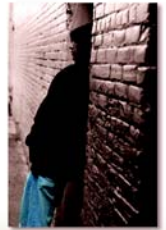


MRC

Social and
Public Health
Sciences Unit

CHIEF
SCIENTIST
OFFICE



Annual Report 2008

MRC Social and Public Health Sciences Unit

Welcome

Welcome to our annual report, in which we present a complete list of publications and presentations for 2008, and some selected highlights of research initiated or completed last year.

We were pleased to be joined by many excellent new staff from all over the world (including Botswana, Russia, Australia, France, Portugal, and Italy), representing a wide range of disciplines. As well as contributing to the Unit's research, they will considerably enhance our ability to translate foreign language journal articles when undertaking systematic reviews!

Shona Robison MSP, Minister for Public Health in Scotland, visited the Unit in March to discuss our work and its implications for policy formation. We also hosted a meeting of the House of Commons Health Committee's inquiry into Health Inequalities, and not only on that occasion but throughout the year have provided it with written and oral evidence. We signed a memorandum of agreement with NHS Health Scotland, Scotland's national public health agency, to enhance two-way flows of communication and staff, and Matt Egan, a member of staff in our Evaluation team, was seconded to that agency for a year as a health policy adviser.

We contributed to MRC's revised guidelines on evaluating complex interventions, and continued other fruitful collaborations with other MRC Units and Centres via the MRC's Population Health Sciences Research Network. We were awarded two out of the fourteen grants awarded under the second phase of the National Prevention Research Initiative, and are partners in several major new collaborative initiatives including the Environmental Determinants of Public Health in Scotland project, and the new Centre of Cognitive Ageing and Cognitive Epidemiology at the University of Edinburgh.

I hope you enjoy reading this report. For further information please see our website (www.sphsu.mrc.ac.uk) or contact us at: enquiries@sphsu.mrc.ac.uk.

Sally Macintyre



Shona Robison MSP, Minister for Public Health, Scottish Government, and Sally Macintyre, Unit Director, during discussions of the Unit's work at the Minister's visit in March 2008.



Members of the House of Commons Health Committee arriving for their Scottish session, which the Unit hosted, as part of their enquiry into inequalities in health (from left to right) - The Rt. Hon. Kevin Barron MP (Chairman), Dr Howard Stoate MP, Dr David Harrison (Clerk of the Committee), Sally Macintyre, Dr Doug Naysmith MP, and Dr Richard Taylor MP.

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Mission and goals

The Unit's mission is to promote human health by the study of social and environmental influences on health.

Our goals are:

- to study how people's social positions, and their social and physical environments, influence their physical and mental health and capacity to lead healthy lives
- to design and evaluate interventions aiming to improve public health and reduce social inequalities in health, and
- to influence policy and practice by communicating the results and implications of research to policy, professional and lay audiences.

Major Funders

We are core-funded by the Medical Research Council, and the Chief Scientist Office of the Scottish Government Health Directorates. We also received grant and fellowship support from a range of funders including the Department for Children, School and Families, the Department for International Development, the Department of Health Policy Research Programme, Glasgow Centre for Population Health, Glasgow Housing Association, Ireland Aid, NHS Health Scotland, the Wellcome Trust and the World Health Organisation.

Current staff, students and co-workers

Director

Sally Macintyre CBE PhD FRSE FMedSci

Associate Director

Lyndal Bond PhD (Started 14/01/2008)

Research Staff

Elizabeth Aston PhD (Left 28/11/2008)

Graham Baker PhD (Started 12/05/2008)

David Batty PhD

Michaela Benzeval MSc

Cara Booker PhD

Denise Brown PhD (Left 28/02/2008)

Katie Buston PhD

Carolyn Davies PhD

Geoff Der MSc

Niamh Donnellan MSc (Started 22/09/2008)

Ruth Dundas MSc

Matt Egan PhD (on secondment to NHS Health Scotland from 14/04/08)

Anne Ellaway PhD

Carol Emslie PhD

Candida Fenton MSc (Started 19/11/2008)

Elisabeth Fenwick PhD (jointly funded by the Public Health and Health Policy Section, Glasgow University)

Marcia Gibson PhD

Lindsay Gray PhD

Michael Green MA

Mary-Kate Hannah MSc (career break started 01/07/07 to 2010)

Seeromanie Harding PhD RGN

Marion Henderson PhD

Shona Hilton PhD RGN

Joel Hotchkiss PhD (Started 01/08/2008)

Kate Hunt PhD

Mairi Langan PhD

Erik Lenguerrand PhD (Started 11/02/2008)

Heather Lewars MSc (Left 17/07/2008)

Alastair Leyland PhD FFPH CStat

Karen Lorimer PhD

Catriona Macdonald PhD (Started 12/05/2008)

Laura Macdonald MA

Chloé McAdam (née Hughes) BSc (Started 06/10/2008)

Gerry McCartney, MFPH MB ChB

Maria Maynard PhD

Oarabile Molaodi MSc (Started 06/10/2008)

Catherine Nixon MSc

Alison Parkes PhD

Andrew Paterson MA (From 28/07/2008 to 31/10/2008)

Audrey Prost PhD (Left 31/03/2008)

Emma Rawlins PhD (Started 04/02/2008)

Pieter Remes PhD

Elena Sautkina PhD (Started 13/10/2008)

Deborah Shipton PhD

Kathryn Skivington MSc (Started 25/08/2008)

Denise Smith PhD (Started 08/09/2008)

Helen Sweeting PhD

Hilary Thomson MPH

Noemi Travaglini MSc (Started 02/06/2008)

Patrick West PhD

Melissa Whitrow PhD (Left 11/07/2008)

Daniel Wight PhD

Lisa Williamson PhD

Robert Young BSc

Graduate Students

Nicola Desmond MSc

Sarah Gurney BA

Jane Hartley MRes

Kalonde Kasengele MPH

Douglas Lonie MA

Chloé McAdam (née Hughes) BSc

Caroline Sime DN MPC

Godfrey Siu MIIH

Nicola Smart MA (Started 15/09/2008)

Emily Smith MSc

Catherine Stewart MPH

Alison Teyhan MSc

Honorary Research Staff

Jim Barnes MSc MRCPG,

Crookston Medical Practice

Ian Deary PhD FRCPE FRCPSych,

Department of Psychology, University of Edinburgh

Dave Leon PhD,

Department of Epidemiology and Population Health, London School of Hygiene & Tropical Medicine

Nanette Mutrie PhD,

Department of Sport, Culture and the Arts, Strathclyde University

Phil Wilson DPhil FRCGP,

General Practice and Primary Care Section, Division of Community Based Sciences, University of Glasgow

Support Staff

Samantha Bird, Office Assistant (Started 19/05/2008)

Kate Campbell, Survey Support Officer

Nicola Durkin, Office Assistant (Started 21/04/2008)

Catherine Ferrell MA, Survey Manager

Patricia Fisher HNC, Facilities Manager

John Gibbons BSc, Database Manager/Trainer

John Gilchrist HNC, Computer Officer

Sandy Gray RGN, Research Nurse Supervisor (Left 31/10/2008)

Barbara Hendry RGN, Research Nurse Supervisor (Left 31/10/2008)

Elaine Hindle HNC, Survey Support Officer

Barbara Jamieson MSc, Unit Business Manager

John Kelly NVQ, Survey Office Support Assistant

Fiona McDonald, PA to Professor Macintyre

Jean Money, Secretarial Assistant/Accounts

Crawford Neilson BSc, Computer Systems Manager

Carol Nicol MSc, Programmer/Analyst

Mary Robins HNC, Librarian

Marta Ribeiro BSc, Data Records Manager (Started 28/07/2008)

Julie Watson, Survey Office Support Assistant

Susan Wilkie HND, HR Assistant

Visitors

Elisabeth Kvaavik PhD,

Department of Nutrition, University of Oslo (Left 09/07/2008)

Bruce Newbold PhD,

McMaster University, Hamilton, Ontario (From 01/2008 – 06/2008)

The West of Scotland Twenty-07 Study



The West of Scotland Twenty-07 Study: Health in the Community is a resource for all Unit programmes. Established in 1987, this study is following three cohorts of people, born in the 1930s, 1950s and 1970s and aged 15, 35 and 55 years respectively when the study began. The aim of the Twenty-07 Study is to investigate the social processes producing or maintaining differences in health by key social positions, in particular social class, area of residence, age and family composition.

In 2008, we published an *International Journal of Epidemiology* cohort profile on the study, which describes the general design and approach of the study as well as including a brief review of findings to date.²⁴ We also updated our study website to make it more user-friendly and informative for participants (http://www.sphsu.mrc.ac.uk/study-sites/2007_study/).



Michaela Benzeval

Programme Director
Michaela Benzeval

Researchers
Michael Green
Karen Lorimer
Deborah Shipton

Clinical advisors
Phil Wilson
Jim Barnes

Nurse supervisors
Sandy Gray
Barbara Hendry

More generally, most of our efforts in 2008 focused on completing the final wave of fieldwork, and in particular, on obtaining a high response rate. The main fieldwork finished in September 2008.

We interviewed 2,568 respondents, carried out an additional 12 proxy interviews with carers of respondents who were incapacitated, and received postal questionnaires back from 23 people living in remote or non-UK areas. Overall therefore we obtained data from 2,603 respondents, which was 78% of people issued at this wave and 68% of baseline respondents still alive. This represents a 4% improvement in response rate over wave 4 (2000/04). For the 1970s and 1950s cohorts, we interviewed more respondents, in terms of absolute numbers, in the final wave than at wave 4. Of those interviewed 10% received follow-up quality control phone calls, in which they were asked selected repeat questions to check on the quality of the data gathered. We also asked about their satisfaction with the interview process. We are currently preparing and cleaning the data collected, writing a fieldwork report, and developing a number of methodological papers based on our experiences of trying different ways to improve retention and evaluating the effects of feeding back clinical results to respondents.



From left to right Karen Lorimer, Michael Green and Deborah Shipton.



Survey Office Staff, from left to right: Elaine Hindle, Catherine Ferrell, Julie Watson, John Kelly and Kate Campbell.

Social & Spatial Patterning of Health

For over 150 years it has been observed that health and longevity vary by both social status and by area of residence in Britain. Previous research in this area has led to an improved understanding of the significant part played by the social and physical environment in the origins of both health and illness, and of the potential role of area-based health promotion initiatives.

The aim of this programme is to study socio-economic and spatial inequalities in health across time and the life course, using data about individuals, households and areas, and a range of geographical and historical scales.

The objectives of the programme are to examine:

- the socio-economic and spatial patterning of changes in health and functioning across three key phases of life
- the relative importance for health, and changes in health, of socially and spatially patterned early life circumstances, exposures in adulthood and cumulative life experience
- the social meanings and significance over time and life of material and psycho-social resources.



Sally Macintyre

Programme Leader

Professor Sally Macintyre

Researchers

David Batty
Geoff Der
Anne Ellaway
Lindsay Gray
Kate Hunt
Catriona MacDonald
Laura Macdonald
Andrew Paterson
Noemi Travaglini

Honorary Researcher Staff

Ian Deary
(University of Edinburgh)
Dave Leon
(London School of Hygiene and
Tropical Medicine)
Nanette Mutrie
(University of Strathclyde)

PhD Students

Sarah Gurney (co-supervision, *Gender and Health*)
Kalonde Kasengele (co-supervision, *Youth and Health*)
Chloé McAdam (née Hughes)

IQ and mortality

Cognitive epidemiology is a newly developing field of research which studies the relationship between mental ability, as measured by IQ tests, and health. Here, we highlight two important publications during 2008: one concerns the relation of IQ with risk of death by homicide in a million Swedish men, and the other its association with a range of psychiatric illnesses.

