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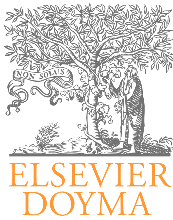

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PLENARY PRESENTATIONS: ABSTRACTS

I[st] World Congress of Children and Youth Health Behaviors / 4th National Congress on Health Education

Viseu-Portugal, 23-25 May 2013

PLENARY CONFERENCE 1: IN THE CONTEXT OF CRISIS — WHAT POLICIES TO PROMOTE HEALTH IN PORTUGAL?

Thursday, 23 May 2013, 09:45-10:45

Francisco George

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http://www.franciscogeorge.pt/text/29301.html

PLENARY CONFERENCE 2: THE IMPORTANCE OF COMMUNICATION IN HEALTH PROMOTION

Thursday, 23 may 2013, 14:35-15:30

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Introduction: The Social Adventure project ("Growing is an Adventure, a Social Adventure") was initiated in 1987. The aim was to study and promote social behaviour and health amongst young people: One of the first projects was 'Social Adventure and Risk', which included interventions towards vulnerable young people including those in hospital, and in special schools and with juvenile offenders and those presenting disruptive behaviour in schools. The aim was to promote social competence by enlarging young people's behavioural, cognitive and emotional repertoire. Subsequently, a complementary project 'Social Adventure in the Community' was developed on Universal Interventions aimed to increase young people behavioural, cognitive and emotional repertoires.The next phase of projects was developed in the early nineties under the title 'Social Adventure and Health' aiming to understand young people's health and lifestyles, interpersonal behaviour, well being, quality of life and personal skills. The projects included (HBSC- Health Behaviour in School Aged Children, www.hbsc.org; Kidscreen, www.kidscreen.org; TEMPEST tempestproject.eu; PeerDriveClean, www.peer-projekt.de; RICHE, www.childhealthresearch.eu; DICE, www.dramanetwork.eu and Y-SAV, Sexual Violence in young people. Collaborations were established in Latin America (LA), and in the Community of Portuguese Speaking Countries (CPLP). More recently begin the projects "Find your own style" and "Trim Your Style Up ", where young people join "Trimming" sessions whose facilitators ("the trimmer") propose reflections on lifestyles, personal and social competences, self-regulation strategies and social interactions and networks.

The importance of communication in the health promotion arena is twofold: From a systemic point of view, policymakers, as well as health promotion professionals, must keep a culture of inter-sectorial collaboration and effective communication in order to build a trans-disciplinary effective teamwork. On another side, from the target population point of view, a culture of assertive and effective interpersonal communication, self-regulation and problem solving is highly connected to health and well being, at least in young people.

The Health Behaviour in School-Aged Children (HBSC) study: (http://www.hbsc.org), in Portugal (http://www.aventurasocial.com) aims at understanding young people's health, health behaviours and well being in their life contexts. It is a WHO collaborative study that involved in 2010 forty one countries. The study began in 1983 and Portugal was involved in 1994 through the Social Adventure team collaboration at UTL and CMDT/ UNL, and has involved till now, more than 35000 pupils. The survey is based on a questionnaire administered in schools by teachers, and uses nation wide samples randomly selected. It includes pupils aged 11, 13 and 15, in Portugal attending 6th grade, 8th grade and 10th grade. A description of methods and results can be found at http://www.aventurasocial.com and http://www.hbsc.org. From 1994, gender differences pointed out a tendency for girls to internalize emotions, life threats or opportunities, presenting more physical and psychological symptoms, less perception of health and well being, less active leisure time, more involvement in school activities, more concerns and worries regarding body image, nutrition and dieting. Boys tend to display more externalizing behaviours such as violent behaviours, physical activities and sports, are more prone to accidents and injuries, more substance use with the exception of tobacco in the recent years, less involvement in school activities, better perception of health and well being, and a more active leisure time and, in recent years, a more extended use of new technologies of information and communication with the exception of mobile phones. Results highlight older students are less healthy and happy, with the exception of bullying that seems to decrease with age and the higher protection against HIV

