ESSOP Annual Meeting 2008

Grand Hotel Reykjavík
Reykjavík, Iceland, October 8-10, 2008

Eurpoean Society for Social Pediatrics and Child Health (ESSOP)
in collaboration with *School of Health and Education, Reykjavík University* and the
Centre for Child Health Services, Primary Health Care Organisation of Reykjavík Capital Area

Health of School-Age Children

Programme Book and Abstracts

HÁSKÓLINN Í REYKJAVÍK
REYKJAVÍK UNIVERSITY

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ESSOP Annual Meeting 2008

ESSOPs Mission statement (2007)

'Health professionals thinking and acting locally and globally to improve the health and well being of children and young people'

We believe in – working *together* to use our skills, resources and knowledge to develop local and global strategies to improve the health and well being of children and young people.

Our methods include – improving communication between all those involved in child and adolescent health and well being, bringing you the latest on the relevant research world wide, developing tools for advocacy, developing tools for teaching, developing tools for involving children and young people themselves, and by providing information about effectiveness and efficacy of interventions, meeting together at conferences, maximising our individual and group effectiveness.

We work with – national social/community paediatric organisations, NGOs working in the same field, child advocacy groups, health professionals involved with child health, governments, economists, sociologists, lawyers and others with the same interests and aspirations.

The benefits of joining us – means that we can work together in making us all a more powerful voice and force for change. You have access to people, strategies and concepts via the internet to promote your ideas, you meet people with similar aspirations and contribute at conferences held in various places throughout Europe. Members of ESSOP can be subscribed to the Journal of Child: care, health and development at a reduced price (which includes online access). For further information you can visit www.blackwellpublishing.com/journals/cch.

What does it cost and where does your money go? Annual membership presently costs 35 Euros (or 50 Swiss francs) and goes to supporting a general secretary, a website with detailed information about the organisations activities and membership, and the development of advocacy and teaching materials. But essentially costs are kept to minimum by involving all the membership in developing the association. You, your knowledge, your actions are the association's main resource.

How often does the association meet? Once a year, in various locations around Europe, and sometimes elsewhere, so as to promote social paediatrics both locally and internationally. Recent conferences: *Health systems and child health: lessons from cross-country comparisons* (Trieste, Italy 2007); *Equity in child health and health care* (Cardiff, Wales, 2006), *Child health care during the period of transition* (Sibenik, Croatia, 2005); and *Early childhood prevention - theories and practices* (Montréal, Canada, 2004).

Membership subscription details - can be found at our website on www.essop.org. Join us now to know how change can be brought about in the field of child and adolescent health and be at the cutting edge of that change.

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I welcome you to the ESSOP Annual Meeting 2008, held in Reykjavík, Iceland for the first time. Under the umbrella of ESSOP, we arrive from different corners of the world to exchange ideas and views on how to promote child health in our respective countries, as well as seeking inspiration to improve our services. The health situation of children in our countries may differ but all have the same right to attain the best possible health. It is in that spirit we make the effort to meet every year and share our experiences.

The theme of this years annual meeting was chosen to throw light on the importance of early childhood development and the health of school-age children. Children attend different school settings at younger age than before and services for them focus increasingly on their development and mental health issues. Thus, we are honoured and priviledged to have with us as guest speakers Dr. Clyde Hertzman from Vancouver, Canada and Dr. Frances Page Glascoe from Vanderbilt, USA. In addition to them, ESSOP members and Icelandic professionals colour and inspire the meeting, either as oral or poster presenters or session chairpersons. I thank all of you for your willingness to participate and thus give the meeting the intended professional scope and depth.

Finally, I would like to thank my colleagues at the School of Health and Education at Reykjavík University and the Centre for Child Health Services, as well as Professor Nick Spencer, the President of ESSOP, who have all contributed in one way or another to the current programme and organisation of the meeting. Finally, the Mayor of Reykjavík and the Minister of Health are gratefully acknowledged for their support.

Feel most welcome to Iceland - I wish all of us a vibrant and inspiring first North-Atlantic ESSOP meeting!

Geir Gunnlaugsson

ESSOP Annual Meeting 2008

Annual Meeting of the European Society for Social Pediatrics and Child Health (ESSOP)

Health of School-Age Children

Conference venue: Grand Hotel Reykjavík
October 9-10, 2008

Wednesday, October 8, 2008

18:30 Registration
Welcome session and refreshments on the invitation of the Minister of Health

Thursday, October 9, 2008

08:00 Registration

Chairperson: Guðjón Magnússon, Professor of Public Health, Reykjavík University

Opening ceremony

09:00 Welcome Geir Gunnlaugsson, Conference Organizer
Nick Spencer, ESSOP President
Guðlaugur Þór Þórðarson, Minister of Health

09:20 Early childhood development and school readiness
Clyde Hertzman, Director of the Human Early Learning Partnership, Department of Health Care and Epidemiology, University of British Columbia, Vancouver, Canada.