Despite the relative novelty of the topic, it is already becoming well established that low IQ is related to an increased risk of later mortality. The most convincing evidence comes from early life before ill health has had much impact on the IQ test results. There are few studies which follow their participants right through from early life to the age at which there are enough deaths to establish an association, if one exists. Because of their extensive population registers and unique personal identifiers, Scandinavian countries lead the world in this type of research. We collaborated with researchers at the Karolinska Institute in Sweden to analyse data on a million men who had their IQ measured at a compulsory military conscription as part of a medical examination. These data were then linked to several population registers including death registers. Low IQ scores have been linked with an increased prevalence of assault. We examined the link between IQ and homicide and found that higher IQ was associated with a reduced rate of death by homicide, even after taking into account socio-economic position.¹³

The other study concerned the link between IQ and a number of psychiatric illnesses. Men who served in the US army during the Vietnam war were given a comprehensive examination at around 38 years of age, including a psychiatric assessment. Five psychiatric disorders were examined: major depression, generalised anxiety disorder, alcohol abuse/dependence, drug abuse/dependence and post-traumatic stress disorder. For all except drug abuse/dependence, the odds of having the disorder were greater for those with lower IQ scores at enlistment.⁴⁴

Availability of and access to physical activity opportunities and links with health behaviours and obesity among adults

This new project was awarded funding in 2008 as part of Phase two of the National Prevention Research Initiative (supported by the UK Clinical Research Collaboration). The project is being carried out in collaboration with Neil Ferguson from the University of Strathclyde and David Ogilvie from the MRC Epidemiology Unit in Cambridge.

Efforts to increase physical activity levels which focus upon changing individuals' behaviour have had limited success. Increasing attention has therefore been directed towards the potential of the local environment (e.g. the availability of physical activity amenities and resources) to influence physical activity levels and obesity. However, the precise mechanisms through which the UK environment can impact upon physical activity levels and obesity are not well understood. One potential contributing factor is the extent to which the availability of and access to facilities for physical activity is distributed equitably across different neighbourhoods. Most studies to date have been conducted in the USA or Australia, limiting their applicability to the UK. In this proposed study, we intend to examine firstly, the extent to which there is equitable distribution of the availability and access (by different modes of transport) to physical activity opportunities; secondly, to examine if the distribution of opportunity is associated with physical activity levels; and thirdly, to determine if this, in turn, is associated with obesity. We will examine these questions in relation to the Scottish population, with a particular focus on adults and fixed physical activity facilities such as sports centres, swimming pools and green space. Knowledge of the extent to which access and use of such facilities and associations with obesity is socially patterned is important for informing the direction and focus of public health and planning policy.



From left to right Anne Ellaway, Kalonde Kasengele, Linsay Gray, David Batty, and Laura Macdonald.

The distribution of health promoting and damaging resources in Glasgow

It has commonly been suggested that in modern cities individual or household deprivation (for example, low income or education) is amplified (for example, lack of jobs or good schools), in ways which damage the health of the poorest and increase health inequalities. We aimed to assess whether this is true by examining the location of 42 resources in the City of Glasgow.⁷¹ Twelve resources were closer to, or more common in, more deprived neighbourhoods: public nurseries, public primary schools, police stations, pharmacies, credit unions, post offices, bus stops, bingo halls, public swimming pools, public sports centres, outdoor play areas, and vacant and derelict land/buildings. Sixteen were closer to, or more common in, more affluent neighbourhoods: public secondary schools, private schools, banks, building societies, museums/art galleries, railway stations, subway stations, tennis courts, bowling greens, private health clubs, private swimming pools, colleges, Accident & Emergency hospitals, parks, waste disposal sites, and tourist attractions. Private nurseries, universities, fire stations, general, dental and ophthalmic practices, pawn brokers, ATMs, supermarkets, fast food chains, cafes, public libraries, golf courses, and cinemas showed no clear pattern by deprivation. Thus it appears that access to resources does not always disadvantage poorer neighbourhoods in the UK. We concluded that we need to ensure that theories and policies are based on up-to-date and context specific empirical evidence on the distribution of neighbourhood resources, and to engage in further research on interactions between individual and environmental factors in shaping health and health inequalities.



Measuring Health

The health of individuals varies according to social and economic characteristics that reflect different exposures to factors that influence health. Since populations are made up of groups of individuals, e.g. by area or by occupation, there are differences between the health of different populations.

The principal focus of the programme is on the health of the Scottish population, and it seeks to improve the methods used to measure population health and its determinants.

More specifically, the aims of the programme are:

- to improve our understanding of the health of the Scottish population, and of the variation in health between particular subgroups
- to consider the importance of different contexts, e.g. school, workplace, area of residence, at different stages in life on subsequent adult health
- to ensure that the statistical methods needed to address complex public health research problems are developed and disseminated
- to evaluate the effects of Sure Start Local Programmes in England, an area-based intervention for young children and their families.

This programme is core-funded by the Chief Scientist Office of the Scottish Government Health Directorates.



Alastair Leyland

Programme Leader

Professor Alastair Leyland

Researchers

Denise Brown
Carolyn Davies
Ruth Dundas
Lindsay Gray
Joel Hotchkiss

PhD Students

Catherine Stewart
Alison Teyhan (*co-supervision,
Ethnicity and Health*)

Population mobility, deprivation and self-reported limiting long-term illness

Individual ill health and neighbourhood deprivation are strongly linked, but this association could be due to either poor areas influencing health – “*making people ill*” – or because those with good health and good employment prospects move to more prosperous areas. Using the 2001 UK census data on self-reported long-term illness in combination with local area information, we tracked migration in and out of 42,604 Scottish local areas, categorising each area in terms of its population decreasing or increasing through migration or remaining stable in size (with high or low turnover).²⁷ In the poorest areas, illness rates were significantly lower in stable populations with low population turnover than in other areas of comparable poverty. Decreasing populations in poor areas had the highest illness rates overall. Policy makers and planners who fail to take account of this pattern of migration (which leaves those in poor health behind while others move to better areas) may see increases in area-based health inequalities which are really a statistical artefact.



Overweight status and psychological well-being in adolescent boys and girls

The prevalence of both obesity and psychological distress in children and adolescents is increasing, while in adults (particularly women) the two are related. Typically this link is explained by individual factors relating to social circumstances (poverty) or lifestyle (diet, exercise, substance use). An alternative explanation is that the association is due to “obesogenic environments” or “area effects”, such as living in deprived locations with poor access to quality foods, sports facilities or even influence from local bodyweight norms (proportion of overweight adults).

Based on two Scottish population health studies of over twelve hundred adolescents (13–15 years) in 1998/9 and 2003/4, we investigated whether environment, social circumstances or lifestyle explain the link between psychological distress and adolescent obesity.⁴⁹ We looked at factors such as area of residence, proportion of overweight or obese adults in that area, psychological distress, physical activity, smoking, alcohol consumption, area deprivation and social class.

We found obesity was linked to psychological distress, but only for girls. Even accounting for social factors (social class, deprivation), lifestyle factors (smoking, alcohol use, physical activity) and area or local factors (proportion of overweight/obese adults), girls showing signs of psychological distress remained more than twice as likely to be overweight. Our findings indicate being overweight is associated with acute psychological distress among adolescent girls and this cannot be explained by social, lifestyle or area factors. Professionals charged with tackling obesity problems should be sensitive to the significant levels of distress experienced by overweight adolescent girls.



From left to right Alison Teyhan , Ruth Dundas, Joel Hotchkiss and Catherine Stewart.

Excess mortality in Scotland and problem drug use:



Death rates in Scotland are higher than in England and that gap is increasing. Traditionally this has been blamed on Scotland's high levels of deprivation, but deprivation accounts for less than 50% of the difference. This puzzling "excess" has become known as the "Scottish effect". One explanation could be Scotland's high rate of problem drug use, with the Scottish rate nearly double that of England. One difficulty is that official data on "drug-related deaths" in Scotland are purposely restrictive because only deaths which are a direct result of an overdose are counted. However, this hides deaths linked to drug taking, such as blood borne infections, suicide and violent assaults. In order to estimate the number of deaths in the Scottish drug using population we matched mortality data to 1,033 problem drug users who participated in a 2001/2 study on Drug Outcomes in Research in Scotland (DORIS) and were followed-up three years later.²⁵ At follow-up, 38 of the DORIS participants had died, with 22 deaths being recorded as drug-related. Of the 16 remaining deaths, six were suicides (including three overdoses), three were due to drug-associated infections, two were due to assaults, one was due to alcoholic liver disease and one due to exposure. If we generalise these patterns of deaths, we estimate that 32% of Scotland's excess mortality rate is attributable to problem drug use.

Compared to smoking, excess drinking, or lack of exercise, relatively few people have a problem with drug use. However, their risk of death is high, with drug users from DORIS study 12 times more likely to die than Scotland's general population. We conclude that successful public campaigns to reduce drug use would have a strong impact on mortality in both Scotland and England, potentially narrowing the gap between Scotland and England by nearly a third.

This project was led by researchers from the University of Glasgow's Drug Misuse Research Unit.



From left to right Mary Robins (Librarian), Catherine Ferrell (Survey Manager), Crawford Neilson (Computer Systems Manager) and Patricia Fisher (Facilities Manager).

Ethnicity and Health

Many diseases such as diabetes, high blood pressure, stroke, heart and kidney disease, and cancers are more common in some ethnic minority groups than in the indigenous White population. Very little is known about the causes of these differences, when and whether they emerge in childhood, or about the transmission of health risks across generations.

A key focus in this research programme relates to the DASH (Determinants in Adolescent Well-being and Health) longitudinal study that contains about 4,000 ethnic minority children. The overall aim of this study is to examine if and when differences in key health indicators develop in childhood, and how these are shaped by social conditions, such as deprivation, family life and school life. Longitudinal data across the life course on ethnic minorities are generally lacking and we use various datasets to examine health at different points of the life course in different contexts and places. We also conduct national and international comparisons of health patterns among migrants and their children to examine how people of the same ethnic ancestry fare in different environments.



Seeromanie Harding

Programme Leader

Seeromanie Harding

Researchers

Graham Baker
Cara Booker
Niamh Donnellan
Lindsay Gray
Erik Lenguerrand
Maria Maynard
Oarabile Molaodi
Emma Rawlins
Melissa Whitrow

PhD Students

Alison Teyhan (*co-supervision, Measuring Health*)

“They’re more like ordinary stroppy British women”: Attitudes and expectations of maternity care professionals to UK-born ethnic minority women

To explore attitudes and expectations of UK-born ethnic minority mothers, we conducted in-depth interviews with 30 health professionals providing maternity and postnatal care in eight NHS maternity units in England that provide services for large proportions of women of Black Caribbean, Black African, Indian, Pakistani and Irish descent.⁸⁸

We found that most of the professionals felt that they could differentiate between UK-born and migrant mothers based mainly on language fluency and accent, but also on ‘Westernised dress’ and ‘freedom’ to make decisions about their care. Overall, professionals found it easier to provide services to UK-born mothers and felt that their needs were more like those of White English mothers than those of migrant mothers. UK-born minority mothers were generally thought to be assertive and expressive, and in control of care-related decision-making. However, some South Asian Muslim women were thought to be constrained by family influences. Women’s education and social class were felt to be major influences on the uptake of maternity care, regardless of ethnicity.