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and unplanned pregnancy. From 1998 to 2010 studies, the analysis of national trends reflected an exceptional "bad wave" back in 2002. A few health indicators improved over time (tobacco use, violent behaviour, and condom use), others remained unchanged (physical activity, alcohol abuse). However, others reflect a worst situation (increase of screen time, increase of sedentary behaviour and overweight). The HBSC study, conducted in Portugal in 2002 (http://www.aventurasocial.com), and a specific study in Lisbon poor neighbourhoods, revealed that foreign adolescents presented inferior school results and involvement. This group feels unhappier, reports a more distant communication with parents and engages in sexual intercourse more frequently, namely unprotected sex and sex associated with alcohol and drugs use. Results from the Portuguese HBSC study suggested that the majority of school-aged (6th, 8th and 10th grades) adolescents are satisfied with their lives and rarely or never refer psychological symptoms. Family affluence has significant impact on feeling happy and on health perceptions. These results revealed influences of poverty on young people health. When family communication is good, together with the ability of families to help in the process of decision making, if school success is reached, if teachers can communicate, cope and care, then young people's health and well being will improve decreasing substance use, violent behaviour, bad nutrition, overweight, sedentary behaviour, and self harm. Compared with other countries within the Health Behaviour in School Aged Children (HBSC) survey, Portugal presents a higher level of stress associated with school work, and a lower perception of academic achievement, along with a more favourable social perception of schooling (peers perceived as friendly) and schools (liking the school, although not specifically the classes).

Roadmap for the future: Based on research carried on and reviewed it is therefore recommend "better classes" together with a different teaching dynamic, better "pupils-teacher-families-policymakers" interaction, better teacher training, increased academic success, higher parental involvement with schools, increased parental schooling, better motivation and interpersonal communication for all the involved, and of course the possibility of a positive expectation towards the future.

PLENARY CONFERENCE 3: SEXUALITY IN SCHOOLS: THE IMPORTANCE OF WORK IN COMMUNITY

Friday, 24 May 2013, 09:30-10:30

Félix López Sánchez

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We live in a society of free market, very liberal, in which the sexual contents have also been converted into a product that is sold and consumed. We just have to seat down in front of the TV screen, analyze the marketing, connect to the Internet, take a look at a kiosk, go the movies or simply take a walk down the street. The contents of sexual nature are all over our society. The way we dress, the way we spend our free time and life in general have changed in an amazing way transpiring new liberties and a more enjoyable meaning of life. Our sons and daughters live amongst these changes; they receive numerous stimulous and information and observe the conduct and life models that the media present. Everything talks about sexuality, while family, educators and healthcare professionals keep quiet. The result is that our children have a lot of information, since they are very young, through media, cultural products and friends, in a way that we can say they are "too much informed", but this information is not accurate, ordinary and, mostly, not legitimated. Therefore, they cannot use this information openly, but yet in a hidden and, frequently, confusing way. It is necessary that family, school and healthcare professionals inform openly about these subjects so that minors have proper and legitimated information, which they can use openly.

What corresponds to each educational agent? Parents have the main job: to answer in an open and simple way to their children's questions, to transmit with words and actions the values that the family considers to be fundamental, using their freedom (except if fundamentalists) and, mostly, give them the possibility of living in a family core (regardless of the type of family) in which they learn through experience that there are people who love each other, respect and treat each other with equity, value themselves, etc. To offer them with words and actions ("deeds are love and not good reasons", so the proverb says) a positive vision of life, of human beings and romantic relations is the most important parents have to offer their children concerning sexual education. Only family can offer this and it is the most essential to their children's sexual and romantic life throughout their life. And this is so, because in family they learn to trust or mistrust people, to know that there are reliable and unconditional people or unreliable people, who give value to what they give on what they get, people who respect or abuse each other, who are empathetic or with a closed heart, tender or though, warm or cold; as a whole that people are worth it or not and romantic relations are wonderful or hell. In family, during the first years of life, it is also, acquired, or not, the "code of intimacy" (Félix López (2009). Amores y Desamores. Madrid: Biblioteca Nueva): to learn to see and be seen, touch and be touched, caress and be caressed, being close to one another, skin to skin, without bordering waters to defend, lay naked and trustful, understand and express emotions, empathetically share emotions (the basis of intimacy), regulate emotions without exploding with quarrelsome impetuosity, etc. This is the language that sexuality and romantic relations will require, language of the ones who truly want each other. If one does not have the ability to trust himself and other, moreover, lacks of intimacy code, his sexual and romantic relations will not drag him out of loneliness, will not be truly satisfactory. Also in family, if that is the case, is where we learn to face conflicts in a civilized and constructive way. Therefore, if the parents are to be separated it is fundamental that experience is converted, in spite of the possible pain, in a learning process fundamental to life, based on the right of the couple's disentail, but also in the obligation to go on, sharing their children's project: in which parents face the mutual agreement separation (even if this is not so in the beginning), avoid, within possible, the pain of the other and do not inflict damage to their children(Félix López (2010). Separarse sin grietas: como sufrir menos y no hacer daño a los hijos. Barcelona: Grao). The school must give professional information, well fundamented, in a systematic and ordered way, because it provides teaching based on universal values, shared an accepted by all: it is the ethic of romantic and sexual relations based on the need of consent of the other to all sexual activity (two people who know to own their body and their intimacy and have to consent all sexual activity: no to sexual abuse to minors, raping, sexual harassment or coercion), the equality of genders (opposing to moral duplication and sexist discrimination), health (healthy conducts in opposition to risks), shared pleasure opposing to selfish, etc. At school, intervention from inadequate models such as the risk model, shouldn't occur (only intended to prevent risks), or moral (using the dogma of abstinence based on religious beliefs, which is unconstitutional in a laic country: this can be legitimately done in family but not at school) or the prescript (which works as if all teenagers had or should have had sexual activity). We defend a biographic model (corresponding to people organizing their sexual and romantic life, so that we must help them to have good information and making their own decisions with responsibility) and professional (in which contrasted information is offered and universal values are transmitted) in a way that concerning sexual education, ideological disagreement does not take place, but yet of education so that the person actually builds his/hers autonomy and takes responsibility for his/hers romantic and sexual life, depending on his/hers ideas and

