Level

Moderator *Dennis Magill*

Community-University Partnerships

I. Making a SWITCH: Opportunities and Challenges in Establishing a Student-Run, Interprofessional Health Clinic in a Saskatoon Core Neighbourhood
Maxine Holmqvist, Reid McGonigle, Ryan Meili

II. Using Community-Based Participatory Research to Develop and Implement Church-Based Cancer Education Modules
Barbra Beck

III. Making Things Work: On Being an Academic Researcher Working with a Community Partner
Nina Boulus

IV. The Art and Science of Integrating Community-Based Participatory Research Principles and the Dismantling Racism Process to Design and Submit a Research Application to NIH
Michael Yonas, Nora Jones

V. Urban Aboriginal Community-Based Research
Alan Anderson, Priscilla Settee

C. Academic Stream

Location Pier 2, Convention Level, Hotel

Moderator *Stephen Hwang*

Environmental Justice

I. The Right to Clean Water: How Community Groups Mobilize to Block Water Privatization
Joanna Robinson

II. Food Deserts: Do Food Deserts Exist in More Disadvantaged Communities and How Are They Studied?
Julie Beaulac

III. Neighborhood Poverty and Inequitable Exposure to Stressful Social Environments: Results From a Community-Based Participatory Research Partnership In Detroit
Shannon Zenk

IV. Pollution and Health in Two Toronto Neighbourhoods: Challenges to Ensuring Environmental Justice
Ronald Macfarlane

V. Community Health Study in "Chemical Valley", Sarnia, Ontario
Dominic Atari

D. Academic Stream

Location Bay, Conference Centre, Street Level

Moderator *Richard Glazier*

Immigrants and Urban Health

I. Community-Based Intervention Strategies to Prevent Obesity Among Turkish and Moroccan Women in Amsterdam
Hilda van 't Riet

II. Serologic Immunity to Chickenpox Among Adult Immigrants and Refugees in Toronto
Kamran Khan

III. The Role of the Urban Environment on Discrimination Among Latino Day Laborers and Migrant Workers in California
Alex Kral

IV. Socioeconomic Disparities in Birth Outcomes By Recent Immigration Status in Toronto, 1996–2000
Marcelo Urquia

V. Help-Seeking Rates For Intimate Partner Violence (IPV) Among Canadian Immigrant Women
Ilene Hyman

E. Academic Stream

Location Metro West Ballroom – Conference Centre, Second Level

Moderator *Anita Palepu*

Injection Drug Use in Urban Settings

I. Vancouver's Supervised Injection Facility: The First Two Years
Mark Tyndall

II. HIV Outbreak Among Injecting Drug Users in the Helsinki Region: Social and Geographical Pockets
Pia Kivela

III. Risk Profile of Individuals who Provide Assistance With Illicit Drug Injections
Nadia Fairbairn

IV. Examining the Effects of Illicit Drug Markets and Local Labor Markets on Employment and Self-Rated Health in Philadelphia
Chyvette Williams

V. Residence in Vancouver's Downtown Eastside and Elevated Risk of HIV Infection Among a Cohort of Injection Drug Users
Benjamin Maas

F. Academic Stream

Location Pier 7&8, Convention Level, Hotel

Moderator *Mark Halman*

HIV Intervention and Risk Reduction Strategies

I. Addressing the Methamphetamine-Sexual Risk-Taking Link Among MSM: Information Exchange Between Science and Practice
Perry Halkitis

II. HIV Risk Taking and Associated Cultural Factors
Clemon George

III. The Delayed Engagement With Healthcare: Experiences of People with HIV/AIDS in Beijing, China
Yanqiu Rachel Zhou

IV. Employing Social Network Analysis in the Evaluation of Information Provision For HIV-Positive Patients: An Exploratory Study Dean Behrens
Warren Winkelman

12:15 pm – 1:30 pm Closing

Location Metro Centre Ballroom – Conference Centre, Second Level

Speakers *Patricia O'Campo* and *David Vlahov*

Student Award Presentations

Arnoud Verhoeff, Chair of ICUH 2006, Amsterdam, Netherlands
Mike Gibbons, ICUH 2007, Baltimore Maryland

Entertainment Red Spirit Singers and Dancers

1. Into the Neighborhood - Mission Barrio Adentro: A Venezuelan Success Story on Bringing Health Care to the Marginalized

Facilitator *María Páez-Victor*

Affiliation University of Toronto

Time **1:00 pm – 4:00 pm**

Location Ontario Institute for Studies in Education of the University of Toronto
OISE: Room OI – 2295
252 Bloor Street West
Toronto, Ontario M5S 1V6

2. Addressing Urban Health Needs: Toronto Public Health Practice Framework

Facilitator *Maria Herrera*

Affiliation Toronto Public Health

Time **1:00 pm – 4:00 pm**

Location Ontario Institute for Studies in Education of the University of Toronto OISE: Room OI
252 Bloor Street West
Toronto, Ontario M5S 1V6

The workshop is on the development of the Toronto Public Health Practice Framework to plan, implement and evaluate appropriate public health programs and services to respond to the complex and diverse nature of a large urban centre. The workshop will engage participants to explore and identify:

- what is unique about large urban centres like Toronto
- appropriate health strategies to respond to these needs
- elements of a Practice Framework including need for organizational change process, foundations for inclusive practice and resources/tools developed to facilitate implementation of practice
- case studies

3. Ethical Challenges in Research with Marginalized Populations

Facilitator *James V. Lavery*

Affiliations Centre for Research on Inner City Health and Centre for Global Health Research, St. Michael's Hospital, Toronto & Department of Public Health Sciences and Joint Centre for Bioethics, University of Toronto

Time **1:00 pm – 4:00 pm**

Location Ontario Institute for Studies in Education of the University of Toronto
OISE: Room OI – 2279
252 Bloor Street West
Toronto, Ontario M5S 1V6

This workshop will examine 3 major challenges in research ethics that have particular relevance for research conducted with marginalized populations: (1) exploitation in research; (2) undue inducements to participate in research; and (3) the ethical importance of community engagement and collaborative partnership in research.

Exploitation in research: Social and economic disparities between researchers and research participants and their communities can exacerbate the risk of exploitation of these individuals and communities in research. This section of the workshop will examine the concept of exploitation in research and review some recent proposals for reducing the risk of exploitation in research with marginalized populations.

Undue inducements to participate in research: the compensation of research subjects for their time, contributions and risks associated with participation in research remains a controversial issue in research ethics. This session will examine the main models of compensation for research subjects and their implications and suitability for marginalized populations. As well, this section of the workshop will examine the concept of coercion and its relationship to undue inducement.

Collaborative partnership in research: although it has had a long-standing significance in community-driven approaches to research in marginalized populations, collaborative partnership has only recently been recognized as a separate principle of research ethics. This session will examine the ethical significance of collaborative approaches to research and look at various ways in which the ethical principle of collaborative partnership may be satisfied in research.

4. How to Understand and Conduct Research on Homelessness: A Practical Guide

Facilitator *Stephen Hwang*

Affiliation Centre for Research on Inner City Health, St. Michael's Hospital

Time **1:00 pm – 4:00 pm**

Location Ontario Institute for Studies in Education of the University of Toronto
OISE: Room OI – 2296
252 Bloor Street West
Toronto, Ontario M5S 1V6

This workshop will teach practical skills that are relevant to community members and new researchers who are interested in the issue of homelessness. Participants will learn how to locate and interpret research on homelessness from a variety of sources. For those who are considering conducting their own research studies with persons experiencing homelessness, this workshop will provide a brief introduction to the skills needed to develop a good research question, select an appropriate research design, mobilize the necessary resources, and collect and analyze data.

5. Introduction to Urban Health

Facilitators *Sandro Galea*
Danielle Ompad
David Vlahov

Affiliation Center for Urban Epidemiologic Studies, New York Academy of Medicine

Time **1:00 pm – 4:00 pm**

Location St. Michael's Hospital
2010 Bond Board Room – 2nd Floor Bond Wing

The purpose of this course to introduce the participant to the principles and methods for the study of urban health. Urbanization is one of the most important demographic shifts worldwide over the past century and represents a substantial change from how most of the world's population has lived for the past several thousand years. The study of urban health considers how characteristics of the urban environment may affect population health. This course will review the empiric research assessing the impact that urban living has on population health and the rationale for considering the study of urban health as a distinct field of inquiry. We introduce a conceptual framework for considering the relationship between cities and health that is focused within three broad themes: the physical environment, the social environment, and access to health and social services. The methodological and conceptual challenges facing the study of urban health, arising both from the limitations of the research to date and from the complexities inherent in assessing the relations among complex urban systems, disease causation, and health will be discussed. Examples from the faculties' research will be provided.

6. Introductory Health Economics: An Urban Health Perspective

Facilitator *Ahmed Bayoumi*

Affiliation Centre for Research on Inner City Health, St. Michael's Hospital

Time **1:00 pm – 4:00 pm**

Location St. Michael's Hospital
Paul Marshall Lecture Theatre, (at) Queen Street. Lobby

This course will introduce the principles and practices of health economics in an urban health setting. The goal is to enhance understanding of how health economics can be used to influence decision making, including researchers, community members, and decision makers. We will provide an overview of the basic principles of health economics using a case study approach focused on issues relevant to disadvantaged populations. Specific topics include: plain language definitions of economic concepts and jargon, clarification of the difference between cost-effectiveness and cost-benefit analysis, incorporating quality of life into economic analyses, economic modeling, understanding and interpreting the results of an economic study, uncertainty and health economics, and incorporating equity concerns into economic analysis. At the end of the workshop, attendees will be able to critically appraise a health economics study.

7. Learning the Research Talk: Introduction to Research Methods, Concepts and Jargon

Facilitator *Sarah Flicker*

Affiliation Wellesley Central Health Corporation

Time **12:00 noon – 4:00 pm**

Location Wellesley Central Health Corporation
45 Charles St. East
Toronto, Ontario M4Y 1S2

This interactive workshop is designed as an introduction to the research methods, concepts, practices, and terminology commonly used in research studies. The overall goal of the session is to familiarize participants with the language used by researchers when presenting their studies. Using conference abstracts, we will begin to unpack and demystify research jargon - so that we can all meaningfully participate in the upcoming conference.

Workshop objectives include:

a. to build research capacity in community partner organizations

b. to assist communities and community organizations in understanding research approaches in community health

c. to demystify research jargon for those new to the field of health research

8. The Politics of the Social Determinants of Health

Facilitator *Dennis Raphael* and *Toba Bryant*

Affiliation School of Health Policy and Management, York University and
Centre for Research on Inner City Health, St. Michael's Hospital

Time **1:00 pm – 4:00 pm**

Location Opposite St. Michael's Hospital
38, Shuter Street – Room B–1245 (Basement)

Despite the increasing recognition of the importance of the social determinants of health and public policies that strengthen these determinants of health by academic researchers, civil society organizations, and the World Health Organization, potent barriers exist that make implementation of such an agenda difficult. These barriers include competing paradigms of health that emphasize biomedical and behavioural approaches to health, ideological commitments by governments to neo-liberal or market-oriented approaches to health care and social service provision, and powerful economic and social forces that oppose equity-based approaches to promoting health and well-being through the development of health public policy. This pre-conference workshop identifies some of these forces, shows how they influence government receptivity to social determinants of health concepts, and identifies means of transcending these barriers to implement a social determinants of health agenda.

9. Using Distance and Travel Time to Measure Access to Health Care and Resources for Healthy Living in Urban Neighbourhoods

Facilitator *Rick Glazier* and *Peter Gozdyra*

Affiliation Centre for Research on Inner City Health, St. Michael's Hospital

Time **1:00 pm – 4:00 pm**

Location Centre for Research on Inner City Health - Conference Room
4th Floor, 70 Richmond St. E
Toronto, Ontario M5C1N8

Geographic accessibility to health care services and to resources such as parks, recreation centres and grocery stores are likely to be important for the health of people living in urban neighbourhoods. A variety of methods can be used to measure concentration of resources as well as distances or travel times. The Geographic Information System (GIS) technique of network analysis utilizes information about residential locations, existing travel routes and available services. Various modes of transit such as walking, public transit and by car can be analyzed. The output of the analysis such as average travel time to a specific service for a given neighbourhood can then be compared with specific health outcomes to look for relationships between travel times and health status.

The objectives of this workshop are to learn: the basics of data representation on maps; about accessibility theory and its possible applications; about Geographic Information System (GIS) tools applied in network analyses including relevant terminology and research design methods; and to apply findings from mock-up scenarios to policies that would result in more optimal service provision.

Paper and transparent maps will be provided to allow for examination of concentrations of population, travel routes, and service locations. Participants in small groups will be asked to consider appropriate research designs and measures for specific scenarios. They will also use overlay maps in order to identify under-serviced areas and neighbourhoods with difficult access to health care services. Groups will present their findings to all workshop participants.

10. What's all this Talk about Community-Based Participatory Research? Building Sustainable Capacities for Urban Health Research Partnerships

Facilitator *Robb Travers*

Affiliation Department of Public Health Sciences, University of Toronto

Time **12:00 noon – 4:00 pm**

Location The Ontario HIV Treatment Network (OHTN)
1300 Yonge Street
Toronto, Ontario M4T 1X3

Unlike more traditional approaches to research, community-based participatory research (CBPR) is described as a "collaborative, participatory, empowering... and transformative" approach to research (Hills & Mullett, 2000). It has also been established as a powerful tool for identifying the social determinants of health within marginalized communities. Through engaging communities and academics as research partners, CBPR is an empowering process that builds sustainable capacities and enhances the relevance and credibility of data. Ultimately, this increases the likelihood of action outcomes to improve quality of life for disadvantaged communities.

This workshop will overview the theoretical underpinnings of CBPR and will provide a core set of principles that drive this approach to research. We will explore challenges associated with conducting CBPR and will learn what facilitates it. Finally, we will highlight the roles played by community and academic partners in each stage of CBPR initiatives and will explore the promise that collaborative inquiry holds for the health of marginalized communities.

4th International Conference on Urban Health

Community Tours
October 26 – 28, 2005

"Toronto is a creative city. Our community often creates innovative approaches that improve quality of life and make Toronto a better place to live, work, learn and grow. Toronto Community Foundation continually encounters leading-edge programs that combine experience, expertise and ingenuity to create practical solutions." Vital Signs, 2005, Toronto Community Foundation" http://www.tcf.ca/pdf/Vital_ideas05_Website.pdf

The Community Engagement Subcommittee of the 4th International Conference on Urban Health is delighted to offer community site visits to conference attendees. These are intended to highlight innovation in urban health programming, advocacy, and research in the community context. Five complimentary site visits are offered this year that exemplify unique and leading-edge initiatives in Toronto reflecting the conference theme "Achieving Social Justice in Urban Communities". Registration is limited. If you sign up on-line, please ensure that you attend. If you change your mind, immediately notify the registration desk at the conference so that we can accommodate others.

Community site visits cover diverse areas of interest and are timed to correspond with conference sessions. They are listed below.

Please check at registration for availability and to register for Community Tours

1. Innovative Harm Reduction Programs

Wednesday, October 26, 1:00 pm – 4:00 pm

Host Organization: Queen West Community Health Centre

Other Participants:
- Safer Crack Use Coalition
- The Works Needle Exchange Programme
- Toronto Harm Reduction Task Force

The Central Toronto Community Health Centres achieves its mission through health promotion, harm reduction, education, community development, and advocacy, and through the provision of medical, nursing, dental and counseling services. CTCHC provides information about their work with marginalized and hard to serve people living in downtown west Toronto. The session will also include information from the Safer Crack Use Coalition who provide harm reduction kits to users and the Toronto Harm Reduction Task Force who provide innovative peer learning opportunities, front-line worker education, networking opportunities, and a regular newsletter.

2. Innovative Lesbian, Gay, Bisexual, Transgender and Transsexual Youth Program

Wednesday, October 26, 1:00 pm – 4:00 pm

Host Organization: The 519 Church Street Community Centre

Other Participants:
- Supporting Our Youth, A Program of Sherbourne Health Centre
- Pride and Prejudice Program, Central Toronto Youth Services

Toronto has numerous programs that work together to improve quality of life for lesbian, gay, bisexual, transgender and transsexual youth. The 519 Church Street Community Centre is a city-funded, multi-service agency located in the heart of Toronto's vibrant gay village. Central Toronto Youth Services' Pride and Prejudice Program is the longest core-funded program of its kind in North America and the Supporting our Youth Program is a unique community development initiative that provides numerous supports and opportunities for LGBT youth. These three leading-edge programs have come together to provide an overview of the history of their services and to showcase some of their innovative programs, advocacy work, and research and educational initiatives.

3. Advocacy and HIV/AIDS

Thursday, October 27, 10:30 am – 12:00 pm

Host Organization: Ontario AIDS Network

Other Participants:
- Voices of Positive Women
- Canadian Treatment Action Council

Toronto has a very large and diverse HIV/AIDS sector that contributes on an international level to advocacy, service and education efforts. Three leading Toronto-based organizations have come together to showcase their innovative work. The Ontario AIDS Network is a network of community-based organizations which were formed as a grass-roots response to the need for AIDS services and information. Voices of Positive Women is a provincial, community-based non-profit organization directed by and for women infected with HIV/AIDS living in Ontario that offers confidential support, outreach, information and education, and represents the issues of women living with HIV/AIDS. The Canadian Treatment Action Council is a national, non-governmental organization directed by people living with HIV/AIDS. CTAC informs public policy and promotes public awareness on treatment access and health care issues that impact people living with HIV/AIDS.

4. Innovative Health Care for the Homeless

Thursday, October 27, 1:45 pm – 3:15 pm

Host Organization: Street Health

Other Participants:
- Health Bus, Sherbourne Health Centre

Street Health is an innovative, community-based health care organization providing services to address a wide range of physical, mental and emotional needs in those who are homeless, poor and socially marginalized. Support, education and advocacy are key components of our services. Sherbourne Health Centre operates the Health Bus – a mobile health clinic that provides a ready point of access and entry to health care for a variety of people in Southeast Toronto. This site visit will focus on innovative health care delivery to the homeless and socially marginalized in densely-populated downtown Toronto.

5. Hospital/Community Partnerships

Thursday, October 27, 3:30 pm – 5:00 pm

Host Organization: Seaton House

Other Participants:
- All programs of Seaton House

Seaton House is a single men's shelter for more than 600 homeless or marginally-housed men operated by the City of Toronto. It provides seven separate programs within one main site and three satellite locations including an infirmary and a moderated drinking program for chronically homeless men. In conjunction with St. Michael's Hospital, located in Toronto's inner city, a unique partnership was developed to provide a full range of health care services for men in the shelter. You will tour the site, meet with service providers, and learn about the development and implementation of this unique hospital-community partnership.

02–02 (C): Transgender People and Access to Care

Samuel Lurie, Jake Pyne, Yasmeen Persad

Transgender people face a daunting range of societal issues that influence barriers in receiving adequate, helpful, appropriate care and emergency services. Well-meaning providers are often unsure or uncomfortable asking basic questions because little training exists on this topic. At the same time, transgender people have emerged as a population at extremely high risk for HIV infection. This is especially of concern in major urban centres such as Toronto where it is estimated that the trans sex-working community has a 63-75% rate of HIV infection (AZTEC, Montreal) and where there is an extremely high incidence of poverty, homelessness, addictions and other social determinants of health. While there is currently increased visibility of people identifying as transgender, they remain an often marginalized and underserved population. In particular, trans people fact significant bartriers in accessing sex-segregated facilities such as shelters, detox centres and drop-ins. This training will provide basic information about transgendered issues and present strategies and resources for incorporating appropriate, effective support in the clinical or advocacy relationship. This session will focus on four essential steps towards providing good care: 1) understanding the range of transgendered possibilities and what that means both medically and socially; 2) differentiating transgender care from work with Gay/Lesbian populations; 3) becoming familiar with referrals and protocols for care; and 4) examining institutional-related barriers and solutions to addressing those barriers. The trainers are members of the transgender community and experienced in leading trainings for both health care and homeless service providers. The workshop is designed to be interactive and skills-oriented to provide participants with information and strategies to use in their current work.

02–03 (C): Sustaining an Urban Community-Based Participatory Research Program Through a National Influenza Vaccine Shortage

Micaela Coady, Sarah Sisco, Danielle Ompad, Kay Glidden, David Vlahov, Sandro Galea, VIVA Intervention Working Group

Introduction: In the U.S., influenza causes 36,000 deaths annually in persons with chronic medical conditions, predominantly in the elderly and in those who are immunocompromised. Rates of obtaining immunization to prevent such deaths are persistently low, particularly for low-income, elderly, Hispanic and African-American populations. Because the reasons for low vaccine uptake in urban areas are complex, we initiated a community-based participatory research project with Harlem Community and Academic Partnership (H-CAP) members in eight neighborhood areas in East Harlem and the Bronx, New York City to explore these issues further. Originally, four of these areas would receive free flu vaccine via door-to-door sampling in Year 1, with the other four areas receiving it in Year 2. Per direction of our subcommittee (the VIVA Intervention Working Group, or VIWG), in Year 1 we conducted bilingual (English-Spanish), street-based outreach to engage the "hard-to-reach," only to encounter a national flu vaccine shortage once flu season arrived. The vaccine shortage threatened to compromise the engagement and trust of our local community members, as well as the future of our project. The VIWG, in collaboration with CUES researchers, had to determine (i) how to sustain our community presence, (ii) if an alternative vaccine could be provided, and (iii) what else we might learn from the shortage. Methods. During the project's first ten months, four outreach workers administered a five-minute questionnaire to community members via venue-based, door-to-door, and capture-recapture sampling, simultaneously delivering information about free flu shots and educating passers-by about the flu vaccine. Results. When the vaccine shortage began in early October, 2004, the following adjustments were made: (i) Outreach workers remained in the streets and provided preventive education about influenza, and news updates outlining where eligible persons could get immunized; (ii) The VIWG discussed pros and cons of alternate vaccines, including FluMist, tetanus, and Pneumovax, as well as challenges of educating people about the substitute vaccine; (iii) With researchers, the VIWG proposed changes to the survey instrument, including exploring knowledge about the shortage, perceived health seeking behaviors, and trust. Conclusions. In January 2006, the NYC Department of Health announced that it had a surplus of flu vaccine. Two of our four areas were thus able to receive flu vaccine before the end of influenza season, with the alternate two areas receiving vaccine against pneumococcal infection. Results, including ramifications of programmatic flexibility through a national vaccine shortage, will be discussed.

02–04 (C): Harnessing Media to Achieve Social Justice in Urban Communities

Katerina Cizek

The National Film Board of Canada is creating a pilot Filmmaker-in-Residence program. The filmmaker will explore how communications media (including video, photography, internet and new media) can work to achieve social justice. This project is a 21st century spin on the NFB's innovative Challenge for Change program that made waves in the late sixties and early seventies. Back then, the NFB sent filmmakers into numerous disenfranchised communities across Canada to hook up with activists, leaders and 'ordinary people' tostimulate the development of an engaged citizenry by using the power of media. From conception to production to distribution, the Challenge for Change program weaved the filmmaking process with community development, self-reflection, empowerment and social change. The current Filmmaker-in-Residence will work to explore contemporary models of Challenge for Change. This review explores the concepts, models, methodology, questions and insights of the filmmaker-in-residence and participatory media in an urban health/medical context. It will feature a look at some proposed case studies and early results. The general conclusion is that the production and consumption of media is critical to inner city citizenship, and when harnessed, can enrich democracy, develop self-_expression, bridge communication and achieve social justice.

03–01 (A): Health Inequity In a Network Society: A Conceptual Framework

Roxana Salehi

Introduction: The purpose of this paper is to construct a comprehensive framework that can assist in conceptualization of health equity issues. In simple terms, health inequity stems from the fact that some differences in access to health care, or in health outcomes, are unfair and unjust. Health inequities, like other types of inequities, arise from the imbalance of power. I bring together Castells' Network Theory and Burris et al.'s Nodal Governance Theory, in order to explain the complex issue of health equity in the context of Low Middle Income Countries (LMICs). Both of these theories deal with the relationships of power within social structures, and hence, are very suitable for this discussion. From the perspective of network theory, hospital X in Ontario is a 'node' within the network of Ontario's health care system. Although it has its unique plans (codes), it is strongly affected by the larger provincial policies. Nodal Governance Theory is concerned with the characteristics of individual nodes: what is the mentality of hospital X? What resources are made available to hospital X? etc. In the first part of this paper, I have delineated what I refer to as the Global Health Network (GHN). Wealthy nations and major capitalist financial institutions can be thought of as the "major nodes" and their policies can be thought of as the 'major codes'. In the second part of this paper, I have studies smaller networks as well as the individual nodes that operate within them using a case study from Africa. **Methods:** The data collected from local and international academic journals, news papers, and conference proceedings, as well as papers published by governmental and non-governmental organizations, served as the empirical basis for the theoretical analysis developed here. **Results:** Policies aimed at increasing health equity succeed or fail depending on the major players (nodes), their agenda (codes) and the characteristics of smaller networks and individual nodes. The current policies and agendas of important nodes within GHN have profound, and for the most part negative, influences on battling health inequities, particularly in LMICs. Although LMICs share common characteristics, each country has its own set of cultural and social traits that make them operate quite differently from any other country. **Conclusion:** The aforementioned theories provide a suitable conceptual framework for analyzing why certain health equity oriented interventions can, or cannot, mobilize positive change.

03–02 (A): Modeling Black-White Preterm Birth Disparity: Ecologic and Multilevel Models

Lynne Messer, Jay Kaufman

Introduction: The disparity between black and white women's adverse birth outcomes has been subject to much investigation, yet the factors underlying its persistence remain elusive, which has encouraged research on neighborhood-level influences. This work considers two main questions: 1) to what extent are neighborhood-level factors (violent crime, deprivation, suboptimal housing) associated with black-white (B-W) preterm birth (PTB) disparity? 2) Is neighborhood-level B-W PTB disparity associated with PTB risk for the women residing in these neighborhoods? **Methods:** The authors examine B-W PTB disparity in Raleigh NC census tracts (1999-2001) using linear and logistic models. Geocoded vital records, city crime reports and US Census data were analyzed. PTB was defined as birth at < 37weeks (& < 3888g) gestational age. B-W disparity was defined as the difference in proportions between black PTB and white PTB per tract. A 10-item standardized index estimated neighborhood deprivation. Tertiles of deprivation, suboptimal housing and violent crime were modeled. Race-stratified random effects logistic models with fixed slope predictor values and randomly distributed tract-specific intercepts were fit; analyses were restricted to tracts with >50 black and white births. B-W PTB disparity was scaled so each 0.1 unit increase in disparity corresponded to a 1% increase in PTB. **Results:** Black and white non-Hispanic women live in different neighborhood environments. Black non-Hispanic women live in tracts with more crime (mean=67 crimes, standard deviation [sd] 49) and deprivation (mean=1.4, sd 3.5), than white non-Hispanic women (mean=29 crimes, sd 35; mean deprivation= -1.1, sd 1.3). At the ecologic-level, high deprivation (third tertile) (difference =0.07; 95%CI: 0.00, 0.15), suboptimal housing (beta=0.10; 95% CI: 0.03, 0.16) and violent crime (beta=0.07; 95%CI: 0.01, 0.14) were associated with increased B-W disparity after adjustment for tract maternal age, education and marital status structures, compared with the first tertiles. Multilevel models adjusted for maternal age, education and tract deprivation found B-W PTB disparity associated with decreased preterm birth odds in white women (Odds Ratio [OR] = 0.98; 95% Confidence Interval [CI]: 0.98, 0.99) and increased odds in black women (OR=1.05; 95% CI: 1.03, 1.06). **Conclusions:** The neighborhood environment may influence preterm birth disparity. Exposure to preterm birth disparity at the tract-level appears differentially associated with preterm birth odds. **Implications:** PTB disproportionately affects disadvantaged populations in the U.S.; understanding how exposure to PTB disparity influences individual risk is important for planning effective policy interventions.

03–03 (A): Maternal & Child Health and Neighborhood Context: The Selection and Construction of Area-Level Variables

Jessica Burke, Julie Rajaratnam, Patricia O'Campo

Introduction: Increasingly, maternal and child health researchers are employing the statistical approach of multilevel modeling analysis to simultaneously examine the relationship between contextual and individual determinants and maternal and child health outcomes. This review addresses the following questions; 1) What categories of neighborhood characteristics have been addressed? and 2) How were those neighborhood characteristics operationalized? **Methods:** A literature review identified 31 relevant articles published between January 1999 and March 2004. The articles were read with special attention toward the measurement of neighborhood characteristics. RESULTS: Twelve categories of neighborhood characteristics represented in the articles include income/wealth, employment, family structure, population composition, housing, mobility, education, occupation, social resources, violence & crime, deviant behavior, and physical conditions. A wide diversity of approaches were used measure these characteristics. The most widely utilized source of data was that of administrative records from the census or local government authorities. Although most authors provided theoretical explanations of their choice to examine broad

neighborhood constructs; few were explicit about why certain indicators were selected to measure these constructs. **Conclusions:** There are theoretical, methodological and practical barriers in the measurement of the neighborhood context which must be addressed for the field to move forward. These barriers will be discussed and recommendations made for addressing them in future research.

