**Results** About 52.6% in 2003 and 67.4% in 2008 of women aged 40 or older reported receipt of a mammogram. Compared to women 40–49 years old, those aged 50–69 had higher odds of having been screened (1.076 in 2003 and 1.354 in 2008), those aged 70 or older had lower odds (0.513 in 2003 and 0.625 in 2008). The odds increase with family income, education, being married, seeing a physician. Having insurance doubles the odds, as does living in a metropolitan area (3.620 in 2003 and 3.322 in 2008). Compared to the North region, residents in all other regions had larger odds.

**Conclusions** The age-group targeted by the national policy had lower odds (0.513 in 2003 and 0.625 in 2008). The odds increase with family income, education, being married, seeing a physician. Having insurance doubles the odds, as does living in a metropolitan area (3.620 in 2003 and 3.322 in 2008). Compared to the North region, residents in all other regions had larger odds.

**Methods** Adults (aged ≥18 years) were randomly selected. A structured questionnaire was used to collect data on sociodemographic characteristics and knowledge of kidney disease. Clinical examination was undertaken including: anthropometry, blood pressure, fasting or random blood sugar, dipstick urinalysis, albumin to creatinine ratio and urine microscopy. Glomerular filtration rate (GFR) was estimated using the Modification of Diet in Renal Disease (MDRD) equation.

**Results** The mean age of participants was 45.8±19.0 years with a male: female ratio 0.8:1. 19% consumed alcohol and 7% smoked. 20% used regular analgesia and 75% used herbal concoctions. The prevalence of hypertension was 30%, diabetes mellitus (DM) (3.7%), obesity (defined by BMI) 2.7% and elevated waist circumference (14.6%). Urine microscopy revealed: haematuria 3.1%, ova of Schistosoma haematobium 1.1% and macroalbuminuria (8.9%). An estimated GFR <60 ml/min/1.73 m² occurred in 12.3%. The prevalence of CKD was 18.8%. Increasing age (OR 0.92, 95% CI 0.83 to 0.96), female gender (OR 4.87, 95% CI 1.34 to 17.74), systolic blood pressure (OR 1.04, 95% CI 1.01 to 1.07) and DM (OR 15.76, 95% CI 1.23 to 199.24) were predictive of CKD.

**Conclusion** CKD and its risk factors are prevalent in this community. The majority had moderately impaired kidney function. There is need for both primary and secondary preventive programmes.

**PREVALENCE, RISK FACTORS AND PATTERNS OF CHRONIC KIDNEY DISEASE IN A RURAL COMMUNITY IN SOUTH WEST NIGERIA**

**Introduction** Chronic kidney disease (CKD) is a global public health problem. Despite the long term difficulties of this condition there is paucity of community derived data in sub-Saharan Africa and especially in Nigeria, the most populated country in Africa. This lack of data is hampering an appropriate response.

**Methods** Health Institute of the University of Porto Medical School, Porto, Portugal; 2Department to regional variation have not been reduced.

**Aim** To relate eating behaviours at 6 months of age with weight for gestational age at birth.

**Results** Approximately 15% of children were SGA and 4% were LGA. Compared to adequate for gestational age children, SGA had more frequently mothers reporting difficulties in feeding at 6 months (OR=1.52, 95% CI 1.01 to 2.31) and eating small quantities of food (OR=1.88, 95% CI 1.27 to 2.49). SGA children had also more feeding difficulties (OR=2.26, 95% CI 1.10 to 4.63) and a higher probability of refusing solid foods (OR=2.21, 95% CI 1.02 to 4.80). No associations were found neither with eating slowly, being hungry (OR 1.78, 95% CI 1.27 to 2.49). LGA children had more difficulties of this condition there is paucity of community derived data in sub-Saharan Africa and especially in Nigeria, the most populated country in Africa. This lack of data is hampering an appropriate response.

**Results and Conclusion** In men, there was significant negative relationship between a length of having a handbook and a relative mortality risk after being adjusted for sex, radiation dose and age at bombing, but in women such a relationship was not found. A man who got a handbook at a young age had a lower mortality risk compared to a man at an old age.

**EVALUATION OF EFFECTS OF ATOMIC BOMB SURVIVORS’ HEALTH HANDBOOKS ON THEIR HEALTH PROMOTION**

**Introduction** Atomic bombs were dropped on Hiroshima and Nagasaki in 1945, and then A-bomb survivors’ health handbooks (shortly ‘handbooks’) were issued by the Japanese government to help A-bomb survivors in 1957. They have been able to receive free medical checkup twice for a year and free medical care for designated disorders. The purpose of the study is to evaluate effects of A-bomb survivors’ health handbooks focusing on the relationship between a mortality risk and a length of having handbook.

**Methods** Objects for analysis were selected from the ABS database of RIRBM Hiroshima University. The number of over-all deaths is 50,590 and the number of censored data is 101,244. Cox’s proportional hazard model was applied for analysing the data. The observation period is from 1970 to 1997 and the time variable is a time from 1st January 1970 to an occurrence of death. Length of having a handbook was defined as the period from registration year as an A-bomb survivor to 1970. Sex, age at A-bomb exposure, radiation dose and a length of having a handbook are used as covariates.

**Results and Conclusion** In men, there was significant negative relationship between a length of having a handbook and a relative mortality risk after being adjusted for sex, radiation dose and age at bombing, but in women such a relationship was not found. A man who got a handbook at a young age had a lower mortality risk compared to a man at an old age.

**THE CHANGING ROLE OF MORTALITY PREDICTORS OVER 20 YEARS OF OBSERVATION**

**Introduction** Longitudinal studies among elderly are concentrated on finding the predictors of mortality. Still, there is an open question if those