Conclusions
Contrary to regular guidelines, outbreak management recommendations involve value judgements by professionals with no or only scarce time for re-evaluation of the decision. Principles of evidence based medicine were not consistently used to extract and analyse evidence for best practice during the LGV outbreak, leading to differences in outbreak management between (or within a) countries Strong points were the timely alert and response systems put in place by 11 countries, the collaboration between public health and clinicians and the involvement of the risk group in disseminating alerts and advocating awareness. More international collaboration is needed to improve the response to international outbreaks and threats.

Cross-border transmission of *Acinetobacter baumannii* to a Belgian nursing home in 2004

Beatrice Jans

B Jans[1], C Suetens[1], B Coignard[2], Y Glupczynski[3], Y De Gheldre[3]
[1]Epidemiology unit, Scientific Institute of Public Health, Brussels, Belgium
[2]Institut de Veille Sanitaire, France
[3]Reference Laboratory, University Hospital of Mont- Godinne (UCL), Microbiology Department, Yvoir, Belgium

Background
Between July 2003 and May 2004, a major outbreak of *Acinetobacter baumannii* producing VEB-1 type, Extended Spectrum β-Lactamases (ESBL) occurred in France. Alerted by the French 'Institut de Veille Sanitaire' (InVS), the Unit of Epidemiology of the Institute of Public Health (IPH) and the reference laboratory of UCL Mont-Godinne set up a surveillance system in Belgian hospitals and laboratories. By the end of March 2004 the two first cases of infection with the resistant *A.baumannii* strain, similar to the French type were detected in two hospitals in Tournai and confirmed by the reference laboratory. The cases, both elderly persons, came from the same Belgo-French border nursing home (NH).
Methods
In April 2004, the Unit of Epidemiology, the reference laboratory and the Sanitary Inspection of the French Community undertook an epidemiological and microbiological investigation in the involved NH. For each participating resident and nursing staff member, screening swabs were taken and a questionnaire was filled in.
Results
In this private NH with 75 low-care NH-beds, 57% of the residents and 47% of the nursing staff participated in the study. Besides the two initial cases, a third resident (asymptomatic carrier) was identified. Within the participating residents, 65% had a French nationality. This migration phenomenon is highly specific for the Franco-Belgian border NH population. Two of the three *A.baumannii* cases where French citizens, previously admitted in French health care facilities. The third case occurred probably by cross-contamination in the NH. In Belgian border NH, French residents often visit French hospitals for diagnostic/therapeutic reasons, have their private French general practitioner and receive the visit of French relatives.
Conclusions
Patient movements between French and Belgian hospitals are scarce. However, they are frequent between northern French hospitals and Belgian NH and are potential transmission paths for micro-organisms who may explain cross-border spread of epidemic strains.

Track F3: Workshop: Contextual and compositional determinants of inequalities

Chairpersons: Alastair H Leyland, Paolo Villari, Giuseppe La Torre
Organiser: EUPHA section on Public Health Epidemiology, Alastair H Leyland. MRC Social and Public Health Sciences Unit, University of Glasgow, Glasgow, UK

*Contact details: a.leyland@msoc.mrc.gla.ac.uk

Although acknowledged that people's health is patterned both by individual socioeconomic circumstances and by those of the area of residence, the issue as to whether it is specific features of the social and physical environment that impact on health (as opposed to population health differences reflecting different concentrations of socioeconomic deprivation) remains contentious. A full understanding of social inequalities requires an understanding of the mechanisms underlying the social patterning of behaviours, health, and mortality and of the extent to which this pattern reflects contextual and compositional differences. Reducing inequalities will require intervention, and successful interventions must distinguish between contextual and compositional mechanisms. This workshop will explore the issues underlying contextual and compositional determinants of inequalities through three papers. Specifically, it will cover the nature of environmental influences on health or health behaviour, ways in which the environmental effect may vary depending on individual socioeconomic circumstances, the relationship between environmental exposure to a physical hazard and area and individual socioeconomic deprivation, and the difficulties in (and consequences of) choosing between models of social aetiology and geographical clustering. All papers consider the implications for targeting interventions—at an individual or community level—and will lead to an open discussion of these issues.

Socioeconomic variation in health-related behaviours: the role of environmental characteristics

Frank J van Lenthe

FJ van Lenthe, CBM Kamphuis, K Giskes, M Huisman, J Brug, JP Mackenbach
Department of Public Health, University Medical Center Rotterdam, The Netherlands

The obesity epidemic demands evidence-based interventions in populations with the highest prevalence. It is generally believed that our 'obesogenic' environment contributes to the epidemic, with an unfavourable distribution of environmental characteristics resulting in higher prevalence of poor diet and physical inactivity in lower socioeconomic groups. Evidence, however, is still scarce. We therefore investigate the contribution of environmental characteristics to socioeconomic inequalities in poor diet and physical inactivity in the Netherlands. Data are taken from the most recent major wave of data collection in the GLOBE study. Participants in all socioeconomic groups indicated a benefit from social support, but people from low socioeconomic backgrounds perceived more barriers to healthy behaviour. Environmental factors partly explain socioeconomic inequalities for aspects of physical inactivity. Changing unfavourable environmental characteristics may substantially

contribute to a reduction in socioeconomic inequalities, physical inactivity, and perhaps in poor diet.