03–04 (A): Exploring Ideological Barriers to Addressing Health Inequalities at the Local Level

Patricia Collins, Julia Abelson, John Eyles

Introduction: In the 1990s, the social determinants of health (SDOH) emerged as a novel framework for conceptualizing the health and well-being of populations. The overarching concept conveyed by the SDOH was that health and disease are determined by numerous factors, not simply access to healthcare services and lifestyle practices. Despite growing acceptance among academics, policy-makers, and service providers, tremendous barriers to operationalizing this concept remain. The objective of this study was to understand how the values of active citizens in Hamilton, Ontario could act as facilitators or barriers to addressing local health inequalities. **Methods:** A postal survey was administered to volunteers and employees of community based organizations (CBOs) in Hamilton. CBOs were targeted because of their role in local service delivery and their unique position to directly address local health inequalities. The target sample size was N=436 respondents. The survey assessed respondents' awareness of the SDOH, as well as their understanding (proxy for openness) and attitudes towards (proxy for support for addressing) the SDOH. It also gauged their SDOH-related political values, left/right self-placement, and political activity. Statistical analyses employed various non-parametric tests, including Mann-Whitney U, Kruskal-Wallis, and the Kendal's tau-b statistic. Statistical significance was determined using the 97.5% level of confidence, to account for multiple comparisons. **Results:** A total of N=240 completed surveys were returned, generating a 55% response rate. Less than half (46%) of respondents were aware of the SDOH prior to the study. Being aware was positively associated with increased openness and greater support for addressing the SDOH. Understanding and attitudes were also significantly associated with demographic characteristics. Liberal values were similarly associated with increased openness and support for addressing the SDOH, whereas the opposite trend was observed with conservative values. Liberal-leaning respondents were more politically active than conservative respondents. **Conclusions:** Greater knowledge transfer of the SDOH framework should be a priority among academics and Health Canada, particularly since awareness was associated with increased support for the SDOH, and greater alignment with SDOH-related political values. Dissemination efforts could be particularly effective if they target demographics that are more receptive to SDOH. The statistical associations observed between values, understanding, attitudes, and political behaviours suggest that liberal values could act as facilitators, while conservative values could pose barriers to addressing local health inequalities.

High-Risk Youth

04–01 (A): The Neighborhood Identification and Engagement Process: A Mixed Methodological Approach for Exploring Urban Youth Violence

Michael Yonas, Patricia O'Campo, Jessica Burke

Introduction: Violence is a significant public health problem facing youth in urban communities. Effective methods are needed for identifying neighborhoods appropriate for study as well as for respectfully approaching and involving neighborhood individuals. This investigation utilized a mixed-methods participatory needs assessment approach to explore and characterize individual and contextual level factors related to urban youth violence. **Methods:** Principle components analysis was conducted on seventeen violence related, demographic, economic, education and employment data variables, to identify, rank and select low-income high and low risk for youth violence study neighborhoods. Once potential neighborhoods were identified, an intensive participatory neighborhood engagement process was initiated. This process involved contacting local businesses, churches, and organizations as well as engaging neighborhood residents by personally walking throughout the selected study neighborhoods, meeting people, describing the project, and identifying those individuals perceived locally as those involved in efforts to address neighborhood youth violence. Identified individuals where invited to participate in in-depth qualitative interviews. **Results:** Principal components analysis yielded four potential U.S. Census Block group neighborhood clusters with contiguous high and low risk for youth violence neighborhoods. While more than 50 individuals were met during the initial neighborhood engagement process, a total of 16 prominent neighborhood individuals (PNIs) from among four neighborhoods were invited to participate and completed the interview process. The majority of these local experts were either current or past residents of the study neighborhoods (13 of 16), and participants included parents, pastors, local program coordinators, and drug dealers. Ten were men, six were women and they ranged in age from 32 to 77 years of age. In depth interviews provided a wealth of information regarding neighborhood history, culture, and the local social and environmental factors perceived as related with youth violence. **Conclusion:** Principal components analysis is a useful quantitative alternative that provides the opportunity for including multiple correlated factors in the process of identifying high and low risk for youth violence neighborhoods. Conducting a patient, transparent, and respectful neighborhood engagement process was essential to developing comfort and trust with local individuals for gaining an insider's perspective of issues related to neighborhood youth violence. This locally customized data gathering process is essential for characterizing, understanding and ultimately addressing a variety of public health issues, including youth violence.

04–02 (A): The Emergency Department - Is it an Appropriate Venue For an Intervention Programme to Reduce Youth Violence?

Carolyn Snider

Introduction: In many urban cities, there is growing concern with youth violence. Emergency departments worldwide are often witness to the life-altering injuries that occur as a result of this violence. Previous studies have shown that victims of violence are more likely to become repeat victims of violence and are frequently perpetrators of future violence. Health care workers regularly discharge youth who have been injured due to violence from the emergency department with little to no violence prevention intervention. This study defines the scope of this problem in Toronto by presenting results of an observational study of injuries caused by youth violence. This inquiry also demonstrates that the emergency department is an excellent venue for an intervention programme to reduce youth violence. **Methods:** An observational study was designed to determine the cause of injury, demographics of the injured, and disposition of the patients aged 19 and under who presented to emergency departments with injuries that resulted from violence during a period of two years (April 2002 - March 2004). Data was collected and analyzed from the National Ambulatory Care Reporting System (NACRS) database collected by the Canadian Institute for Health Information (CIHI). **Results:** A total of 4622 patients aged 19 and under who incurred injuries due to violence visited Toronto emergency departments during the period of this study. Assault or homicide due to bodily force (vs. sharp objects, guns or other) was the most common cause of injury due to violence (52%) [95%CI 50-53%]. Patients aged 15-19 accounted for 76% of the injuries [95%CI 75-77%]. Males accounted for 72% [95%CI 71-73%] of victims. The majority of patients (90% [95%CI 89-91%]) were discharged directly from the emergency department. **Conclusions:** Males aged 15 - 19 who have been assaulted by bodily force form the most common group of youth incurring injuries due to violence who visit Toronto emergency departments. Large proportions (90%) of these youth are discharged directly from emergency departments. Given victims often become repeat victims and/or future perpetrators, an opportunity exists for the development of youth violence prevention initiatives in emergency departments. A sound understanding of previous youth violence intervention programmes in emergency departments will be essential in the development of an effective programme for emergency departments in Canada.

04–03 (A): Risky Alcohol Use and Daily Cannabis Use Differ Between Low Educated Dutch Adolescents Living in and Outside the City of Amsterdam: A Result of Differences in Pleasure-Seeking Behaviour?

Ineke Stolte, Adèle Diepenmaat, Wilco Schilthuis, Marcel Wal

Introduction: The prevalence of alcohol and cannabis use is known to be associated with neighbourhood differences and with pleasure-seeking behaviour (e.g. café, disco, cinema, coffee shop). These neighbourhood differences might be partly due to the availability of locations for pleasure and therefore pleasure-seeking behaviour. Our study objectives were 1) to investigate the prevalence of risky alcohol use and daily cannabis use among Amsterdam students of intermediate vocational (IV) schools, living in and outside Amsterdam, and 2) to investigate which specific locations for pleasure-seeking are related to risky alcohol and daily cannabis use. **Methods:** A survey was conducted among 4370 students of IV schools in Amsterdam. Only Dutch students who reported that they had been drinking or blowing in the month prior to the questionnaire were included, resulting in a study population of 1309 students (median age 17 years). Self-reported information about socio-demographics, alcohol use, cannabis use, and pleasure-seeking behaviour was collected using a questionnaire. Risky alcohol use was defined as daily drinking or 3-6 times a week more than three standard glasses of alcohol. Students answered questions about whether they visited various locations for pleasure seeking or not. Univariate and multivariate logistic regression was used for analyses. **Results:** The overall prevalence of risky use of alcohol was 20.6% (264/1281), with the prevalence being significantly higher among students living outside Amsterdam compared to them living in Amsterdam (OR: 1.64, 95%CI [1.19-2.25]). The overall prevalence of daily blowing was 13.1% (84/643) with the prevalence being significantly lower among students living outside Amsterdam (OR: 0.46, 95%CI [0.29-0.74]). Locations for pleasure-seeking that were independently related to risky alcohol use were café, disco, coffee shop, and house party, while visiting a coffee shop was independently related to daily cannabis use. Pleasure-seeking behaviour did not explain the differences in risky alcohol and daily cannabis use between students living in and outside Amsterdam. **Conclusion:** Risky alcohol use and daily cannabis use differed for students in and outside the city of Amsterdam, despite the fact that all students attained school in Amsterdam. As differences were not explained by pleasure-seeking behaviour, there have to be other social or cultural (non-ethnical) differences between students living in and outside Amsterdam. Interestingly, visiting a coffee shop is an important determinant for both daily cannabis use and risky alcohol use, even though coffee shops are not allowed to sell cannabis to individuals aged younger than 18 years.

04–04 (A): Environmental Influences on Youth Gambling: Is the Deck Stacked?

Jason Gilliland, Dana Wilson, Nancy Ross

Introduction: The proliferation of government-sponsored gambling venues in North America over the past two decades has created one of the most controversial social justice issues facing urban communities today. This paper presents results from a study of youth video lottery terminal (VLT) gambling, which links ecological aggregate and local individual-level data to gain a richer understanding of how neighbourhood environments influence opportunities for, and participation in, risky health-related behaviours. **Methods:** Locations of all high schools and establishments holding VLT licenses in the Census Metropolitan Area (CMA) of Montréal were geocoded by street address. Geomatic techniques were used to derive measures of VLT proximity to schools. Census tracts were characterized by socio-economic indicators and measures of VLT concentration. A survey of students was conducted to discover individual-level behaviours and attitudes concerning VLT use. Data were analyzed using logistic regression. **Results:** Geomatic analyses revealed that video lottery opportunities are heavily concentrated near high schools and students from neighbourhoods of low socio-economic status are the most heavily exposed. Logisitic regression analyses indicated that higher levels of gambling by youth are associated with elements of the social and physical environment, such as: low parental supervision, having friends who play VLTs, and the presence of VLTs near school. **Conclusion:** Gambling activity is linked to opportunity, and the spatial distribution of VLTs reflects local geographies of socio-economic disadvantage. Any effort to reduce the burden of gambling-related health and social problems must recognize the spatial distribution, indeed socio-spatial distortion, of gambling opportunities in the environment.

05–01 (A): Urban Income Inequality and Health

Sponsored by the Canadian Population Health Initiative (CPHI)/Canadian Institute for Health Information (CIHI)

Elizabeth Gyorfi-Dyke (Moderator), James Dunn, Nancy Ross, Nazeem Muhajarine

CPHI-funded researchers Dr. James Dunn, Dr. Nancy Ross, and Dr. Nazeem Muhajarine will provide an overview of recent research findings related to urban income inequality and health. Drs. James Dunn and Nancy Ross will present key findings from their CPHI-funded research program examining the relationship between income inequality and population health in Canadian society, the factors that contribute to this relationship and how the Canadian situation differs from the United States. Dr. Nazeem Muhajarine will present findings findings from his CPHI-funded research project examining community and family characteristics, income dynamics and child health outcomes.

Drs. Dunn and Ross are currently developing a set of socio-economic indicators for metropolitan areas (i.e., cities of more than 50,000) in Canada and the U.S. in order to investigate which factors are most strongly related to income inequality and population health. A number of issues will be discussed, including the relationship between residential segregation (based on income) and population health in Canadian and U.S. cities; the relationship between the wage gap and population health in the two countries; and the time it takes for changes in income inequality to affect population health outcomes in Canada.

Dr. Muhajarine's research project, conducted by researchers at the University of Saskatchewan and at Dalhousie University, identified children born to mothers living in four major cities in the provinces of Saskatchewan and Nova Scotia over two select years. The research team collected data related to parents, birth outcomes, and children's use of all health care services up to six years after birth. Information about the neighbourhoods in which children lived at birth and health services available to them were also examined. Dr. Muhajarine will present key findings from his research including the factors and conditions that may lead to healthy outcomes in children in the first six years of life.

Peer-Led Harm Reduction

06–01 (C): Crystal Clear: A Peer to Peer Health Promotion Project

Caitlin Padgett

Issue: A coalition of community agencies established a peer training and outreach program. It empowers marginalized street-involved youth using methamphetamine to make safer, healthier choices, and address drug-related issues such as trauma, abuse, poverty, homelessness, depression and other linked mental health concerns. Setting: According to anecdotal evidence, methamphetamine predominates as the drug of choice for the 700 to 1000 street youth in Vancouver's Downtown South, a community of about 80,000 residents. In preliminary results from a survey of street youth in Vancouver's south downtown, over 70% reported trying the drug, while 47% of that group reported using methamphetamine within the last seven days. This evidence suggests youth who are afflicted by poverty and homelessness are some of Vancouver's most vulnerable residents. Project: The youth participants are selected to pursue the goal of participatory research, street level outreach, harm reduction and support, and advocacy, as well as increasing the awareness of the larger community about the needs of street-involved youth that use methamphetamine. Their training involves extensive skills building, development of a training curriculum for street-involved youth, training in crisis intervention, emergency response, peer support and advocacy, and development of peer-driven resources stemming from a community mapping exercise, and training in participatory research and survey development. The participants also training with leading doctors and mental health workers familiarized with health concerns specific to street-involved youth. **Outcomes:** The peer networks developed the youth's capacity to act as peer educators within the informal social networks that already exist within their community. The peer education increases each individual's ability to minimize harm related to methamphetamine use, to examine beliefs and knowledge of methamphetamine use for themselves and their peers, and to develop an analysis of the impact of methamphetamine use on their peers and the community at large. The youths' peer advocacy and referrals increase access to support groups for youth that are HIV or Hepatitis C positive, and increase access to community detox and health services. The project has partnered with a community clinic to conduct a pilot study of the peers ability to increase referrals of street-involved and marginalized youth to primary health care and needle exchange. A model of training, health promotion and integration has been developed and is transferable to any urban community or sub-community in need of increased awareness and access to health-related services, education and advocacy.

06–02 (C): Community and Public Health Impacts of Medically Supervised Smoking Facilities for Crack Cocaine Users: A Peer-Led Feasibility Study

Kate Shannon, Tomiye Ishida, Arthur Bear, Rob Morgan, Megan Oleson, Mark Tyndall

Introduction: There is growing attention being paid to the serious public health and community harms associated with crack cocaine smoking, particularly the risk of HIV and Hepatitis C transmission. In response, community advocates and policy makers in Vancouver, Canada are proposing to pilot a medically supervised smoking facility (SSF) for non-injection drug users. Current reluctance on the part of health authorities and Health Canada is due in part to the lack of information related to the direct harms associated with crack cocaine along with questions regarding the potential uptake of such a facility were it to open. As such, a partnership between the Rock Users' Group of Vancouver Area Network of Drug Users (VANDU) and a community-based research project at the BC Centre for Excellence in HIV/AIDS, undertook an assessment of the willingness to use a SSF among crack cocaine smokers. **Methods:** Through a participatory research process, members of the Rock Users' Group were involved in all aspects of the research, including defining research needs, developing research tools, recruitment of participants through alley patrol, and peer-administering of questionnaires. After providing written informed consent, participants were invited to

complete an interviewer-administered questionnaire. They were given Can$10 for their participation. Univariate analyses were use to determine associations with willingness to use a SSF and a logistic regression was performed to adjust for potentially confounding variables ($p < 0.05$). **Results:** Among 437 regular crack cocaine smokers, 303 (69%) reported a willingness to use a SSF should one be made available. Willingness to use a SSF was associated with rushed crack smoking in public places (aOR=4.37, 95% CI: 2.71-8.64), borrowing crack pipes (aOR=2.50, 95% CI: 1.86-3.40), smoking crack in public places (aOR=2.48, 95% CI: 1.65-3.27), crack bingeing (aOR=2.16, 95% CI: 1.39-3.12), having equipment confiscated or broken by police (aOR=1.96, 95% CI: 1.24-2.85), and recent injection drug use (aOR=1.72, 95% CI: 1.09-2.70). **Conclusions:** There was a high level of willingness among regular crack users to use a medically supervised smoking facility and this was especially evident among individuals who reported risky crack use behaviors. The results suggest a strong potential for a SSF to reduce the health related harms of crack smoking, address issues of public order and provide an opportunity to connect with a highly marginalized population.

06–03 (C): The Vancouver Area Network of Drug Users (VANDU): The Evolution of a User-run Organization in Vancouver's Downtown Eastside

Rob Morgan, Greg Liang, Julia Chapman, Evan Wood, Thomas Kerr

Objectives: In 1997, in response to the emerging health crisis among injection drug users (IDUs) and to government inaction, a group of individuals gathered in Vancouver to form a user-run organization. This group eventually became the Vancouver Area Network of Drug Users (VANDU). This study reports on an effort initiated by Health Canada to describe the genesis, evolution, organizational structure, and activities of VANDU. **Methods:** In accordance with VANDU's philosophy we employed a community-based case study methodology. Peer researchers worked with external researchers in gathering data using various methods and sources, including structured interviews, participant observation, and organizational documents. Key informants included founding and current VANDU members, employees, policy makers, funders, and services providers. **Results:** While the early organizing work of VANDU focused on political activism and advocacy, the organization has since expanded its activities and now participates on community and government task forces, and provides public health and education programs for IDUs. Current activities include support groups for women with HIV, persons with hepatitis C, and methadone users. VANDU also operates a street- and hotel- based syringe exchange program, and alley patrols that provide care to the most marginalized drug users. At present VANDU has over 1,000 members, and approximately 800 peer volunteers participate in VANDU programs each year. **Conclusions:** VANDU has demonstrated that IDUs can organize themselves and make valuable contributions to their community and the community at large. Lessons learned in Vancouver's Downtown Eastside will be extremely valuable for IDU and persons that work with drug users elsewhere.

06–04 (C): Community Driven, Participatory Research Projects

Holly Kramer, Andrew Nolan, Valerie Cartledge, Frank Coburn, Gerry Leslie, Tammy Mackenzie

The Toronto Harm Reduction Task Force (THRTF) is an association of professionals, agencies and community members working together to reduce the harms to individuals and communities associated with substance use/distribution. Defining harm reduction as: "...decreasing the adverse health, social and economic consequences of drug use, without requiring abstinence..." *1 the THRTF has built a reputation for working with users/ex-users, benefiting from their life expertise to offer a social justice/public health response to substance use. Since 2002, three peer driven projects *2 have been instrumental in building capacities.

Manual

22 peer workers (users/ex-users) collaborated to conduct research, enabling them to design, write, edit, produce and distribute a guide for peer workers and agencies. This 100+ page manual includes sections on harm reduction, boundaries, confidentiality, orientation, training, supervision and appendices illustrating samples (e.g. mission statement, employment contract, skills inventory). 250 hard copies, 500 licensed copies and electronic access has been available to harm reduction workers and users internationally via www.canadianharmreduction.com ("Ichip" page).

Network

15 users/ex-users with experience as peer educators worked together to form a Toronto-based harm reduction network for peers. Regular meetings were held to conduct community based research through participation in front line workers meetings. Other harm reduction training events were also utilized. This network continues to have an impact through participation of members in planning the City of Toronto's new Drug Strategy Initiative.

Education & Training

6 peer educators conducted community based research and developed/ delivered a full day workshop based on the manual to fellow peer workers. 20 peer workers from five Toronto agencies attended the pilot and reported a high level of satisfaction with receiving training from their peers. Three project participants obtained paid peer positions as a direct result of their involvement with this project, and continue to deliver training to peer workers.

*1) (Riley, et al)

*2) With funding support from the City of Toronto, Drug Prevention Grants (Toronto Public Health), and the Government of Canada's Supporting Community Partnerships Initiative administered by the City of Toronto.

*3) In the fall of 2005 we began work on a play relating to homelessness/substance use. 10-12 users/ex-users who have experienced homelessness and use/used illicit drugs will write, produce, and present the play, "No Fixed Address" to premier at the annual THRTF harm reduction forum in the spring of 2006.

Advocacy for Social Justice in Urban Health

07–01 (C): Improving the Post Approval Surveillance System for Prescription Drugs

Louise Binder, Jean-Pierre Belisle, Patrick Cupido, Mardie Serenity

Because of the passive nature of the current Post Approval Surveillance System (PASS) for prescription drugs, most of the mid-term and long-term side effects of medications take too much time to be identified and/or recognized. This negatively impacts the quality of life of persons taking certain drugs and could be avoided by a more proactive and consumer-centered PASS. Since 1998, the Canadian Treatment Action Council (CTAC) has initiated a series of interventions to improve the situation, using anti-HIV drugs as its pilot focus. **Method:** In 1998, CTAC created a PASS Committee which hosted consultations and developed a discussion paper which was published in 2000. This Committee recommended the establishment of an Advisory Committee to oversee the implementation of a community-based participatory research project — the PASS study — to test various community-based methods of reporting adverse events to anti-HIV drugs. Using a common survey, three reporting methods were tested between November 2002 and June 2003 : a national bilingual toll-free line; face-to-face interviews in Montreal, Toronto and Vancouver; and a free reply mail/fax survey. In addition, four focus groups were conducted within the Aboriginal community. Following the completion of the final report in July 2004, a second Advisory Committee was created to oversee the ongoing dissemination of the results within the community and the identification of the path forward. **Results:** Of the three methods tested by the PASS study, face-to-face interviews were the most successful with 933 surveys collected, while only 97 were obtained via mail/fax and 40 via phone interviews. Face-to-face Interviews were successful because HIV+ respondents were approached in familiar surroundings (e.g. peer-driven organizations) and often by interviewers perceived as trustworthy (e.g. HIV+ individuals, treatment activists). The information collected via interviews also seemed more reliable than that obtained via mail/fax. In total, 996 respondents reported at least one adverse event. This indicates that a community-based reporting system can capture information that is not obtained through the existing PASS. **Conclusion:** Our community-based participatory research has demonstrated that face-to-face interviews are a successful reporting method and that community-based organizations, especially peer-driven organizations located in large urban areas, can become key sentinel components of an improved PASS. A community-friendly summary version of the final report will be widely disseminated during Fall 2005. Workshops will be held to share the results with the communities which participated in the research and to identify with them the next steps and strategies for action.

07–02 (C): In Our Own Voices. Surveying Asian Pacific American Lesbian, Gay, Bisexual, and Transgender People

Alain Dang

Introduction: Asian Pacific Americans (APA) are among the fastest growing minority groups in the United States. More and more APA lesbian, gay, bisexual, and transgender (LGBT) people are coming out of the closet, yet they still face invisibility, isolation, and stereotyping. The lives of APA LGBT people involve a complex web of issues arising from being sexual, racial/ethnic, language, gender, immigrant, and economic minorities. This study presents an opportunity to center communities at the margins. It looks at multiple identities, experiences, and concerns as individuals and communities within the broader context of experiences as Asian Pacific Americans in the mostly white LGBT community, and as queers among APA communities. **Methods:** The survey focused on basic demographic information, experiences with discrimination, policy priorities, and political behavior. Also included were questions that asked about the attitudes of APA LGBT individuals towards both LGBT and straight organizations that are either predominantly APA or predominantly white. **Results:** Among the key findings of the report: • Nearly every respondent (95%) had experienced at least one form of discrimination and/or harassment in their lives. For example, 82% said that they had experienced discrimination based on their sexual orientation, and 82% had experienced discrimination based on their race or ethnicity. • The three most important issues facing APA LGBT community members were immigration, hate violence/harassment, and media representation. • Nearly all respondents (96%) agreed that homophobia and/or transphobia is a problem within the APA community. And, over 80% agreed that APA LGBT people experience racism within the predominantly white LGBT community. • The majority of respondents felt that LGBT organizations inadequately address issues of race (58%), class (80%), and disability (79%). **Conclusion:** This study documents the diversity of experiences, identities, needs, and political perspectives that exist within the larger LGBT and APA communities in the U.S. It details and validates a myriad of APA LGBT experiences. Social activists and researchers can utilize the findings to advocate for and implement policy changes at the local, state, and national levels. Respondents reported significant homophobia in the APA community and racism in the LGBT community. It is interesting that respondents reported being more comfortable working in predominantly white LGBT environments than they did working in predominantly straight APA environments. Predominately straight APA organizations and predominately white LGBT organizations must expand efforts to serve all members of their communities, including Asian and Pacific American LGBT people.

07–03 (C): Women in Transit: Organizing for Social Justice in Our Communities – A PAR project of the Bus Riders Union

Martha Roberts

Introduction: The Bus Riders Union (BRU) is a multi-racial membership-based organization of over 800 transit dependant bus riders in the Lower Mainland of British Columbia. The BRU represents the mass transit and public health needs of the transit dependent. We work with regional authorities and bus riders to put the needs of transit dependent people, overwhelmingly working class, and disproportionately people of colour, at the centre of public policy. We organize because affordable, reliable and environmentally sound mass transit is a human right. Human and environmental needs must be the leading social, political and economic priority. **Methods:** In 2004 the BRU completed a participatory action research project critically examining the

impacts of public transit mega-projects and privatization on the lives, health, and environment of transit-dependent women. Thousands of women were directly involved on buses and in communities. Women's direct testimonies and vision, collected on the 'Right to Public Transit Violation Report Form' culminated in a hard-hitting popular report 'Women in Transit: Organizing for Social Justice in Our Communities'. This report contains three key themes: Defend and Expand Public Services; End Transit Racism; and Public Health and Environmental Justice. In the fall of 2004, transit-dependant women presented this research to the regional transit authority TransLink and won the support and attention of many local grassroots organizations and the media. **Results:** This PAR project involved women from the grassroots in the democratic processes of the region and resulted in major gains. One significant public health victory was the extension of Night Owl service from 1:30 am to 3:30 am; previously hundreds of late night workers grappled with sleep derivation and/or economic hardship due to loss of working hours. The BRU witnessed a significant shift in the consciousness of TransLink directors as directors began to speak openly about the implications of their decisions on transit-dependant communities. **Conclusion:** BRU involvement in regional democratic processes and our popular education on the bus have sparked a new campaign and further PAR research to 'Lower the Fare, Now! For Community Health and Social Justice'. It is an environmental and social justice imperative for low-income communities to stand together and speak publicly about our health and environmental needs. The combination of popular qualitative and quantitative research and community organizing continues to positively impact the health of our communities; we uphold this combination as an important model for the future of social change. To preview our report see: http://bru.resist.ca/wit

07–04 (C): **The Development of Peer-driven Intervention for Individuals Requiring Assistance With Injection**

Diane Tobin, Ann Livingston, Ron Morgan, Nadia Fairbairn, Evan Wood, Thomas Kerr

Introduction: Receiving assistance with injections is a common practice among illicit injection drug users (IDU) that carries significant risk for health-related harm, including increased risk for HIV infection and overdose. The Vancouver Area Network of Drug Users (VANDU) is a drug user-run organization focused on political activism, advocacy and the provision of peer support programs for IDU. In response to the ongoing problem of assisted injection and related government inaction, VANDU has developed a peer-driven intervention to address the risks associated with dangerous practice. **Methods:** The VANDU Injecting Team has been initiated as a harm reduction strategy for IDU who require assistance with illicit drug injections. The Injecting Team, in collaboration with VANDU's existing outreach-based Alley Patrol Program, provides education regarding safer assisted-injection and instruction on how to self-inject to those who need it. The effectiveness of this intervention will be evaluated through an ongoing prospective cohort study of local IDUs. **Results:** We will report on the specific activities of the Injecting Team, the evaluation methodology, and the evaluation results to date. **Conclusions:** Drug user-driven activities have been shown to reach vulnerable populations that are not adequately served by existing public health programs. The VANDU Injecting Team has potential to address a significant gap in current programs for IDU by providing peer education and support to those requiring assistance with injections.

