Birth and risk of preterm birth, but there are few analyses in which outcomes of birth, within a specific country, are classified by both mother’s country of birth and ethnicity.

**Setting** Live singleton births in England and Wales of babies whose ethnicity was recorded as being Black African or Black Caribbean in 2005 and 2006.

**Aim** To compare rates of preterm birth and low birth weight in this group of babies born to mothers born in African and Caribbean countries or England and Wales.

**Method** In England and Wales birth weight and mother’s country of birth are recorded at birth registration whereas ethnic group of baby and gestational age are recorded in the data set generated when the NHS number, a national unique patient identifier, is issued. Linking these two data sets has made it possible to assess the association between mother’s country of birth, baby’s ethnicity and birth outcomes. Data from the linked data set were used for the analysis. Countries were grouped according to UN geographical regions.

**Results** Mothers of babies of African ethnicity, born in Eastern or Northern Africa had significantly lower odds than those born in England and Wales of having a preterm baby. This remained significant after adjusting for mother’s age at birth and sex of baby. In terms of low birth weight, after adjusting for gender, mother’s age at birth and gestational age, mothers of babies of African ethnicity born in Middle and Western Africa had significantly lower odds of having a low birth weight baby compared with those born in England and Wales. Similarly, after adjusting for the available confounders, mothers of babies of Caribbean ethnicity, born in the Caribbean countries had lower odds of having a low birth weight baby compared with mothers born in England and Wales.

**Conclusion** Generally, preterm birth and low birth weight rates of babies of African or Caribbean migrant women born in England and Wales seems to be higher than those who migrated to England and Wales having themselves been born in African or Caribbean countries. Further research is needed about the possible causes of this difference in birth outcomes.

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**P49 MODIFYING HEALTH PROMOTION INTERVENTIONS FOR ETHNIC MINORITY GROUPS: SYSTEMATIC REVIEW OF EMPIRICAL EVIDENCE**

**Background** Health promotion interventions have proved to be cost-effective strategies to reduce morbidity and mortality associated with smoking, physical inactivity and poor diet in the general population. Some ethnic minority groups are disproportionately affected by these lifestyle factors, and existing evidence suggests that adapting evidence-based health promotion interventions for these populations may prove to be an effective strategy to tackle health inequalities.

**Objectives** To identify high-level evidence for health promotion interventions which have proven effectiveness for the general population and construct a framework of effective interventions, including any recommendations relating to ethnic minority populations.

**Design** A systematic overview was conducted with two reviewers independently searching and identifying guidelines and systematic reviews of interventions for smoking cessation, improving nutrition and physical activity. SIGN, NICE and Clinical Evidence databases were searched for relevant guidelines. Cochrane Library, Campbell Collection, HTA reviews and DARE databases were searched for systematic reviews. Data on the effectiveness of interventions were extracted.

**Results** 19 guidelines were identified as relevant. 2599 systematic review records were identified and assessed for eligibility. 187 systematic reviews were included in the final analysis. The guidelines revealed a large evidence base for smoking cessation interventions, but highlighted major gaps in relation to how best to increase physical activity and improve nutrition. There was little advice in these guidelines on how to adapt interventions to meet the needs of ethnic minority populations. The 187 systematic reviews were screened to identify any additional effective interventions not included in the guidelines. All effective, evidence-based interventions have been compiled into a summary framework. The 187 systematic reviews were also subjected to a detailed assessment of the population composition to determine whether any subgroup analysis for ethnic minority groups was undertaken. Approximately half of the reviews reported the inclusion of ethnic minority groups; however, no reviews conducted subgroup analyses according to ethnicity and ethnic-specific recommendations were scarce.

**Conclusions** The evidence base reviewed provides specific guidance on effective interventions for smoking cessation, but generic advice for increasing physical activity and improving nutrition. Identification of the range of evidence-based interventions for these three areas has led to the development of a summary framework that can be utilised for health promotion interventions. Interventions already proven to be effective in the majority population are, if appropriately adapted, likely to prove effective in minority ethnic populations. This work will advance current guidance on how to approach adaptation.
CINAHL, BIOSIS, Cochrane, ISI Web of Science, Lilacs, Campbell and SCEH.

Results In total, 48,740 records were identified. 95 empirical studies were identified as relevant and included in the analysis. The majority of adapted intervention studies took place in the USA, conducted with African-Caribbean origin populations and these predominantly involved women. All studies conducted with Chinese-origin populations took place in the USA while the majority of studies with South Asian-origin populations were conducted in the UK. Multi-component interventions targeting physical activity and nutrition were the most common followed by smoking cessation interventions. Interventions utilised a variety of adapted methods, resources and/or settings. The components of the adaptation process identified include methods such as ethnically matching programme facilitators; subsidising gym memberships and promoting low-cost alternatives to usual exercise options. Resources include culturally targeting materials (eg, using ethnic actors in videos and including photos of foods commonly consumed by the population in promotional material); utilising existing community resources (eg, religious leaders) and accommodating for differing linguistic and language competencies. Settings include holding interventions in familiar locations and utilising culturally appropriate scenarios to elicit behaviour change.

Conclusions A large body of evidence exists for adapted interventions. Identification of the components involved in the adaptation process for ethnic minority populations is a critical step for building on existing adaptation principles. Furthermore, this study will enable the development of a framework to guide the adaptation of mainstream evidence-based guidelines to be salient for different populations and contexts.

Health services/Policy

P51 SURVIVING INTENSIVE CARE: A SYSTEMATIC REVIEW OF HEALTH CARE RESOURCE USE AFTER HOSPITAL DISCHARGE
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Background Intensive care units (ICUs) are an expensive resource. However, this expense does not end at hospital discharge. ICU survivors continue to experience significant morbidity. As the demand for ICU is likely to increase substantially, there is a need to establish how much health care resource survivors consume following discharge from hospital. This will enable appropriate service planning and policy development to meet the needs of these patients, and will improve the precision of economic evaluations relating to ICU.

Aims We conducted a systematic review to determine the reported use of major health care resource by ICU survivors following discharge from hospital and to identify factors associated with increased resource use.

Methods Studies were included if the study population derived from an adult, general ICU population, health care resource use was reported at the patient level and the publication was in the English language. Two reviewers independently screened abstracts, rejecting those clearly not meeting inclusion criteria. A single reviewer then retrieved the full texts and assessed them for inclusion. Costs were inflated to 2009 using the consumer price index and converted to US dollars using the purchasing power parity method.

Results From 3922 articles, nine fulfilled criteria for inclusion. Two studies were conducted in the UK; three in Canada and four in the USA. Six studies used a cohort design; the remaining three collected data as part of a trial. The number of patients for which resource use was reported ranged from 66 to 963. Mean age ranged from 40 to 66. There was substantial variation in the cost categories included in each study. Following standardisation to a common currency and year, variation in resource use was apparent (range $1610–$45 173). Studies undertaken within the USA reported the highest costs; those in the UK reported substantially lower costs. The larger proportion of resource was consumed in secondary care (range 53–96%). Factors associated with increased resource use included increasing age, co-morbidities and organ dysfunction score.

Conclusion This review is the first to bring together the literature relating to post-hospital discharge health care resource use for survivors of ICU. There was substantial variation in the cost of resource use between studies. Given the paucity of identified studies and their