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significantly correlated with poisoning and suicide rates. Poisoning and suicide appeared minimally associated with rates of psychiatric co-morbidity; the exception being an increase in poisoning rates with increasing prevalence of mood disorders in rural districts ($p<0.05$).

Interpretation: Suicide and poisoning rates were higher in rural districts, suggesting that living in densely populated areas may be protective. In contrast to high-income countries, socioeconomic factors were found to predict poisoning and suicide to a greater extent than psychiatric morbidity. Factors relating to health care access showed mixed results, and should be investigated further. Given these results, increasing accessibility to health services, particularly in rural districts of lower socioeconomic standing, may be an important means of reducing suicide.

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Abstract #: *2.030_NCD*

The Experiences of Task Shifting to Reduce Mental Health Disparities in Underserved, Rural Communities

*R. Bischoff[1], P. Springer[1], **N. Taylor**[2], K. Cruickshank[1]; [1]University of Nebraska-Lincoln, Lincoln, USA, [2]University of Nebraska-Lincoln, Lincoln, NE, USA*

Background: There are huge disparities worldwide in access to mental health care, with disparities not only existing in low income countries but also in developing countries like the United States. To begin to address the large disparities of mental health both locally and globally, unconventional models of mental health care need to be considered. Task shifting is an unconventional strategy to address the worldwide workforce crisis by expanding the workforce to include mid-level providers and non-professionals. In task-shifting, certain activities (tasks) that are normally performed by highly trained mental health care providers are redistributed to a non-professional workforce, or a workforce with limited training and scope of practice, often under the supervision of a highly trained professional. Despite evidence of the effectiveness of task shifting, little is known about the experiences of those who engage in task shifting.

Methods: The purpose of this phenomenological research project is to understand the experience of task shifting. We have applied our collaborative-care model in rural, underserved areas of Nebraska. Through task shifting, members of the community take on the responsibility to address mental health disparities in their community. They do this through education, identifying and coordinating existing resources, improving referral quality, and carrying out mental health programming. To understand their experience of task shifting, eight community members were interviewed using a semi-structured interview. The Colaizzi analysis approach will be used to analyze the interviews.

Findings: Data collection for this study has been completed and analysis is underway. We anticipate the analysis to be done by November. Preliminary themes include challenges, definitions of success, strengths, barriers, and impact on the community and individual level. Key themes will be described with excerpts to illustrate the experiences within each theme.

Interpretation: Understanding the experience of those who carry out tasks that have been shifted to them is important to increasing the effectiveness of task shifting. Implications include understanding motivations for those engaged in task shifting, identifying characteristics of individuals who are well suited for task shifting mental health responsibilities, understanding which tasks can be shifted, and providing a voice for those engaged in task shifting.

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Abstract #: *2.031_NCD*

An Epidmilogical Study of Health Outcome among Internal Migrants in Beijing, China

*G. **Tian**[1], T. Guan[2]; [1]University of Copenhagen, Copenhagen K, Denmark, [2]Peking Union Medical College, Beijing, China*

Background: The relationship between internal migration and health outcome in China is important to investigate due to the large scale of mobilized population. Previous studies on internal migration and health in China were almost all conducted by using self-reported health status, rarely by using other health indicators. In this study, we aimed to examined the relationship by using Bejing's vital statistics 2007-2012 to provide better evidence.

Methods: Internal immigration status was identified through comparing household registered residency and permeant residency. Occupation categories was re-coded in line with Erikson and Goldthorpe and Portocarero Class Categories (EGP). All-cause mortality, age-stratified mortality, and gender mortality were calculated for residents with *Hukou* (native population) and residents without *Hukou* (internal migrant population). Education level, occupation category and marriage status were profiled for both groups.

Findings: The all-cause mortality rates were significantly higher among native population than migrant population (5.23% vs 0.74% in 2007, 5.49% vs. 0.70% in 2008, 5.77% vs. 0.69% in 2009, 6.08% vs. 0.69 in 2010, 5.70% vs. 0.64% in 2011, and 5.91% vs. 0.66% in 2012). Younger native population out performed its migrant counterpart on mortality across 2007-2012 (0.06% vs. 0.08%), while mortality of older native population is still higher than its counterpart (2.19% vs. 0.48% in aged 15-64, 4.68% vs. 2.70% in aged 65+). Female migrants have the lowest mortality comparing to male migrants and female and male natives (0.68%, 0.93%, 5.02%, and 6.37%) . More than half (57.89%) of deaths among natives are people with low education, comparing to 41.90% of migrants. Most of deaths of both groups are from people with less prestige occupation or unemployed. The percentage of deaths from unmarried migrants is 12.27%. The percentage is 3.26% for natives.

Interpretation: The results confirmed conclusions from previous studies that international and internal migrants generally enjoy better health outcomes than native population. Also, the results are in line with existing literature on adverse health outcomes of migrant's children.

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