Urban Neighbourhoods

08–01 (A): **Finding Good Places to Play: Exploring Social Justice and Public Park Provision in Urban Neighbourhoods**

Martin Holmes, Patricia Tucker, Jason Gilliland, Jennifer Irwin, Meizi He, Paul Hess

Introduction: Research indicates that rising rates of childhood obesity in North American cities are due not only to individual-level factors (i.e., genetics, lifestyle), but various environmental factors as well. For example, it is suggested that whether (or not) good quality public parks are available in the local environment has a significant influence on physical activity levels among youth. This study examines the location of neighbourhood parks in the city of London, Ontario in order to determine if these public facilities are adequately and equitably distributed throughout the city. **Methods:** A geographic information system (GIS) was employed to map the current distribution of public parks throughout the entire census metropolitan area (CMA) of London. The spatial patterning of parks are analyzed in relation to neighbourhood socio-economic characteristics (e.g., income, education, employment), as determined with data from the 2001 Census of Canada. City of London planning districts (n = 43) are used as a proxy for neighbourhoods. Comprehensive field surveys were conducted in every urban and suburban neighbourhood in the CMA (rural districts were excluded) in order to qualitatively assess every public park in the City according to a list of environmental factors (e.g., equipment, maintenance, greenspace). A census was taken at each park to record level of use. **Results:** The preliminary results of this study suggest that neighbourhood recreational opportunities are equitably distributed and only a small number of areas appear to be 'recreational deserts'. Nevertheless, a closer look in the field reveals that all parks are not created equal. Significant differences in quality appear between areas of high and low socioeconomic status in terms of park amenities, maintenance, safety, and aesthetical appeal. Moreover, park use is directly related to quality. **Conclusions:** The preliminary findings of this ongoing study suggest that although little disparity exists in the allocation of City parks in London according to neighbourhood social characteristics, a socio-spatial disparity exists with respect to the quality of public parks provided to each neighbourhood. These findings are crucial in the struggle against childhood obesity as exercise has been offered as one way in which obesity can be avoided. It is also of great importance that these social relations are uncovered as people in areas of lower SES are at a higher risk of becoming obese and developing related disorders. Planners, health promoters and health educators must all become aware of these differences in order to make changes that create healthier environments.

08–02 (A): The Usefulness of Geographic Information Systems (GIS) to Reduce Inequalities in Urban Road Safety

Cloutier Marie-Soleil, Patrick Morency

Introduction: Every day, thousands of pedestrians are victims of road accidents worldwide. In Montreal, Canada, it is a mean of five pedestrian a day that are injured in a road accident. Moreover, it is well known that accidents are unevenly distributed among social classes and urban areas. Researches have found that social and material deprivation are linked to higher risk of accident, due to many known risk factors such as traffic density, greater in poorer neighbourhood. In 2004, WHO urged communities and governments to target this rising public health problem. This paper argues that spatial analysis and geographic information systems (GIS) can create relevant and unique information on the extent and location of this problem in cities in order to integrate public health objectives in transportation decision-making. Briefly, GIS are computer systems that allow management, analysis and reporting of thematic data within their geographic context. Methods: GIS can be used to show clearly where and for which population transportation health effects are important. The mapping of the harmful outcomes of transportation, including pedestrian accidents and pollution (air and noise), has the potential to highlight inequalities in the building and management of urban infrastructures. This allows to go beyond "blaming" individuals and to take into consideration the effect of the surroundings environment on the health and well-being of urban residents, this issue being persistent in public health. Results: The usefulness of GIS in the advocacy of pedestrian safety has been demonstrated in a pilot study carried out in Montreal. It can be used to influence stakeholders (city planners, police, politicians, citizens) on major issues. Once the geographic distribution of pedestrian insecurity is shown on maps, the magnitude of the problem becomes obvious, as well as the need for global environmental measures, for example targeting traffic and vehicle speed. Changes in streets design need to be implemented on a larger scale than the usual selection of a few intersections in order to reduce inequalities among citizen in terms of access to safe transportation and reduction of health impacts. Conclusion: The study completed in Montreal has already influenced the way to view road insecurity: Montreal transportation planning will now adopt a new perspective including pedestrian and cyclist safety. Maps resulting from this project are now used by many interest groups to improve their knowledge of the situation and their strategy of action. The presentation will take this example to illustrate the points mentioned above.

08–03 (A): Socioeconomic Inequality of Urban Core Neighbourhood Residents in Saskatoon

Mark Lemstra, Cory Neudorf, Leanne McLean, Johnmark Opondo, Judith Wright

Introduction: The Saskatoon Health Region, and its broad base of community partners, have developed a system to identify and address socioeconomic inequalities in health status. The Comprehensive Community Information System (CCIS) will collect a broad range of health and social indicator information that will be interactive, flexible and available to the community at no cost on the web. The authors present a scenario on how information from a core, urban neighbourhood can be used. Methods: There are six neighbourhood associations in Saskatoon (all touching) that meet a definition of low income status defined a priori by 2001 census information. The health status of this core neighbourhood (n=18,228) was compared to the rest of Saskatoon (N= 184,284) for the year 2001. Health information was received directly from Saskatchewan Health and Population Health at the Saskatoon Health Region. The disease rates are age standardized by ICD9 code. Results: Comparing 2001 age-standardized hospital separations between the core neighbourhood and the rest of Saskatoon, the rate ratio was significantly higher for suicide attempts (RR=3.75; 95% CI 2.65-5.30), mental disorders (RR=1.85; 95% CI 1.56-2.19), injuries and poisonings (RR=1.54; 95% CI 1.39-1.72), diabetes (RR=3.98; 95% CI 2.72-5.82), chronic obstructive pulmonary disease or COPD (RR=1.38; 95% CI 1.00-1.92) and coronary heart disease (RR=1.34; 95% CI 1.07-1.68). For number of patients that visited a physician once, the rate ratio between the core neighbourhood and the rest of Saskatoon had significant differences for mental disorders (RR= 1.24; 95% CI 1.20-1.28), injuries and poisonings (RR= 1.06; 95% CI 1.03-1.09), diabetes (RR= 1.49; 95% CI 1.37-1.61) and COPD (RR= 1.22; 1.17-1.28). Reviewing public health information, we found that comparing the core neighbourhood to the rest of Saskatoon resulted in rate ratios of 4.32 for chlamydia (95% CI 3.68-5.07), 7.76 for gonorrhea (95% CI 5.46-11.02), 8.04 for hepatitis C (95% CI 5.90-10.95) 4.21 for teen pregnancy (95% CI 3.16-5.60), 5.48 for infant mortality (95% CI 2.00-15.02) and 1.46 for low birth weight (95% CI 1.01-2.12) Space limits discussion of comparisons between the low income neighbourhood and the affluent neighbourhood, of which differences in health were magnified. Conclusion: Significant health disparity was found in Saskatoon when comparing a low income neighbourhood to the rest of Saskatoon. The Comprehensive Community Information System can be used to identify health disparity at the local level and then assist with planning and prioritization of human and financial resources at various government and community levels.

08–04 (A): Neighborhood Mapping as a Participatory Tool for Evaluating Community-Based Urban Health Initiatives

Anne Wallis, Patricia O'Campo, Robert Aronson

Introduction: Although neighborhood or community mapping has been used widely in needs assessment and formative research for program planning, there are few examples illustrating the utility of neighborhood mapping in evaluation research. The purpose of this paper is to demonstrate the use of neighborhood mapping in the context of an evaluation of an urban-based infant mortality prevention program. Neighborhood mapping is a process of collecting data through direct observations and from secondary data sources to describe the physical conditions of neighborhoods, the locations of institutions and resources, and the social and demographic characteristics of residents. Neighborhood mapping is also an analytic tool used to present data visually in order to observe the spatial distribution of neighborhood characteristics. This paper describes the use of neighborhood mapping in the community evaluation of Baltimore City Healthy Start, a federally funded infant mortality prevention initiative. Methods: The primary objectives of the community evaluation were to assess the nature of the local context (including physical and social features, community assets, and community concerns), which may influence program implementation and outcomes, and to study the nature and course of community-level change. Data on physical features were

collected by community residents during street-by-street neighborhood walkthroughs. Other data sources included the U.S. Census, Maryland Vital Records, the Baltimore City Liquor Board, and other routinely collected data from Baltimore City Planning Department. Analytic methods included geo-coding; factor analysis, which was used to create spatial density indicators of neighborhood features; and multiple regression. **Results:** We used neighborhood mapping to create visual displays based on address information of neighborhood features (e.g., locations of liquor stores) and program participation levels. We also assessed interaction between participation level and residential context, and we mapped baseline indicators to study the process and direction of neighborhood transformation. **Conclusions:** We suggest that these methods can strengthen evaluations by involving participants in data collection and engendering a more complete understanding of physical context as a research variable to better understand participant outcomes and create powerful visual displays of contextual data.

08–05 (A): Spatial Association Between Diabetes Prevalence and Neighbourhood Characteristics and Environments for Healthy Living in Toronto, Canada

Peter Gozdyra, Gillian Booth, Maria Creatore, Kelly Ross, Liane Porepa, Richard Glazier

Objective: Diabetes mellitus is rapidly increasing in prevalence in most developed countries, related in large part to unhealthy dietary patterns, lack of physical activity and resulting obesity. This project examines associations between diabetes and neighbourhood social and demographic characteristics. It also investigates relationships between diabetes and density of and geographic accessibility to sources of healthy and unhealthy foods, places facilitating physical activity and community-based health services in Toronto neighbourhoods. **Methods:** We analyzed the geographic distribution of age-sex adjusted diabetes prevalence rates in Toronto and their association with mean household income and percent visible minority populations using Pearson correlation coefficients. We further examined spatial associations between diabetes and grocery stores, convenience stores, parks and recreation centres, fast food outlets, and family doctors accepting new patients and diabetes community programs. Neighbourhoods were used as areal units for two types of accessibility analyses: 1) area density of each factor per capita, and 2) minimum average travel time to the closest factor by walking and/or public transit. Local Indicator of Spatial Association (LISA) analyses were conducted to examine spatial correlations between diabetes prevalence and accessibility to neighbourhood environments for healthy living. **Results:** High rates of diabetes coincided to a large degree with Toronto's low household income and high visible minority neighbourhoods (correlations -0.61 with income and 0.58 with visible minority populations, both p-values < 0.001). Clusters of high diabetes and poor accessibility to healthy factors (or good accessibility to the unhealthy factor) were mostly limited to low income and high visible minority neighbourhoods, but not all such neighbourhoods had poor accessibility and poor accessibility was found in a variety of different kinds of neighbourhoods. **Conclusions:** Diabetes in Toronto disproportionately affects low income and high immigration neighbourhoods, some of which have poor accessibility to resources of healthy living. These analyses represent inter-sectoral and multi-disciplinary approaches that can be used for planning community services and allocating resources to neighbourhoods and for policy development. Further study of diabetes rates and accessibility to neighbourhood resources for healthy living in low income and high visible minority neighbourhoods is warranted.

Policies and Interventions to Promote Social Justice

09–01 (A): Barriers to Disability Benefits for Homeless and Underhoused People

Laura Cowan, Sarah Shartal

The transition into and out of homelessness is affected by many factors, perhaps most importantly by the availability of affordable housing and people's incomes. Government disability benefits in Ontario (through the Ontario Disability Support Program) generally provide enough income for an individual with a disability to maintain stable, albeit marginal, housing. However, front-line staff working in the homeless community saw many homeless people living with disabilities. Street Health, a community-based agency providing services to homeless men and women, undertook an action research project to explore why many homeless people with disabilities did not receive benefits, and to assist people to secure benefits through the Ontario Disability Support Program (ODSP). **Methods:** A series of interviews were conducted with 85 homeless people with disabilities, and personal histories regarding disability and past attempts to secure disability benefits were created. Information was also gathered to inform current applications for disability benefits, and applications and appeals were made. **Results:** Several aspects of ODSP created barriers to accessing benefits for study participants. Many barriers to getting information and application forms for ODSP existed, such as participants' lack of telephone access (70%) and inability to follow automated telephone instructions (85%), which first contact with the system requires. The majority of participants (85%) were not able to fill out ODSP forms without assistance. Medical forms presented significant barriers for the majority of participants, e.g. 65% could not get clear diagnoses for their conditions. Characteristics inherent in the application process posed significant barriers, including the system's lack of accommodation of disabilities, and applicants' experiences of indignity and lack of respect throughout the process. Delays once applications were submitted were also important barriers to receiving benefits, as a total wait time of 8-9 months led many participants to lose housing or become increasingly ill waiting for benefits. 30 of the ODSP applications undertaken for this project have successfully secured benefits, while an additional 55 applications and appeals continue. **Conclusions:** There are multiple barriers at various stages of the ODSP application process that make it difficult for homeless people with disabilities to apply for and secure benefits. The findings from this study point to several recommendations for how to make ODSP more accessible, including implementing face to face interviews between applicants and program staff; making program workers available to applicants in accessible community spaces; reducing language and literacy barriers to applying; and reducing wait times for benefits.

09–02 (A): Dismantling Racism: Promoting Social Justice Through Individual Awareness, Institutional Policy Change and Institutional and Community Partnerships

Michael Yonas, Vanessa Jeffries, Mondi Mason, Mary Linker

Introduction: Research indicates that U.S. racial and ethnic groups continue to experience lower quality health services that perpetuate health disparities. In order to address these disparities, Chatham County Public Health Department (CCPHD) has implemented a comprehensive Dismantling Racism (DR) initiative. This report summarizes the process of implementing a DR process in a local public health department as a form of promoting social justice. **Methods:** Recognizing the need to examine the dynamics of race and power and its affect on health department staff and county residents, CCPHD contracted with ChangeWork, an independent consultant, to facilitate the DR process. Using an organizing approach, CCPHD focused its efforts on: (1) understanding racism and developing a common definition; (2) realizing how racism impacts Whites and People of Color; (3) understanding how racism impacts health disparities; and (4) developing an action plan to become an ant-racist organization. Multi-day trainings were conducted to examine the dynamics of institutional racism and power in U.S. society. A "Change Team", comprised of health department staff, community representatives, and academic partners, was established to organize around the DR process. "Caucuses", consisting of individuals from specific identity groups, met to collectively provide a forum for support, discussion and problem solving. Collaboration with university partners provided capacity for evaluation, the development of a surveillance system to monitor DR activities, and cultural competency training. **Results:** Results include: 1) institutionalized policy that requires all employees to participate in the DR training within the first year of employment; 2) development of an Action Plan to begin the process of transforming the organization at the individual, organizational, and institutional/community levels, and 3) participants continued involvement in the Change Team and Caucuses. Additionally, public awareness of the DR initiative has led to increased public perception of the CCPHD. The ongoing development of the Change Team, as well as institutional and community partnerships continues to expand support for and organize around the DR initiative and its goals. **Conclusion:** Although challenging, dedication of key leaders to the DR process has led to organizing and social change necessary to work towards social justice in the form of eliminating health inequities. Lack of consistent support from top leadership is a critical challenge but developing community allies in support the dismantling racism process has been a valuable component of continuing the efforts toward creating an anti-racist public health department. Benefits and challenges of maintaining academic and institutional partnerships will be discussed.

09–03 (A): Is the Public Ready? Understanding Public Attitudes Toward Federal Action to Reduce Inequalities in Healthcare – United States' Perspectives

Kalahn Taylor-Clark

Introduction: Federal policymakers and educational campaign planners have recently dedicated increasing attention to healthcare inequalities in the United States. These efforts come at a time when public interest in broad racially targeted government legislation is decreasing while support for greater healthcare spending is increasing. This paper explores the trend in public support for government action to reduce racial healthcare inequalities from 1995-2004, and disentangles the influence of two factors that have been shown in the literature to affect public attitudes in other areas, knowledge about inequalities and perceptions of causal responsibility. The goal of this presentation is to help campaign planners increase the public visibility of disparities and to offer insight for policymakers seeking to create sustainable racially targeted healthcare programs. **Methodology:** I use national survey time series data from Kaiser Family Foundation/Washington Post and Harvard University from three points in time (1995, 2001, 2004). Cross tabulations show main independent variable, demographic and political party differences in support for federal action to reduce inequalities. Three binary logistic regressions regress support for government action on the main independent, demographic, and political party variables. **Results:** There is a significant and declining trend in public support for federal intervention to deal with racial inequalities in healthcare. Further, although knowledge about the existence of inequalities has increased over time, knowledge does not seem to significantly influence overall support. Respondents who believed that discrimination against African Americans is the most important reason that healthcare inequalities exist were most likely to say that the government should do something to ensure that African Americans have equal quality healthcare services as Whites. Further, people who don't know why inequalities exist and people who believe that patient behavior (i.e. not seeking care enough or not following physicians' recommendations) is the major reason for inequalities in healthcare were the least likely to say that the government should be responsible for dealing with the problem. Finally, most people cited access/structural causes (i.e. poverty or residential segregation) as the major reason for the existence of inequalities. This belief conferred increased support for federal action. **Conclusion:** Policy advocates seeking to raise the profile of inequalities in healthcare should be aware that the public's mood toward race targeting may challenge the viability of proposals. Also, campaign planners seeking to increase support for federal efforts should consider publicly exposing discrimination and access problems associated with inequalities in healthcare.

09–04 (A): Recognition of Sexual Diversity in Urban Health Policy

Nick Mulé

Introduction: This paper focuses on the micro aspect of a large qualitative, international comparative research study that looked at the degree of recognition accorded to lesbians, gays and bisexuals (LGBs) in public health promotion policies. The study compared Canada, the UK and USA, focusing at the micro level on Toronto, Manchester and New York City. The purpose was to determine whether sexually diverse individuals were recognized as a distinct population with unique and specified health needs within formalized municipal health policy. **Methods:** This study was conducted between 2001 and 2003, in which data were gathered via content analysis of existing governmental public health promotion policies and semi-structured interviews carried out with policy makers in the municipalities of Toronto, Manchester and New York City. Macro-sociological discourse analysis was then applied to the gathered data in determining results, implications and recommendations. **Results:** Recognition of LGBs as

distinct populations in policy was found in the equity realm in all three urban centers, with Bs being absent from one. Although, inclusion of sexually diverse populations in municipal equity policy is seen as progressive, particularly in comparison to policies at other governmental levels of these countries, municipal level public health promotion policies generally lack the infusion of these populations with regard to funding, programming, services and structural integration. **Conclusion:** The municipal level of government presents as the most promising of all levels of government researched in each of the three countries studied regarding recognition of sexually diverse populations in policy. Recognition within the equity realm nevertheless, does not necessarily extend to public health promotion policy to address the unique and specified health and wellbeing issues of sexually diverse populations, particularly outside of HIV/AIDS, in an infused manner. The implications of these findings speak to specialized sexually diverse health service organizations and programs and their need to advocate for improved policy recognition and municipal support, policy makers and their need to be more inclusive in policy development and implementation and the sexually diverse communities themselves to question why their broad health and wellbeing issues are not being equitably addressed.

09–05 (A): Pharmacists As Health Service Linkages: Expanding Service Referrals to Injection Drug Users Through the Expanded Syringe Access Program, New York City, 2001–2004

Wendy Caceres, Shannon Blaney, Nirali Shah, La Roux Pendleton, Katherine Standish, David Vlahov, Crystal Fuller

Introduction: The Expanded Syringe Access Demonstration Program (ESAP), effective in 2001 in New York State, permits sale of syringes without a prescription with the goal of reducing HIV and other infectious disease transmission by increasing sterile syringe access among injection drug users (IDUs). The New York Academy of Medicine in collaboration with Beth Israel and the National Development and Research Institutes evaluated the program. The ESAP evaluation and a community based participatory research intervention to increase ESAP participation in Harlem suggest that the pharmacist-patient relationship has potential to reduce disparities in access to healthcare and drug treatment for IDUs in much the same way syringe exchange programs have done. **Methods:** As part of the evaluation, annual anonymous cross sectional telephone surveys of pharmacists in New York City assessed attitudes and practices around pharmacy syringe sales between 2001-2004. **Results:** Each year following the inception of ESAP, pharmacists' negative attitudes, namely beliefs that the community would be littered with dirty syringes due to ESAP (55%, 49%, 43%, 43%), that their business would suffer because customers would not want to wait in line with IDUs (40%, 37%, 34%, 25%), and that their business would suffer because the community would think that their pharmacy encourages drug use (39%, 33%, 31%, 24%, Cochran-Armitrage test for trends $p<0.01$, $p<0.0001$, $p<0.0001$ respectively), significantly declined. Pharmacists' positive attitudes such as support of in store pamphlets on safe injection (70%, 82%, 94%, 95%), and beliefs that selling syringes to IDUs is an important part of HIV prevention (72%, 76%, 80%, 85%), and would decrease HIV transmission (75%, 78%, 85%, 86%, Cochran-Armitrage test for trends $p<0.0001$ for all) significantly increased from 2001-2004. In the 2004 survey, 88% of ESAP pharmacists were willing to take time to offer drug treatment information (n=153), about half believed the customers would be willing to receive this information and about 59% reported having had a conversation with IDUs (n=138) with injection safety and drug treatment being the most common topics. **Conclusion:** The increase in supportive attitudes of pharmacists towards ESAP and their willingness to spend extra time with syringe purchasing customers, suggests that pharmacists could play a key role in linking underserved populations, in this case IDUs, with available health and social services in the community. The design and implementation of a feasibility project utilizing pharmacists as linkages to health and social services is underway with community partners.

Urban Crises

10–01 (A): Surmortality Related to the August 2003 Heat Wave. An Ecological Study of Socio-Economic Factors in Paris (France)

Emmanuelle Cadot, Alfred Spira

Introduction: During the August 2003 heat wave in France, almost 15,000 excess deaths were recorded. Paris was severely affected with 1,067 excess deaths corresponding to an excess death rate of 190%. The aims of this ecological study was to describe spatial distribution of deaths within Paris and to examine the impact of neighborhood socio-economic characteristics on the excess death rates according to the place of residence. **Methods:** The study population included all people who died between August 1st and 20th, 2003 and during the same period in reference years (2000, 2001, 2002). Spatial heterogeneity in mortality distribution was analysed by calculating standardized mortality ratio (SMR) within Paris at quartier level (N=80). Households' average income and the two classical Carstairs and Townsend deprivation index were used as indicators of socio-economic status. The analysis is based on an hierarchical bayesian model at the quartier level. **Results:** Large differences were observed in SMR computed by quartier of residence. Maps showed a gradient of excess deaths increasing from the north-west to the south-east in 2003 and a classical zone of excess deaths in the north-east during reference years. We therefore observed a shift in excess mortality towards the South in August 2003. Contextual socio-economic conditions had a significant impact on mortality both during heat wave and referral years. The principal contextual factor in August 2003 was the households' average income: between the richest and the poorest districts, the relative risk of mortality was 0.60 [0.49-0.74]. However, during the heat wave, the socio-economic factors impact was weaker than during the reference years. Analysis of residual relative risks of mortality underlined the finding that the excess deaths observed in the south part of the town were not well explained. **Conclusions:** Spatial distribution of the excess deaths observed in August 2003 generated a new map of the capital. The impact of socio-economic context independently of the individual socio-demographic characteristics was proved. These results suggest that the heat wave was not simply the consequence of high temperature. They confirm a double level of risk during heat wave: individual and contextual, and that both must be taken into account to understand the effects of a heat wave on mortality and its prevention.

10–02 (A): **High Rise Building Evacuation: Lessons Learned From the World Trade Center Disaster**

Robyn Gershon, Kristine Qureshi, Melissa Erwin, Marcie Rubin, Martin Sherman

Introduction: In an urban setting, the number of occupants of both residential and business high rise buildings can be considerable; in New York City alone, there are more than 2,000 high rise office buildings. Since most fire safety plans rely upon "defend-in-place" tactics, the plans for full building evacuation are usually not detailed or even addressed. Fortunately, very few high rise buildings experience catastrophic events that necessitate a full evacuation, and even in those that occur, data from evacuees is rarely, if ever, collected. Consequently, we know very little about the facilitators and barriers to high rise building evacuation. **Methods:** A large sample of evacuees from the World Trade Center, Towers 1 and 2, were surveyed as part of the World Trade Center Evacuation Study, using a confidential, 10 page, 95 item questionnaire. **Results:** Data from the first 700 respondents to the survey indicate that a number of individual, organizational and structural (environmental) factors served as barriers to the initiation and progression of the evacuation process. Frequently cited individual barriers included: (1) lack of familiarity with the safety features of the building, including stairwell locations; (2) searching for personal articles, colleagues, friends, or someone to evacuate with; (3) waiting for directions (lack of independent behavior); (4) inappropriate footwear; and (5) poor physical condition or current health problem. Organizational barriers included: (1) lack of training and practice in evacuation, only 25% of respondents had ever fully evacuated the building, most during the 1993 bombing; (2) lack of empowerment of individual employees to act independently; (3) poor delineation of training responsibilities; (4) lack of planning for the disabled- especially when elevators were inoperable; and (5) lack of planning at the street level. Structural barriers included: (1) lack of back-up or alternative communication systems; (2) locked egress (security lock-out); (3) poor design at cross-over points in stair wells; (4) failure of emergency egress systems inside the elevators. **Conclusion:** A number of modifiable risk factors at the individual, organizational, and structural levels were identified. Fire safety planning for high rise occupancies should address all aspects of full building evacuation, with a special emphasis on the factors identified here. The lessons learned from the WTC Disaster can be useful to building owners and managers, emergency responders, city planners and developers, and high rise occupants.

10–03 (A): **Hurricane Katrina, the Race/Class Conundrum and the Triumph of Neoliberalism in U.S. Politics**

Adolph Reed

11–01: **Panel: Community, Professional, and Scientific Collaboration for Environmental and Social Justice in the South-West of Spain**

Aurelio González, Janet Howitt, Antonio Muñoz, Joan Benach

In Spain, during the last decade despite increased social concerns and occupational, environmental, and health care government regulations, social inequalities in health are large (i.e. 35.000 excess of deaths estimated annually among the economically deprived populations) and have grown in recent years. While areas of Andalusia have recently benefited from the development and economic growth that has brought investments on tourism, services and industries, in the early 60s many undesirable industries (high pollution and poor working conditions) were located in these poorer areas because the land and labor were inexpensive, and under Franco's dictatorship communities lacked political power to oppose them. Today, in western Andalusia the significance of existing pollution and environmental threats associated with many industries is such that an environmental group has raised a formal complaint to the European Commission. To understand why polluting industries, occupational hazards and social factors are consistently situated in specific communities, it is necessary to look upstream. To remedy public health consequences of this situation it is necessary that communities downstream be empowered to understand and participate more effectively in determining their own futures. Therefore, an integrated and cross-disciplinary research approach is needed. Community members often feel frustration when these concerns fail to be satisfied by findings of scientific studies and non accomplished political promises. Only an integrated approach, involving both scientists and communities will provide a broad picture able to obtain proper explanations and action against adverse health effects and environmental contaminants. While each community needs to generate local responses according to their specific environmental and social problems, a number of general lessons may be drawn from the public health crisis faced by the south-west of Spain. In this panel we'll describe the health problems of a number of municipalities, we'll illustrate the struggle for justice taken by environmentalists and citizens that want to protect environment and human health, and we'll explain grassroots activities and strategies of civil and environmental movement which fight against economic and political interests that benefit from the lack of power of citizens.