Some health professionals had specific behavioural expectations and unconscious stereotypical views, including preconceived ideas about ethnic minority mothers’ tolerance of pain in labour, use of pharmacological pain relief measures and mode of delivery, which may have the potential to affect clinical practice.

All cause and cardiovascular mortality in African migrants living in Portugal: evidence of large social inequalities

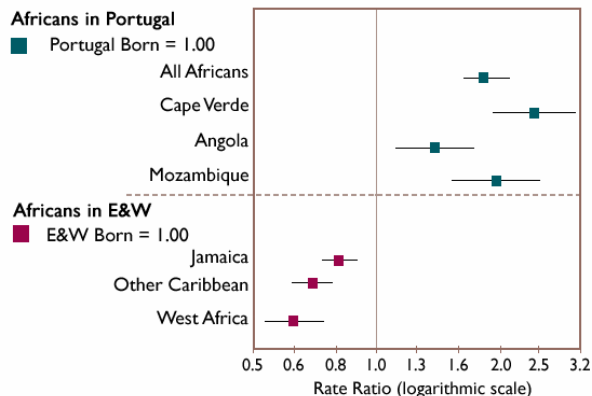
The cause of high levels of hypertension, stroke and diabetes in African origin populations remains a scientific challenge. Recent migration of people from West Africa to Western and Southern European Union countries offers the opportunity to examine the influence of different social environments on cardiovascular disease in Africans. Portugal, one of the main receiving countries, provides an interesting context in which to examine the effect of social factors on African cardiovascular mortality as it is still relatively poor compared to Western European countries, and has a high stroke but low coronary mortality.

Standardised death rates (1998-2002) by country of birth, occupational class and marital status were derived from data provided by the Portuguese National Statistical Office. African migrants had considerably higher mortality rates for both coronary heart disease and strokes compared with the Portuguese.⁵² There were large differences by class and marital status and adjusting for these factors explained a substantial part of the higher mortality risks.

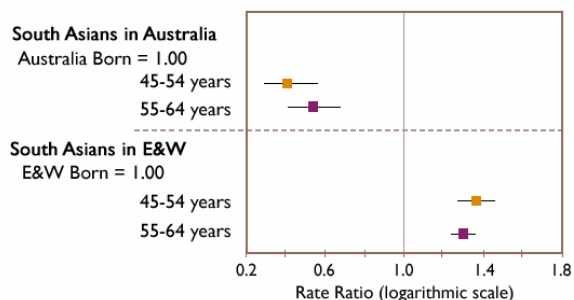
The relatively poorer health of African migrants to Portugal is not unexpected given the history of under-development and poor health in home countries. Compromised growth could influence the development of cardiovascular risk. Our findings, however, suggest that adverse socio-environmental factors (e.g. lifestyle, access to health care) are strongly linked to their high mortality. Investigating how best to achieve risk reduction in Africans should be a public health priority in Portugal.

Cardiovascular Disease Mortality 1999 - 2003

African Migrants (men): Coronary Heart Disease mortality high in Portugal, low in England and Wales (E&W)



South Asian Migrants: Cardiovascular mortality low in Australia, high in England & Wales (E&W)



Adapted from; Harding S, Teyhan A, Rosato M, Santana P. (In Press European Journal of Cardiovascular Prevention and Rehabilitation);
Harding S, Rosato M, Teyhan A. Heart 2008; 94:463-70;
Gray L, Harding S, Reid A. Eur J Public Health 2007; 17:550-4.



From left to right Cara Booker, Maria Maynard, Emma Rawlins, Graham Baker and Oarabile Molaodi.

The DEAL Study - Obesity in ethnic minority children and adolescents: developing acceptable parent and child-based interventions in schools and places of worship



The prevalence of childhood obesity is greater in some ethnic minority groups and findings from the Determinants of Adolescent Social Well-being and Health (DASH) Study provided important clues on the potentially modifiable mechanisms, notably parental and adolescent health-related behaviours and family life. In 2008 we received funding for a follow-up study to inform the design of an exploratory trial of culturally acceptable intervention components to reduce the risk factors for obesity among ethnic minority children. It explores the use of a population approach (in schools) and a targeted approach (in temples, mosques, churches).



We are using a mixture of focus group discussions, in-depth interviews and structured questionnaires to explore what children, parents, grandparents, teachers and religious leaders think hinder and promote engagement with healthy eating and active living. We are assessing the cultural appropriateness of validated measures of physical activity, dietary behaviour and self-efficacy, and of potential elements of interventions informed by the data collected. We are also assessing the potential for wider community support from local councils, community clubs, faith forums, etc.



The emergent findings suggest that while the school setting may be better for the implementation of healthy lifestyles intervention, places of worship provide valuable opportunities for family and culturally specific support for the implementation of the intervention. The study will enhance policy initiatives by developing the evidence base about culturally acceptable interventions to reduce the risk of obesity in children.



Niamh Donnellan



Erik Lenguerrand

Youth and Health

There is considerable concern about the physical and mental health of young people, and about their high levels of risk behaviours, such as smoking or drug use. There is a real possibility that things are getting worse and that stress is one of the major factors involved.

This programme aims to increase our understanding of this important stage in life in order to promote young people's current and future health, and reduce later health inequalities. The specific objectives of the programme are to describe and explain:

- health and health risk behaviours from childhood through adolescence to adulthood
- the role of the family in relation to health, lifestyles and life chances, and the extent to which family influences cut across class
- the influence of the school, peer group and youth culture on health, health behaviours and lifestyles, and the extent to which these are separate from class, gender and the family
- variation in levels of stress between social classes, schools and peer group positions.

To address these questions, we draw on three main studies: the youngest cohort of the Twenty-07 Study, born in 1972; the 11 to 16/16+ Study of a cohort born in 1983-4 and followed through to early adulthood, and our most recent study, 'Peers and Levels of Stress' (PaLS) which, in 2006, gathered data on peer groups, levels of stress, mental health and disorder in 15 year olds.

Some of our key findings and achievements over the last year are highlighted below.



Patrick West

Programme Leader

Professor Patrick West

Researchers

Helen Sweeting

Robert Young

PhD Students

Kalonde Kasengele (*co-supervision, Social and Spatial Patterning of Health*)

Douglas Lonie

Nicola Smart (*co-supervision, Gender and Health*)

Emily Smith



Measuring stress in adolescents: the collection and analysis of cortisol in a school setting

Stress is typically thought of as a psychological term, but it also has a biological element, because when people are stressed, their bodies react by releasing chemicals into the blood. One of these chemicals is cortisol, which acts to increase blood pressure and blood sugar levels. Cortisol has become a widely used biological marker of both cumulative and recent stress and is easily measured via saliva samples. While such an objective stress measure is highly desirable, little is known about normal cortisol levels among adolescents.

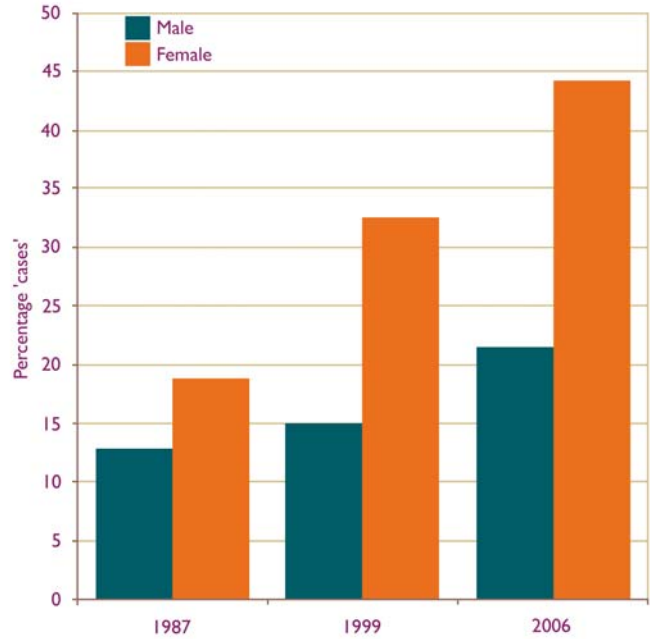
In the PaLS school-based study, 15 year old pupils provided two salivary cortisol samples 30 minutes apart during their first morning class, and information on other factors linked to cortisol (e.g. time since waking, life events, gender, height, weight) was also collected.⁶¹ Cortisol levels were consistent with those of other studies (median levels from the first of the two samples of 10.5 nmol/L for males and 11.6 nmol/L for females). The amount of cortisol varies naturally during the day; levels are highest in the early morning and lowest around midnight. Consistent with this, levels fell by more than 10% between the first and second samples in around three-quarters of the participants. Levels were higher when samples were collected on a Monday (following the weekend when people usually get up later), time of collection was earlier, time since waking was shorter, and among those who reported recent death of a friend and splitting with a boy/girlfriend. In boys, age, physical maturity, recent eating and smoking also affected cortisol levels. This method of obtaining cortisol from large numbers of participants in a real-life setting suggests an alternative to the restriction of lab-based fixed-time collection methods and provides norms for morning cortisol levels in adolescence.

Time trends in ‘psychological distress’ among young people in Scotland: 1987-2006

Research evidence on time trends in the mental health of children and young people is mixed. While some studies have identified increases, others have not, or have shown complex trends. Comparisons are also hampered by methodological problems including the use of different measures or the inclusion of participants from different geographical locations or age groups. We have been able to examine changes over time using three studies of 15 year olds, all of whom lived in or around Glasgow, were in statutory schooling and completed the same measure of psychological distress (anxiety and depression assessed using the 12-item General Health Questionnaire, or ‘GHQ-12’) in 1987 (Twenty-07 Study), 1999 (11 to 16) and 2006 (PaLS).⁹⁹

We found steep increases in psychological distress between 1987 and 1999 for girls, which continued between 1999 and 2006. Boys also showed a rise in distress over the later time period (see graph). Evidence of differential increases in particular types of items (e.g. those representing anxiety and depression, versus loss of confidence or self-esteem) was weak, in comparison with increases in *all* dimensions of psychological distress. Our results suggest the need for greater attention at the level of primary care or, given evidence that this age group find it difficult to consult their GP with mental health concerns, within school or alternative counselling services. Our next important step is to identify causal explanations for these increases.

Levels of psychological distress at each date: percentages of GHQ-12 ‘cases’ among males and females in 1987, 1999 and 2006



From left to right Robert Young, Helen Sweeting, Douglas Lonie and Emily Smith.

Pupils' experiences of the primary-secondary transition and consequences for well-being and attainment



Schools spend considerable time ensuring a successful transition from primary to secondary school, but how much does this really matter for pupil's well-being and educational attainment? Expert opinion is divided, with one side suggesting that children's anxieties are relatively short-lived while others suggest a poor transition can have a profoundly lasting negative effect. Because of the lack of longitudinal research, especially over a long timespan, the question remains unanswered.

A unique perspective on this issue is provided by our 11-16/16+ Study, in which around 2,500 pupils were followed from their primary school (aged 11) through secondary school (aged 13 and 15) into the post-school period (aged 18/19).¹⁰⁹ Throughout, a wide range of information was collected about their health and well-being, social background and personal characteristics, and at age 13 they recalled their experiences of the primary/secondary transition.