beliefs, and not the ideas and beliefs of the educators. Sexuality is a field where the most specifically human area is the freedom to make decisions; is not a pre-programmed and determined instinct, but yet that people can and should make decisions respecting each other. It is not a time of uniformity, but still a time in which each person builds his/her life with freedom and responsibility. The healthcare professionals must create specific cultures, especially to teenagers and young people, to open the door to these contents in interviews with minors and offer efficient help in the prevention and facing the risks associated to sexual activity. Public health is at the margin of sexual health and this is not appropriate in a non confessional country that looks after its citizens.

PLENARY CONFERENCE 4: A GOOD START IN LIFE AND EARLY PREVENTION: POLICY, EVIDENCE-BASED PROGRAMS AND MONITORING METHODS IN SWEDEN

Friday, 24 May 2013, 10:45-11:45

Anna Jansson, Anna Bessö, Pi Högberg, Johanna Ahnquist, Anja Romqvist, Ann-Cristine Jonsson, Jenni Niska, Matt X. Richardson

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Sweden's public health policy, which explicitly aims to create social conditions for good health on equal terms for the entire population, is comprised of eleven objective domains, the third of which addresses "Conditions during childhood and adolescence". Two national strategies, one for developed universal parental support and one for alcohol, narcotics, doping and tobacco prevention, provide specific guidance within this objective domain. Nationally-driven activities within the two strategies include a combination of universal, prevention-based parental support programs, as well as development projects targeted at families where children are at a higher risk for ill-treatment. A number of health behaviour monitoring systems are also in place to follow developments within the objective domain. The Swedish National Institute of Public Health (SNIPH) finances (€ 16 million) twenty municipally-based parental support projects to promote children's and young people's health. Each project involves a principal municipality that provides programs to increase local parental support collaboration, the number of health-promoting arenas and meeting places for parents and the supply of evidence-based universal parental support programs. Each project also involves collaboration with university researchers for monitoring implementation and measuring program effects. Health economic analysis of parental support work and regional knowledge dissemination of successful activities are also included in the strategy. For children growing up in families with higher levels of risk or ill-treatment due to addiction, mental or physical illness or violent relations, the SNIPH finances (€4.2 million) organizations to offer support or treatment programs. Knowledge development activities include identification of protective factors, program implementation monitoring and effect evaluation, as well as the production of systematic reviews of interventions. Health behavior monitoring systems are also employed to both guide national prioritization as well as to measure development. Here, the SNIPH annually (since 2004) conducts a national public health survey including a youth segment of the population, covering questions about physical and mental health, substance use, contact with healthcare services, living habits, financial conditions, work and occupation, safety and social relationships. Statistics Sweden annually conducts the Living Conditions Survey of Children among 10-18 year olds including questions about general wellness, school situations, leisure-time activities and relationships with friends, parents, and teachers. The survey participants are selected from households where parents also answered a similar survey on living conditions, and the children's answers are then linked to the information submitted by the adults as well as register data regarding the parents' occupations, education and income. The SNIPH also finances a non-governmental organization, the Swedish Council for Information on Alcohol and Other Drugs (CAN), who conduct an annual nation-wide school survey on alcohol and other drugs among students in years 9 and 11. CAN also coordinates of the European School Survey Project on Alcohol and Other Drugs (ESPAD), conducted every four years with data on more than 100 000 students. These activities within the scope of the national public health policy aims to reduce the increasing trend towards psychological problems among Sweden's youth by addressing the social determinants of children's health in a comprehensive and systematic manner.