Global Urban Health

12–01 (A): **The Urban Environment From the Health Perspective: The Case of Belo Horizonte, Minas Gerais, Brazil**

Waleska Caiaffa, Fernando Proietti, Maria Cristina Mattos, Amélia Augusta Friche, Sônia Mattos, Maria Angélica Dias, Maria da Consolação Cunha, Eduardo Pessanha, Claudia Oliveira

Introduction: We determine spatial patterns of mortality and morbidity of five major health problems in an urban environment: homicides, pregnancy among adolescents (<20 years old), asthma hospitalization in children <5 years old and two mosquito-borne diseases - dengue and visceral leishmaniasis. **Methods:** The ecological study was conducted in Belo Horizonte, the third largest city in Brasil, with about 2.5 million inhabitants. All events were obtained through the City Health database and geoprocessed using the address of residence and 80 unit of planning (UP) composed by census tract units. We use thematic maps, index of comparative mortality/morbidity by UP and the overlapped rank of the 20th worse UP rates for each event. **Results:** A spatial pattern of high rates of homicides, proportion of young mothers and hospitalization of asthma were overlapping in areas social and economically disadvantaged. For mosquito-borne diseases, high rates with great dispersion were found in unprivileged areas in contrast with very low rates among privileged ones. **Conclusions:** Our results pointed toward a coexistence of heavier

10:30 am – 12:00 pm **Tour of Local Community Organizations**

Location Please assemble in the Metropolitan Grand Ballroom Foyer

12:00 pm – 1:45 pm **Luncheon**

Location Metro West Ballroom

1:45 pm – 3:15 pm **Breakout Session 2**

- Community Stream – Peer-Led Harm Reduction Location Pier 2
- Community Stream – Advocacy for Social Justice in Urban Health Location Pier 3
- Academic Stream – Urban Neighbourhoods Location Metro Centre Ballroom
- Academic Stream – Policies and Interventions to Promote Social Justice Location Bay
- Academic Stream – Urban Crises Location Metro West Ballroom

1:45 pm – 3:15 pm **Tour of Local Community Organization**

Location Please assemble in the Metropolitan Grand Ballroom Foyer

3:15 pm – 3:30 pm **Refreshment Break**

Location Metro East Ballroom

3:30 pm – 5:00 pm **Breakout Session 3**

- Community Panel: Community Health and Social Justice - Community, Professional, and Scientific Collaboration for Environmental and Social Justice in the Southwest of Spain
  Location Metro West Ballroom
- Academic Stream – Global Urban Health Location Metro Centre Ballroom
- Academic Stream – Homelessness and Housing Location Pier 2
- Academic Stream – Mental Health Location Bay
- Academic Stream – Gender and Urban Health Location Pier 3

3:30 pm – 5:00 pm **Tour of Local Community Organizations**

Location Please assemble in the Metropolitan Grand Ballroom Foyer

FRIDAY, OCTOBER 28, 2005

8:00 am – 9:00 am **Poster Session III and Continental Breakfast**

Location Metro East Ballroom

8:00 am – 9:00 am **Annual General Meeting of the International Society for Urban Health**

Location Bay

9:00 am – 10:30 am **Plenary Session**

Location Metro Centre Ballroom

10:30 am – 10:45 am **Refreshment Break**

Location Metro East Ballroom

10:45 am – 12:15 pm **Breakout Session 4**

- Community Stream – Innovative Youth Engagement Location Pier 3
- Community Stream – Community-University Partnerships Location Metro Centre Ballroom
- Academic Stream – Environmental Justice Location Pier 2
- Academic Stream – Immigrants and Urban Health Location Bay
- Academic Stream – Injection Drug Use in Urban Settings Location Metro West Ballroom
- Academic Stream – HIV Intervention and Risk Reduction Strategies Location Pier 7&8

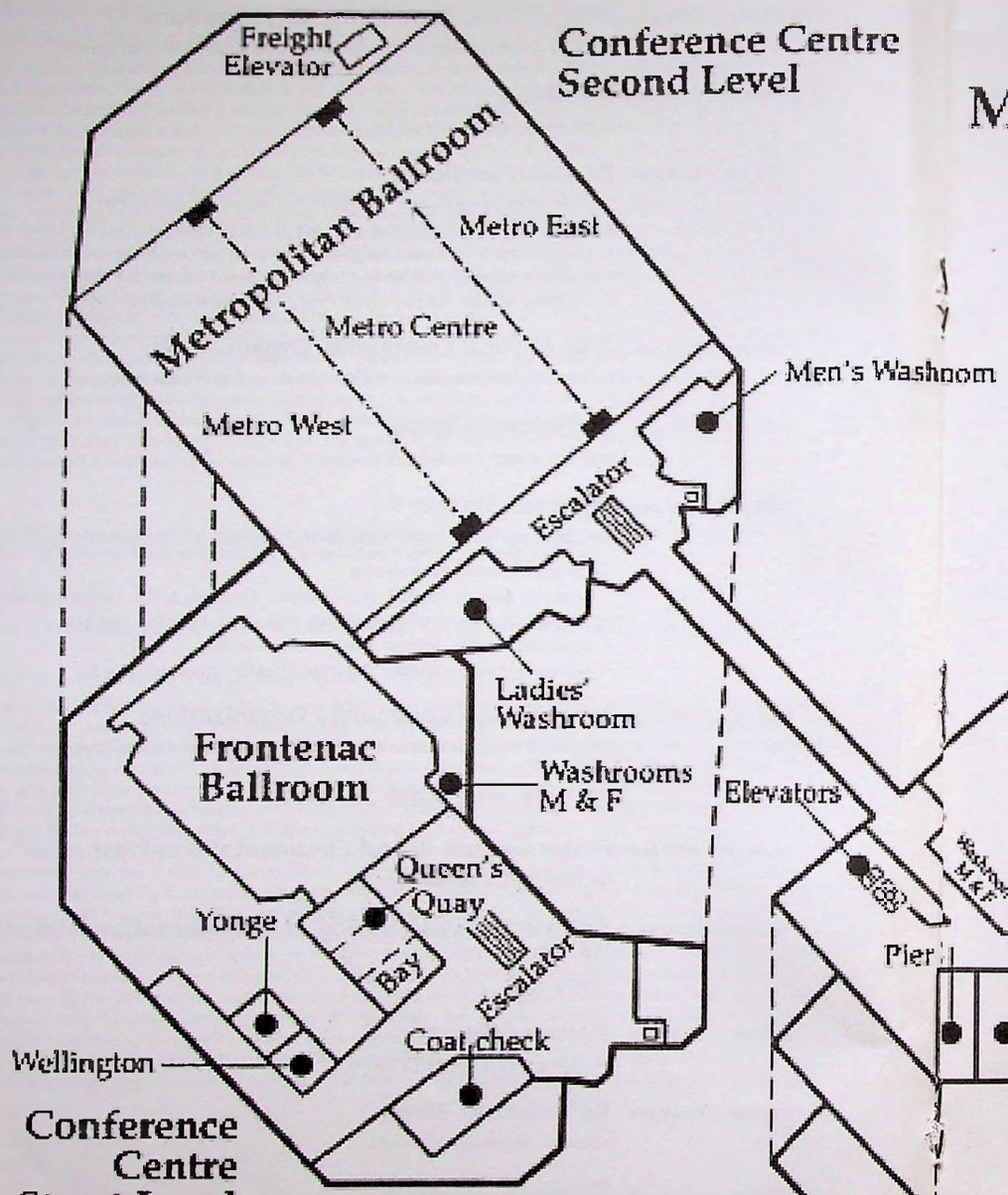
12:15 pm - 1:30 pm **Closing**

Location Metro Centre Ballroom

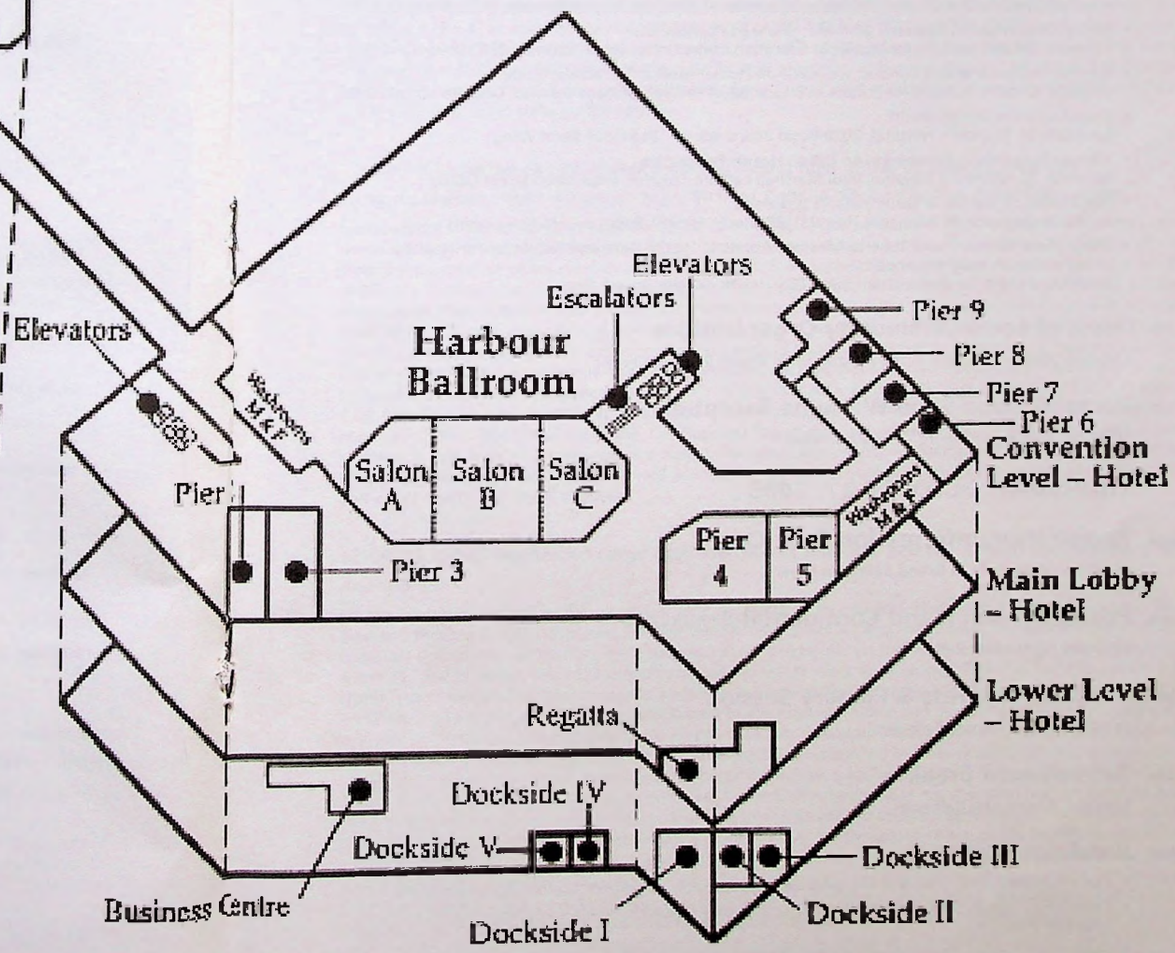
Meeting and Banquet Facilities

THE WESTIN HARBOUR CASTLE
Toronto

Conference Centre Second Level



Conference Centre Street Level



Westin Harbour Castle Floor Plan

PROGRAM at a Glance

WEDNESDAY, OCTOBER 26, 2005

9:00 am – 7:00 pm **Registration/Information Desk Open**
Metropolitan Grand Ballroom Foyer

Pre-Conference Workshops

12:00 pm – 4:00 pm
- Learning the Research Talk: Introduction to Research Methods, Concepts and Jargon
  Location Wellesley Central Health Corporation
- What's all this Talk about Community-Based Participatory Research? Building Sustainable Capacities for Urban Health Research Partnerships
  Location The Ontario HIV Treatment Network (OHTN) 1300 Yonge Street

1:00 pm – 4:00 pm
- Into the Neighborhood - Mission Barrio Adentro: A Venezuelan Success Story on Bringing Health Care to the Marginalized
  Location Ontario Institute for Studies in Education of the University of Toronto, OISE: Room OI- 2295
- Addressing Urban Health Needs: Toronto Public Health Practice Framework
  Location Ontario Institute for Studies in Education of the University of Toronto, OISE: Room OI-2281
- Ethical Challenges in Research with Marginalized Populations
  Location Ontario Institute for Studies in Education of the University of Toronto , OISE: Room OI -2279
- How to Understand and Conduct Research on Homelessness: A Practical Guide
  Location Ontario Institute for Studies in Education of the University of Toronto, OISE: Room OI- 2296
- Introduction to Urban Health
  Location St. Michael's Hospital, 2010 Bond Board Room - 2nd Floor Bond Wing
- Introductory Health Economics: An Urban Health Perspective
  Location St. Michael's Hospital, Paul Marshall Lecture Theatre, (at) Queen Street Lobby
- The Politics of the Social Determinants of Health
  Location Opposite St. Michael's Hospital, 38 Shuter Street - Room B-1245 (Basement)
- Using Distance and Travel Time to Measure Access to Health Care and Resources for Healthy Living in Urban Neighbourhoods
  Location Centre for Research on Inner City Health - Conference Room

1:00 pm – 4:00 pm **Tours of Local Community Organizations**
Location Please assemble in the Metropolitan Grand Ballroom Foyer

5:00 pm – 7:00 pm **Poster Session I and Welcome Reception**
Location Metro East/Metro Centre Ballroom

THURSDAY, OCTOBER 27, 2005

7:30 am – 5:00 pm **Registration/Information Desk Open**
Location Metropolitan Grand Ballroom Foyer

7:30 am – 8:45 am **Poster Session II and Continental Breakfast**
Location Metro East Ballroom

9:00 am – 10:15 am **Welcome Address & Plenary Session**
Location Metro Centre Ballroom

10:15 am – 10:30 am **Refreshment Break**
Location Metro East Ballroom

10:30 am – 12:00 pm **Breakout Session 1**
- Community Stream – HIV and Marginalized Populations Location Metro Centre Ballroom
- Community Stream – Community-Based Participatory Research: Barriers and Facilitators
  Location Pier 3
- Academic Stream – Conceptualizing and Measuring Social Justice Location Pier 2
- Academic Stream – High-Risk Youth Location Bay
- Invited Panel – Urban Income Inequality and Health Location Metro West Ballroom

burden of diseases for those living in areas of the city where misery, poverty, lack of political public health may be modulating social health problems. A possible environmental intervention in one mosquito-borne disease might be playing a role in the occurrence of other. This study may provide useful information for a joint urban planning, articulated for use in health impact assessment.

12–02 (A): Sexual Behaviors of Street Children in Lahore, Pakistan: The Risk of Survival

Susan Sherman, Christopher Martin, Salman Quereshi, Tariq Zafar

Background: There are an estimated 5,000 street children in Lahore, Pakistan, a disproportionate number whom engage in risky sexual behaviors that place them at risk for such deleterious outcomes such as victimization and HIV/STIs. Understanding the extent and nature of these children's sexual practices and how sex functions in their life can inform interventions that address the root causes and consequences of unsafe sexual practices. **Methods:** Since August, 2003, Project SMILE has provided food, medical care, and social support to street children on a mobile van daily throughout Lahore, Pakistan. All recipients of services filled out a brief registration form which included demographic information, drug use patterns, and sexual behaviors. The current analysis describes the sexual behaviors of all registrants, comparing variables of interest between those who have and have not had sex. A multivariate logistic model examines correlates of ever having had sex. As 96% of participants were male, the current analysis is restricted to boys (n=604). **Results:** Participants were a median of 13 years old and 53% had no formal education. The median length of time living on the streets was 18 months and 80% primarily slept on the streets, as opposed to their parents' home. Forty-one percent of the sample reported ever having had sex and of those, 65% reported having had recent (in the past 3 months) sex with a man and 81% reported recent sex with boys their own age. The median age of sexual debut was 10 years old (IQR: 9, 11). Of those who reported having had sex, 94% had exchanged sex for shelter, food, or entertainment, 62% reported having had sex with men, and 80% had had sex with boys. In the presence of other variables, correlates of having had sex were: months spent on the street (AOR: 1.20; 95% CI: 1.10-1.50), ever having used drugs (AOR: 2.90; 95% CI: 1.629-5.175), and ever having been arrested (AOR: 1.554; 95% CI: 1.079-2.238). **Conclusions:** Having sex is prevalent among very young street children in Lahore and is part of a constellation of risky survival and coping mechanisms. Rising rates of HIV have been documented in Pakistan in the past few years, and street children will be one of the first groups to bear the brunt of the disease burden. Targeted programs towards men who take advantage of street children's vulnerability as well as those targeting street children are needed.

12–03 (A): Reported Use of Violence Among Young Men in Dar es Salaam, Tanzania

Suzanne Maman, Fiona Kouyoumdjian, Richard Kaballa, Melissa Roche, Jessie Mbwambo

Introduction: Violence has been demonstrated to be a risk factor for various negative health outcomes, recently including HIV. Given the magnitude of this public health problem, relatively little is known about the epidemiology of violence, in particular from the perspective of young men in developing country contexts. **Methods:** Men between the ages of 16 and 24 living in Dar es Salaam, Tanzania, were enrolled in an intervention study aimed at reducing violence and HIV risk behaviours between May and August 2004. Baseline data for the study were analyzed using Stata 7.0. **Results:** 949 men were enrolled in the study. More than 10% (101) men reported a history of childhood sexual abuse, and 42.7% (406) reported serious physical violence in childhood. Almost half (46.14%) of men reported feeling that it is acceptable for a man to beat his partner in specific situations. Of the 660 men who reported having had intercourse, 23.2% (153) reported having been sexually or physically violent ever with a sexual partner. Odds of violence was higher in those men with a history of sexual (OR 1.90; OR: 1.15-3.00) and physical (OR 1.89; 95% CI 1.30-2.75) violence in childhood, and in those men who reported thinking that violence was acceptable under many conditions (OR 3.27; 95% CI 1.29-8.29). **Conclusions:** Young men at the beginning of their sexual lives report a history of violence, a high level of acceptance of violent behaviours, and common physical and sexual violence with sexual partners. Ongoing basic epidemiologic data as well as innovative interventions are required to reduce violence and thereby the risk of HIV and other health and social sequelae.

12–04 (A): Urban Health in a Large city: The Case of Mumbai, and the Role of the Voluntary Sector

Anant Bhan

Mumbai experienced the heaviest rainfalls ever experienced by any part of India in a single day on July 26, 2005. Many people died and thousands were displaced and lost their property, homes and livelihoods. The sudden rise of floodwaters disrupted the transport system and commuters were stranded at various points on the roads for hours on end in pouring rainfall and without access to food or water. Since the airport and railway tracks were also flooded, Mumbai became cut off from the rest of the world. The collapse of cellular networks added to the misery. The response of the government machinery and also the public health authorities was slow and this contributed to the high morbidity and mortality. Information was not readily available and the crisis response cell was not able to do an effective job. Hospitals became over crowded and an outbreak of leptospirosis occurred. Panic buying of antibiotics by a misinformed population led to unavailability of crucial drugs, as well as unnecessary ingestion of antibiotics, which have doubtful prophylactic value for leptospirosis. The exaggerated coverage of health problems by the media also caused widespread confusion. Correct information was not available and an attempt was made to conceal the truth to protect the government's image. The case of the Mumbai floods is a symptom of the malaise of lop sided development in a urban economic centre in the developing world, as well as the failure of the public health system in settings where governments are withdrawing from public services like education, health under the guise of 'reforms' being pushed by the neo-liberal economic world order. The impact of the floods was most on disadvantaged populations like those living in slums in low lying areas who had nowhere to escape, and on women and children, a phenomenon observed also in last year's Tsunami. Social justice, gender, equity, effect of environment are all at play in this paradigm. While Mumbai is back to 'normal' today, the experience of 26/7 should be a pointer to structural failures in urban governance and public health, which lead to such a high toll during disasters. A complex web of factors influences urban health and there are lessons to be learnt from such experiences to be able to respond much more effectively in the future.

Homelessness and Housing

13–01 (A): The Aging of the Homeless Population: Fourteen-Year Trends in San Francisco

Judith Hahn, Margot Kushel, David Bangsberg, Elise Riley, Richard Clark, Andrew Moss

Introduction: Homelessness is associated with high rates of health and substance use problems. The number of homeless persons has increased in the past 25 years, as have emergency shelter capacities and free meal programs, yet only one study has examined trends in the homeless population. **Methods:** We examined trends in fourteen years of cross sectional studies of homeless adults (age 18 and older) that were conducted at homeless service providers in San Francisco, from 1990 to 2003. We limited the analysis to those who were literally homeless (defined as spending any nights in a shelter or outside), and were sampled at any of four shelters and two meal programs that were visited repeatedly across the time periods. The sample size for analysis was 3534. **Results:** In the study period, the median age increased from age 37 to 46, at a rate of 0.66 years per calendar year (p=50) homeless were in poorer health while using fewer drugs and alcohol. **Conclusions:** The homeless population as a whole is getting older and experiencing more outdoor living and chronic homelessness. The aging phenomenon seen in our sample is consistent with trends seen in several other cities. This effect is consistent with a static cohort. Without a substantial influx of new homeless persons, an intervention such as supportive housing, which aims to house the difficult to house chronically homeless, could result in a significant lessening in the total numbers of homeless. These results also indicate that homeless health and service providers need to plan for the medical conditions associated with the aging and increasing street living among the homeless.

13–02 (A): Risk Behaviours For Sexually Transmitted Infections (STIs) in Canadian Street Youth: Does Time Spent On The Street Matter?

Olayemi Agboola, Jennifer Suishansian, Maritia Gully, The ESCSY study group

Introduction: Street youth (SY) maybe more preoccupied with meeting their daily basic needs than with concern for health risks; for most, this is the risk they have to face just to survive. Their life style may predispose them to engage in high-risk behaviours such as unprotected sex, sex with high risk partners and multiple sex partners that increase their risk of contracting and transmitting STIs. **Methods:** The Enhanced Surveillance of Canadian Street Youth (ESCSY) is a repeated cross-sectional survey that monitors STI prevalence and associated risk behaviours among SY aged 15-24 years. In 2003, youth who were able to speak either French or English and had been absent from their parent's/caregivers' residence for at least three consecutive nights took part in the survey which consisted of interviewer-administered questionnaires. Participants were recruited from drop in centres in 7 cities across Canada.Youth self-reported time spent on the streets. Statistical analyses were carried out using SAS version 8. **Results:** 1656 SY were recruited in 2003. 60.2% reported spending all the time on the streets in the past month while 39.8% reported spending some of the time on the streets. Mean age was 19 years. SY who reported spending all the time on the streets had on average more lifetime sexual partners (32 vs.20) and more partners in the past 3 months (4 vs.2) than those who reported spending some of the time on the streets. SY who reported spending more time on the street were more likely to report using injection drugs (29.8% vs. 15.6%, p <.0001), to binge drink in the past three months (42.5% vs. 31.4%, p=0.0001), to report ever being obligated to have sex (20.1% vs. 15.3%, p=0.008), to ever trade sex (22.3% vs. 18.1%, P=0.05), and to have sexual partners that use injection drugs (82.6% vs. 73.6%, P=0.0002) and non-injection drugs (18.9% vs.5.3%, P=<.0001). They were also less likely to report using condoms with male sexual partners (18.9% vs.5.3%, P=<.0001). **Conclusions:** SY may become initiated and engage in high risk behaviours the more time they spend on the streets. Programs aimed at getting youth off the street in the least amount of time would help to alleviate this problem. Effective interventions for STI prevention need to be developed targeting this section of the nation's youth. Harm reduction approaches including information about safe sexual behaviours and safe drug use, also needs to be available to street youth.

13–03 (A): Access to Health Care for Homeless People with Serious Health Conditions in Toronto, Canada

Stephen Hwang, Shirley Chiu, Erika Khandor, Kate Mason, Laura Cowan, George Tolomiczenko, Alex Kiss, Marko Katic, Donald Redelmeier, Wendy Levinson

Introduction: Homeless people have poorer health status than the general population and often experience difficulties obtaining needed health care. However, little information is available on homeless people's access to care under Canada's system of universal health insurance. This study examined access to health care among single homeless persons in Toronto who reported having a serious health problem. **Methods:** Recruitment of randomly selected homeless persons took place at 55 shelters and 23 meal programs in Toronto, Ontario. Enrollment at each site was proportionate to the number of unique homeless individuals using the site each month. Enrollment was stratified by sex to allow oversampling of women. Between December 2004 and March 2005, 360 homeless persons unaccompanied by dependent children were interviewed. Participants were asked if they had any of 22 serious health conditions, including cardiovascular and respiratory diseases, hepatitis and other liver diseases, gastrointestinal ulcers, diabetes, anemia, epilepsy, cancer, and HIV/AIDS. Data were obtained on demographics, usual sources of health care, barriers to obtaining care, and recent experiences with health care providers. **Results:** Analyses were based on the 198 participants (55% of the total sample) who reported having at least one serious health condition. Of these individuals, 31% were female; 26% were aged 16-24, 55% were aged 25-49, and 19% were aged 50-70. Median monthly income was C$300. More than one serious health condition was reported by 63%. Although only 12% of the Canadian general population does not have a primary care provider, 33% of homeless individuals had no usual source of care or used an emergency department as their usual source of care. Within the last two years, 50% of homeless persons reported not following their clinician's advice or treatment plan at least one time; 35% of these individuals stated that the plan was too difficult to follow and 25% cited the cost of treatment. Within the last 12 months, 31% reported a health care visit in which they felt they were judged unfairly or treated

with disrespect because they were homeless. **Conclusions:** Despite Canada's system of universal health insurance, many single homeless persons in Toronto who have serious health conditions have no regular primary care provider. Discrimination on the basis of homelessness is a commonly reported barrier. Because adequate income and housing are central to enabling access to health care, social programs and policies should be re-examined to ensure that all Canadians can benefit from the health care system.

13–04 (A): Women Sleeping Rough: Health Outcomes After Five Years On the Streets of Boston, 2000–2004

James O'Connell, Jill Roncarati, Stacy Swain

Purpose: The obstacles to health care faced by women who live on the streets (rough sleepers) are daunting. A dearth of literature exists concerning medical illnesses and health outcomes of urban female street dwellers. Previous efforts to care for this population have been limited to acute and episodic interventions and lack of continuity. The Boston Health Care for the Homeless Program (BHCHP) utilizes a multidisciplinary team to offer comprehensive and consistent care directly on the streets. The Street Team works with outreach teams from shelters, conducts hospital-based clinics and provides specialty and inpatient care at Massachusetts General Hospital (MGH) and Boston Medical Center (BMC). Immediate access is available directly from the street to dual diagnosis detoxification units as well as BHCHPs 90-bed medical respite. **Methods:** In January 2000, a cohort of 119 high-risk persons was identified including 28 women. The entire cohort was identified from over 800 street persons cared for by the Street Team. All persons in this cohort were over age 18, had lived on the streets for at least six months, and met at least one of several criteria for increased morbidity and mortality. 88% of the high-risk cohort suffer from the tri-morbidity of chronic medical illness, major mental illness, and active substance abuse. Data is recorded on each patient at a weekly meeting. Other data sources include BHCHPs electronic medical record, hospital records, and a supplemental street database maintained by the team. **Results:** After five years, we identified the whereabouts of all 28 women: 5 (18%) are deceased, 1 (3%) is in a nursing home, and 2 (7%) are in recovery programs. 16 (57%) are housed or living fulltime with families. Only 4 (14%) remain on the streets. Only one woman did not have health insurance. The average age was 46 years, and the demographics included 23 (80%) White, 3 (11%) Black, 1 (3%) Native American, and 1 (3%) Hispanic. Cirrhosis was the cause of 3 deaths, 1 woman died of Huntington's Disease and another from suicide. **Conclusions:** Mortality and morbidity are high among those living on the streets. BHCHPs service delivery model provided continuity of primary and preventive care to a high-risk cohort of women sleeping rough, with primary care outcomes comparable to those achieved for the sheltered homeless population receiving care from BHCHP. The Street Team offers a model of street care for cities seeking strategies to reach this vulnerable and disenfranchised population.

13–05 (A): Homelessness Following Eviction in Amsterdam

Matty de Wit, Igor van Laere, Theo Sluijs

Introduction: To combat the problem of homelessness in Amsterdam, a study was conducted to answer the following questions: - What households are evicted and how many end up homeless? - What is done to prevent eviction? - What is done to prevent long-term homelessness of evicted households? **Methods:** Data were collected through interviews with all parties involved in evictions. Questionnaires about characteristics of all households at risk were completed by housing corporations and nuisance coordination centers. Structured interviews were held with 120 recently (<2 years) homeless persons about their first period of homelessness. **Results:** The number of evicted households in Amsterdam is increasing. In 2003, 1300 households were evicted; 90% because of rental arrears, 5% due to nuisance and 5% to illegal occupation. The majority of evicted households consisted of single men (56%); 16% included children. For households with rental arrears, only a minority of housing corporations paid house visits. These corporations have a lower percentage of evictions (23% versus 38%). Housing corporations do report to be aware of social and medical problems in a substantial part of the households with rental arrears (alcohol: 4%, drugs 7%, psychiatry 12%). However, the only assistance offered is a written referral to financial help. From the households evicted because of rental arrears, for only 17% the destination after eviction is known, of which 18% become homeless immediately. For nuisance households, a preventive network approach exists, resulting in more contact with care providers and more information on the underlying problems and destination after eviction. Of the recently homeless persons, 39% lost their last housing due to eviction. One third of the recently homeless stayed with friends immediately after loosing their home, 25% slept outside and 21% in a shelter. Within three months after loosing their home, 71% slept outside or in a shelter. **Conclusions:** Little assistance is offered to those evicted because of rental arrears, even though housing corporations are aware of underlying problems. Home visits can help in decreasing the number of evictions. For the majority of evicted households, no information on their whereabouts after eviction was available, implying that no help is offered to prevent them from becoming and remaining homeless. Implications A pilot project has now started for active outreaching help to households with rental arrears, similar to the network approach for nuisance households. Two projects have started to stimulate a quick return back to society for the recently homeless.