The majority (66%) reported some difficulties adjusting to the new school environment (e.g. school size) and nearly half (47%) reported worries about other pupils (e.g. bullying). Pupils of lower ability and lower self-esteem at age 11 had more difficulties in coping with school matters, those with lower self-esteem, who had been bullied and who were already anxious, had more problems coping with other pupils. However, already having a friend in secondary school reduced this concern. Most importantly, controlling for a range of other factors (e.g. ability, social background), poor transitions were independently related to higher levels of depression and lower exam grades both later on in school (aged 15) and after leaving school (aged 18/19). Our study considerably adds to the transitions evidence base and demonstrates that for some young people a bad transition can have profound consequences for later well-being and attainment.

Sexual and Reproductive Health

Sexual health is a major public health concern in the UK, due to high rates of sexually transmitted infections, unwanted pregnancies, and regretted sexual experiences. In the UK, young people, men who have sex with men, and Afro-Caribbean people are particularly vulnerable to poor sexual health. In east and southern Africa, sexual ill health is extremely serious, with HIV prevalence between 5% - 40% amongst adults. It is made worse by underdevelopment and in turn hinders development.

The broad aims of this programme are to better understand the key social factors that shape sexual risk behaviour, to develop appropriate programmes to improve sexual health, and to evaluate such programmes.

Research in this programme includes:

- original studies being conducted in the UK and East Africa, primarily Tanzania, using both qualitative methods, e.g. in-depth interviews and participant observation, and quantitative methods, e.g. questionnaire surveys and an HIV prevalence survey using saliva samples
- bringing together existing research findings by systematically reviewing the published literature
- developing new programmes through research and consultation with vulnerable groups and service providers, followed by careful assessment of initial ideas
- evaluating programmes using a range of methods from randomised controlled trials to detailed qualitative research.



Daniel Wight

Programme Leader

Daniel Wight

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PhD Students

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Caroline Sime (*co-supervision, Gender and Health*)
Godfrey Siu

School effects on sexual behaviour and smoking

Beyond the formal curriculum, schools can influence pupils' behaviour through their social organisation and culture. 'School effects' refer to the influence that schools have on pupils (e.g. in relation to health) distinct from the other influences on those pupils. We explored school effects, amongst 15/16 year olds, for reported sexual experience and smoking.^{56 57}

Longitudinal data from ~5,000 pupils in 24 SHARE Study schools in Scotland were linked to qualitative and quantitative data on school characteristics, such as quality of relationships between pupils and teachers. Overall, 42% of girls and 33% of boys reported experience of heterosexual intercourse. School rates ranged from 23%-61%. Individual-level socio-economic and cultural factors explained much of the variation between schools. Importantly, school characteristics did not explain further variation. The remaining difference was accounted for by school-level socio-economic factors, suggesting that the culture and socio-economic environment of the neighbourhood further influenced sexual behaviour. This was the first analysis of school effects on sexual behaviour.

Smoking was reported by 25% of males and 39% of females; school rates ranging from 8% - 33% for males and from 28% - 49% for females. Once individual socio-economic and cultural factors were taken into account there was still much variation between schools. This variation was strongly associated with pupils' rating of teacher-pupil relationships and attitude to school. In addition, researchers' rating of the schools' focus on caring and inclusiveness was associated with smoking rates. These findings provide support for the school-wide or "Health Promoting School" approach to smoking prevention.

The sexual health of incarcerated young offenders



Little is known about the sexual and reproductive health of incarcerated male young offenders, a key group in attempts to address sexual health inequalities. This study explored the lives of a small number of young offenders in terms of their attitudes and experiences in relation to girlfriends, contraception, pregnancy and fatherhood, sex education, sexually transmitted infections (STIs) and health service use for sexual health matters.¹¹⁹ Sixty-seven inmates were surveyed at HM Young Offenders Institution (YOI), Perth; in-depth interviews were conducted with 40 of them.

One of the most striking findings was that the majority of the men reported having undergone STI testing. Most had sought testing for the first time within the YOI, largely because the process was so convenient. Apathy and unawareness that testing was available, rather than objections or embarrassment, were the main reasons why some did not seek a test within the YOI.

This suggests that an opt-out STI screening programme in YOIs would probably result in very high testing rates. Strategies to combat apathy with regard to STI testing might also increase take-up outside prison, as would offering tests in institutional settings frequented regularly by the young men.





Involving parents in sexual health promotion in Tanzania

Involving parents in sexual health promotion means their children can be reached before starting sex and can be engaged in discussions that are responsive to children's questions and needs. Furthermore, many parents in sub-Saharan Africa feel that their own life experiences have limited relevance to their children and they are therefore keen to acquire information and skills to help protect their children from sexual risks.

A needs assessment in northern Tanzania, in collaboration with the National Institute of Medical Research, Tanzania, the Liverpool School of Tropical Medicine, and the London School of Hygiene and Tropical Medicine, led to the development of a community-based parenting intervention, *Mema kwa Jamii*. Targeted at parents of 10-14 year olds, the curriculum of five sessions aims to: raise awareness of sexual health issues; address prevailing gendered power relations; provide parenting skills and knowledge; and strengthen community efficacy to influence their children's futures through active learning and community mobilisation.

In each community a representative group of opinion leaders participate in the five sessions. They then lead similar sessions themselves with small groups recruited from their peer networks. Participants in these groups then recruit and facilitate further groups of peers, and this cyclical process is repeated until saturation is reached within the target group.

To assess the appropriateness of the intervention, how people respond and how it can be improved, an evaluation is being conducted in four contrasting villages in Mwanza Region. This involves observation of sessions, in-depth interviews and group discussions with opinion leaders, parents, and adolescents. Results should be available in late 2009.



From left to right: Marion Henderson, Lisa Williamson, Katie Buston, Godfrey Siu and Denise Smith.

Gender and Health

Our current research in the gender programme focuses on four main areas. These are: sex differences in health and illness; gender and health behaviours (both in relation to the contribution that health behaviours make to sex differences in health and the ways health behaviours are linked to gender identities); gender and help-seeking; and gender and the understanding and experience of health and illness. Here we highlight some of our current work on gender and the understanding and experience of illness, and gender and health behaviours.

We were pleased to welcome Nicola Smart to the Gender team in 2008. Nicola will be studying gender and attitudes to alcohol. We were sorry to say goodbye to Heather Lewars but we appointed Dr Saadia Tayyaba to replace her. Saadia will join the Unit early in 2009.



Kate Hunt

Programme Leader

Professor Kate Hunt

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Caroline Sime (*co-supervision, Sexual and Reproductive Health*)
Nicola Smart (*co-supervision, Youth and Health*)

Media influences on health behaviours in male and female adolescents

We are undertaking research looking at the influence of the media on health behaviours in male and female adolescents. Studies from USA and Germany have shown an association between images of smoking in films and smoking initiation in early adolescence. We examined this association in early adulthood (at age 19) using the Unit's 11 to 16/16+ Study. In this older group, we found no association between images of smoking in films and young adults' own smoking in either sex.⁶⁰ We speculated that this difference with findings from the US and Germany could reflect greater media literacy in older adolescents, the influence of other media (e.g. TV) images of smoking, or greater visibility of real-life smoking in Scotland. We are currently investigating these associations in 14-15 year olds in another area of Scotland, and ongoing PhD research is using qualitative methods to investigate how young people interpret media portrayals of health behaviours and how this relates to their perceptions of what is appropriate for themselves and the opposite sex.

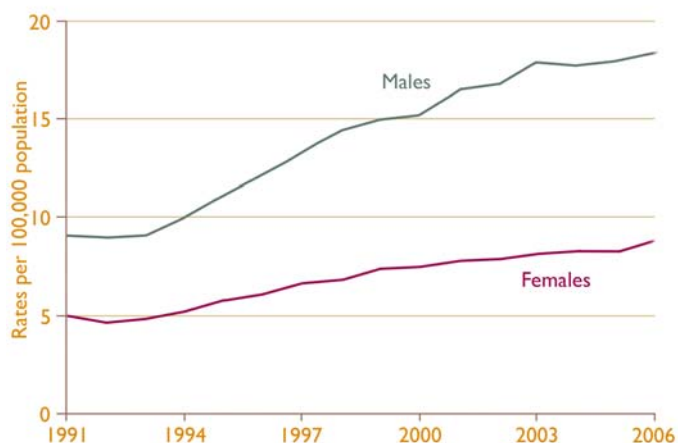


Gender and alcohol consumption across the life course

Within Western Europe, the UK has one of the highest levels of binge drinking, and although hazardous drinking has historically been regarded as a male problem, increases among young women have led to suggestions that women are beginning to drink more like men. Despite media portrayals which emphasise drinking among young women, and recent media headlines asserting that young women in the UK are the 'worst binge drinkers in the world', in analyses of data from the Twenty-07 Study we confirmed that men are at much greater risk of alcohol-related problems.⁴¹ For example, at age 28, 45% of men and 20% of women were classed as 'binge' drinkers (equivalent figures at ages 48 and 68: 29% vs 7%, and 12% vs 1%). Other work suggests that, amongst men who were born in the early 1930s, disadvantaged circumstances across the life course, but particularly in adulthood, were associated with detrimental patterns of alcohol consumption and problem drinking in late middle age.¹²

We are examining the associations between gender and alcohol in other ongoing work. For example, one project is exploring whether gender differences in alcohol-related deaths vary in different parts of Scotland. Alcohol-related deaths have doubled over the last decade for both men and women. Men drink more alcohol, and have higher rates of alcohol-related death, than women. Scotland has one of the highest rates of alcohol-related death in western Europe, but some areas in Scotland have very high mortality from alcohol-related deaths and some have very low rates. We are exploring which areas have the highest rates of alcohol-related deaths in men and women, and whether there are areas in Scotland where the gender gap is unusually large or unusually small. To do this analysis, we have divided Scotland into 144 areas (typical population 35,000 people) based on the census and obtained records of alcohol-related deaths between 2000 and 2005 for each area.

Death rates from alcohol-related causes in the UK
(source ONS)



Source: National Statistics website: www.statistics.gov.uk
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From left to right Nicola Smart, Carol Emslie, and Caroline Sime

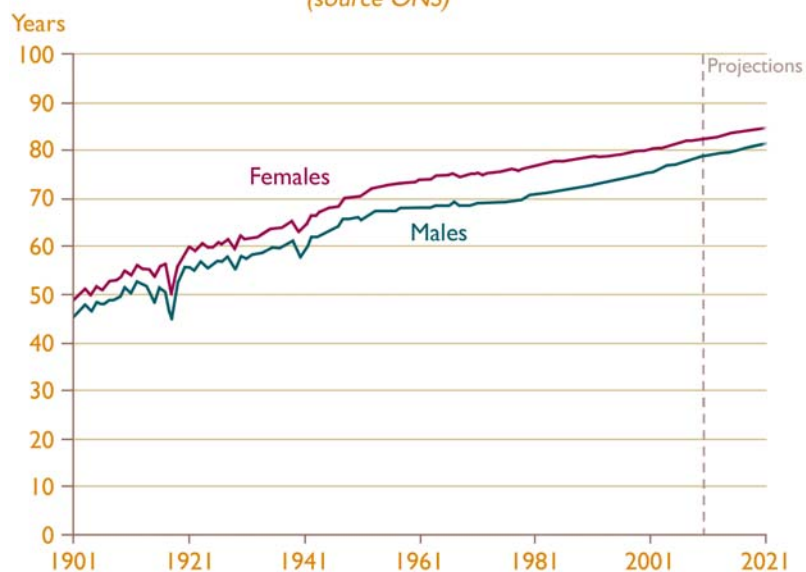
Lay perceptions of gender differences in life expectancy



In the UK, as in most parts of the world, life expectancy at birth is longer for women than men (currently 81.5 years for females and 77.2 for males) but there is little research on 'lay' understandings of this gender difference. We interviewed 45 people sub-sampled from the youngest (born in the early 1970s) and middle (born in the early 1950s) cohorts of the West of Scotland Twenty-07 Study in order to explore this question.⁴² Our data suggest that respondents were well aware of women's increased longevity, but found this difficult to explain. Although many accounts were multifactorial, socio-cultural explanations were more common, more detailed and less tentative than biological explanations. Biological explanations ranged from general descriptions of women having a different 'makeup' to narratives which drew on scientific terms such as 'hormones' and 'genetics'. References to biology were almost always combined with socio-cultural explanations. Different socio-cultural explanations (i.e. gendered social roles, 'macho' constraints on men admitting to symptoms and consulting health professionals, and gender differences in health-related behaviours) were linked by the perception that life expectancy will converge as men's and women's lives become more similar. Female respondents were more likely to focus on women's reproductive and caring roles, while male respondents were more likely to focus on how men were disadvantaged by their 'provider' or 'breadwinner' role.