PLENARY CONFERENCE 5: CHILDHOOD OBESITY IN THE WHO EUROPEAN REGION: A CHALLENGE WITHIN A CONTEXT OF ECONOMIC CRISIS

Friday, 24 May 2013, 14:30-15:30

João Breda

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Overweight is one of the biggest public health challenges of the 21st century: all countries are affected to varying extents, particularly in the lower socioeconomic groups. The picture is not improving in most countries of the WHO European Region. The figures for children from the WHO Childhood Obesity Surveillance Initiative show that, on average, one child in every three aged 6-9 years is overweight or obese. The prevalence of overweight (including obesity) ranged from 24% to 57% among boys and from 21% to 50% among girls. Simultaneously, 9-31% of boys and 6-21% of girls were obese. Variations exist in the prevalence of overweight and obesity not only between European countries but also between socioeconomic groups within those countries with variations among regions, population subgroups (e.g. gender), and over time. This has major implications for the region, which comprises an extremely diverse population in geography, culture, lifestyle and level of economic development. As observed in high-income countries and more recently in many middle-income countries, the social gradient in obesity reverses when the obesogenic environment changes, such as wider access to energy-dense and nutrient-poor food. Prevention policies to tackle this disease burden have been developed through a series of strategic initiatives globally and at the European level, including the European Charter on Counteracting Obesity, the Action Plan for the Implementation of the European Strategy for the Prevention and Control of Noncommunicable Disease, and the Health 2020 framework.

PLENARY CONFERENCE 6: NON-FATAL SUICIDAL BEHAVIOUR IN ADOLESCENTS

Saturday, 25 May 2013, 09:30-10:30

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Adolescence is a phase of life that is full of emotional turmoil, where the triple fallacy that we all must be beautiful, powerful and perfect has the most impact. It is therefore a dangerous trap in which youth frequently fall into. The core question "Who am I?" does not usually find satisfying answers in personalities that are more vulnerable to boredom and emptiness as the borderline. Growing is also an aggressive act of assertiveness, grandiosity (sometimes