Mental Health

14–01 (A): Stressful Neighborhoods and Depression: An Examination of 25 Metropolitan Areas in Canada

Flora Matheson, Rahim Moineddin, James Dunn, Maria Creatore, Piotr Gozdyra, Richard Glazier

Objective: Both sociological and epidemiological research indicate that features of the social environment in which we live are important predictors of healthy lives. In this study we adopt an ecological approach to examine the association between

environmental stress at the neighborhood-level and prevalence of depression. Methods: Rates of depression for each neighborhood (census tract) are derived from the 2001 Canadian Community Health Survey, a national Canadian probability sample of approximately 49,743 respondents living in 3,224 urban census tracts. Measures of environmental stress and control variables are derived from the 2001 Canada census. Using factor analysis of census data we developed two measures of neighborhood stress - neighborhood instability and material deprivation. Factor analysis further identified two additional neighborhood characteristics, ethnic diversity and social dependency that might act as protective agents. **Results:** The adjusted model for the full sample, which included demographic variables (average age, proportion female and population) and an indicator for region (i.e., Atlantic, Quebec, Ontario, Prairies, Alberta and British Columbia), showed that neighborhood instability (OR = 1.101, CI = 1.021 - 1.190) and material deprivation (OR = 1.112, CI = 1.019 - 1.214) increase the risk of neighborhood depression. Ethnic diversity (OR=0.864, CI= 0.800 - 0.936) and social dependency show protective effects (OR=0.914, CI= 0.845 - 0.991). Stratified analyses explore these relationships for a male and female sub-sample. **Conclusions:** Understanding the association between contextual effects and mental health problems is important in providing population strategies that reduce the burden of disease through public health interventions.

14–02 (A): A Learning Collaborative to Improve Mental Health Service Use for Low-income, Urban Youth

Mary Cavaleri, Geetha Gopalan, Mary McKay

Introduction: The current study examines the effects of the Learning Collaborative, an inter-agency program developed to improve mental health service use among low-income, urban children. Despite many youth experiencing pressing mental health difficulties, most are not engaged in treatment or drop out prematurely. Children residing in low-income, urban communities are in particular jeopardy, given they evidence higher than average rates of mental health difficulties, yet have the lowest rates of service use. Recent studies provide strong evidence that intensive engagement interventions implemented during initial contacts with youth and their families can boost service use substantially. Yet despite these promising interventions, there is relatively little guidance as to how community mental health agencies can assist youth and families in becoming involved in needed mental health services. The Learning Collaborative was designed for this purpose by 1) bringing multiple agencies across New York City together with the goal of improving service use among low-income, urban youth with mental health needs; 2) training the agencies in administering intensive engagement strategies; and, 3) monitoring agency progress and any difficulties in implementation. II. **Methods:** Fifteen outpatient child mental health agencies within New York City partnered to form the Learning Collaborative with the goals of 1) improving the show-rate for the first intake appointment for all new evaluations of children and adolescents, and 2) improving attendance at any scheduled clinic appointments subsequent to the first kept intake appointment. Key features of the Learning Collaborative included provider training focused on evidence-based phone contact and initial interview engagement skills, evaluating the effects of new engagement procedures, and fostering providers' ability to form collaborative working relationships with adult caregivers and youth. III. **Results:** As of April 2005, outcomes indicate significant success in increasing proportion of youth and families keeping first intake appointments. More specifically, after five months, Learning Collaborative members report an almost 20% increase in the proportion of kept intake appointments. This represents 324 more children completing intake evaluations when compared to baseline estimates. IV. **Conclusions:** Results suggest that utilizing the collective strength of the Learning Collaborative can change the strategies mental health agencies use to engage and retain low-income, urban youth. These results may also direct policy-makers and stakeholders to implement empirically-validated engagement strategies such as these to improve service use for low-income, urban children and families throughout the mental health care service sector.

14–03 (A): Affective Suffering in Older Women: Evidence of a Threshold Affect that Varies by Race/Ethnicity

Cecile Yancu

Introduction: The persistent finding of women's excess of depression continues to be a source of great debate with vulnerability having been attributed to a variety of psychosocial factors, particularly those conditions unique to women's lives. One striking consistency with such explanatory models is that all appear to be predicated on a generalized assumption that one's risk of depression is greater because one is either a woman (a biological distinction) or a female (a role-based or social-psychological distinction). What is not clear from the epidemiological evidence to date is whether this fundamental sex/gender vulnerability assumption remains equally viable across diverse racial/ethnic groups, and in particular among older women. **Methods:** The generalizability of greater female vulnerability to depressed mood is questioned using a representative study of 1,475 racial/ethnically-diverse, older women residing in the urban northeast. Depressive suffering was assessed both categorically and linearly with the Index of Affective Suffering (IAS), a flexible hierarchal measure designed to combine intensity and extensity of suffering. In-home interviews by specially trained raters also collected demographic, functional and social health data. Prevalence rates of affective suffering were examined separately for Latino (46.8%), Black (36.5%), and White (18.6%) women. **Results:** Categorical analysis showed that both older Latino and white females were significantly more likely to report a clinically-relevant level of affective suffering than similarly aged black women. Moreover, when affective suffering was analyzed across a spectrum of mood impairment these data detected a threshold effect in the upper range of affective suffering that was present among Latinas and white females but not so among the Black women in this sample. **Conclusions:** These findings point to a need for research to appreciate the heterogeneity of older women. With women now routinely living 25 to 30 years beyond menopause many health research and advocacy organizations have called for studies of those conditions that affect women differently, predominantly or out of proportion relative to men. At the same time numerous studies have highlighted the existence of considerable disparity along racial/ethnic lines in both health and health care. In this light, one implication of this study is that research focused on the recognition, presentation, and treatment of depressive symptoms may benefit from examining them both dimensionally and within the context of racial/ethnic variation. Promoting such cultural sensitivity could benefit future efforts to detect and/or intervene among older persons suffering from depressed affect in a way that combines individual attributes and social context.

14–04 (A): Mental Illness as a Risk Factor For Poor Health, Substance Use, and Dependence Among Unmarried Urban Mothers

Nancy Reichman, Julien Teitler

Introduction: Mental illness is thought to play a key role in shaping unmarried mothers' ability to be self-sufficient. It may permeate many aspects of their lives and compound other disadvantages they face. However, diagnosed mental illness among unmarried mothers is rarely available in population-based longitudinal data sets. As a result, little is known about the extent to which this aspect of maternal health impedes self-sufficiency and contributes to material hardship among unmarried mothers and their children. **Methods:** In this paper, we: 1) document the prevalence of mental illness among urban unmarried mothers; 2) assess the extent to which the prevalence of mental illness varies by neighborhood poverty; 3) examine how mental health affects employment, reliance on public assistance, and material hardship among urban unmarried mothers; and 4) investigate the co-occurrence of mental illness and other prenatal psychosocial and behavioral risk factors, including smoking, drinking, and using illicit drugs and whether the effects of mental illness are mediated by these behaviors. We use data from three waves of the Fragile Families and Child Wellbeing study, a panel study of 4898 randomly sampled urban U.S. births that occurred between 1998 and 2000. Survey data from mothers and fathers are linked to information from the mothers' hospital medical records prior to the initial interview and census tract level characteristics. The survey data, which span 3 years beginning at the birth of a child, are rich in measures of maternal employment, program participation (TANF, food stamps, Medicaid, WIC, housing), and material hardship (hunger, homelessness, utility shutoffs, inadequate medical care, poor physical health). The medical records contain detailed information on both pre-existing mental illness and substance use. **Results and conclusions:** We estimate nested multiple logistic regression models, first controlling for a rich set of sociodemographic factors, then including measures of census tract poverty, and then including potentially mediating factors including substance use and neighborhood characteristics. Preliminary results indicate that diagnosed maternal mental illness is an important "third" factor explaining many outcomes for this population. The results have important implications for public assistance programs that target urban unmarried mothers.

14–05 (A): Quality of Life Outcomes for Mental Health Care Clients Engaged in the Workman Theatre Project

Nicole Koziel, Lisa Brown, Michael Bagby

Individuals experiencing mental health problems face significant societal stigma and often lack social support. An international movement in Art in Mental Health is attempting to use involvement in the arts to assist mental health care clients to develop their strengths and forge relationships with others, as well as to educate the public on mental illness. The Workman Theatre Project (WTP) was established in Toronto in 1987 to meet these objectives by providing artistic support and training to individuals who receive mental health care services and by showcasing their work to the public. This study explored the impact that the Workman is having on its members' quality of life in the following domains: mental health, social adjustment, daily functional capacity, living conditions, and overall sense of wellbeing. A series of three questionnaires were developed and used in conjunction with the World Health Organization Quality of Life Assessment, brief version (WHOQOL-Bref). Since previous research has struggled to find appropriate standardized instruments to evaluate Art in Mental Health program outcomes, this study compared the domains found in the WHOQOL-Bref to five areas of life identified as important by study participants. Results indicate that the WTP improves member enjoyment of life, sense of meaning in life, and satisfaction with self. Positive effects are also noted in the areas of social relationships, concentration, energy, and capacity for work. Members report that the Workman has greatly affected their overall quality of life, and this effect increases the longer that members have belonged to the organization. Increased confidence and a sense of inclusion are two areas not directly surveyed, but which were frequently identified in an open-ended question. No effects were found in living conditions. Participants' self-selected areas of importance in life were congruent with those identified by WHOQOL-Bref. However, the WHOQOL-Bref fails to capture the importance of creative expression in this population. Approximately two-thirds of Workman members choose some form of artistic expression as one of the most important areas of their life. The WTP and other art organizations in Canada are working to support mental health consumers/survivors and break down stigma against mental illness. While the United Kingdom has set up a national advisory board to investigate Art in Mental Health programs, Canada has not devoted much attention to this area. With the potential to transform the lives of economically and socially disadvantaged individuals, this study hopes to encourage similar interest and research in Canada.

Gender and Urban Health

15–01 (A): Gender Differences in Depression Among Low Income Recent Immigrants in Canadian Urban Centres

Katherine Smith, Flora Matheson, Rahim Moineddin, Richard Glazier

Introduction: Immigrants tend to initially settle in urban centres. It has been previously established that immigrants have lower rates of depression than the Canadian born population, with the lowest rates among immigrants who have arrived most recently in Canada. It is known that women and individuals with low income are more likely to have depression. Given that recent immigration appears to be a protective factor for depression and female gender and low income are risk factors, the aim of this study was to explore a recent immigration-low income interaction by gender. **Methods:** The study used 2001 Canadian Community Health Survey 1.1 data. The sample consisted of 44,754 adults living in 25 Canadian census metropolitan areas. Depression was measured using a cut-off of 4 on the Composite International Diagnostic Interview-Short Form. Recent immigration was defined as immigration to Canada within the previous 10 years. Low income individuals were those whose household income fell below Statistics Canada's threshold based on number of occupants per household. Logistic regression was

used to examine the effect of the interaction on depression in an unadjusted model and in a model controlling for age, marital status, educational attainment, and visible minority status. **Results:** The rate of depression in Canadian urban centres was 8.7%, 6.3% for men and 10.9% for women. For recent immigrants, females with low income were 3.3 times (11.1% vs. 3.4%) more likely to be depressed than their male counterparts. For high income recent immigrants, this ratio was 1.3 (5.4% vs. 4.1%). Among non-recent immigrants, these ratios were 1.3 (16.5% vs. 12.4%) and 1.7 (11.0% vs. 6.5%), respectively. For men, low income recent immigrants had a slightly lower rate of depression than high income recent immigrants (3.4% vs. 4.1%). Male low income non-recent immigrants were 3.6 times (12.4% vs. 3.4%) more likely to be depressed than male low income recent immigrants. The interaction term for income and immigration was significant in the adjusted models for men (p=0.034) and women (p=0.048). **Conclusions:** These results confirm what we know about the effects of income, immigration and gender on depression. The novel finding is a differential income effect where male recent immigrants have lower than expected rates of depression and female recent immigrants have higher rates. These findings have implications for public health planning, immigration and settlement services and policy development. Future research should explore the mechanisms through which income and immigration exert their effects.

15–02 (A): Gender Issues and the Health of Disadvantaged Persons

Rhonda Love

Gender as a descriptive, analytical and theoretical category is a major factor in understanding the health of disadvantaged populations. Gender is socially constructed but this understanding is not reflected in most of our health-related research. Most of our research simply asks people to describe themselves as either male or female and this does not capture any nuanced understanding of what it is to be a "man" or a "woman." This presentation is a critique of current social-epidemiological work from the perspective of "gender" and takes a global perspective on health. It will be argued that men and women have different life experiences and different frames of reference which affect their representation in health research in theorizing about health. Although much of our health-related research examines data by sex, there is an under-theorizing of gender in our work. For example, research on social capital and social cohesion may show that men and women have different experiences of social life and social life as it relates to health, but feminist theory, which takes as its starting point the different social experiences of men and women, has not been a major starting point for health researchers. Mental health, as an example, is experienced differently by men and women yet social scientists and health researchers are often in theoretical and methodological "silos" and do not inform one another's research into this critically important focus on health. The failure of theoreticians and others to incorporate feminist thinking into most social epidemiological work limits both feminist theorizing and the applicability of health research to everyday life. This presentation will explore ways in which feminist theory can inform social epidemiological theorizing and research and will offer suggestions for policy research that will have direct applicability to both academics and community-based health workers.

15–03 (A): Whither Gender in Urban Health?

Victoria Frye, Patricia O'Campo, Sara Putnam

Remarkably rare in the current public health discourse surrounding "urban health" is the notion of gender as a social construct, femaleness as a status characteristics or even women as a distinct population subgroup. The subsequent observation that women are differently or uniquely affected by urbanization, urbanicity and urban living conditions is consequently underemphasized. Recently proposed conceptual models of urban health have admirably focused on context and place and acknowledged the complex and dynamic relationship between the individual and environment. However, with a few notable exceptions, conceptual models or empiric studies within the public health literature have not sought to understand how a gendered social and physical environment influences the health and well-being of women and men. In contrast, urban sociologists have clearly demonstrated the profound influence that race, class and gender have on the health and well-being of young, inner city Black men (see for example Anderson, 1999), particularly on their expression and experience of violence. This work connects social and physical structure to culture and place. In addition, earlier work within environmental health has framed an understanding of how women interact with their environments as intersecting "life spaces" (Kettel, 1996) that transcend urban/rural and social/physical dichotomies. In this paper we argue for an explicitly sociological approach that first acknowledges status characteristics as fundamental social structures and systems. Thus, gender is seen as a social structure that intersects other fundamental social structures such as race and class (Risman, 2004). Adopting such an approach forces an intersectional analysis of how the health of an individual who is socially situated as and has the status characteristics of a woman, Black and poor person is influenced by her environment, which has also been shaped by these fundamental social structures of gender, race, and class. This approach results in an understanding of how "life places" influence women's health. In this paper, we apply this approach and describe how the health of urban women has been affected by a gendered social and physical environment using the examples of violence and HIV.

15–04 (A): Housing Policy, Women, and Health in Canadian Cities

Toba Bryant

Introduction: Health and health policy are increasingly conceptualized as concerned with broader societal issues that influence population health rather than focused on health care. The development of progressive health policy can serve to reduce health inequalities within populations in general, between men and women, and among groups of women. These health policy approaches should address what are called the social determinants of health, particularly the social determinants of housing and income. **Method:** Consistent with the conference themes of health status of disadvantaged populations and policies promoting social justice, this project examined how housing policy, income policy and gender interact to influence women's health. 2001

Census and employment survey data were used to examine a number of income and housing indicators such as housing tenure, shelter costs, core housing need, and shelter-to-income ratios by gender and household type in Montreal, Toronto, and Vancouver Census Metropolitan Areas (CMAs). The households of particular interest were unattached men and women aged either less than or older than 65 years, couples with children, and female and male lone-parents. **Results:** The study found that female lone-parents and unattached elderly females are the most socially and economically disadvantaged of all groups examined. They are most likely to rent and have core housing need. They are also more likely than their male counterparts to live in poverty for longer periods of time. These situations result from Canadian public policy decisions concerning the availability and quality of these health determinants to the population. **Conclusions:** Women's incomes provide the context in which the effects of housing occur and these have detrimental effects on women's health. Because of their low income women are particularly vulnerable to federal and provincial housing and income policies. Recent policy change such as the implementation of vacancy decontrol in Ontario and the absence of a national housing strategy have fostered housing and income insecurity for low-income women in Canada. This economic insecurity has implications for the health of these women and their children as extensive research has documented the health effects of material deprivation which is closely related to income status.

Innovative Youth Engagement

16–01 (C): Toronto Teen Survey (TTS) Phase One: How Do We Meet the Specific Sexual Health Needs of Youth in Diverse Urban Environments?

Susan Flynn, June Larkin, Sarah Flicker, Jason Pole, Alycia Fridkin

Background: ground: Youth do not have comprehensive knowledge of risk factors associated with unprotected sexual activity or the skills necessary to ensure their own sexual health. One size fits all prevention strategies aimed at youth have not proven effective. As Toronto's youth community becomes more racially and culturally diverse, community-based organizations must adapt their approaches. The need to examine how youth feel about services is an important first step. Planned Parenthood of Toronto, a community-based agency, in conjunction with the University of Toronto, academic partner, and the City of Toronto, policy maker, will undertake research to create an accessible and effective sexual health strategy for diverse youth. **Methods:** The TTS uses a community-based participatory research model to engage teens in developing a positive response to some of the issues they face on a daily basis in their lives. In phase one, a diverse group of 12 youth aged 13-17 years worked collaboratively to develop a research design, instruments and protocol. They developed a survey to determine what sexual health services are being used by youth, what barriers prevent youth from using sexual health services and what solutions are required to increase access to sexual health services. To ensure diversity and representation a Youth Advisory Committee (YAC) was recruited through a combination of distribution techniques. YAC met six times and sessions were facilitated by a research coordinator and recorded by a note taker. **Results:** The YAC developed the protocol for a city-wide youth survey. YAC were extremely vocal about sexual health issues and services in their communities. The group reflected many of the same issues identified through research including a lack of comprehensive sexual health knowledge and dissatisfaction with current resources. Sessions revealed that although youth in urban centres face similar sexual health issues, the way sexual health is understood and practiced is very different depending on the community of youth being served. Choices youth make operate within larger socio-cultural and political contexts which must be considered in effective program planning. Implications: The findings have the potential to improve quality of life for Toronto youth and consequently their communities. Sexual health as a health goal aims to enhance life and relationships, and is an integral aspect of the overall health and well being of every person. Acceptance of and action for positive, responsible youth sexuality has the potential to have a great impact on our whole social fabric.

16–02 (C): Young People in Control; Doing It Safe. The Safe Sex Comedy

Juan Walter, Pepijn v. Empelen

Introduction: High prevalence of chlamydia and gonorrhoea have been reported among migrants youth in Amsterdam, originating from the Dutch Antilles, Suriname and Sub-Sahara Africa. In addition, these groups also have high rates of teenage-pregnancy (Stuart, 2002) and abortions (Rademakers 1995), indicating unsafe sexual behaviour of these young people. Young people (aged 12 - 30) from the so-called Urban Scene (young trendsetters in R&B/hip hop music and lifestyle) in Amsterdam have been approached by the Municipal Health Service (MHS) to collaborate on a safe sex project. Their input was to use comedy as vehicle to get the message a cross. For the MHS this collaboration was a valuable opportunity to reach a hard-to-reach group . **Methods:** First we conducted a need assessment by means of a online survey to assess basic knowledge and to similtaneously examine issues of interest concerning sex, sexuality, safer sex and the opposite sex. Second, a small literature study was conducted about elements and essential conditions for successful entertainment & education (E&E) (Bouman 1999), with as most important condition to ensure that the message is realistic (Buckingham & Bragg, 2003). Third a program plan was developed aiming at enhancing the STI/HIV and sexuality knowledge of the young people and addressing communication and educational skills, by means of drama. Subsequently a safe sex comedy show was developed, with as main topics: being in love, sexuality, empowerment, stigma, STI, HIV and safer sex. The messages where carried by a mix of video presentation, stand up comedy, spoken word, rap and dance. **Results:** There have been two safe sex comedy shows. The attendance was good; the group was divers' with an age range between 14 and 50 year, with the majority being younger than 25 year. More women than men attended the show. The story lines were considered realistic and most of the audients recognized the situations displayed. Eighty percent of the audients found the show entertaining and 60% found it educational. From this 60%, one third considers the information as new. Almost all respondents pointed out that they would promote this show to their friends. **Conclusion:** The show reached the hard-to-reach group of young people out of the urban scene and was considered entertaining, educational

and realistic. In addition, the program was able in addressing important issues, and impacted on the perceived personal risk of acquiring an STI when not using condoms, as well as on basic knowledge about STI's.

16–03 (C): Youth-Led Research: A Successful Model of Community-Based Participatory Action Research

Omar Guessous, Michael Armstrong

Whereas traditional research views youth as subjects and/or recipients of research, youth-led research (YLR) redefines them as researchers and decision-makers. They are provided with the necessary tools, guidance, and structure to investigate a topic that is salient to their lives and communities. This paper provides a case study of Fulton Youth Investigators (FYI), a YLR effort, that is facilitated by the authors. The group consists of nine African American youth who attend public high schools and who are concerned with documenting the educational inequalities within their county school system. Specific areas of inquiry include resources and infrastructure, social climate, administrative support, and racism. The youth are using mixed-methods that combine survey, interview, photographic, and archival data. The youth are responsible for the research process including the study's formation, design, data collection using self-created tools, and analysis. As an action-oriented project, the youth are also creatively disseminating the findings and implications to decision-makers and community members in order to raise awareness and promote systems change. This mixed-methods case study will present empirical evidence for YLR's significant contributions to social justice and urban health. The qualitative data consists of monthly interviews, focus groups, and detailed observational data. The quantitative data stems from time-series surveys that the youth completed throughout the YLR process. Anecdotal and visual illustrations will be provided to enrich the presentation. This study found that unlike traditional youth development settings that tend to be hierarchical and potentially adultist, YLR settings are more socially just because of their democratic and empowering process and structure. This model also enhances youths' sense of agency, identity, and leadership-all indicators of positive youth development. YLR, especially when it emphasizes consciousness-raising and social justice, also promotes sociopolitical development-the attitudes, skills and long-term commitment that underlie activism and community engagement. Because YLR tackles issues of concern to youth, it typically confronts oppression and injustice (e.g., FYI's focus on race- and class-based inequalities). YLR can therefore promote the well-being of communities. Such is the case for FYI, with its obvious focus on education quality-a consistent predictor of health outcomes. This paper will conclude with implications for youth workers and action researchers who are concerned with social justice work for youth, by youth. Indeed, our previous and current research clearly indicates that such work is not only central to adolescent development, but also predictive of mental health and academic outcomes (Watts & Guessous, in press).

16–04 (C): Queer Youth Speak: A Model for Developing Equitable Partnerships for Community-Based Research

Christine O'Rourke, Ayden Scheim, Melanie Ollenberg, Cathy Callaghan, Joan Nandal

The aim of this paper is to contribute to the knowledge base of community mobilization, hospital-community agency-youth research partnerships, and how to create empowering community-based research processes. This paper describes the development stages of a community based research project between the queer youth community, Shout Clinic, and The Community Research and Evaluation Team (CRPET) at the Centre for Addiction and Mental Health (CAMH). The purpose of this preliminary research is to identify research priorities for homeless LGBTQ youth who self-identify as having lived experience with mental health and/or substance use concerns. The intended outcome of this project is to create a youth steering committee to facilitate the development of a policy relevant community based research proposal. That proposal will reflect what youth have told us about the strengths and challenges in their communities and their research priorities. The partnership between the youth community, Shout Clinic and CRPET is based on the shared values of research that is empowering and collaborative, that draws on the strength of lived experience, that is reflective of the needs of community members, that is committed to bridging the gap between research and practice, and that supports social change. Within this context, the partners work as equals on all stages of the project, respecting members' diversity of experience, expertise, and leadership style. The team committed time to ongoing partnership building activities, such as a "social location" mapping exercise to look at the identity and lived experience of individual team members and the project team as a whole. This neutralized power differentials, recognized all members of the team as equals and experts in their own right, verbalized biases and intentions, built trust between members, and gave a framework to relate to the population being consulted. In this presentation, members from each partner community (youth community, community agency and hospital), will reflect on the process, lessons learned, benefits and challenges of creating meaningful, equitable partnerships. We argue that having all members participate as experts and equals improves data collection, generates a richer body of research and a richer understanding of how youth, community agencies and hospitals can work together as agents of change.

16–05 (C): A Community-Based Participatory Approach to Assess the Context of Sexual Risk Taking in Urban, African-American Girls

Shani Peterson, Denise Kelly

Introduction: In the U.S., African-American girls and women living in urban areas have the highest rates of HIV infection nationwide. In response to this health crisis, a multitude of behavioral interventions targeting adolescent sexual risk taking have been developed. Unfortunately, many interventions have been created in the absence of youth and community development activities. This may limit the effectiveness of community-based interventions. The goal of Project Power was to employ principles of community-based participatory research (CBPR) to assess, and ultimately improve sexual health outcomes in urban African-American girls. **Method:** Project Power participants were recruited from existing summer and after school programs in a community center affiliated with a Baltimore-based community serving organization, from neighborhood schools, and through word of mouth. The program met twelve times, for two hours a day, over a six week period. To assess the context of sexual risk taking, each day participants were asked to answer questions related to sexuality in a journal. **Results:** Approximately 22 girls between ages 11 and 15 participated in the program. Of those participants, 27% attended at least half of all 12 sessions.

Another 27% attended at least 4 sessions. To analyze the journals, each participants' journal entries were transcribed. Then, all entries were collapsed by topic, into one document. Next, a content analysis was conducted to extract sexual themes. Identified themes were related to power (sexual coercion, interpersonal conflict), safety (rape, physical abuse), and self-efficacy (pregnancy, HIV infection, peer pressure, substance abuse). The journal entries demonstrated that urban girls are concerned with their sexual health, but often feel powerless to protect and/or assert themselves in the context of romantic relationships. They also are keen observers and are able to identify clear links between alternative risky behaviors (e.g. substance abuse) and sexual risk taking. **Conclusion:** The findings from this study suggest that the context of adolescent sexual risk behaviors should be considered when developing and implementing community-based risk prevention programs. By increasing our understanding of adolescent sexuality, we can be better equipped to protect the sexual health of urban girls.

Community-University Partnerships

17–01 (C): Making a SWITCH: Opportunities and Challenges in Establishing a Student-Run, Interprofessional Health Clinic in a Saskatoon Core Neighbourhood

Maxine Holmqvist, Ryan Meili, Sheila Achilles, Reid McGonigle, Patrick Lapointe

The Student Wellness Initiative Toward Community Health (SWITCH) is a student organization dedicated to establishing and maintaining a student-directed interprofessional primary health clinic in a Saskatoon core neighbourhood. Through this clinic, SWITCH aims to improve the health of the community, to enhance the education of future health professionals and to strengthen the relationship between Saskatchewan's post-secondary educational institutions and the community-at-large while providing key services to a low income, primarily Aboriginal population. This service-learning project is a unique collaboration involving student volunteers from nine different disciplines, the Saskatoon Health Region-Primary Health Services, the Westside Community Clinic, Saskatchewan's educational institutions (the University of Saskatchewan, the University of Regina and the Saskatchewan Institute of Applied Science and Technology), the White Buffalo Youth Lodge and many other community-based organizations. SWITCH seeks to simultaneously address a lack of access to healthcare for a marginalized urban population and a relative gap in the education of health professional students regarding the delivery of appropriate services to disadvantaged groups. Inspired by the Community Health Initiative by University Students (CHIUS) in downtown Eastside Vancouver, a group of interested students formed SWITCH in 2003. Initially, SWITCH members assessed community strengths and needs through a variety of formal and informal methods. Guided by this information, interprofessional primary healthcare teams composed of students and professional mentors will provide integrated, culturally sensitive services based out of the Westside Community Clinic on evenings and weekends. An extensive ongoing evaluation process was designed in order to monitor operations and provide insight into the opportunities and challenges of working with urban communities. The SWITCH clinic will open in October, 2005, following a two year process of community consultations, partnership building and program development. The result is a distinctive intervention in which students, professional mentors and community partners will provide clinical services and health promotion programs to an underserved urban community. SWITCH has been innovative in terms of addressing the unmet health needs of an urban population in Saskatoon and developing a community-based educational program for future health professionals. A number of important challenges that have arisen from this ambitious project, including divergent views on desired outcomes and process on the part of the various partners, funding and liability issues, sustainability, and ongoing community member involvement, will be discussed.