Life expectancy at birth in the UK

(source ONS)



Source: National Statistics website: www.statistics.gov.uk
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Evaluating the Health Effects of Social Interventions

Policy makers, such as politicians and civil servants, make decisions on a daily basis which affect our lives and possibly our health. These include decisions about whether and where to build new roads, how much to spend on building new housing, and how best to improve the public's health. To help with this decision-making process they need continual access to good quality health research.

The aim of this programme is to ensure that policy decisions which may affect our health are based on the most reliable research evidence available, rather than on poor evidence, anecdote or conventional wisdom. The programme contributes to this by carrying out new studies, and bringing together existing research and publishing it in summary form.

The objectives of the programme are:

- to undertake systematic reviews of the effectiveness of social or health interventions – policies programmes and projects – in improving health
- to carry out primary studies evaluating the health impacts of social and health policies and interventions.

This programme is core-funded by the Chief Scientist Office of the Scottish Government Health Directorates.



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Programme Leader

Lyndal Bond

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Information Scientist

Candida Fenton

SHARP



There is a lot of evidence to show that bad housing is connected to poor health, but there is not much evidence to show what happens to health when housing improves. Building on our systematic review of housing improvement and health and the Renton Study, the SHARP Study was designed to investigate the experience of about 330 households who moved into new houses (our intervention group) in comparison with a similar number of households who didn't move (our controls). Over a two-year period we measured the health of both groups and related effects of major housing improvement information about the neighbourhood, such as the availability of services, people's sense of community and their experience of crime. We found:

- Housing conditions improved for people who moved to new houses. In particular, dryness, building repair, heating, amenities and perceptions of space and safety improved.
- Neither physical nor mental health changed a great deal for those who moved house, although those who gained a private garden or more space reported better mental health.
- Crime and anti-social behaviour were reported to be less of a problem for people who moved
- People who moved said they felt safer and had a stronger sense of community.^{128-131 134 135}

SHARP was a collaborative project with Professor Ade Kearns, Department of Urban Studies, University of Glasgow, funded by Chief Scientist Office and Communities Scotland

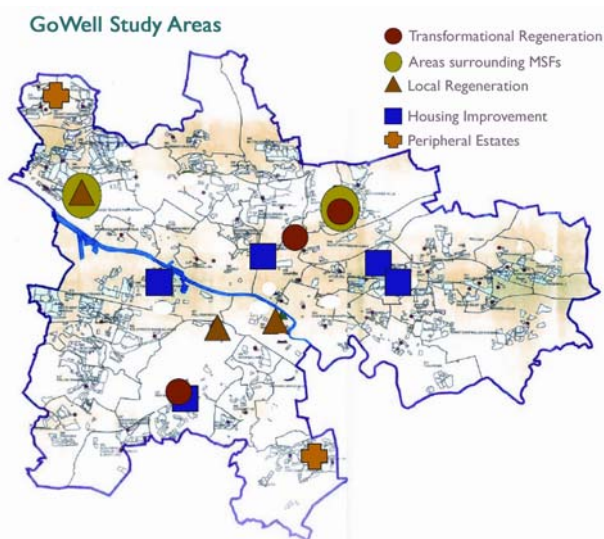
GoWell is a 10-year prospective evaluation of the health and well-being impacts of a major programme of community regeneration across Glasgow. The evaluation involves a number of Glasgow neighbourhoods undergoing different kinds of major regeneration, or refurbishment (see figure).

A major part of our work during 2008 was the completion of the second wave of the *community health and well-being survey*. This involved a random sample of about 4,000 households across the 15 study areas. In addition, we sought to re-interview people who took part in the wave 1 survey who are still living at the same address (the *tracker study*). As part of this second survey, in early 2009 we will be conducting a *tracer study* of a sample of people who took part in wave 1 and have moved out of their areas. The longitudinal information will help us to examine change over time and whether there are any differences between people who move away from communities and those who stay.

We have completed the evaluation of three Glasgow Housing Association community-based programmes (GoWell 'nested studies') and continued with the analysis of the wave 1 (baseline) survey examining the health and well-being effects of living in high-rise flats, and whether a person's environment affects the level of physical activity they undertake.

In 2009, we will be examining in detail the effects of tenure mix (the mix of social renters, owner occupiers and private renters) on health and social outcomes in GoWell study areas. We will also be taking forward the GoWell economic evaluation. GoWell provides a timely opportunity to assess the cost-effectiveness of regeneration initiatives in relation to improving health and well-being.

GoWell is a collaborative partnership between the Glasgow Centre for Population Health, the University of Glasgow, and the MRC Social and Public Health Sciences Unit, sponsored by Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow and Clyde.



From left to right Hilary Thomson, Marcia Gibson, Kathryn Skivington, and Elena Sautkina.

Systematic reviews examining social interventions and their effects on social inequalities in health

Health is influenced by social and environmental factors which vary depending on an individual's social position as determined by factors such as income, class and gender. There is a great deal of evidence describing the nature of these health inequalities in society, but much less about effective ways to tackle them. We have undertaken a number of systematic reviews examining the effects of population-level and non-healthcare interventions on health and inequalities in health.

Our reviews of **population-level tobacco control** found that higher prices appeared to reduce smoking among younger people, lower-income adults, and those in manual occupations. Smoking restrictions in schools may be more effective in girls, and restrictions on sales to minors may be more effective in white than non-white groups.^{72 100 124}

In our systematic reviews of **organisational-level workplace interventions**, we found increasing employee control through increased participation in decision-making may benefit the health of lower grade

workers and those from ethnic minorities. Interventions that increase demand or decrease control adversely affect the health of employees. These findings lend support to work place initiatives to increase job control and autonomy.^{7-9 38}

In our systematic review of reviews examining the impact of **non-healthcare interventions on health outcomes and health inequalities** we found few studies included data on health impacts on different social groups but there was some evidence that housing and work environment interventions had the potential to tackle health inequalities.¹¹⁷ There is clearly a need for more research on how higher level interventions affect health and health inequalities.

We are undertaking a review of the impact on health and wider determinants of health of major sporting events. The findings will inform a health impact assessment of the 2014 Commonwealth Games. We have also updated the review of housing improvements and health; this will be made available in 2009.



Courtesy of Designhive/Glasgow 2014.

Understandings and Use of Public Health Research

This is not a core-funded programme but over the years we have carried out a considerable body of research into public, scientists', practitioners' and policymakers' understandings and use of public health research. Engaging with the public on issues of biomedical research is an important aspect of the MRC's drive towards improving public health. The public are increasingly exposed through written and broadcast mass media (including the internet) to a vast array of findings from medical research and therefore it is becoming increasingly important to investigate lay and professional understandings of how this research is presented and what it means for their health. Much of the written and broadcast media material stems from epidemiological research and deals with everyday risks (e.g. smoking, diet, where you live), or stories which become particularly controversial over a period of time (e.g. BSE, MMR vaccine). The aims of this "virtual" programme are twofold. First, to examine presentations and understandings of public health threats (and particularly those which could disrupt effective public health interventions or undermine public confidence in health research more generally) and secondly, to contribute to improving understanding of the processes and complexities involved in knowledge translation.



Communicating Health Information & Research into Practice & Policy (CHIRPP)

Programme Leaders

Professor Kate Hunt, and
Professor Sally Macintyre

Researchers

Shona Hilton
Mairi Langan



Shona Hilton



Mairi Langan

Following on from our past research on parents' perceptions of the measles, mumps and rubella vaccine (MMR), the CHIRPP project (funded by the MRC's Population Health Sciences Research Network - www.populationhealthsciences.org) aims to gain a better understanding of how research findings are reported, understood and acted upon by the public and health professionals. The project uses immunisation as a case study through which to examine these issues. Most of the fieldwork for this project has been conducted in 2008 and here we highlight three ongoing projects.

1. Health professionals' engagement with research evidence

Health visitors have a pivotal position in providing parents with up-to-date evidence-based care for child health. The controversy over the safety of the MMR vaccine drew attention to the difficulties that health visitors face when new research which questions current guidelines and practices is published. In 2007, some years after the MMR controversy was at its height, we administered a survey to health visitors (n=185, 81.1% response rate) attending their annual professional conference. The survey asked about the sources used to find out about new research evidence on immunisation and examined barriers and facilitators to using research evidence in practice. It also assessed health visitors' confidence in using research evidence. These data are currently being analysed. During 2008 we followed up this research by conducting 30 telephone interviews with community practitioners to find out what they think makes evidence more comprehensible, convincing and useable. The analysis of these interviews is ongoing.

2. Newsprint media representations of the introduction of the HPV vaccination programme in the UK

In September 2008, the human papillomavirus (HPV) immunisation programme was introduced in the UK for schoolgirls aged 12 to 13 years (with a two year 'catch up' campaign for girls up to 18 years of age). Cervarix®, the bivalent vaccine chosen by the Department of Health shows high efficacy in preventing infection against HPV types 16 and 18 and it is estimated that the programme will thus offer protection against viruses responsible for 70% of cervical cancer. To be most effective, the vaccine needs to be administered before exposure to the virus; i.e. before young people become sexually active. We anticipated that, given the pervasive nature of mass media in everyday life and public interest in stories about health, illness and disease, a vaccine given to young girls to prevent a sexually transmitted infection was likely to attract media attention. In 2008 we examined coverage of the introduction of the HPV vaccination programme in 15 national UK newspapers (over the period from Jan 2005 to Dec 2008). We are currently in the process of conducting content analysis on 344 articles identified to date.



3. Representations of the introduction of the HPV vaccination programme in the UK in key practitioner journals and magazines

We have complemented this analysis of the 'popular' print media with an analysis of the coverage of the introduction of the HPV vaccination programme in a selection of key publications (Jan 2005 to Dec 2008) read by health professionals. Content analysis will examine how evidence on the HPV vaccine has been presented to health professionals. This work will contribute to the timely dissemination of scientific knowledge and the wider debate about how research evidence can be made more useful to practitioners and policymakers, and towards a greater understanding about public engagement with science in order to optimise our effective use of public health research.