almost fantasy-like thinking), intensifying impulses, challenges, and the discovery of boundaries. The suicidal behaviour of youth always raises anguish and perplexity. Why? For what? However, no one commits suicide from emptiness; no one commits suicide to be ignored. That is, there is always a story or a narrative to tell. Make no mistake: they may appear hidden, but they always exist. One of the golden rules is not to fear talking about the idea of death. When we referred to the possibility of a depressed patient staying cloistered, suffering from guilt, death or suicidal ideas, we are, of course, describing situations whose gravity can engage the patient in a suicidal process, as if it was a trail of disturbing memories and frightening experiences. Internal dialogues such as: "I'm worthless, I am a loser in life, the world is too dangerous, I no longer expect anything good in the future" represent a good example of the difficulty for a therapeutic approach. The impulsiveness of youth can play an important role in certain disruptive behaviors, including the path to suicidal action. In bipolar patients, special attention should be given to the "switching" risk, with possible dangerous activations in the beginning of the transition from a depressive phase to hypomanic or even a manic phase. In the specific cases of mixed euphoric-depression symptomatology, attention is required due to the possibility of increased suicide risk. Recently, there has been an emphasis on temperamental traits of greater vulnerability that are important for the transition into the act, such as perfectionism, low self-esteem, impulsivity and identity crisis. These last two aspects are intrinsically related to borderline personality disorder, a slightly hazy area that some authors argue is a variant of certain mood disorders (Orbach & Iohan-Barak, 2009). The Suicide Research and Prevention Unit of the Hospital Centre and University of Coimbra (Portugal) that we founded 20 years ago (1992-2012), have long revealed our patient population's profile, the vast majority configuring non-fatal suicidal behaviours and coming from the Emergency Services Department. A brief summary of the data coming from 463 youth (15-24 years old) observed is the following: 19 years old-average age; 80% Female gender; 70% Medicine overdose; 60% Bad family relationship; psychiatric disorder of a family member; 50% Excessive smokers; 40% Suicide or suicide attempted of a family member; 30% Child abuse or mistreatment; with no group activities; 20% Victims of sexual assault; abusers of alcohol; not religious; 10% Pesticide intoxication; educated in institutions; previous psychiatric hospitalizations. Such data are collected either through clinical observation or through the application of our preferred instrument that assesses suicidal behavior ("Entrevista de Avaliação de Comportamentos Suicidários"-EACOS). Many of these patients that adopt recurring behaviors of this type, regardless of whether they are depressed or not, often exhibit personality disorders such as borderline and histrionic. We are essentially talking about a population that does not tolerate frustration and conflict in the world of affection. For patients who say they are not loved and feel rejected, even by the nuclear family, and as something lasting, we call it Sentencing Family Rejection. We also proposed a triple pathology for such patients, especially the recurring: of feeling, of time and of power. That is, they feel everything excessively, they deal poorly with time due to their impatience, and with the relations of power they become uncomfortable when they interpret themselves as neglected or marginalized within the family (Saraiva, 1999; 2006). These families often have high levels of emotional over-involvement and hypercriticism (Santos, Saraiva & Sousa, 2009). From the diagnosis standpoint the following comorbidity frequently reoccurs: Depression or adjustment disorder; Personality Disorder (cluster B > C > A, borderline, histrionic, dependent…); Substance use/abuse (alcohol, drugs); Impulse-control disorder (impulsive-explosive). In the particular case of young people who cut themselves, we now know that it is a problem of Public Health in certain countries, having been advanced worrying figures (Klonsky et al., 2011). The majority of these behaviours follow a pattern of secrecy, a form of "private insanity" or "lonely alienation", but almost always far from suicidality. The intended goal is the rapid relief of an anxious state. The references to loneliness, sadness, boredom, emptiness, or anger are very common, although many of these patients have difficulty to put in words what they feel. This is precisely why they exhibit the possible "revolt" through the body, as a variant of alexithymia. "In the oscillation between fantasy and reality, the bleeding is the relief. It serves to lower the emotional strain of bitterness or hopelessness, to solve in the immediate moment a suffering regarded as atrocious and unending" (Saraiva, 2006). It is also possible to find a multitude of speculations, some perhaps unrealistic, about the phenomenon, but the most important is to listen to what patients often say: "I prefer the pain of the body to the pain of the soul".

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PLENARY CONFERENCE 7: BAN TOBACCO ADVERTISING, PROMOTION AND SPONSORSHIP: PROTECTING CHILDREN AND YOUTH

Saturday, 25 May 2013, 14:30-15:30

Sofia B. Ravara

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Globally, tobacco use is the main cause of preventable death. More than two thirds of smokers experiment, uptake smoking and become addicted to tobacco in their teenage years. Half of those who do not manage to quit will die prematurely due to this deadly behavior. Preventing youth smoking is extremely difficult. Health education programs have not been consistently effective. Therefore, protecting children and youths from tobacco industry (TI) marketing and from exposures that enhances the likelihood of experimentation with tobacco, should be a public health priority. Currently, TI is highly regulated in many countries due to bans on advertisement, promotion and sponsorship. Partial and poorly-enforced bans are however ineffective to protect children and youth from exposure to powerful tobacco brands imagery. This is still the case in many countries that have approved the FCTC. In addition, the TI has successfully evaded bans on promotion/advertisement/sponsorship, developing aggressive tactics targeting specially youths and girls, including: 1) breaches on bans on advertisement/promotion/sponsorship of cultural and sporting events; 2) aggressive point-of-sale promotion; 3) brand-stretching; 4) Internet promotion; 5) pack design and flavors to appeal to and hook specially girls and youths; 7) placement of smoking and tobacco imagery in films or on television. Civil society should be aware of children and youth susceptibility to tobacco imagery exposure, including adult smoking visibility and environmental tobacco smoke exposure in private and public settings. Health professionals, educators, ONGs, policy-makers and society at large should work on strong partnership to promote tobacco control best practices and protect children and youth from tobacco exposure.