17–02 (C): Using Community-Based Participatory Research to Develop and Implement Church-Based Cancer Education Modules

Barbra Beck, Staci Young

Introduction: Age-adjusted cancer incidence rates in Wisconsin between 1996 - 2000 were 450 per 100,000 for whites, and 523.5 per 100,000 for African-Americans. Similarly, age-adjusted cancer mortality rates in Wisconsin between 1996 - 2000 were 193.5 per 100,000 for whites and 271.6 per 100,000 for African-Americans.(1) These numbers suggest a need for more cancer education and prevention within the African-American community in Wisconsin. Churches, which are often cornerstones within the African-American community, offer a natural gathering place to provide health education. They have a strong tradition of caring for others, providing fellowship, support and education. The purpose of this study is to assess the effectiveness of church-based, cultural and literacy appropriate cancer education modules for African-Americans which were developed using a Community Based Participatory Research (CBPR) process. **Methods:** A CBPR process was used whereby church members and academic representatives jointly developed four, one-hour, culturally and literacy appropriate, interactive cancer education modules that addressed 1) cancer in the African-American community, 2) breast cancer, 3) colorectal cancer, and 4) prostate cancer. Each module covered attitudes toward screening, myths, incidence and mortality rates, signs and symptoms, and prevention strategies for the respective cancer types. Modules were implemented by church members at four separate one-hour education sessions over a one-month period. A written, eight-item pre and post test was administered to assess changes in respondents' attitudes and knowledge of various cancer types and screening recommendations. Descriptive statistics were used to compare pre and post test responses. **Results:** Participation at the education sessions ranged from 24 - 28 church members who represented various ages and economic groups. Post test responses improved or stayed the same, when compared to pre test scores, for all survey items for all modules. Questions addressing attitudes toward screening, risk factors, signs and symptoms, and lifestyle choices showed the greatest increase in correct responses. Questions that addressed incidence and mortality showed fewer positive responses for both pre and post tests. **Conclusions:** Results indicate that using CBPR to develop and implement culturally and literacy appropriate cancer education modules for African-American churches positively affects respondents' attitudes toward screening, and knowledge of risk factors and signs and symptoms of various cancer types. Results also suggest that applying CBPR to the development and implementation of other health education materials for African-American church communities may also yield positive results. References 1. American Cancer Society. Cancer Statistics. 2004

17–03 (C): Urban Aboriginal Community-Based Research

Alan Anderson, Priscilla Settee

This presentation addresses models of community-based participatory research; specifically, it focusses on involvement of urban Aboriginal communities in research, drawing from the experience of the Bridges and Foundations Project on Urban Aboriginal Housing. This comprehensive project, based in Saskatoon in 2001-2005, has involved collaboration between universities and other institutions of higher education, Aboriginal organizations, homebuilders, and other community organizations. Over 2000 Aboriginal residents of this western Canadian city were interviewed; over fifty separate projects were conducted, many by Aboriginal/community organizations, including some contracted directly with and conducted by particular First Nations bands. The salient purpose of this presentation will be to discuss Aboriginal views of research, and particularly the notion of respectful research ethics, distinguishing between traditional academic views of the expectations of Aboriginal communities. The presentation will raise pertinent questions concerning the viability of traditional academic research practices, especially when Aboriginal communities are being studied; it will suggest new approaches to participatory research; and will discuss changing relationships in the form of confidence-building between Aboriginal and non-Aboriginal communities.

17–04 (C): Making Things Work: On Being an Academic Researcher Working With a Community Partner

Nina Boulus

Introduction: Recently, there has been increasing focus on bridging between university researchers and community-based health organizations. Various training programs illustrate support for such collaborations , however, little research has been conducted to explore this movement. To address this issues I reflect upon my current research . Together with the community partner, a non-profit community healthcare centre , I explore the implementation of the Electronic Medical Record (EMR). **Methodology:** The fieldwork was initiated in October 2004, and is still in progress. For collection and analysis of empirical data, I employed a combination of techniques, including interviews and participant observations. I also attended several EMR-training sessions provided by the vendor, and participated in several Practice Enhancement Collaboratives organized by the Vancouver Coastal Health Authority. The theoretical framework for this ethnographic research constitutes an institutional ethnographic approach, supplemented with a social constructivist approach. **Results:** In this shifting landscape, the focus of the research evolves according to which issues the clinic views as important or interesting. This change towards a greater involvement and real time in situ feedback, implies that I am being asked to focus on certain issues, which are not necessarily of my own "neutral" preference. Fostering such a close collaboration with the community partner, provides me with easy access to the field; however, at the cost of greater dependence on the community partner. In such a case, it is naive to think I can objectively talk 'in the name of' the clinic. Instead I acknowledge the fact that I am a dynamic participant actively engaged in the construction of the knowledge. One may then ask whether it is possible to preserve a critical stance while being so closely involved in the project. **Conclusions:** I argue that collaborative research can neither be simply good or bad, nor can they be unproblematically measured on a scale of usefulness or successfulness. The case presented here illustrates that action research harbors both threats and promises for potential new research practices. If we acknowledge that such applied research implies intervening and affecting the research, we can move the discussion towards a more detailed and reflective exploration of such engagement. It can be instructive and fruitful to focus on finding local and practical strategies to deal with such complex collaborations. Aiming to change the social world, we should view ourselves as part of the world rather than distancing ourselves from it.

17–05 (C): The Art and Science of Integrating Community-based Participatory Research Principles and the Dismantling Racism Process to Design and Submit a Research Application to NIH

Michael Yonas, Nora Jones, Eugenia Eng, Anissa Vines

Introduction: In public health research, significant merit has been accorded to community-academic partnerships and their use of participatory and transparent approaches to eliminate disparities in health and healthcare. In such research efforts, it is critical to engage participants, and their providers early to build trust and collaboration to ensure that findings are context-sensitive and culturally-relevant. Yet, missing from the scientific literature are the nuances and practicalities of: (1) convening potential research partners; (2) adopting common language and framework for discussing institutional racism; and (3) collectively distilling research questions, study design, methods and funding options. This paper presents the details from a 18-month planning grant that integrated an Undoing Racism (UR) process with a community-based participatory research (CBPR) approach to establish a community-academic research partnership that conceptualized, designed, wrote, and submitted an NIH grant. **Methods:** All partners participated in formal UR and CBPR training. UR training was conducted by the People's Institute for Survival and Beyond which provided the skills for assessing how racial oppression and white privilege and supremacy are internalized, and how racism and discrimination is operationalized throughout the major institutions in society. All partners signed a "full value contract" describing the CBPR principles to be followed. Multi-disciplinary CBPR teams met to conceptualize the goals, aims, and objectives of the proposed research, integrating UR and CBPR knowledge and principles. **Results:** Results include the formation of the Health Disparities Collaborative, a partnership with the local municipal healthcare system, and the submission of 2 NIH grant proposals to support the Collaborative's efforts. Over 15 weeks, the Collaborative worked in teams to develop the research questions, methodological approaches, and a research budget for exploring potential deviations from reasonable breast cancer care obtained by African American patients, as compared to White patients, and their association with racial disparities in breast cancer mortality. **Conclusion:** The formation of effective research partnerships requires commitment, energy, patience, and respect. Lessons include: (1) community organizing strategies to identify and recruit partners were effective with local organizations, academic institutions, and the hospital system, but less so with the private medical care community; (2) adopting a common language and framework for exploring institutional racism was essential and generated a power analysis of racial and ethnic health disparities; (3) signing a full value contract by each partner was necessary to codify the principles of CBPR; and (4) creating a structure for equitable participation to respectfully accommodated conflict within the Collaborative.

18–01 (A): The Right to Clean Water : How Community Groups Mobilize to Block Water Privatization

Joanna Robinson

The Right to Clean Water: How Community Groups Mobilize to Block Water Privatization Introduction The issue of water rights has become increasingly important globally, particularly in debates over water scarcity and stewardship, ownership, environmental health and social justice. My paper focuses on the global movement for water rights. It analyzes two episodes of collective action related to the privatization of municipal water delivery systems and discusses how water as an environmental health and social justice issue is used to mobilize collective action on a global scale. Methods I examine two case studies or 'episodes' of collective action around water rights and privatization: Stockton, California, and Greater Vancouver, Canada. While the privatization of the Greater Vancouver Regional District's water treatment system was successfully prevented, this was not the case in Stockton, California, despite overwhelming public opposition. Using theories of resource mobilization, I examine the how community groups mobilized in response to the threat of water privatization, including the use of issue framing, social networks, and political opportunity structures. I use content analysis, such as media reports, documents, publications and Minutes from the community organizations involved in each episode to identify critical factors in the organization of people around the issue of water and privatization and to determine why one movement succeeded while the other failed. Results Based on the analysis of the archival documents used, I argue that the anti-water privatization movement in Greater Vancouver was successful because the problem was framed as both a social justice and environmental health issue, allowing for the mobilization of people from multiple organizations. In Stockton, the movement failed because of the single issue frame which did not allow for the mass mobilization of people across different social movements. The findings show that community groups that use both a social justice and environmental health frame, as well as build coalitions with public health advocates are more successful in achieving their desired outcome, compared to those groups that use a single-issue frame. Conclusion My paper adds to the sociological understanding of social movements and social change as well as to the understanding of how water as an urban health issue is used to mobilize people on a global scale. It also contributes to the understanding of globalization and the emergence of global social movements, particularly those organized around water.

18–02 (A): Food Deserts: Do Food Deserts Exist in More Disadvantaged Communities and How Are They Studied?

Julie Beaulac

Introduction: The study of food deserts is concerned with the potential place effect of eating patterns. Currently, controversy exists regarding the existence of food deserts. This review seeks to respond to the question of whether food deserts - systematic geographical variations in access to food - exist in more disadvantaged communities. More specifically, the purpose of this review is to provide a methodological summary of how food deserts are studied and to review the empirical evidence on food retail store and food item characteristics by socio-demographic characteristics at the spatial level (e.g., socio-economic status, ethnicity). A response to this research question is timely, particularly given the increasing international attention on the causes and potential solutions of obesity, diabetes, and other nutrition related concerns. **Methods:** Both published and grey literature was included and study inclusion criteria were carefully formulated. Two main research methodologies are discussed in this review: analysis of the characteristics of food items through market basket comparison (e.g., availability, price, and quality of food items) and analysis of the characteristics of food stores by spatial area (e.g., distance, type of food stores, number of residents to available food store). In addition, mixed methods are discussed. Twenty-eight studies were included in this review. **Results:** Overall, evidence supports the hypothesis that systematic variations in access to food exists, disfavouring more disadvantaged geographic areas. Regardless of the methodological approach, support was provided for a significant gap in access to food, to the disadvantage of inner city and rural/remote areas and geographic areas characterized by low income and predominately minority residents. **Conclusions:** Sufficient evidence does currently exist that inequitable access is sometimes and for some places a real concern. Improved equity in access to healthy affordable food within environments will necessitate changes to be made at the community and policy level. More research is needed, however, to confirm that the same socio-demographically patterned disparity in access to food is a problem in Canada and countries other than the US and the UK. At the same time, however, it is also time to more forward and study (1) how to effectively identify food deserts and (2) effective interventions to tackle the problem of systematic and inequitable access to healthy affordable foods in more disadvantaged communities.

18–03 (A): Neighborhood Poverty and Inequitable Exposure to Stressful Social Environments: Results From a Community-Based Participatory Research Partnership in Detroit

Shannon Zenk, Amy Schulz, Carmen Stokes, Barbara Israel, Graciela Mentz, Srimathi Kannan

Introduction: Racial and socioeconomic disparities in health are among the most important health issues of our time. The Healthy Environments Partnership (HEP), funded by the National Institute of Environmental Health Sciences [R01 ES10936-01], is a community-based participatory research partnership affiliated with the Detroit Community-Academic Urban Research Center working to increase understanding of aspects of the social and physical environments that contribute to racial and socioeconomic disparities in cardiovascular disease risk in Detroit, Michigan. In this presentation, we examine relationships between neighborhood poverty, neighborhood racial composition, and self-reported stressors, as important predictors of health outcomes, among Detroit residents. **Methods:** Using data from the HEP survey, a stratified random sample survey (n=919) administered to African-American, white and Latino residents of Detroit, we used hierarchical linear modeling (HLM 6.0) to examine relationships between neighborhood (census block group) poverty, neighborhood racial composition, and self-reported stress, controlling for individual age, gender, marital status, race/ethnicity, income, education, and labor force participation. Neighborhood poverty level was defined as follows: low-poverty (40%). Neighborhood racial composition was defined as follows: low African-American (80%). **Results:** We found statistically significant effects of concentrated poverty and, to a lesser extent, neighborhood racial composition on self-reported stressors. Living in a moderately-poor or high-poverty neighborhood

was associated with greater stress associated with the social environment, physical environment, and child well-being. Residents of high-poverty neighborhoods reported less financial vulnerability than residents of low-poverty neighborhoods. Residence in a neighborhood with a medium or high proportion of African-American residents was associated only with stress related to everyday unfair treatment. There were no neighborhood effects on safety stress or perceived control of stress as measured by the Cohen perceived stress scale. **Conclusion:** Our results contribute to evidence that concentrated poverty in urban neighborhoods is associated with a range of self-reported stressors. Associations remained statistically significant after controlling for neighborhood racial composition, as well as a wide variety of individual characteristics. Taken together with evidence suggesting that stressful life conditions are associated with health, the differential distribution of stressful life experiences by neighborhood poverty level may contribute to disparities in health within urban areas. Community-based participatory research partnerships that work together to elucidate these relationships can also pool their resources to develop strategies to address the inequalities that underlie these health disparities.

18–04 (A): Pollution and Health in Two Toronto Neighbourhoods: Challenges to Ensuring Environmental Justice

Ronald Macfarlane, Loren Vanderlinden, Angela Li-Muller, Murray Finkelstein, Anthony Ciccone

Introduction: In the late 1980s, municipal authorities were proposing to expand the sewage treatment plant at Ashbridges Bay (ABTP) in Toronto and begun an environmental assessment process. To address unresolved concerns, the City of Toronto entered into a mediation process with representatives of the surrounding community, which resulted in an agreement to undertake various studies, including an Air Emissions Study of the ABTP and a Health Status Study of South Riverdale and The Beaches communities. **Methods:** Toronto Public Health gathered a Project Advisory Committee consisting of representatives of the community, City staff, government experts and other stakeholders who were involved in defining the scope of the studies, provided input into the study design, and reviewed draft reports. Each study was led by a project team consisting of Toronto Public Health staff, academic experts and the consultant hired to undertake the research. In the Air Emissions Study, an inventory was made of the all chemicals that could potentially be emitted from the plant and emissions of 17 chemicals of most concern were modelled over time until 2010. Modelling results were compared against air quality standards and health benchmarks. The Health Status study looked at mortality (for circulatory and respiratory causes), hospitalization (for circulatory and respiratory causes), and cancer mortality and incidence (for lung, brain and blood-related cancers). Comparator neighbourhoods were identified using a deprivation index that considered income, education and unemployment. On study completion in May 2005, results were reported to the Toronto Board of Health and a public meeting. **Results:** Overall, with the closing of the incinerators (in 2003) and the installation of odour controls the impact of ABTP emissions on local air quality is reduced and meet health-based criteria by 2010. The health status study results suggested that there were higher rates of death and hospitalization in these communities compared to similar neighbourhoods elsewhere in Toronto. **Conclusions:** While it was not possible to assess the relative contribution of various factors, it was concluded that the differences in health outcomes were likely due to an inequitable distribution of adverse influences on health, including both socio-economic factors and local sources of industrial pollution. There is a challenge to identifying the most appropriate public health response to concerns about the impact of pollution on residents in a neighbourhood, especially when facilities of concern meet environmental standards. This presentation discusses ways to address environmental justice issues.

18–05 (A): Community Health Study in 'Chemical Valley', Sarnia, Ontario

Dominic Atari, Isaac Luginaah, Eleanor Maticka-Tyndale, Karen Fung, Iris Xu, Kevin Gorey, Margaret Keith, Abe Reinhartz

Introduction: This research investigates the perceptions of health risks posed by the environment in the Sarnia, Ontario. The Sarnia area is highly industrialized with major companies like Bayer, Dow Canada, and Esso all having plants located there. These industries are all clustered along the St Clair River. Hence the area is generally known and as 'Chemical Valley'. Recently the area and many others in the Great Lakes region received popular and political attention when Health Canada using existing levels of environmental pollution designated some geographic regions as 'Areas of Concern'. 'Chemical Valley' found itself within the St. Clair River 'Area of Concern'. This 'labeling' was based on the hypothesis that environmental pollution negatively affects health. Further, the Health Canada report concluded that there is limited scientific research, on the environmental determinants of health in designated 'Areas of Concern'. This presentation is part of a larger research program that responds to the call by Health Canada for investigations into the health of populations living in these areas. It addresses residents' risk awareness, understanding of and responses to living in a 'place' called 'Chemical Valley' and in a designated 'Area of Concern'. **Methods:** We conducted 27 in-depth interviews with key informants and community members. The interviews were guided by a checklist containing topics related to our key objectives. The contents were analyzed using grounded theory. Results While residents identified the beauty of the waterfront and employment opportunities as major benefits of living in the area, the images of Sarnia as a highly industrialized landscape referred to as 'Chemical Valley' were obvious during the interviews. Participants frequently referred to numerous industrial plants, invisible and odourless emissions, noise annoyance, soot deposits, the orange haze, smog and traffic in the area. Children and long-term health effects were a major concern for participants. The stigma associated with 'Chemical Valley' within an 'Area of Concern' was applied not only by 'outsiders' but also differentially within Sarnia itself, with people from the North end of the city, frequently saying those in the South, and geographically closest to the 'Valley' are the ones to worry. Residents tend to employ emotion-focused coping strategies such as pragmatic acceptance, and problem-focused strategies such indoor evacuation. **Conclusions:** These findings suggest that there is a need for local health policy that moves beyond the focus on technological measures to reduce emissions to address the psychological and social concerns of residents in 'Chemical Valley'.

19–01 (A): Community-based Intervention Strategies to Prevent Obesity Among Turkish and Moroccan Women in Amsterdam

Hilda van 't Riet, Henriëtte Dijkshoorn, Renée Corstjens

Introduction: Over 80% of Turkish and Moroccan women in Amsterdam are overweight. However, little is known about effective strategies to prevent overweight in these groups. This project aimed to identify determinants and prevention opportunities and to develop interventions with participation by the target population and intersectoral collaboration with stakeholders from professional and policy making backgrounds. **Methods:** The research identified specific determinants of obesity for Turkish and Moroccan women in Amsterdam and possibilities for prevention of obesity, by conducting in-depth interviews with professionals involved with these women: community migrant activity workers, dieticians, fysiotherapists, community sports workers, and others. Furthermore, target group women were interviewed and invited for group discussions, together ensuring involvement of all stakeholders early in the project. During intervention development, group meetings were held with target group women and other stakeholders. Jointly, decisions on interventions to be developed were taken. Target group women volunteered to participate in subgroups to help develop the interventions and ensure activities fit into their daily lives and take into account the obstacles the women experience, as the research had shown. **Results:** Obesity was considered a problem among the women. All women showed interest in performing sports activities, main obstacles for participation being the presence of men, time of day, price and distance. Aerobics classes were favourite with the target group and have been organized for women only, during school hours, for an affordable price, in two nearby places. Women indicated knowing what is healthy or unhealthy about nutrition, but not how to implement it at home, therefore, an intervention was developed to learn skills for daily life. The intervention consisted of a tour in shops where the women buy their daily groceries with a dietician and two cooking sessions with healthier versions of traditional recipes. **Conclusions and implications:** The community-based approach enabled the tailoring of interventions to the needs and possibilities of the target groups, providing opportunities for structural embedding and policy change. This may lead to longterm increased physical activity among the target group and availability of a tailored nutrition intervention for all Turkish and Moroccan women in Amsterdam. Lessons learned are: all stakeholders have to be informed and involved early in the project; they have to be informed of all steps and results continuously to keep them involved; the start of the activities has to be as fast as possible, after the joint decision process, otherwise the target group will loose interest.

19–02 (A): Help-Seeking Rates for Intimate Partner Violence (IPV) Among Canadian Immigrant Women

Ilene Hyman

Objective: Violence against women has been identified both as a major public health issue throughout the world. Although there are many forms of violence against women, this paper deals specifically with intimate partner violence (IPV). Despite the serious adverse health impacts of IPV on women's lives, studies suggest that many abused women do not seek help. However little research has been conducted on help-seeking for IPV among immigrant women. It is well recognized that immigrant women are not a homogeneous group and that factors such as length of stay influence health and health behaviour. The objective of this study was to examine rates of help-seeking for intimate partner violence (IPV) among recent (0-9 years in Canada) and non-recent (10+ years in Canada) immigrant women. **Methods:** The study involved the secondary analysis of data from the 1999 GSS, a national, cross-sectional, voluntary telephone survey conducted by Statistics Canada since 1985. Help-seeking variables included disclosure of IPV, reporting IPV to police, use of social services subsequent to IPV, and barriers to social service use. **Results:** Among the 8,842 female respondents with had a current or ex- partner with whom they had contact within the previous 5 years, 1,596 (18.0%) were immigrants and within this group, 389 (24.4%) were recent and 1,207 were non-recent immigrants. Recent immigrant women who experienced abuse were less likely than non-recent immigrant women to disclose IPV to family, friends or neighbors, or others but differences in rates of disclosure were not statistically significant. Compared to non-recent immigrant women, recent immigrant women were significantly more likely to report IPV to the police (50.8% vs.26.0%). Recent immigrant women were significantly less likely to use social services compared to non-recent immigrant women (30.8% vs. 52.8%). The majority of non-recent immigrant women did not seek help because they did not want or need help. The main reason why services were not used among abused non-recent immigrant women was the same as that reported by women in the general population **Conclusions:** This study was among the first to examine help-seeking for IPV among recent and non-recent immigrant women using a large population-based representative sample. Findings indicate that immigrants are not a homogeneous group and rates of help-seeking, particularly reporting IPV to police and using social services, vary according to length of stay in the host country. Study findings have important implications for prevention and detection of IPV in immigrant communities and future research.

19–03 (A): Serologic Immunity to Chickenpox Among Adult Immigrants and Refugees in Toronto

Kamran Khan, Kim Chow, Miriam Cho, Vicky Fong, Jun Wang, Meb Rashid

Introduction: Chickenpox is a highly contagious illness caused by the varicella zoster virus. Prior studies have suggested that the global distribution of varicella is correlated with distance from the equator (i.e. higher incidence in temperate versus tropical climates). While chickenpox has historically been considered a right of passage for children born in Canada, children from less developed parts of the world often remain susceptible to this infection into adulthood. Thus, some immigrant groups are at elevated risk of developing chickenpox in Canada as adults. This scenario is particularly worrisome given that chickenpox can cause severe illness in adults, with more than one in three infections resulting in death. Despite this fact, Citizenship and Immigration Canada (CIC) does not require that new immigrants provide evidence of immunity to varicella during their immigration medical exam. Universal or targeted screening for immunity may be useful in identifying at risk groups who could benefit from vaccination. However, the efficiency of this approach is unclear given the current lack of information regarding the epidemiology of immunity to varicella among adult immigrants. **Methods:** We identified 328 adults, 15 years of age or older,

who were screened for serologic immunity to varicella as part of a recently developed screening protocol at a downtown Toronto community health centre. We subsequently determined if these individuals had any immunization records from their native country or from within Canada. We then examined the relationship between several demographic factors and immunity to varicella. **Results:** 93% of immigrants had no prior immunization records. Overall, 89% of the 328 immigrants tested for immunity to varicella were found to be immune; 84% of those under the age of 20, 89% of those between 20 and 39 years of age, 94% of those between 40 and 59 years of age, and 100% of those 60 years of age or older. Gender, education status, household income, and immigration status were not associated with immunity to varicella. Of note, 47% of immigrants from the Caribbean islands (n=34) were identified as lacking immunity to varicella. **Conclusions:** Immunity to varicella appears to be suboptimal among younger adult immigrants and those emigrating from the Caribbean islands. Targeted screening of these groups may be warranted in order to identify individuals who could benefit from varicella vaccination and subsequently prevent the development of this highly contagious and potentially life-threatening illness.

19–04 (A): The Role of the Urban Environment on Discrimination Among Latino Day Laborers and Migrant Workers in California

Alex Kral, James Quesada, Daniel Cearley, Andrea Scott, Assunta Ritieni

Introduction: Latino migrant workers are often marginalized in the US based upon ethnicity, language, documentation status, poverty, and occupational status. Such discrimination can contribute to the risk environment for these individuals and have deleterious health effects by limiting basic access to health care, employment, housing, and food. **Objective:** To assess whether Latino migrant laborers differentially experience discrimination based upon whether they are living in urban or non-urban areas. **Methods:** Ethnography and quantitative data collection were conducted with Latino day laborers in San Francisco, CA (SF - urban) and migrant agricultural workers in Monterey County, CA (MC - non-urban) in 2004-2005. Ethnography was conducted in each area by local ethnographers. The quantitative study included 251 participants and consisted of a 45 minute survey, conducted in Spanish, and HIV testing/counseling. **Results:** The quantitative sample was 72% male, 42% under 30 years old, and 88% Mexican or Mexican American. The median amount of time since moving to the US was 21 months. There were sizable differences in self-reported discrimination by urban/non-urban location. Discrimination overall was reported by 65% of urban workers and 46% of non-urban workers. Urban workers were more likely than rural workers to report discrimination based on Hispanic descent (48% vs. 26%); language (54% vs. 15%); poverty (35% vs. 7%); and documentation status (44% vs. 5%). Laborers in the urban setting were also more likely to report that discrimination limited their access to health services (27% in SF vs. 4% in MC), employment (62% in SF vs. 17% in MC), and housing/food (36% in SF vs. 13% in MC). All reported differences are statistically significant ($p < .05$). Ethnographic data corroborate these findings. **Conclusion:** Experiences of discrimination are more common among Latino day laborers in urban settings than migrant workers in non-urban settings. Self-reported discrimination has an adverse effect on to access to health and other basic services. Work is needed understand the features of the urban environment that contribute to the experience of discrimination among Latino laborers.

19–05 (A): Socioeconomic Disparities in Birth Outcomes By Recent Immigration Status in Toronto, 1996–2000

Marcelo Urquia, Richard Glazier, John Frank, Rahim Moineddin

Introduction: The city of Toronto receives around half of all the immigrants to Canada every year. Immigrants arrived within a five-year period account for one third of all deliveries in recent years, contributing to shape the reproductive outcomes of the entire city. While it is well known that socioeconomic disadvantage increases the risk of adverse birth outcomes, it is uncertain how this affects the outcomes of recent immigrant mothers. This study assesses the differential effects of socioeconomic disadvantage in selected birth outcomes among infants born to recent immigrant mothers and long-term Toronto residents. **Methods:** A study population of 142,748 infants born in Toronto in the years 1996 - 2000, including several maternal and pregnancy characteristics, was extracted from the Discharge Abstract Database. Information on recent immigration status of the mothers was obtained from the Ontario Health Insurance Plan, and socioeconomic position (SEP) was expressed as a score based on neighborhood low-income quintiles, obtained from the Census 1996. A cross-sectional design was used to model preterm birth (PB), low birth weight (LBW), and full-term small-for-gestational-age (FT-SGA), by means of multiple logistic regression. All analyses were carried out with SAS 8.2. **Results:** After controlling for maternal and pregnancy characteristics, the adjusted Odds Ratios between the most disadvantaged and the most advantaged quintiles were consistently stronger among long-term residents compared to recent immigrants: AOR (95% CI): 1.30 (1.19-1.43) versus 1.01 (0.86-1.18) for PB; 1.50 (1.35-1.68) versus 1.24 (1.05-1.46) for LBW; and 1.60 (1.35-1.89) versus 1.32 (1.04-1.68) for FT-SGA, respectively. The difference between the two subgroups is also evident for the remaining income quintiles. **Conclusions:** Recent immigrants are contributing to reduce Toronto's PB rates and also the SEP disparities in PB, LBW, and FT-SGA, beyond the pattern that would exist in the absence of such immigration. Long-term resident women living in low-income areas constitute a more vulnerable population for birth outcomes, suggesting the influence of lasting socioeconomic disadvantage. The differential role that socioeconomic disadvantage plays in these subgroups should be taken into account by health promotion and prenatal programs. Further research is encouraged to unravel differential pathways leading to adverse birth outcomes in these subpopulations.