Knowledge translation: supporting the dissemination and implementation of MRC research on public health and health services policy

This three-year project is funded by the MRC Population Health Sciences Research Network. So far we have conducted a scoping review to draw together existing evidence on effective knowledge translation and implementation strategies. We have also conducted a survey across MRC and non-MRC research Units and programmes within the UK, which were identified by contacting ten UK funding agencies. We used this to elicit researchers' views on the barriers to and facilitators of knowledge translation of research, and to identify areas of innovation in dissemination practices.

The survey is currently being followed up with interviews, and we will use these quantitative and qualitative data to explore how the uptake of publicly-funded clinical and public health and health services research could be enhanced.

The project is being carried out in collaboration with the Centre for Research and Dissemination at the University of York (Paul Wilson), the MRC General Practice Research Framework (Irwin Nazareth) and the University of Kent (Mike Calnan).

Professional Activities by Unit Staff in 2008

National and International Scientific Committees (including Steering Groups, Expert Panels, and Policy and Funding Committees)

2008 Research Assessment Exercise Main Panel A	Forestry Commission, The Outdoor Environment as a Means of Tackling Poor Health and Health Inequalities Study Steering Committee
2014 Commonwealth Games Health Legacy Group	
2014 Commonwealth Games Legacy Executive Group	Glasgow Centre for Population Health, Psychological, Social, and Biological Determinants of Health (pSobid I) Study Steering Committee
BMA Scottish Junior Doctors Committee	
Caledonia Youth Board of Trustees	Health Protection Scotland, Advisory Panel for the Scottish Human Papilloma Virus Prevalence Study in Schools and Colleges
Centre for Research on Families and Relationships (Edinburgh)	Health Protection Scotland, Risk Communication Group
Children 1st and Glasgow Centre for Child & Society, Young Fathers Research Advisory Group	London School of Hygiene & Tropical Medicine, School Ethos Project Advisory Committee
Cochrane Public Health Review Group (Advisory Group), University of Melbourne	Men's Health Forum Scotland, Operational Management Group
Communities Scotland, Scotland's Housing & Regeneration Project (SHARP) Advisory Committee	Men's Health Forum, Academic Wing
Department for Children, Schools & Families, Targeted Mental Health in Schools Evaluation Project Academic Advisory Group	Midspan Study Steering Committee
Department of Health, National Healthy Schools Programme, Advisory Committee	MRC Advisory Board
Department of Health, Public Health Research Consortium	MRC College of Experts
DiEt and Active Living (DEAL) Study, UK, Research Advisory Group	MRC Council
Division of Community Based Sciences, University of Glasgow, Executive Committee	MRC Data Sharing and Support Services Project
Division of Community Based Sciences, University of Glasgow, Research Committee	MRC Equalities Project Steering Group (Science and Funding Sub-committee)
Environment Research Funders Forum Horizon Scanning Project, Expert Panel	MRC Population Health Sciences Research Network
ESRC Interdisciplinary Early Career Fellowships Competition Funding Committee	MRC Regulatory Support Advisory Group
ESRC Investigator Interview Panel	National Institute for Health and Clinical Excellence (NICE), Implementation Strategy Group
ESRC 'Middle-class, adolescence and diet' Advisory Group	NERC Environment and Human Health Research Programme Grant Assessment Panel
European Public Health Association, Governing Council	NHS Greater Glasgow and Clyde, Glasgow Gay Men's Sexual Health Strategic Framework Group
European Public Health Association, Section on Migrant Health	NHS Greater Glasgow and Clyde Sustainability Planning and Implementation Group
European Public Health Association, Section on Public Health Epidemiology	NHS Health Scotland, Health Promoting Schools Evidence Base Advisory Committee
EU URBAN-NET, Expert Panel	NHS Health Scotland, Review Group of the MMR Discussion Pack/Website
Faculty of 1000 Medicine: Social and Behavioural Determinants of Health Section	NHS Scotland, Children and Young People's Mental Health Indicators Project, Advisory Group
	Rowett Institute of Nutrition and Health, University of Aberdeen (in collaboration with the Institute of Applied Health Sciences, University of Aberdeen and NHS

Grampian), Evaluation of Schools (Health Promotion and Nutrition) (Scotland) Act 2007, Expert Panel

Royal Statistical Society Glasgow Local Group

Scottish Development Centre for Mental Health, Board of Directors

Scottish Executive Health Department, Expert Reference Group for Measuring Health Inequalities in Scotland

Scottish Government Health Department, National Sexual Health & HIV Advisory Committee

Scottish Government Health Department, National Sexual Health & HIV Advisory Committee Action 13 Survey Subgroup

Scottish Government Health Department, National Sexual Health & HIV Advisory Committee MSM Project Subgroup

Scottish Government Health Department, National Sexual Health & HIV Advisory Committee HIV Action Plan Subgroup

Scottish Government, Short Term Technical Advisory Group on Measuring Health Inequalities

Scottish Intercollegiate Guidelines Network (SIGN) Guideline 42: Management of genital Chlamydia trachomatis infection Update Development Group

Scottish Longitudinal Study Research Board

Scottish Public Health Observatory Steering Group

Scottish Public Health Trainees Group

Scottish Public Health Training Committee

Society for Social Medicine Committee

Suicide Information Research and Evidence Network Steering Group

UK Government, Foresight Advisory Panel

UK Indoor Environment Group Interest Group

UK Transport Research Centre Expert Panel

University of Glasgow Faculty of Law, Business and Social Sciences Ethics Committee

University of Glasgow Faculty of Medicine, Ethics Committee

Wellcome Trust Pathogens, Immunology and Population Health Strategy Committee (formerly Populations and Public Health Strategy Committee)

WHO Environmental Burden of Disease Attributable to Housing, Expert Panel

WHO Housing and Health International Expert Group

WHO Scottish Health Behaviour in School-aged Children Study Advisory Group

Editorships and Editorial Boards

Ethnicity and Health

European Journal of Public Health Editorial Advisory Board

Global Public Health

Health & Place

Health Education

Journal of Youth Studies

Medical Decision Making

Pharmacoeconomics

Sociology of Health & Illness

The Open Urban Studies Journal

Organisation of conferences

Men's Health Forum Scotland

Scottish/Swedish/Finnish Health Inequalities Workshop



PhD Awards for Unit Researchers

Four Unit staff were awarded their PhDs from the University of Glasgow in June 2008. From left to right, Mairi Langan conducted a contemporary history of the origins and development of UK Biobank, Kate Hunt's thesis explored gender and health by systematically comparing the health and health experiences of men and women, Seeromanie Harding examined mortality and morbidity patterns in ethnic minorities in England and Wales, and Lisa Williamson studied young women's contraceptive careers.

Unit Publications in 2008

Books

1. Elliot R. *Women and Smoking since 1890*. Abingdon: Routledge, 2008.
2. Henderson M. *How do secondary schools influence teenagers' health behaviours? Schools that enhance versus schools that diminish students' health behaviours – taking account of different student characteristics at each school*. Saarbrücken, Germany: VDM Verlag Dr. Muller Aktiengesellschaft & Co. KG, 2008.

Book section

3. Armstrong R, Waters E, Roberts H, Oliver S, Anderson L, Petticrew M. Systematic reviews of health promotion and public health interventions. In: Hegggenhoughen K, Quah S, eds. *Encyclopedia of Public Health*. San Diago: Academic Press, 2008:297-301.

Refereed Journal Articles

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138. Raab G, Burston A, Henderson M, Storkey H, Elliot LS, Davies J. *Final Report on the randomised controlled trial of Zero Tolerance Respect (pre-sex education/citizenship education) in Midlothian Primary Schools. Report to CSO (CZG/2/313)*. Edinburgh: Napier University, 2008.
139. Raab G, Burston A, Henderson M, Storkey H, Elliot LS, Davies J. *Short-term evaluation of the Zero Tolerance Respect package in Midlothian primary schools, a randomised controlled trial*, 2008.
140. Roberts H, Petticrew M, Macintyre S, Liabo K, Stevens M. *Randomised controlled trials of social interventions: report of a pilot study of barriers and facilitators in an international context*. Glasgow: MRC Social and Public Health Sciences Unit, Occasional Paper 19, 2008.
141. Sweeting H, Young R, West P. *The Peers and Levels of Stress ('PaLS') Study: basic frequencies and documentation*. Glasgow: MRC Social and Public Health Sciences Unit, Working Paper no. 17, 2008.
142. The National Evaluation of Sure Start (NESS) Research Team (including Leyland A.H.). *The impact of Sure Start Local Programmes on three year olds and their families*. London: Institute for the Study of Children, Families and Social Issues, Birkbeck, University of London, NESS/2008/FR/027, 2008.

143. Thomson H. HIA forecast: cloudy with sunny spells later? (Viewpoint). *European Journal of Public Health* 2008; **18**:436-8.
144. Young R. In My View: there are many good things about Goths. *The Sunday Post January 28, 2008*:40-1.
145. Young R, van Beinum M. *Self-Harm Online Continuing Professional Development Module*. London: Royal College of Psychiatry, 2008.

THESES

146. Harding S. Mortality and morbidity patterns in ethnic minorities in England and Wales: evidence from the office for National Statistics Longitudinal Study [PhD]. *MRC Social and Public Health Sciences Unit*. Glasgow: University of Glasgow, 2007.
147. Lewis R. Parent-child communication about sex and sexuality: everyday practices, processes and meanings [PhD] (supervised by Katie Buston): University of Edinburgh, 2008.