Air pollution, social deprivation, and mortality. a multilevel cohort study of 470 small neighbourhoods in Oslo, Norway

Øyvind Næss

Ø Næss[1], F Piro[1], P Nafstad[1], G Davey Smith[2], AH Leyland[3]
[1]Institute of General Practice and Community Medicine, University of Oslo, Norway
[2]Department of Social Medicine, University of Bristol, UK
[3]MRC Social and Public Health Sciences Unit, University of Glasgow, UK

Adverse health effects may be attributed to exposure to air pollution (NO_2), but this is not equitable. We investigate how different measures of social deprivation are associated with NO_2 and mortality. All inhabitants in Oslo 1992 aged 50–74 years were included. An air dispersion model estimated hourly levels of exposure in the period 1992–1995 in all 470 administrative neighbourhoods. The follow-up of deaths was from 1992 to 1998. The data were linked to the census, education and death registers. The proportion of deprived individuals in each neighbourhood was standardized to make estimates comparable. NO_2 had a significant effect on mortality in both men and women. This effect was attenuated by adding individual level indicators of deprivation. After including contextual indicators the effect of NO_2 was reduced even further. Neighbourhood deprivation explained the effect of air pollution on mortality independently of individual level deprivation for most indicators. Policies regarding air pollution, such as urban planning, should consider the impact on health inequalities at this level.

Neighbourhood socioeconomic context, individual socioeconomic position and risk of myocardial infarction in Stockholm

Johan Hallqvist

J Hallqvist, F Mattsson, M Kölegård Stjärne
Department of Public Health Science, Karolinska Institutet, and Centre for Health Equity Studies, Stockholm, Sweden

Despite studies suggesting contextual effects on risk of disease, causal interpretations and public health implications are still being discussed. We discuss the consequences of adopting a framework of social aetiology or geographical clustering when disentangling contextual from compositional factors. Stockholm Heart Epidemiology Program (SHEEP) is a population based case–control study of myocardial infarctions in Stockholm. In these analyses 1547 cases and 2063 controls aged 45–70 were included. Different aspects of social context, e.g. median income, were related to MI risk. After adjusting for individual social characteristics a low level of neighbourhood socioeconomic resources had a relative risk of 1.88 for women and 1.52 for men. Adult social position was related to risk of MI and was partly explained by neighbourhood context. As the concept of context is often area-based it also invokes the question on what grounds we should choose between individual level and community level actions and revisits Rose's distinction between population and high-risk strategies of prevention.

Track F4: Public health and decisionmaking

Weak links: international health surveillance in a world containing 'non-states'

Martin Mckee

M Mckee[1], R Atun[2]*
[1]London School of Hygiene and Tropical Medicine, London, UK
[2]Imperial College, London, UK
*Contact details: martin.mckee@lshtm.ac.uk

Background
The emergence of influenza strain H5N1 has catapulted the global system of health surveillance into the international political arena. This system operates within the framework of the recently revised International Health Regulations, which place obligations on national authorities to reduce the threat of infections emanating from their territory. Yet there are many parts of the world where these obligations cannot be met, including some territories that have many of the characteristics of states yet whose legal position is contested. Several of these 'non-states' are in Europe (Northern Cyprus, Transdneistria, Kosovo, Abkhazia, Nagorno Karabakh), nearby (Palestine, Western Sahara), or have substantial exchange of goods and people with Europe (Taiwan). This paper explores the mechanisms that exist to incorporate these territories into the global surveillance system.
Methods
Interviews with key informants in the territories concerned and in relevant international and non-governmental agencies, review of policy documents and news items.
Results
The extent to which 'non-states' are incorporated within the international system varies considerably. For some, although national surveillance systems are weak, links with the WHO are relatively good, as in Northern Cyprus and Kosovo. For others, in territories that are small and politically isolated (such as those in the Caucasus), public health surveillance is extremely weak and international links are fragmentary. Taiwan is a special case because it has a strong national system but is isolated at the insistence of the People's Republic of China. In several places (Cyprus, Palestine), public health activities are reaching across communities divided by politics.
Conclusions
The global surveillance system is only as effective as its weakest links. There are several areas where Europe has a specific interest in strengthening these links. In some cases, this may offer, as a by-product, the basis to address some of the underlying political problems.

The intangible benefits of multisectoral partnerships

Leslie Boydell

L Boydell
Institute of Public Health in Ireland, Belfast, UK
*Contact details: leslie.boydell@publichealth.ie

Issue
Partnership and public participation in decision making has become central to policy making and implementation. Simultaneously, there is growing commitment to evidence-based policy and a requirement to demonstrate value for money for the time and resources invested in partnerships. We have carried out research to investigate the benefits of multisectoral partnerships, how they can be measured and what contribution they make to tackling inequalities in health.
Description
The research involved in-depth case studies of two multisectoral partnerships in Northern Ireland, whose goals are focused on reducing inequalities in health within a geographical area. Based on the analysis of the data gathered, a conceptual model was developed describing how effective partnerships can impact on the conditions required to reduce inequalities in health. In the