Injection Drug Use in Urban Settings

20–01 (A): Vancouver's Supervised Injection Facility: The First Two Years

Mark Tyndall, Evan Wood, Ruth Zhang, Julio Montaner, Thomas Kerr

Background and Objectives: North America\'s first government sanctioned supervised injection facility (Insite) was opened in September 2003 as part of a comprehensive approach to problem drug use. It was established in the Downtown Eastside (DTES) of Vancouver that is home to an estimated 7,000 injection drug users (IDUs) with HIV prevalence rates approaching 30%. It is

open 16 hours per day (10:00 am - 4:00 am) and allows individuals to inject pre-obtained drugs in a clean, monitored environment. We describe the attendance, demographic characteristics, drug use patterns, and interventions conducted during the first 24 months of operation. **Methods:** A non-obtrusive, but highly efficient database has been established at Insite. Clients are required to sign- in at each visit using a moniker of their choice. In addition to attendance records, the database records type of drug being injected, time at Insite, nursing interventions, counseling, and referrals. The data is kept in a secure database that ensures client confidentiality. All users of Insite are asked to sign a waiver that outlines the liabilities and expectations of the participants. **Results:** Attendance has remained steady at between 600 to 800 visits per day and over 4,700 different individuals have used the site at least once. The median age is 39 years, 73% are male, and 22% are Aboriginal. The drugs injected are mainly opiates (37% heroin, 13% morphine, 5% dilaudid, 1% oxycotin) and cocaine (29% cocaine powder, 4% crack cocaine). There have been no fatal overdoses (OD), although the staff has performed 190 OD interventions. Over 2,000 referrals have been arranged and include addiction counseling, withdrawal management, hospital assessment, methadone maintenance therapy, and housing. **Conclusions:** Insite is now well established in the DTES community and has been used by over 4,700 individuals during the first 2 years. Concerns that women, people of Aboriginal ethnicity, and cocaine users would be underrepresented have been largely unfounded. Health and social outcomes are being prospectively measured in order to evaluate the health and social impacts of Insite on this community and determine if more of these facilities are required.

20–02 (A): HIV Outbreak Among Injecting Drug Users in the Helsinki Region: Social and Geographical Pockets

Pia Kivela, Anneke Krol, Susan Simola, Mari Vaattovaara, Pekka Tuomola, Henrikki Brummer-Korvenkontio, Matti Ristola

Introduction: Incidence of newly diagnosed HIV infections among injecting drug users (IDUs) in Helsinki rose from 0 per 100000 inhabitants in 1997 to 2,9 in 1998 and to 11,1 in 1999. Thereafter incidence declined to 2,1 in 2003. If HIV has spread among young or casual drug users, continued transmission might occur among IDUs and between IDUs and the general population. Here we studied the sociodemographic profile and spatial distribution of HIV-positive IDUs who were diagnosed in the beginning of the Finnish outbreak and those diagnosed later. **Methods:** Data were collected from interviews of 176 HIV-positive IDUs who attended the university hospital in Helsinki from 1998 until 2003. The indicator used to illustrate the spatial differentiation within the Helsinki metropolitan area is % employed males aged 25-64. **Results:** The HIV outbreak occurred among a very marginalized population of IDUs characterized by a long history of injecting drug use (10,7 years), mean age of 32 years, homelessness (66,3%), and history of imprisonment (74,7%) and psychiatric hospital care (40,6 %). Compared with 98 early cases diagnosed during the first 2 years of the epidemic, 47 recent cases diagnosed after 2001 were slightly (4 years) older but equally marginalized. Except for the Helsinki city centre, both early and recent cases had been living or using drugs in the same deprived neighbourhoods with the highest unemployment rates. Up to 40% of cases in the biggest clusters did not have contact with the city centre where the needle exchange services were available. **Conclusion:** The Finnish HIV outbreak is restricted socially to a very marginalized IDU population, and spatially to local pockets of poverty. This favors early decentralization of prevention activities in low prevalence countries.

20–03 (A): Risk Profile of Individuals Who Provide Assistance With Illicit Drug Injections

Nadia Fairbairn, Evan Wood, Will Small, Jo-Anne Stoltz, Kathy Li, Thomas Kerr

Introduction: Receiving assistance with injections is a common practice among illicit injection drug users (IDU) that carries significant risk for health-related harm, including increased risk for HIV infection. However, little is known about individuals who provide assistance with injections. In order to better understand this risk behaviour among IDU, the present study was undertaken to characterize individuals who provide assistance with illicit drug injections. **Methods:** We evaluated factors associated with providing help injecting among participants enrolled in the Vancouver Injection Drug User Study (VIDUS) using univariate and logistic regression analyses. We also examined the self-reported relationship between the provider and the receiver of assisted injections, if compensation was offered for assistance with an injection, and the type of compensation offered. **Results:** Of the 704 IDU followed between December 31, 2003 and May 1, 2004, 193 (27.4%) had provided help injecting during the last six months. Variables independently associated with providing help injecting included: lending one's own syringe (adjusted odds ratio [AOR] = 3.99, $p = 0.004$), frequent heroin injection (AOR = 3.75, $p < 0.001$), unstable housing (AOR = 2.15, $p < 0.001$); bingeing (AOR = 2.01, $p = 0.012$), frequent cocaine injection (AOR = 1.95, $p = 0.002$), and frequent use of crack cocaine (AOR = 1.85, $p = 0.002$). Help was most often provided to a casual (47.1%) or close friend (41.5%). Of the 96 (49.7%) individuals that received compensation for providing help, the most common forms of compensation were drugs (44.6%) and money (22.8%). **Conclusion:** Providing help injecting was a common practice among IDU in this cohort that was independently associated with various high-risk behaviours, in particular, markedly elevated levels of syringe lending. These findings indicate the need for interventions, such as increased education concerning proper sterile injecting techniques and policy changes to allow assisted injection at safer injection facilities (SIF), which aim to offset the risks associated with this dangerous practice.

20–04 (A): Examining the Effects of Illicit Drug Markets and Local Labor Markets on Employment and Self-Rated Health in Philadelphia

Chyvette Williams, Aaron Curry, Julie Becher, Dennis Culhane

Introduction: Unemployment is a serious problem in inner cities and adversely affects health. Lack of convenient, adequate-wage jobs and presence of illicit drug markets contribute to inner city unemployment. Evidence suggests that illicit drug markets are often geographically located in economically disadvantaged neighborhoods, including neighborhoods with few and/or "undesirable" businesses. Theoretically, illicit drug markets can be linked to unemployment via several mechanisms including historical redlining practices and by offering residents an alternative to mainstream employment. To date, no one has examined the effect of this phenomenon on the health of local residents. The primary aim of this study is to examine the effect of local labor markets, presence of drug markets, on individual employment status and self-rated health. **Methods:** This is a multi-level study employing data at both the individual and census tract levels. Individual-level employment and health data (N=4133) come from a representative sample of adults living in Philadelphia in 2002. Tract-level data (N=365) come from both the Philadelphia

Police Department and the 2000 US Census. We use multiple logistic regression to test the association of local labor market and illicit drug market presence on individual employment status and self-rated health. We use the percent of non-institutionalized, non-disabled working age persons who are not in the labor force (discouraged workers) and average commute time to work (job spatial mismatch) as measures of job availability in local areas, and the number of drug arrests in an area as a measure of illicit drug market presence. **Results:** Significant positive correlations were found between drug market presence and percent of population not in the labor force. In unadjusted models, drug market presence and depressed local labor markets were significantly associated with both poorer self-rated health and increased unemployment. Further, unemployment was significantly associated with poorer self-rated health status. Results from adjusted models controlling for demographics, show that the relationship between depressed local labor markets, individual unemployment, and poorer self-rated health persists. **Conclusion:** Drug market presence and depressed labor markets are associated with poorer health and the relationship is mediated by employment status. Drug market presence varies significantly by race and socioeconomic status variables, which may account for the attenuated relationship between drug market presence and health in the adjusted models. Implications for policy indicate a need for business re-investment and improved drug control strategies in disadvantaged neighborhoods in order to improve health of urban residents. Additional research in this area is needed.

20–05 (A): Residence in Vancouver's Downtown Eastside and Elevated Risk of HIV Infection Among a Cohort of Injection Drug Users

Benjamin Maas, Nadia Fairbairn, Evan Wood, Julio Montaner, Kathy Li, Thomas Kerr

Background/Objectives: Vancouver's Downtown Eastside (DTES) is home to over 16,000 long-term residents, and approximately 4,700 of Vancouver's estimated 8,000 injection drug users (IDUs) live in the underprivileged neighborhood. This study was undertaken to investigate geographic residence in a poor, urban neighborhood as an environmental risk factor for HIV infection among IDUs. **Methods:** We evaluated baseline factors associated with DTES residence among participants enrolled in the Vancouver Injection Drug User Study (VIDUS), a prospective observational cohort study. HIV incidence rates were examined using Kaplan-Meier methods and Cox proportional hazards regression. **Results:** Of 1035 IDUs recruited between May 1996 and December 2004, 582 (56.2%) reported DTES residence at baseline and 453 (43.7%) reported residing elsewhere in Vancouver. At baseline, DTES residents were more likely to be 24 or older (odds ratio [OR] = 1.6; $p = 0.004$), Aboriginal (OR = 1.6; $p = 0.003$), reside in unstable housing (OR = 6.9; $p < 0.001$), be involved in the sex trade (OR = 1.3; $p = 0.044$), inject cocaine daily (OR = 1.8; $p < 0.001$), and to inject drugs at a shooting gallery (OR = 1.4; $p = 0.03$). At 48 months after recruitment, the cumulative HIV incidence rate was 16.1% among those who resided in the DTES compared to 8.9% among those who resided in other areas of Vancouver ($p < 0.001$). In the adjusted Cox model, DTES residence remained independently associated with time to HIV seroconversion (relative hazard = 2.02, 95% CI: 1.35-3.00, $p < 0.001$) after adjustment for other statistically significant risk factors. **Conclusion:** While some risk factors were more common among DTES IDUs, DTES residence remained an independent predictor of HIV seroconversion after substantial multivariate adjustment. Targeted structural interventions and broader community-level development programs are needed in higher-risk neighborhoods like the DTES in addition to the more general public health efforts that target IDU risk behaviors. Overall, these findings indicate the need for a greater recognition of geographic location as a determinant of HIV transmission in urban settings and an increased awareness of the higher infection risk associated with residence in an under-serviced urban neighborhood.

HIV Intervention and Risk Reduction Strategies

21–01 (A): Addressing the Methamphetamine-Sexual Risk-Taking Link among MSM: Information Exchange Between Science and Practice

Perry Halkitis, Barbara Warren

Behavior researchers at New York University's Center for HIV/AIDS Studies & Training in collaboration with the Lesbian, Gay, Bisexual and Transgender Community Center of New York City conducted a targeted capacity expansion project to develop methamphetamine prevention education and services targeted to gay, bisexual and other men who have sex with men (MSM) in the greater New York metropolitan area. The infrastructure project was funded by the Substance Abuse and Mental health Service Administration (SAMHSA) and included the development of two components (1) internet and community-based outreach with development of prevention education methods, resources and activities, and (2) development and evaluation of a prevention counseling intervention using Motivational Enhancement Therapy to reduce risk behaviors, targeting potential and current users of methamphetamine and other club/party drugs commonly associated with sexual risk taking and the transmission of HIV. The overall goal of this project, the Crystal Meth Prevention and Intervention Services Initiative (CMPII), was to develop the capacity to implement an outreach, education and intervention initiative targeted at gay, bisexual and other men who have sex with men (MSM, ages 18 and up, in New York City who are current or potential users of crystal methamphetamine and other frequently associated party drugs (e.g., MDMA, ketamine etc.). Our work led to the development of print and Internet based materials, the first of their kind in New York City, as well as trainings of local area practitioners and dissemination of intervention strategies targeting the dual methamphetamine-HIV transmission epidemic. We propose to share the processes involved in this collaboration with an emphasis on the manifestation of the science-practitioner model, and provide quantitative findings from our Internet-based data collection system as well as our peer forums and therapist trainings. The work that will be described provides a strong model of translation of behavioral research into the communities of need.

21–02 (A): HIV Risk Taking and Associated Cultural Factors

Clemon George

Introduction: Epidemiologists have not yet fully accepted the principles of community based research and as a result, these studies do not fully serve the needs of their target populations. Further, studies of the determinants of high risk behaviour for HIV seldom take into account participant's cultures, further reducing their utility for prevention initiatives. The present work

illustrates this gap and identifies different ways of improving epidemiological studies. **Methods:** Three epidemiological research of sexual behaviour were critically analyzed to appraise how sexual orientation, cultures, and ethnicities of participants, within the context of their social, economic and political environments were integrated into the studies. The first study was a cross sectional study of sexual behaviour among high school students, conducted in Dominica in 2000. The second study looked at the changes in high risk sexual behaviour among men who have sex with men (MSM) in Montreal (1997 - 2003). That study was based on the Omega Cohort, a longitudinal study to determine the incidence of HIV in Montreal and psychosocial, demographic and other factors associated with seroconversion to HIV. The third study characterised the sexual and other high risk behaviour of 4 groups of MSM — White born in Canada, White born outside of Canada, other race/ethnicity born in Canada, other race/ethnicity born outside of Canada — based on data gathered from the Omega Cohort and the Vanguard Project, a similar study to the Omega study but carried out in Vancouver. **Results:** The results of the studies themselves are important to HIV prevention activities in these populations: the first study showed that early sexual activity and inconsistent condom use were frequent among girls; the second study showed that the proportion of men practising unprotected anal intercourse (UAI) increased over time; the third study showed that White men who were born outside of Canada were more likely to practice UAI while travelling outside of their home province. However, there were clear indications that the usefulness of the studies to community based AIDS organizations could have been improved, if the target communities were involved in all stages of the research process. **Conclusion:** The results of this study emphasize the need for a more targeted approach to epidemiological studies of diverse populations. It is imperative that scientific investigators adopt a community based approach in carrying out epidemiological studies so that more appropriate and meaningful results will be obtained, leading to more effective intervention strategies.

21–03 (A): The Delayed Engagement With Healthcare: Experiences of People With HIV/AIDS in Beijing, China

Yanqiu Rachel Zhou

Introduction: Epidemiological reports state that by the end of 2003, the estimated cumulative number of HIV cases in China was 840,000 (SCAWCO & UNTG, 2004). However, only about 10 per cent of the estimated HIV/AIDS cases were confirmed by health authorities (ibid.), which means that the predominant majority of this population has not yet accessed AIDS-related health services. Most current research on HIV/AIDS in China is carried out from an epidemiological perspective, paying little attention to the health and health practices of people living with HIV/AIDS (PLWHAs). This paper focuses on examining the healthcare experiences of Chinese PLWHAs, shedding light on various barriers this population faces in accessing healthcare. **Methods:** Using a phenomenological approach, the data of this study were collected through semi-constructed in-depth face-to-face interviews with 10 forefront professionals working with Chinese PLWHAs and with 21 adult PLWHAs in Beijing, China. With the permission of the participants, the interviews were audio-taped or recorded in notes. The transcribed interviews and interview notes were analyzed by using N-vivo, a software program for qualitative data analysis. **Results:** Healthcare is perceived as one of their primary needs by Chinese PLWHAs in this study. Three main themes in this regard are identified. First, the post-infection healthcare access of Chinese PLWHAs was constrained by the availability of health-related resources and social discrimination towards PLWHAs in China. Lack of AIDS knowledge had delayed PLWHAs in taking the HIV test, which, subsequently, delayed their engagement with health care services. Second, affordability was reported to be a salient barrier to PLWHAs' accessing antiretroviral drugs, while the widespread discrimination also inhibited those who had medical welfare using it. Though some participants obtained free medication through participating in drug trials, extreme side effects to these medicines were often reported. Third, PLWHAs' interactions with health workers played an important role in their post-infection health and well-being, though the negative interactions in this regard often proved to be destructive. **Conclusion:** The results of this qualitative study illustrate the gaps existing between the current institutional resources (e.g., knowledge dissemination, health/social welfare and service delivery) in China and the post-infection needs of Chinese PLWHAs as a group. This type of knowledge is important for developing more sensitive and responsive policies, programs, and service delivery systems for this population, which, in turn, will improve their access to health services and quality of life in the long term.

21–04 (A): Employing Social Network Analysis in the Evaluation of Information Provision for HIV-Positive Patients: An Exploratory Study

Dean Behrens, Warren Winkelman

Introduction: Health information, such as that found in brochures and on public web sites, has little to no effect on behaviors or health outcomes if it is not accepted and used by patients. We intend to demonstrate through social network analysis that consideration of social context of information provision is essential to maximize the positive impact of information promoting health and wellness behaviors among urban dwelling HIV-positive individuals. **Methodology and Methods:** An exploratory approach was employed: 81 individuals with HIV infection or at risk for HIV infection were recruited through focused advertising in daily Toronto newspapers. Semi-structured interviews captured each individual\'s HIV-illness experience, ego-centered social environment, information and socio-emotional support needs, demographics, personality traits, and health status. Data were collected concerning the size and density of individuals' socio-emotional and informational support networks, the types of relationships within the networks, the characterization of the relationship with each member of the networks, and the perception of HIV stigma. In addition, a sub-group of 41 HIV-positive persons were re-interviewed six months later to assess for changes over time. **Results:** HIV-positive patients' perceived health status is directly related to perceived informational and socio-emotional support. At a network-level of analysis, the perceived stressors and social stigma particular to HIV infection have no confounding effect on the relationship between perceived support and perceived health status. **Conclusions:** As in other populations of chronic patients, informational and socio-emotional forms of support are mutually interdependent for urban-dwelling HIV positive patients. However, at a network level, information provides benefits that can potentially overcome the powerfully destructive impact of HIV-related social stigma. This implies that for some urban-dwelling HIV-positive patients, information to promote healthy behaviors, sexual and otherwise, may be more effective and perceived as more useful when distributed through the personal social networks of HIV-positive patients themselves (through virtual communities, shared private weblogs, private listservs, and on-line support groups), rather than through broad, public campaigns employing the media, public health institutions, AIDS service organizations and community health centers.

Poster Presentation – Wednesday, October 26, 2005 5:00 – 7:00 pm

P 01 Home Based Care Promotion: Improving Access to Quality Services and Livelihood in the Face of AIDS
Joseph Kamoga

P 02 Spatial Variations in AIDS Outcomes Within a Large Metropolitan Area: Increasing Disparities in the Post-HAART Era
Paul Robinson

P 03 Social Support and Not Socioeconomic Status Is Predictive of Depressive Symptomatology in Patients Undergoing Coronary Artery Bypass Graft Surgery
Roberta Hood

P 04 Factors Contributing to Drug Abuse Among Truck Driver in Selected Urban Area of Eastern Part of Nepal
Anil Deo

P 05 Health Profile of the Street Children of Chandigarh, India
Shyman Lamsal

P 06 Impact of Sexual Abuse/Assault On HIV-Risk-Related Behaviours in Street Youth
Alison Paradis

P 07 Developing Resiliency in Children Living in Disadvantaged Neighbourhoods
Wayne Hammond

P 08 Dilemma of Free Health Care in Spokane, WA
David Bunting

P 09 How HIV/AIDS Have Affected Health Care Services in Urban Centres of Botswana
Josiah Muritu

P 10 Sustaining an Urban Community-Based Participatory Research Program Through a National Influenza Vaccine Shortage
Micaela Coady

P 11 How Do Youth in Urban Communities of Beirut Self Identify
Maya El Shareef

P 12 Mobility in Prostitution and the Impact of Health
Thérèse Van der Helm

P 13 Personal Perspectives, Experiences and Consequences of Food Insecurity in Ottawa
Elizabeth Kristjansson

P 14 Social Citizenship and Health Inequality: Sex-Industry Workers in Victoria, BC and Sacramento, California
Helga Hallgrimsdottir

P 15 Neonatal Family-Focused Clinical Pathways Promote Positive Outcomes For an Inner City Community
Brenda Stade

P 16 Integrated Ethnic-Specific Health Care Systems: Their Development and Role in Increasing Access to and Quality of Care For Marginalized Ethnic Minorities
Joshua Yang

P 17 Effectiveness of Educational Program For Diabetics On Hba1c Values
Veena Joshi

P 18 Fetal Alcohol Spectrum Disorder: Meeting the Needs of the Urban Aboriginal Community
Brenda Stade

P 19 Successful Strategies to Regulate Nuisance Liquor Stores Using Community Mobilization, Law Enforcement, City Council, Merchants and Researchers
Tahra Goraya

P 20 Accessibility Does Not Necessarily Mean Using the Health Facilities
Mohammad Fararouei

P 21 Making a SWITCH: Opportunities and Challenges in Establishing a Student-Run, Interprofessional Health Clinic in a Saskatoon Core Neighbourhood
Ryan Meili

P 22 Differences in Mortality Between Amsterdam Heroin Users of Different Ethnic Groups and the Influence of Injecting
Marcel Buster

P 23 Release From Jail: Moment of Crisis Or Window of Opportunity For Female Detainees in Baltimore City?
Rachel McLean

P 24 The Health Behaviors of African American Men At Historically Black Colleges and Universities: Is There Limited Research?
Daphne Watkins

P 25 Bandar
Wangari Muriuki

P 26 Street Outreach – An Innovative Capacity Building Approach
Valine Vaillancourt

P 27 Behavior Change Trials of Improved Practices (TIPS) For Anemia in Pregnancy and IFA Tablets Consumption in Vadodara Urban, India
Alpesh Shah

P 28 Profiling Children With Prenatal Cocaine Exposure: A Pilot Study
Brenda Stade

P 29 Homemaking/Making Home: The Domestic Lives of Women Living in Poverty and Using Illicit Drugs
Emma Haydon

P 30 Subway Health and Safety Hazards
Robyn Gershony

P 31 Health Capacity: A Different Perspective
Ian Potter

P 32 Food Insecurity in Ottawa - Perspectives and Experiences of Community Workers
Vivien Runnels

P 33 The Cultural Context of Postpartum Depression: Results From a Quantitative and Qualitative Study With First- and Second-Generation Immigrant Women
Paola Ardiles

P 34 Pilot Development and Early Assessment of Maternal and Child Health Handbook At an Urban Public Maternity Hospital in Bangladesh
Shafi Bhuiyan

P 35 Is Canada's Universal Health Care System Universal? A Description of Undocumented Immigrants At an Inner City Community Health Centre in Toronto
Meb Rashid

P 36 The Transformation of an Old and Dismissed Hospital Into a Multi-Functions Center. A Project For the Seaside Hospital in Venice Lido, Italy
Raniera Barbisan

P 37 Evaluation of a Harm-Reduction Program For Street-Youth With/At Risk For Contracting Hepatitis C: Results From a Two-Year Study
Alan Simpson

P 38 Healthcare Availability and Accessibility in an Urban Area: The Case of Ibadan City, Nigeria
Femi Agholor

P 39 Drug Use Among Canadian Street Youth: A Comparison Between Injection Drug Users and Non-Injection Drug Users
Olayemi Agboola

P 40 The Public Injecting Scene in the City of Vancouver
Will Small

P 41 Successful Methods For Studying Transient Populations While Improving Public Health
Beth Hayhoe

P 42 The Community-Hospital Integration Program Framework: Community-Hospital Partnerships to Improve the Population's Health
Richard Blickstead

P 43 Longitudinal Patterns of Health Care Utilization Among Community-Based Injection Drug Users in Baltimore MD: 1989–2004
Noya Galai

P 44 The Characteristics of Contamination in Mining Area in Nandan Guangxi and Its Effect On Sustainable Economy Development
Xiying Zhang

P 45 Public Health and Urban Sprawl in Ontario – A Review of the Pertinent Literature
Riina Bray

P 46 Emerging Urban Health Service Model-Surat City, India
Vikas Desai

P 47 Socioeonomic Status and Surgery in Children: Myringotomies and Tonsillectomies in Ontario, Canada, 1996–2000
Ruth Croxford

P 48 The Development of an Interdisciplinary and Teaching Medical/Dental Clinic For Inner City Street Youth As a Satellite Clinic of the Bruyere Family Health Network: A Demonstration Project
Melanie Mason

P 49 "Dialogue On Sex and Life": A Reliable Health Promotion Tool Among Street-Involved Youth
Tracey Methven

P 50 Immigration and Socioeconomic Inequalities in Cervical Cancer Screening in Toronto, Canada
Aisha Lofters

P 51 Mobilizing For Food Security and Health Research
Charles Levkoe

P 52 HIV Positive in New York City and No Outpatient Care: Who and Why?
Victoria Sharp

P 53 Measuring Specific Features of Neighborhood Environments
Mahasin Mujahid

P 54 A Scale to Evaluate the Urban Neighborhood and Social Physical Environment
Danielle Ompad

P 55 Drugs, Culture and Disadvantaged Populations
Cecilia Rado

P 56 Health Care For One. Health Care For All!
Katharina Kovacs Burns

P 57 Relationship of RBC Folate Level, Serum Vitamin B12 Level and BMD in the Elderly Population
Senait Teklehaimanot

P 58 Good Playgrounds Are Hard to Find: Parents' Perceptions of Neighbourhood Parks
Patricia Tucker

P 59 Nutritional Status of Socioeconomically Disadvantaged Urban Child in Bangladesh: An Anthropometrical, Haematological and Biochemical Study
Zahirul Hoque

P 60 Modeling Black-White Preterm Birth Disparity: Ecologic and Multilevel Models
Lynne Messer

P 61 Seeding Research, Sprouting Change: A Funder's Perspective
Sarah Flicker

P 62 Meeting the Needs of a Very Diverse Community
Yasmin Vali

P 63 Health Services – For the Citizens of Bangalore – Past, Present and Future
Savita Sathyagala

P 64 Identification and Optimization of Service Patterns Provided By Assertive Community Treatment Teams in a Major Urban Setting: Preliminary Findings From Toronto, Canada
Jonathan Weyman

P 65 Availability and Access Exemplified: A Case Study
Ruth Ewert

P 66 Racial/Ethnic Disparities in Trends of Cardiovascular Disease Risk Factors According to Body Mass Index
Deyu Pan

P 67 Associations of Maternal Depressive Symptoms With Offspring Substance Use From Childhood to Young Adulthood in a National U.S. Sample
Jen Jen Chang

P 68 Bringing Health Care Outreach to the Workplace: Strategies For NYC's South Asian Taxi Drivers
Mitchell Rubin

P 69 Toronto Community Health Profiles: A Strategy For Reducing Health Inequalities
Dianne Patychuk

P 70 Racial and Ethnic Differences in Unmet Need For Vision Care Among Children With Special Healthcare Needs in the United States
Kevin Heslin

P 71 Assessing the Relationship Between Community Resources and Neighborhood Health and Well-Being in London, Ontario
Sean Mcintyre

P 72 Identifying and Managing Intestinal Parasitic Worm Infections in New Immigrants and Refugees to Toronto
Kamran Khan

P 73 Processes of Initiation Into Injection Drug Use
Nooshin Khobzi

P 74 Contaminated 'Therapeutic Landscape': Perceptions of the Aamjiwnaang First Nation
Kevin Smith

P 75 Health Care and Ethnic Minority Immigrants: A Canada – United States Comparative Analysis
Daniyal Zuberi

P 76 Applications of Community-Based Participatory Research (CBPR) in the Development of Innovative Urban Health Interventions
Shani Harris Peterson

P 77 Promoting Justice and Well-Being in the Community Through Organizational Change
Leslie Collins, Scot Evans, Diana Mccown, Courte Voorhees

P 78 Count Us In! – How a Community Based Participatory Research Project On Social Inclusion "Walks its Talk"
Krissa Fay, Michael Fay, Karen Haan, Tekla Hendrickson, Adonica Huggins, Barbara Miles, Ramin Shokat Pourtorab, Catherine Turl

P 79 Youth Voices: Expression and Action Through Media Technologies
Harvey Skinner, Charlotte Lombardo, Suhail Abual Sameed, Aamer Esmail, Rob Davis, Junie Henry

P 80 Social Inclusion, Social Justice and HIV/AIDS: A Community-Based Research Approach to Examine the Link Between HIV/AIDS, Health and Housing
Saara Greene, Ruthann Tucker, Amrita Ahluwalia

P 81 Community-Oriented Environmental Undergraduate Research Projects
Venera Jouraeva

P 82 Ensuring Fair and Accountable Government: Ombudsman Ontario
Judith Klie

Poster Presentation – Thursday, October 27, 2005 7:30 – 8:45 am

P 01 Prisoner Health Care in Australia – Opportunities For Addressing Health Deficits
Michael Levy

P 02 Race and Criminal Justice Involvement Among Injection Drug Users
Alexis Martinez

P 03 Size of the Ethnic Community and Health Status of the Aging Chinese in Canada: Are Smaller Urban Cities Better For the Health of Aging Chinese-Canadians?
Daniel Lai

P 04 Sherbourne Health Centre: Innovation in Healthcare For the Transgendered Community
James Read

P 05 Using Feminist Action Research to Examine the Relationship Between Employability and Women's Health
Vera LeFranc