Unit Presentations given by Staff in 2008

1. Alves J, Gale CR, Mutrie N, Correia J, Batty GD. Effect of a six month exercise intervention on body weight in previously overweight/obese women: randomised controlled trial in a slum ("favela") in a developing country (Brazil) [Poster]. *XVIII IEA (International Epidemiological Association) World Congress of Epidemiology*. Porto Alegre, Brazil, 2008.
2. Alves J, Figueiroa J, Alves LV, Batty GD. Physical activity in a very low income population in NE Brazil [Poster]. *XVIII IEA (International Epidemiological Association) World Congress of Epidemiology*. Porto Alegre, Brazil, 2008.
3. Aston E. Drug use and offending: the relationship over the teenage years. *European Society of Criminology Conference*. Edinburgh, UK, 2008.
4. Aston E, Bond L, Thomson H. Young people in GoWell regeneration areas. *GoWell Seminar Series for the Scottish Government*. Edinburgh, UK, 2008.
5. Aston E, Thomson H. Youth Diversionary Projects and community safety: challenges for evaluation. *European Society of Criminology Conference*. Edinburgh, UK, 2008.
6. Aston E, Thomson H. Youth Diversionary Projects: challenges in evaluating the health effects of a social intervention. *International Conference on Urban Health*. Vancouver, Canada, 2008.
7. Batty GD, Lewars H, Emslie C, Gale CR, Hunt K. British Medical Association-endorsed guidelines for 'sensible' alcohol consumption: is exceeding them actually detrimental to health and social circumstances? Evidence from a population-based cohort study. *SSM (Society for Social Medicine) Meeting*. Southampton, UK: *Journal of Epidemiology & Community Health*, 2008; **62**:Suppl1;A9.
8. Batty GD, Shipley M, Macintyre S, Der G, Mortensen L, Dundas R, Deary IJ. Does IQ explain socioeconomic differentials in mortality? Comparison with the explanatory power of traditional risk factors in a prospective cohort study. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:117.
9. Batty GD. IQ in early adulthood: associations with somatic and psychiatric health outcomes in the Vietnam Experience Study. Invited Symposia: Why is IQ a predictor of death? *XXIX International Congress of Psychology*. Berlin, Germany, 2008.
10. Batty GD. Pre-morbid IQ, the metabolic syndrome and mortality: the Vietnam Experience Study. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
11. Batty GD, Gale CR, Mortensen L, Langenberg C, Shipley M, Deary IJ. Pre-morbid IQ, the metabolic syndrome and mortality: the Vietnam Experience Study. *SER (Society for Epidemiologic Research) Meeting*. Chicago, USA, 2008.
12. Batty GD, Leon D, Benzeval M, Macintyre S. Profiles of the Aberdeen Children of the 1950's Study and the Twenty-07 Study [Poster]. *Cohorts and Prospective Studies: A North-South Networking Meeting*. Arusha, Tanzania, 2008.
13. Benzeval M. The West of Scotland Twenty-07 Study: Health in the Community. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
14. Bond L, Butler H. Can you do an RCT if the intervention is not standardised? The Gatehouse Project a process of change not a product. *Randomised Controlled Trials in the Social Sciences: Methods and Synthesis. 3rd Annual Conference*. York, 2008.
15. Bond L. Evaluating the health effects of social interventions. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
16. Bond L. Evaluating the health effects of social interventions: what works to reduce health inequalities? *UK Health Select Committee*. Glasgow, UK, 2008.
17. Bond L. Rethinking health promotion in schools: Lessons from the Gatehouse Project. *Health and Ethics Health Challenge Wales: Evidence for Policy Seminar Series*. Cardiff, 2008.
18. Bond L. School-based interventions for improving young people's health. *Continuing Professional Development Scottish Government, Directorate General for Health and Wellbeing, Chief Medical Office Directorate, Public Health Professionals Group*. Edinburgh, UK, 2008.
19. Bond L. Transforming the work of schools to embed health promotion: building on the Gatehouse Project. *Workshop for the Festival of Social Science*. London, UK, 2008.
20. Booker C, Harding S. Systematic review of retention methods used to retain ethnic minority populations in cohort studies [Poster]. *2nd Conference of Migrant Health in Europe*. Sweden, 2008.
21. Buston K. Behind and beyond the prison bars: young offenders talk about sex and relationships. *External seminar series MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
22. Butler H, Trafford L, Walter R, Drew S, Bond L. Focus on wellbeing in school improvement – a systems level focus. *5th World Conference on the Promotion of Mental Health and the Prevention of*

- Mental Health Disorders*. Melbourne, Australia, 2008.
23. Davies CA, Leyland AH. Trends and inequalities in acute myocardial infarction in Scotland. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
 24. Davies CA, Leyland AH. Trends and inequalities in acute myocardial infarction recurrence rates in Scotland, 1988-2003. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:116.
 25. Davies CA, Leyland AH. Trends and inequalities in short and long-term acute myocardial infarction case-fatality rates in Scotland, 1988-2004. *SSM (Society for Social Medicine) Meeting*. Southampton, UK: *Journal of Epidemiology & Community Health*, 2008; **62**:Suppl1;A13.
 26. Der G, Young R. Introduction to Structural Equation Modelling. *Robertson Centre for Biostatistics, Seminar Series*. University of Glasgow, Glasgow, UK, 2008.
 27. Desmond N. Contrasting risk priorities for health: the social construction of risk perception in NW Tanzania. *First ISA (International Sociological Association) Forum on Sociology ' Sociology and Public debate'*. Barcelona, Spain, 2008.
 28. Drew S, Hargreaves J, Butler H, Bond L. Horses for Courses: Teachers' perspectives on implementing and sustaining a complex student health and wellbeing intervention [Poster]. *5th World Conference on the Promotion of Mental Health and the Prevention of Mental Health Disorders*. Melbourne, Australia, 2008.
 29. Dundas R, Davies CA, Leyland AH. Cause-specific inequalities in male mortality by individual socioeconomic status in Scotland, 1999-2003. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:Suppl1;96.
 30. Dundas R, Leyland AH, Macintyre S. Compositional and contextual effects of early life on adult health: findings from the Aberdeen Children of the 1950s study. *SSM (Society for Social Medicine) Meeting*. Southampton, UK: *Journal of Epidemiology & Community Health*, 2008; **62**:Suppl1;A2.
 31. Dundas R, Leyland AH. Inequalities in mortality by individual social class in Scotland. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
 32. Ellaway A. Area and health in Glasgow. *Health Commission for Glasgow*. Glasgow, UK, 2008.
 33. Ellaway A, Ferguson N, Ogilvie D. Availability of and access to physical activity opportunities across Scotland and links with health behaviours and obesity among adults. *The European network for the promotion of health-enhancing physical activity (HEPA Europe)*. Glasgow, UK, 2008.
 34. Ellaway A, Macdonald L, Macintyre S, Travaglini N. Is proximity to physical activity opportunities in the West of Scotland associated with health related behaviours and outcomes? *The European network for the promotion of health-enhancing physical activity (HEPA Europe)*. Glasgow, UK, 2008.
 35. Ellaway A. Neighbourhoods and health. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
 36. Emslie C, Hunt K. Gender, generation and alcohol. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
 37. Emslie C, Hilton S, Hunt K, Chapple A, Ziebland S. "I don't want you to think that I'm some poor case and you can't have a laugh with me any more": young men and women's experiences of disclosing a cancer diagnosis to friends and family. *BSA (British Sociological Association) Medical Sociology Group Annual Conference*. Brighton, UK, 2008.
 38. Emslie C, Hunt K. Research on men's health in MRC SPHSU [Poster]. *Men's Health Forum National Conference*. Glasgow, UK, 2008.
 39. France E, Wyke S, Hunt K, Ziebland S. Drawing on experience in health decision making: a secondary analysis of qualitative data. *NIHR Delivery and Organisation Programme Conference*. Manchester, 2008.
 40. France E, Wyke S, Hunt K, Ziebland S, Entwistle V. Patients' use of personal experience (experiential knowledge) in health decision making. *Alliance for Self Care Research Seminar*. Carnoustie, Scotland, 2008.
 41. France E, Wyke S, Hunt K, Ziebland S. Patients' use of personal experiences in antenatal decision making. *BSA (British Sociological Association) Medical Sociology Group Annual Conference*. Brighton, UK, 2008.
 42. Gibson M, Bamba C, Petticrew M, Sowden A, Whitehead M, Wright K. Tackling the wider determinants of health and health inequalities: evidence from systematic reviews. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:115.
 43. Gray L. Comparisons of health indicators in selected European areas. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
 44. Gray L. Glasgow-based comparisons of obesity in men and women within Scotland and the rest of Europe. *ScotPHN Obesity, Policy and Practice in Scotland Conference*. Edinburgh, UK, 2008.
 45. Gray L, Batty GD, Der G, Hunt K, Leyland AH. Psychological distress as a predictor of future cardiovascular disease and mortality: pooled analyses of three large Scottish cohort studies (1995 to 2006). *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:6.

46. Gray C, Anderson A, Dalziel A, Hunt K, Leishman J, Wyke S. Tackling male obesity. The Camelon Weight Management Group Model. *Alliance for Self Care Research Seminar*. Carnoustie, Scotland, 2008.
47. Harding S. Culture & socio-economic disadvantage as risk for mental health problems - findings from the DASH study (invited speaker). *Meeting of the Section of Psychiatry in association with the CARE International Foundation on Young people: Wellbeing, Recovery and Resilience*. Royal Society of Medicine, London, UK, 2008.
48. Harding S. Ethnic variations in developmental experiences in children (invited speaker). *Seminar series of the Department of Epidemiology and Public Health*. Queen's University, Belfast, UK, 2008.
49. Harding S. Ethnicity and health. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
50. Harding S. Health and resilience among ethnic minority adolescents: findings from the MRC DASH study (invited speaker). *Public Health Sciences Section Seminar Series*. University of Edinburgh, Edinburgh, UK, 2008.
51. Harding S. Health in our multi-ethnic Scotland. Future Research Priorities. A draft consultation report (Invited discussant). *Meeting hosted by NHS Scotland*. Glasgow, UK, 2008.
52. Henderson M, Wight D, Nixon C, Parkes A. Engaging with young people in secondary schools. *NHS Health Scotland in partnership with Scottish Government and Healthy Respect: Creating a Healthy Respect for Sexual Health*. Conference Centre, Heriot Watt University, Edinburgh, UK, 2008.
53. Henderson M, Wight D, Parkes A, Nixon C. Healthy Respect SHARE CPD: SHARE and parents' surveys baseline findings. *Secondary School Survey*. Musselburgh, 2008.
54. Henderson M, Wight D, Parkes A, Nixon C. Learning from school centred sexual health interventions. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Uppsala, Sweden, 2008.
55. Henderson M, Wight D, Parkes A, Nixon C. Secondary School Survey. *Healthy Respect SHARE CPD: SHARE and parents' surveys baseline findings*. Heriot Watt University, Edinburgh, UK, 2008.
56. Hilton S, Bedford H, Calnan M, Hunt K. Competency, confidence and conflicting evidence: key issues affecting health visitors' use of research evidence in practice. *Community Practitioners and Health Visitors Association Annual Conference*. Harrogate, 2008.
57. Hilton S, Hunt K, Langan M, Hamilton V, Petticrew M. Mind the gap: Trends in the reporting of MMR evidence in key UK clinical and professional journals between 1988 and 2007 *BSA (British Sociological Association) Medical Sociology Group Annual Conference*. Brighton, UK, 2008.
58. Hilton S, Hunt K, Langan M, Hamilton V, Petticrew M. Translating the evidence: Content analysis of commentaries on MMR vaccination evidence in key UK clinical and professional journals between 1988 and 2007. *Qualitative Health Research Conference*. Banff, Canada, 2008.
59. Hilton S. Understanding and use of public health research. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
60. Hughes C, Macintyre S, Mutrie N. Socio-economic variations in the quality of play provision in Glasgow, UK. *International Society for Behavioural Nutrition and Physical Activity Annual Meeting*. Banff, Canada, 2008.
61. Hunt K. Gender and health. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
62. Hunt K. Researching people's experiences of health and illness. *Comrie Inner Link*. Comrie, UK, 2008.
63. Hunt K. Researching the link between gender and health. An overview of the Gender and Health Programme at MRC SPHSU. *Department of Public Health, University of Glasgow*. Glasgow, UK, 2008.
64. Hunt K. Why might class gradients in health differ by gender? [Keynote address] *Gender, class and health inequities - integrated perspectives on public health research and policy*. University Hospital of Umea, Umea, Sweden, 2008.
65. Leyland AH, Gray L. The impact of household on health measures, lifestyle, and health seeking behaviour. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:10.
66. Leyland AH. Inequalities in mortality in Scotland: insights into the changes. *Invited seminar to Norwegian Public Health Institute*. Oslo, Norway, 2008.
67. Leyland AH. Measuring health. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
68. Leyland AH, Dundas R. The social patterning of death due to assault in Scotland: population-based study. *SSM (Society for Social Medicine) Meeting*. Southampton, UK: *Journal of Epidemiology & Community Health*, 2008; **62**:Suppl1;A3.
69. Lonie D, West P, Wilson G. "It just makes me feel better": music and emotional health over the youth-adult transition. *10th International Conference on Music Perception and Cognition*. University of Hokkaido, Hokkaido Japan, 2008.
70. Lonie D, West P, Wilson G. Popular music and embodied emotion; the meeting point of structure and agency. *British Sociological Association Annual Conference*. University of Warwick, Warwick, UK, 2008.