P 06 Measurement of Socioeconomic Status of Immigrants to Canada
Farah Mawani

P 07 A Systematic Review of the Effectiveness of Behavioural Interventions to Improve Adherence to Antiretroviral Therapy in HIV/AIDS
Sergio Rueda

P 08 Care and Treatment For Hepatitis C in Active Substance Users
Brian Edlin

P 09 Realities and Complexities of Community Involvement: Experiences From Impoverished Urban Neighborhoods in Lebanon
Afamia Kaddour

P 10 Parental Influence On Adolescent Sexual- Risk Behaviors: The Role of Communication (An Urban Perspective)
Salvation Okoro

P 11 The Evaluation of an Inter-Agency Collaborative Care Team Serving Homeless Men At an Inner City Shelter
Vicky Stergiopoulos

P 12 Employing Healthy City Platform to Build Up Smoke-Free Environments: Tainan Experience
Susan C. Hu

P 13 Socioeconomic Status and Mortality: For Whom Is There a Gradient?
Amani Nuru-Jeter

P 14 Perceived Impact of HIV and Its Associated Treatment On Activity Limitations: Role of Symptom Burden
Sean Rourke

P 15 Content Validation of the Injection Drug User Quality of Life Scale (IDUQOL)
Anita Palepu

P 16 Healthy Child Screening: An Innovative Service Initiative
AnnMarie Marcolin

P 17 Paying the Price to Stay Alive: HIV Medications and Longevity With HIV Without Future Hopes
Laura Park-Wyllie

P 18 Two Year Results From the Evaluation of Vancouver's Safer Injection Facility
Thomas Kerr

P 19 Underground Community Participatory Research: Cannabis Compassion Clubs As Outlaw Social Justice
Andrew Hathaway

P 20 The Health of Street Youth Compared to Similar Aged Youth
Beth Hayhoe

P 21 A Collaborative Process to Achieve Access to Primary Health Care For Black Women and Women of Colour: A Model of Community Based Participartory Research
Notisha Massaquoi

P 22 Sharing Expertise: A Role For the Hospital Lactation Consultant in the Community
Dina McGovern

P 23 Stigma and Labeling in a Culturally Diverse Society
Hazel Markwell

P 24 Prevalence of Oncogenic Human Papillomavirus Infection and Pap Test Abnormalities in Street Youth
Eileen McMahon

P 25 Determinants of Psychological Distress Associated With SARS in a Canadian Inner City Hospital
Lorraine Lee

P 26 Health & Housing: Assessing the Impact of Transitional Housing For People Living With HIV/AIDS
Sue Ferrier

P 27 Child Morbidity and Health Seeking Behavior Among Slum Residents in Nairobi City, Kenya
Jean Christophe Fotso

P 28 Healthy Cities For Canadian Women: A National Consultation
Sandra Kerr

P 29 Correlates of Homelessness Differ By Gender Among Poor and Marginally Housed Persons
Elise Riley

P 30 Indoor Air Quality As an Issue of Social Justice
Ann Phillips

P 31 Urban Health in a Large City: The Case of Mumbai, and the Role of the Voluntary Sector
Anant Bhan

P 32 Welcome to UFO: Community Based Participatory Research With Young Injection Drug Users in San Francisco
Lydia Guterman

P 33 Welfare: Definition By New York City
Maribeth Gregory

P 34 The Need or Developing a Firm Health Policy For Urban Informal Workers: The Case of Urban Farmers in Kenya
Chrispus Kiliko

P 35 Utilization of Mammography Screening and Predictors of Utilization Among Muslim Women in Southern California
Magda Shaheen

P 36 Working Conditions and Mental Health Among Elderly From Three Underprivileged Urban Communities in Beirut
Monique Chaaya

P 37 Understanding Dominican Mothers' Beliefs, Knowledge and Practices Related to Feeding Infants and Children
Lynn Babington

P 38 Radiation Induced Pollution in Kerala in South India: Health Care Availability and Access to the Local Poor
Subodh Kandamuthan

P 39 Preparing Social Workers to Be Leaders in Response to Aging Urban Populations: The Practicum Partnership Program
Sarah Sisco

P 40 From Resistance to Celebration: The Anatomy of a Dynamic and Cost Effective User-Run Needle Exchange/Harm Reduction Program in Toronto
Raffi Balian

P 41 How Can Community-Based Funding Programs Contribute to Building Community Capacity and How Can We Measure This Elusive Goal?
Tammy Simpson

P 42 Justice As a Determinant of Community Well-Being: Illustrations From the Lives of People With Disabilities
Ora Prilleltensky

P 43 Title Mobile Behaviour Change Communication As a Tool For HIV/AIDS Prevention Strategy
Wale Alabi

P 44 Intra-Urban Dynamics of Dengue Epidemics in Belo Horizonte City, Brazil, 1996–2002
Waleska Caiaffa

P 45 Implementing an HIV and STD Screening Program in an Emergency Department (ED): Lessons Learned
Abigail Silva

P 46 Maternal & Child Health and Neighborhood Context: The Selection and Construction of Area-Level Variables
Jessica Burke

P 47 Enhancing and Supporting Local Capacity Through Community Integration
Susan Owen

P 48 Understanding Homosexuality in the Context of HIV/AIDS: Illness Experiences of Men Who Have Sex With Men in China
Yanqiu Rachel Zhou

P 49 Beyond Participatory Research: Promoting Recovery-Oriented Praxis Based On the Indigineous Knowledge of Consumer/Survivors
Joan Nandlal

P 50 Levelling the Playing Field – Bridging Services For Underserved Cancer Patients
Joanne Hohenadel

P 51 Can Social Responsibility Be Taught? Exploring the Impact of a Service Learning Strategy On Attitudes of Health Sciences Students Towards Poverty, Homelessness and Future Practice
Dyanne Semogas

P 52 Evolution of Research Design With Workplace Stakeholders As Part of the Process
Desre Kramer

P 53 Paws For Thought
Paula Tookey

P 54 Heart Failure: An Urban Crisis
Maribeth Gregory

P 55 Assessing the Effectiveness of Different Methods of Communication On Farsi-Speaking Immigrants' Perception Toward and Intention to Use a Government-Sponsored Health Information Program in Greater Vancouver Area
Irving Rootman

P 56 Folic Acid Knowledge and Use in a Large Multi-Ethnic Pregnancy Cohort: the Role of Language Proficiency
Manon Van Eijsden

P 57 Intra Urban Disparities and Environmental Health: Some Salient Features of Nigerian Residential Neighbourhoods
Olumuyiwa Akinbamijo

P 58 Disabled Children in Kerala in South India: A Fresh Look Into Their Health Status and Quality of Life
Subodh Kandamuthan

P 59 Do Older Widows Better Off in Urban Setting in India: Evidence From National Sample Survey
Pushpanjali Swain

P 60 Health Sector Reforms in Kenya and Its Implications On Healthcare Access and Availability
Chrispus Kiliko

P 61 Perceptions About Immunization Among African American and Hispanic Parents in Los Angeles County
Magda Shaheen

P 62 Community Health Integration in Action: Collaborative Approaches to Improve the Health of Urban Populations in Toronto Downtown West
Eleanor Sam

P 63 A Study On Patients Perspectives Regarding Tuberculosis Treatment
Sathiya Chander

P 64 Eating Our Way to Justice: Widening Grassroots Approaches to Food Security, the Stop Community Food Centre As a Working Model
Charles Levkoe

P 65 The Mobile Health Unit: An Urban Reproductive Health Model For Immigrant and Refugee Women
JoAnne Hunter

P 66 Hunger: A Serious Medical Issue For OW and ODSP Recipients. Everyone Should Be Entitled to Healthy Food – Learn About Prescribing a Special Diet Needs Supplement
Marika Schwandt

P 67 The Relationship Between Social Capital and Substance Abuse Treatment Utilization Among Drug Using Puerto Rican Women
Humberto Reynoso-Vallejo

P 68 Enumerating Toronto's Homeless Population: A Review of the Controversy and Methodological Options
Brent Berry

P 69 A Health Screening Instrument Adapted to the Unique Needs of New Immigrants and Refugees in Toronto
Kim Chow

P 70 Domestic Violence in Nigeria-Addressing the Issues in the Niger Delta Context
Ifode Ajari

P 71 International Cooperation in Health Care Between Low-Middle Income Countries: the Case of Venezuela's "Barrio Adentro"
Sergio Rueda

P 72 Friends in Good Places: A Mixed-Methods Evaluation of the Neighborhood Health Initiative in Des Moines, Iowa
Disa Lubker

P 73 High Risk Youth and Health Problems in Urban Areas
Rana Ahmad

P 74 Stigma, Rights and HIV
Rana Ahmad

P 75 Delineating Neighborhoods For Studies of the Urban Social and Physical Environment
Danielle Ompad

P 76 The Casey House Approach: An Innovative Case Management Model
Lisa Shishis

P 77 Estimates of HIV, HCV and Syphilis in Two Mexican Border Cities Derived From Respondent Driven Sampling: Do Referral Networks Influence Disease Prevalence?
Jonathan Magis

P 78 Antiretroviral Therapy in HIV Infected Infants: When to Initiate Therapy an African Experience
Kingsley Okonkwo

P 79 The Baltimore Health and Nutritional Exam Survey (BHANES)
Chris Gibbons

P 80 Toronto Centre For Substance Use in Pregnancy: One-Stop Care For Pregnant Substance Users
Alice Ordean

P 81 Strategies to Overcome Barriers to Population Sampling: Experience From the Rapid Surveys in Los Angeles County (LAC)
Magda Shaheen

P 82 Identifying Key Techniques TO Sustain Interpretation Services For Assisting Newcomers Isolated By Linguistic and Cultural Barriers From Accessing Health Services
S. Gopi Krishna

P 83 Building a Healthy City: Community Engagement in Neighbourhood Environmental Planning
Paul Young

P 84 The Demographics, Lifestyle Patterns and Expressed Needs of the Street Dwellers in the City of Manila: Implications On Urban Health Service Delivery
Gregory Vincent Ferrer

P 85 Program and Policy Directions: Including Low Income Women With Children
Rachel Rapaport Beck

P 86 Do Lesbians Need Papanicolau Tests?
Amanda Hu

P 87 Embodied Marginalization: Young Men With Muscular Dystrophy and Symbolic Violence
Barbara Gibson

P 88 Serologic Immunity to Measles Among Adult Immigrants and Refugees in Toronto
Kamran Khan

P 89 Variation in the Spatial Accessibility of Low- and No-Cost Mammography Facilities By Neighborhood Socioeconomic and Racial Characteristics in Chicago
Shannon Zenk

P 90 Health Disparities Among Older Immigrants in Urban Canada
Nidhi Kumar Tyagi

P 91 Who Benefits From Community Based Participatory Research: A Case Study of the Positive Youth Project
Sarah Flicker

P 92 Measurement of Cyclist Exposure to the Potential Dangers of Daily Activity-Travel Patterns in the Region of Montreal
Marcellin Gangbé

P 93 Why Do Urban Children in Bangladesh Die: How to Save Our Children?
Tarek Hussain

P 94 African American Community-Based Tobacco Control Organizations
Pamela Jones

P 95 Urban Health Informatics: Linking Data For Multilevel Mapping of Health Policy and Health Disparities
Irina Campbell

P 96 From 'Working For' Towards 'Working With' Community
Tarek Hussain

P 97 Disproportionate Impact of Diabetes in a Puerto Rican Community of Chicago
Abigail Silva

P 98 Investigating Barriers to Accessing Sexual Health Services For Vancouver Asian Men Who Have Sex With Men: A Community Based Participatory Approach
Shimpei Chihara

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P 01 Are Sexually Assaulted Women's Needs Being Met? Preliminary Findings From an Evaluation of a Medico-Legal Intervention For Rape
Janice Du Mont

P 02 Health Problems and Health Care Use of Young Drug Users in Amsterdam
Anneke Krol

P 03 Hepatitis C Virus Infection Screening and Care Behaviours of Canadian Family Physicians
Lisa Graves

P 04 A Neighbourhood Cohort For Population and Environmental Health: Air Pollution in Vancouver. 1976–2001
Michael Buzzelli

P 05 Violence Among Women Who Inject Drugs
Nadia Fairbairn

P 06 Location and Health in Two Contrasting Neighbourhoods in Hamilton, Ontario, Canada
Anneliese Poetz

P 07 Ethnic Differences in Unwanted Sexual Experiences Among Adolescents in Amsterdam, the Netherlands
Adèle Diepenmaat

P 08 Newborn Babies and Their Mothers in Belo Horizonte City, Brazil, 2001: A Spatial Analysis
Waleska Caiaffa

P 09 Awareness About Contraceptives Among Rural and Urban Youth of New Delhi, India
Rajat Kapoor

P 10 Mother and Child Health Status and Services On Decline in Urban Slum of Vadodara, India
Prakash Kotecha

P 11 Transgender People and Access to Care
Samuel Lurie

P 12 Turning Up the Volume: Marginalized Women's Health Concerns
Betty Jane Richmond

P 13 Socioeconomic Position and Excess Mortality During the Heat Wave of 2003 in Barcelona
Carles Muntaner

P 14 Religiosity and Elderly Mental Health: Evidence From Refugee and Non-Refugee Underprivileged Urban Communities
Monique Chaaya

P 15 Applying a Social Justice Framework to Community Mental Health: The Clubhouse Approach to Opportunity and Recovery
Brenda Singer

P 16 Empowering School Clinics of Urban Communities As Partners in TB Treatment: The Philippine Experience
Loyd Brendan Norella

P 17 Mental Health Needs of Transitional Street Youth
Elizabeth McCay

P 18 Health and Human Capital in Developing-Country Slums
Mark Montgomery

P 19 Health and Livelihood Implications of Marginalization of Slum Dwellers in Provision of Water and Sanitation Services in Nairobi City
Elizabeth Kimani

P 20 Body Mass Index in Urban Canada: Neighbourhood and Metropolitan Area Effects
Nancy Ross

P 21 Youth Research and Evaluation: Growing Up in Canadian Cities
Jackie Amsden

P 22 Relationships Between Premature Mortality and Community Income Levels in Manhattan
JL Burcham

P 23 Validity of Retinomax Autorefractor to Comprehensive Eye Examinations in School-Aged Children in Los Angeles County
Magda Shaheen

P 24 A Time Series Analysis of the Relationship Between Social Disadvantage, Air Pollution, and Asthma Physician Visits in Toronto, Canada
Tara Burra

P 25 Mental Healthcare Utilization Patterns of Ethiopian Immigrants in Toronto
Ilene Hyman

P 26 Assessing the Relationship Between Children's Health and Parents' Employment Status in Professional Immigrant Families Living in Vancouver
Clyde Hertzman

P 27 Healthcare Services: The Context of Nepal
Meen Poudyal Chhetri

P 28 Being Street Sick: Exploring Health Issues of Canadian Street Youth
Jeff Karabanow

P 29 Using Community Based Participatory Research to Assess Milwaukee Public Housing Women's Perceptions of Breast Health
Barbra Beck

P 30 Providing Primary Healthcare to a Disadvantaged Population At a University-Run Community Healthcare Facility
Tracey Rickards

P 31 The Impact of an FHN Satellite Clinic On the Health of Inner City Ottawa Youth
Melnaie Mason

P 32 Programming For HIV/AIDS in the Urban Workplace: Issues and Insights
Joseph Kamoga

P 33 Developing a More Woman-Centered Focus On Reproductive Health
Ifode Ajar

P 34 Impact of Homelessness On Health and Supports Needed For Successful Housing: Perspectives of Individuals Experiencing Homelessness This Research Study Is Supported By a Small SSHRC Grant
Isolde Daiski

P 35 Health Status of Children in Urban Slums of Chennai
M. Uma Mheswari

P 36 Smoking Cessation in Oaxaca, Mexico: A Limited Priority Among Health Care Providers
Lindsay Rhodes

P 37 Citizenship For IDU and People Living With HIV/ AIDS
Elisa Yoshida

P 38 Prevalence of Elevated Blood Pressure, Random Blood Glucose and Proteinuria Among Asymptomatic Adults in Singapore
Veena Joshi

P 39 Everyday Life in a Disadvantaged Neighbourhood and Its Impact On Health: Insights From an South Australian Study
Fran Baum

P 40 Perceptions of and Responses to Intimate Partner Violence Among Canadian Born and Immigrant Young Women
Robin Mason

P 41 Human Health and Inner City Deprivation in the Third World: The Crack in Social Justice
Usman Raheem

P 42 Addiction Shared Care: The Effectiveness of a Shared-Care Model For Addiction Patients
Meldon Kahan

P 43 Seeds, Soil, and Stories: An Exploration of Community Gardening in Southeast Toronto
Carolin Taron

P 44 Upgrading Inner City Infrastructure and Services For Improved Environmental Hygiene and Health: A Case of Mirzapur in U.P. India
Madhusree Mazumdar

P 45 Integrating TQM (Total Quality Management), Good Governance and Social Mobilization Principles in Health Promotion Leadership Training Programmes For New Urban Settings in 12 Countries/Areas: The Prolead Experience
Faten Abdelaziz

P 46 Urban-Rural Differences in Depression and Its Help-Seeking in Canada 2002
Tonia Forte

P 47 Voluntary Counseling and Testing For Human Immunodeficiency Virus in Pregnant Nigerian Women: An Evaluation of Awareness, Attitudes and Beliefs
Kingsley Okonkwo

P 48 Planning Healthy and Sustainable Cities in Africa
Geoffrey Nwaka

P 49 Community Palliative Care in an Urban Setting: Building a Model
Joe Bornstein

P 50 Hamilton's Hospitals-Shelters Working Group
Niki Gately

P 51 Improving Water and Sanitation Access For the Urban Poor: A Case Study of Nairobi
Ann Yoachim, MPH

P 52 Potentially Healthy Municipalities Network: A Way to Achieve Urban Health
Ana Maria Sperandio

P 53 Profiles in Urban Health in 9 Cities of the Americas
Marilyn Rice

P 54 Migration Trends and Drug Treatment Needs Among Injection Drug Users in the Mexico/U.S. Border City of Tijuana, Mexico
Kimberly Brouwer

P 55 Personal and Social Network Factors Associated With Secondary Syringe Exchange Among Injection Drug Users
Prithwish De

P 56 Maternal Cultural Participation and Child Health Status in a Middle Eastern Context: Evidence From the Urban Health Study
Marwan Khawaja

P 57 Toward Social Justice:Environmental Quality, Health Outcomes and Urban Social Capital in Low-Income Areas in Francistown, Botswana
Tirelo Moroka

P 58 Social Conflict As a Core Concept in Urban Health
Samuel Friedman

P 59 Hospital Capacity and Use in America's Cities and Suburbs During Shifting Economic Times: Implications For the Safety Net in Metropolitan Areas
Dennis Andrulis

P 60 Access to Identification and Services
Jane Kali

P 61 Gentrification and Health
Russell Lopez

P 62 An In-Depth Analysis of Medical Detox Clients to Assist in Evidence Based Decision Making
Aslam Anis

P 63 Exposure and Potential Health Risks to Toronto Residents Posed By Two Chemical Contaminants
Miriam Diamond

P 64 Urban Health in Kathmandu, Nepal: A Review of Innovative and Effective Programs
Poonam Kandel

P 65 Psychosocial Factors Associated With Perceived Forgone Healthcare: A Comparative Study in Paris, France, and Antananarivo, Madagascar
Pierre Chauvin

P 66 Harnessing Media to Achieve Social Justice in Urban Communities
Katerina Cizek

P 67 Income Related Health Disparities in Metropolitan Canada
Jalil Safaei

P 68 the World Trade Center Health Registry: A Unique Resource For Urban Health Researchers
Deborah Walker

P 69 Right to Health Care Campaign
Sathiya Chander

P 70 Repeat Substance Using -Suicidal Clients -How Can We Be Helpful?
Yvonne Bergmans

P 71 Depression and Anxiety in Migrants in Amsterdam
Matty de Wit

P 72 Early Detection of Emerging Diseases in Urban Settings Through Syndromic Surveillance: 911 Data Pilot Study
Kate Bassil

P 73 Traffic Intensity, Lodging Value and Hospital Admissions For Respiratory Disease Among the Elderly in Montreal (Canada): A Case-Control Analysis
Audrey Smargiassi

P 74 Psychological Vulnerability in Individuals Infected With HIV Predicts Poor Psychological and Physical Outcomes: A Longitudinal Study
Sarah Rubenstein

P 75 Urban Agriculture and Food and Nutrition Security in Kampala, Uganda
Fiona Yeudall

P 76 Mental Health and the Corrections System: Population-Based Analyses in Urban, Semi-Urban, and Rural Settings
Julian Somers

P 77 Urban Change and Health Conditions: The (In)Visible Challenge and Its Implications For Environmental Justice Among Low Income Communities in Kampala City Uganda
Paul Mukwaya

P 78 International Perspectives On Public Health Policy
Dennis Raphael

P 79 Voices For Vulnerable Populations: Communalities Across CBPR Using Qualitative Methods
Martha Ann Carey

P 80 Free Primary Education: A Reality Or a Mirage For the Urban Poor in Nairobi City?
Eugene Darteh

P 81 Demographic Characteristics of People Seen With Tuberculosis in Lagos State University Teaching Hospital (Lasuth) Chest Clinic
Wale Alabi

P 82 Violence in Families and Intimate Relationships: Challenges For Health Promoters
Margaret Malone

P 83 Women Sleeping Rough: Health Outcomes After Five Years On the Streets of Boston, 2000–2004
James O'Connell

P 84 Geographical Accessibility and Health Promotion – Filling an Urban Research Gap?
Eric Hemphill

P 85 The Rotterdam Youth Monitor: Local Evidence-Based Youth Policy
Erik de Wilde

P 86 Lessons From a Community Empowerment Project; Role of Self-Help/Mutual Aid Strategies in Development and Delivery of Health Promotion and Disease Prevention Educational Materials
Roya Rabbani

P 87 Unraveling Socioeconomic Disparities in Mental Health Service Use in Canada: Finding the Appropriate Targets For Policy Intervention
Kenneth Lee

P 88 Urban Environment and the Changing Epidemiological Surface: The Cardiovascular Disease From Ilorin, Nigeria
Usman Raheem

P 89 Young People in Control; Doing It Safe. The Safe Sex Comedy
Juan Walter

P 90 A Wired Waiting Room: Can Health Information Websites Empower Everyone?
Karen Smith

P 91 Influence of Demographic Structure On Health Services Use By Urban Older Adult Population in Madrid Region (Spain)
Maria Eugenia Prieto

P 92 The Environment of Youth Related to Tobacco in Lebanon: Analysis By Gender and Tobacco Type
Mayssa Nehlawi

P 93 Confronting Stigma: The Use of Narrative Inquiry With Individuals Who Have Experienced Chronic Homelessness and Alcoholism
Dyanne Semogas

P 94 The Inner City Public Health Project
Leeann Owens

P 95 Does Racial Concordance Between Patients and Providers Influence Trust in the Health Care System For Homeless, HIV-Infected Patients in NYC?
Nancy Sohler

P 96 Solid Waste and Environment in Mumbai (India)
Uttam Sonkamble

P 97 The Environmental Justice in the Metropolis of Tirana
Luan Balliu

P 98 Advanced Access Scheduling: Decreasing Barriers to Health in Marginalized Inner City Populations
Yuriy Tatuch

P 99 Homicides, Adolescent Pregnancy, Asthma and Two Mosquito-Borne Diseases – Dengue and Visceral Leishmaniasis in a Urban Context: The Belo Horizonte Observatory On Urban Health (BHOSUH) Experience
Waleska Caiaffa

P 100 Hispanic Males and Healthcare Access: A Snapshot of New York City
John Jasek

P 101 Building a Caring Community
Terry Kettleson

P 102 The Impact of Social Support, Depression and AIDS Diagnosis On Health-Related Quality of Life in Adults With HIV-Infection
Sarah Lyons

P 103 Mapping the Physical Environment of Inner City Workplaces
Iggy Kosny

P 104 Health Care Access and Healthy Lifestyle Measures Among New York City Adults With Multiple Cardiovascular Disease Risk Factors
Dejana Selenic

P 105 Treating the "Untreatable": The Politics of Public Health in Vancouver's Inner City
Denielle Elliott

P 106 Ethnic Health Care Advisors in Information Centers On Health Care and Welfare in Four Districts of Amsterdam
Arnoud Verhoeff

P 107 The Single Practice Network Initiative: Harnessing Private Sector Resources of Urbancommunities in the Fight Against Tuberculosis
Loyd Brendan Norella

Information

Message Centre

Attendees cannot be paged while attending the Conference, however, a message board will be located in the Registration/Information area. If you are expecting a message or wish to leave one for a colleague attending the Conference, please direct your caller to 416-869-1600 and ask for the Urban Health Conference office. We respectfully ask that you turn your cell phones and pagers off or to vibrate only while in Conference sessions.

Speaker Preparation Area

A speaker preparation area for Guest and VIP speakers is located in the Conference Office, in the Yonge Room in the Conference Centre, Street Level.

Posters

Posters will be located in the Metro East Ballroom from Wednesday, October 26 to Friday, October 28. All participants are encouraged to visit the poster area during specific times, as well, continental breakfast and refreshment breaks will be served in the poster viewing area.

Continuing Medical Education

This event is an accredited group learning activity as defined by the Maintenance of Certification program of the Canadian College of Health Service Executives (CCHSE). Individuals wishing to receive a certificate of attendance must submit a complete program evaluation form to the registration desk and request on the form that a certificate of attendance be mailed to them.

Accreditation

This program meets the accreditation criteria of the College of Family Physicians of Canada and has been accredited for up to 10.5 Mainpro-M1 credits.

The Continuing Education Office, Faculty of Medicine, University of Toronto designates this educational activity for a maximum of 10.5 category 1 credits toward the American Medical Assocation Physician's Recognition Award. Each physician should claim only those credits that he/she actually spent in the activity.

This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification program of the Royal College of Physicians and Surgeons of Canada, approved by University of Toronto for 10.5 hours.

Restaurants

Toronto offers a wide variety of restaurants covering most palates and costs. For more information on local restaurants, contact the information desk.

Medical or Other Emergencies

If you should experience an emergency situation, please contact the Registration/Information desk, or dial the hotel operator for assistance.

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Centre for Research on Inner City Health
St. Michael's Hospital

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GGD Amsterdam

The 5th International Conference on Urban Health (ICUH) Amsterdam 25 – 28 October 2006

Dear Colleague:

The annual meeting of the International Society for Urban Health (ISUH) has become the leading international forum for the discussion of issues relating to urban health. This conference provides ample opportunity for researchers, practitioners, community members, and policy makers to present leading-edge research and reviews relating to urban health and to discuss how to translate research into practice and policy. The past conferences have had increasing international attendance and representation from a wide variety of research disciplines.

Conference theme

Population mobility and its effect on urban health

With special interest in the consequences of migration on health and health care in urban settings.

Scientific programme

The conference will consist of plenary lectures, symposia, workshops and poster sessions providing an opportunity for education and discussion on the latest information relevant to all aspects on urban health. Oral presentations and posters will be selected from abstracts submitted.

Intended audience

Participants include domestic and international researchers, community-based organisations, students, policy makers and representatives from the public foundation sectors.

Organising Committee, under the auspices of the International Society for Urban Health:

President: Arnoud Verhoeff, Municipal Health Service Amsterdam, the Netherlands.
Conference co-ordinator: Maria Oud, Municipal Health Service Amsterdam, the Netherlands
Programme support: Willem Schokker, Municipal Health Service Amsterdam, the Netherlands

On-line registration

Registration will only be possible via the internet: www.icuh2006.com as of March, 1, 2006.

Abstract submission

Abstracts can be submitted on-line from March, 1, 2006, until June, 15, 2006. Abstract submissions by both community members/organisations and academic researchers are welcome. Further information will follow on the website www.icuh2006.com

The International Society for Urban Health

Are you interested in joining the International Society for Urban Health or do you want more information? Visit their website: www.isuh.org.

Conference

English will be the official language of the conference.

Exhibition

Facilities for the exhibition of scientific and professional material will be available. Potential exhibitors may request exhibition documents from the Conference Secretariat.

Conference venue

The ICUH 2006 conference will be held at the
Vrije Universiteit
Aula Complex
De Boelelaan 1105
Amsterdam

Amsterdam – a compact metropolis!

How best to introduce a unique city that has so much to offer? Amsterdam is bursting with culture and a perfect mixture of history and the energy of a trendy metropolis. At the same time, Amsterdam is compact and all the city's tourist attractions and places of interest are within walking distance from one another.

2nd Announcement

The 2nd announcement will follow in February 2006.