71. Lonie D, West P, Wilson G. Popular music and everyday emotional wellbeing over the youth-adult transition: does taste matter? *Music, Health and Happiness Conference*. Royal Northern College of Music, Manchester, UK, 2008.
72. Macintyre S. The built environment and health: challenges and opportunities for health research. *Presentation to Wellcome Trust Pathogens, Immunology and Population Health Strategy Committee*. London, UK, 2008.
73. Macintyre S. Deprivation amplification revisited: recent work on the location of health promoting and damaging amenities in Glasgow. *ENRGHI 2008 - 13th Emerging New Research on Geographies of Health and Impairment Conference*. St Andrews University, St Andrews, UK, 2008.
74. Macintyre S. Ethical issues in obesity policy. *Symposium on Ethical issues in obesity and alcohol policy: an overview of the report by the Nuffield Council on Bioethics. Faculty of Public Health Annual Conference*. Cardiff, 2008.
75. Macintyre S. Fairer and healthier: where does physical activity fit in? *National Policy Seminar: Physical Activity and the National Performance Framework, Scottish Government*. Edinburgh, UK, 2008.
76. Macintyre S. MRC Social & Public Health Sciences Unit - 2008 Overview. What are we doing and why? *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
77. Macintyre S. Public Health: aspects of obesity. *The Biomedicine Funders Forum*. London, UK, 2008.
78. Macintyre S. Social/public health interventions and the harm/good balance: should we be looking at effects on inequalities in health as well as overall effects? [Video presentation]. *Multiple Intervention Programs Symposium - Addressing Health Inequities*. Ottawa, Canada, 2008.
79. Macintyre S. Tackling health inequalities: what works? *Holyrood Communications Conference Series. Scotland's Population Health Challenges: Smoking, Alcohol, Obesity and Inequality*. Glasgow, UK, 2008.
80. Macintyre S. Who you are or where you are? Social and spatial patterning of health. *European Society for Health and Medical Sociology (ESHMS) 12th Biennial Congress*. Oslo, Norway, 2008.
81. Macintyre S. Who you are or where you are? Social and spatial patterning of health. *Annual Conference & Meeting of the European network for the promotion of health-enhancing physical activity (HEPA) Europe*. Glasgow, UK, 2008.
82. MacLean A, Sweeting H, Hunt K. Rules for boys and guidelines for girls: the impact of gender-related expectations and stereotypes on symptom reporting. *BSA (British Sociological Association) Medical Sociology Group Conference*. Brighton, UK, 2008.
83. Manderbacka K, Arffman M, Leyland AH, Karvonen S, Keskimäki I. Are there regional differences in mortality amenable to health care in Finland? [Poster] *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:162.
84. Mason P, Kearns A, Bond L, Tannahill C. Physical activity in Glasgow's urban environment: initial findings from the GoWell programme. *1st Annual Conference of HEPA Europe*. University of Strathclyde, Glasgow, UK, 2008.
85. Maynard M, Harding S. Psychological well-being scores in adolescents from minority ethnic groups in relation to perceived quality of parenting. *Caribbean Health Research Council scientific meeting*. Paramaribo, Suriname, 2008.
86. Maynard M, Rosato M, Teyhan A, Harding S. Trends in suicide among migrants in England and Wales. *Biennial Swedish/Finnish/Scottish Workshop on Health Inequalities*. Musselburgh, UK, 2008.
87. Maynard M, Rosato M, Teyhan A, Harding S. Trends in suicide among migrants in England and Wales 1979-2003 [Poster]. *2nd Conference of Migrant Health in Europe*. Malmo, Sweden, 2008.
88. Mutrie N, Campbell A, Emslie C, Heffernon K, Kearney N, McConnachie A, Ritchie D, Whyte F. Exercise for women undergoing treatment for breast cancer: the somatopsychic rationale revisited. *Research seminar at the University of Queensland*. Brisbane, Australia, 2008.
89. Mutrie N, Campbell A, Emslie C, Heffernon K, Kearney N, McConnachie A, Ritchie D, Whyte F. Exercise provides somatopsychic benefit for clinical patients: the case of breast cancer survivors. *European College of Sports Sciences (ECSS)*. Lisbon, Portugal, 2008.
90. Ogilvie D, Mitchell R, Mutrie N, Petticrew M, Platt S. Personal and environmental correlates of active travel and physical activity in a deprived urban population [Poster]. *International Conference on Physical Activity and Public Health*. Amsterdam, The Netherlands, 2008.
91. Rawlins E, Baker G. DiEt and Active Living (DEAL) study: obesity in ethnic minority children and adolescents: developing acceptable parent and child-based interventions in schools and places of worship. *Imperial College Longitudinal Studies Seminar Series*. London, UK, 2008.
92. Remes P. Promoting condom acceptability among adolescents by challenging community norms on adolescent sexuality in Mwanza region. *International IUSSP Seminar on Potential and Actual Contributions of Behavioural Change to Curbing the Spread of HIV*. Entebbe, Uganda, 2008.
93. Remes P, Komrower J, Benedict J, Basil V, Kimaryo M, Chagalucha J, Obasi A, Wight D. Reducing young people's sexual risk by challenging community norms on adolescent sexuality in Mwanza region (Poster). *Second East African*

Community International Health and Scientific Conference. Arusha, Tanzania, 2008.

94. Remes P, Wight D, Komrower J, Basil V, Nyalali K, Kimaryo M, Changalucha J, Obasi A. "We, parents, are indeed the origin of many problems of young people." Delivering 'good things' for parents and communities: findings from the process evaluation of a parenting intervention pilot in rural Mwanza. *XVII International AIDS Conference*. Mexico City, Mexico, 2008.
95. Remes P, Basil V, Komrower J, Nyalali K, Charles J, Wight D, Changalucha J, Obasi A. "We're surpassed by our children!": parents & caregivers demand parenting interventions to support youth HIV/STI risk reduction in rural Mwanza, Tanzania. *XVII International AIDS Conference*. Mexico City, Mexico, 2008.
96. Santana P, Harding S, Williamson L, Teyhan A, Rosato M. AIDS mortality in African migrants living in Portugal: evidence of large social inequalities. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:64.
97. Sime C. Men's experiences of having breast cancer. *Men's Health Forum Scotland National Conference*. Glasgow, UK, 2008.
98. Sime C. Men's experiences of having breast cancer: an overview of my PhD research. *West of Scotland Breast Nurses Forum*. Ross Hall Hospital, Glasgow, UK, 2008.
99. Smith E. A retrospective investigation into experiences associated with being obese during adolescence. *GGHB Health Efficiency Access Treatment (HEAT) Target team*. Glasgow, UK, 2008.
100. Smith E, Sweeting H, Wright C. Young adults experiences of having been obese as adolescents. *BSA (British Sociological Association) Medical Sociology Group Annual Conference*. Brighton, UK, 2008.
101. Sweeting H, Young R, West P. Friendships, identity and behaviours in youth. *Tenth Nordic Youth Research Conference: Bonds and Communities - Young people and their social ties*. Lillehammer, Norway, 2008.
102. Sweeting H. Obesity - findings from the West of Scotland 11 to 16 Study. *ScotPHN Obesity Research, Policy and Practice in Scotland meeting*. Edinburgh, 28th May, 2008.
103. Teyhan A, Harding S, Rosato M, Santana P. Cancer mortality in African migrants living in Portugal. *EUPHA (European Public Health Association) Conference*. Lisbon, Portugal: *European Journal of Public Health*, 2008; **18**:45.
104. Teyhan A, Harding S, Leyland AH. Influence of neighbourhoods on ethnic differences in children's physical activity [Poster]. *2nd Conference of Migrant Health in Europe*. Malmö, Sweden, 2008.
105. Thomson H, Thomas S, Sellstrom E, Petticrew M. Best available evidence on housing improvement and health: a systematic review. *SSM (Society for Social Medicine) Meeting*. Southampton, UK: *Journal of Epidemiology & Community Health*, 2008; **62**:Suppl1;A4.
106. Thomson H, Thomas S, Sellstrom E. Does housing improvement lead to health improvement? Findings of a systematic review of world literature. *European Housing Research Network Annual Conference* Dublin, Ireland, 2008.
107. Thomson H, Thomas S, Sellstrom E. Housing improvement and health: new and improved evidence from a systematic review of intervention studies. *Housing & Health Conference*. University of Warwick, Warwick, UK, 2008.
108. Thomson H. Housing investment and health. *Presentation to Shona Robison MSP, Scottish Government Minister for Public Health*. Glasgow, UK, 2008.
109. Townsend A. Conversations on occupation: activity, identity and chronic illness. *Cafe Scientifique*. University of British Columbia, Vancouver, Canada, 2008.
110. Weiss A, Gale G, Batty GD, Deary IJ. The influence of intelligence and neuroticism on later mortality in Vietnam-era veterans. *International Society for Intelligence Research (ISIR) conference*. Decatur, USA, 2008.
111. West P. Is the mental health of young people really getting worse and why might that be? *External seminar series*. Dept of Health & Human Sciences, University of Essex, Essex, UK, 2008.
112. West P. Panellist. *Scottish Child Psychotherapy Trust Annual meeting 'Wednesday's Children'*. Napier University, Edinburgh, UK, 2008.
113. West P, Sweeting H, Young R. Which is more important for health in youth: family socioeconomic status or the peer group? *Tenth Nordic Youth Research Conference: Bonds and communities - Young people and their social ties*. Lillehammer, Norway, 2008.
114. West P. Youth and health. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
115. Wight D. North-south research on HIV/AIDS: perpetuating unbalanced collaborations. *Anthropology of Health and Illness Seminar*. Edinburgh University, UK, 2008.
116. Wight D. Sexual health and families. *First joint meeting of NHS Health Scotland and MRC Social and Public Health Sciences Unit*. Glasgow, UK, 2008.
117. Williamson L, Flowers P, Knussen C, Hart G. HIV testing trends among gay men in Scotland: 1996-2005. *Gaycon 08 - National Conference for Scotland on Gay and Bisexual Men's Sexual Health and Wellbeing*. Glasgow, UK, 2008.
118. Young R, Furnivall J, Wilson P. Are there subgroups of young people who self-harm? A

latent class analysis of young people's and professionals' reports. *Twelfth European Symposium on Suicide and Suicidal Behaviour*. Glasgow, UK, 2008.

119. Young R, West P, Sweeting H. Do "alternative" teens have poorer mental health? a study of contemporary adolescents peer-group identity. *Tenth Nordic Youth Research Conference: Bonds and communities - Young people and their social ties*. Lillehammer, Norway, 2008.
120. Young R, Henderson G. Facilitation/Presentation, Self-harm and Suicide stream. *Towards a Mentally Flourishing Lanarkshire Event*. Hamilton, UK, 2008.
121. Young R. Needs assessment of young people who self-harm: insights from two Scottish studies. *Lanarkshire Self-harm Health Needs Assessment, Stakeholder Consultation Meeting*. South Lanarkshire Council. Hamilton, UK, 2008.
122. Young R. Young people who deliberately harm themselves, how, why and who: insights from recent public health research. *Nottingham University, Division of Psychiatry, Postgraduate Seminar series*. Nottingham 2008.
123. Young R. Young people, alcohol and anti-social behaviour. *Annual Eastern Drugs and Alcohol Coordination Team Conference, Alcohol: How We Measure Up*. Belfast, UK, 2008.



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A Research Unit supported by the Medical Research Council and the Chief Scientist Office of the Scottish Government Health Directorates, at the University of Glasgow.