10:10 *Coffee break*

Session 1: School readiness

10:40 Age maturation and school performance
Júlíus Björnsson, Director of Educational Testing Institute, Reykjavík

11:10 Social influences on early childhood and school readiness
Nick J. Spencer, University of Warwick, UK

11:40 Voices of Icelandic Children
Margrét María Sigurðardóttir, Children´s Ombudsman, Iceland

12:10 *Lunch*

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Session 2: **Late childhood and early adolescence**
Chairperson: Ragnar Grímur Bjarnason, Chairman of the Icelandic Pediatric Association

13:15 Research, policy and practice for adolescents
Inga Dóra Sigfúsdóttir, Dean of School of Health and Education, Reykjavík University
13:50 Adolescent at risk in a global environment
Thórólfur Thórlindsson, Director of the National Public Health Institute, Reykjavík
14:30 Health indicators for school aged children
Mitch Blair, Consultant Reader in Paediatrics and Child Public Health, Northwick Park Hospital, London, UK

15:00 *Coffee break*

15:20 **Poster session**
Chairperson: Nick Spencer, University of Warwick

15:50 Panel discussion with speakers: *Determinants for health of young children*
Moderator: Guðjón Magnússon, Professor of Public Health, Reykjavík University

16:50 End of day

18:30 Reception the Reykjavík City Hall at the invitation of the City Mayor

Friday, October 10, 2008

Session 3: **Developmental screening of young children**
Chairperson: Anna Björg Aradóttir, Chief Nursing Officer and Chief of Division of Clinical Quality and Public Health, Directorate of Health

08:30 Identifying children likely to have school problems
Francis Glascoe, Professor of Paediatrics, Vanderbilt University, USA
09:25 Identification of young children with developmental problems in Iceland
Geir Gunnlaugsson, Professor of Public Health, Reykjavík Unversity and Director of the Centre for Child Health Services, Iceland

10:00 *Coffee*

Session 4: **School health services**
10:25 School health services – what for?
Olivier Duperrex, Medical Director, Unité des Éscoles en Santé du Canton de Vaud, Switzerland
10:55 6H–cube for health promotion in Icelandic compulsory schools
Ragnheiður Ósk Erlendsdóttir, Head of Section of School Health Services, Centre for Child Health Services, Iceland
11:25 380° Prevention that works! LazyTown - The Only Brand dedicated to Kids Health
Magnús Scheving, Creator and CEO of LazyTown

12:00 *Lunch*

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13:00 **Poster session**
Chairperson: Mitch Blair, Consultant Reader in Paediatrics and Child Public Health, Northwick Park Hospital, London, UK

Session 5: Health for the future
Chairperson: Gülbin Gökçay, İstanbul University, Institute of Child Health Çapa, Istanbul, Turkey.

13.30 School performance and health in youth
Anders Hjern, Professor, Centre for Epidemiology (EpC) , Stockholm, Sweden
13:50 Why we need to tackle climate change as a matter of urgency
Tony Waterston, Newcasle upon Tyne, UK

Session 6: Free papers
Chairperson: Gyða Haraldsdóttir, Psychologist, Head of the Section for Development and Behaviour, Centre for Child Health Services, Reykjavík

14:15 Recent developments on school health services in Turkey
Serpil Uğur Baysal, Institute of Child Health, Istanbul University, Turkey
14:28 How can Community Paediatricians help to reduce school exclusion of young people with behavioural difficulties?
Anthony Tam, Southwark Children´s Services, London, UK
14:41 How to handle death in the school
Stella Tsitoura, 2nd Pediatric Clinic, University of Athens, Greece
14:54 The effect of route of tobacco smoke exposure of breastfed and non-breastfed infants on urinary cotinine levels
Gonca Yılmaz,′ Department of Pediatrics, Keçiören Training and Research Hospital, Ankara, Turkey
15:07 Assessment of general health findings with relation to blood lead levels in school children in Kırıkkale, Turkey
Selda Bülbül Hızel, Kırıkkale University, School of Medicine, Department of Pediatrics
15:20 Psychosocial maladjustment influences symptoms severity and treatment efficacy in functional dyspepsia in children
Igor Radziewicz-Winncki, Department of Health Promotion and Environmental Nursing, Medical University of Silesia, Katowice, Poland

15:35 *Coffee*

15:55 Panel Discussion: Future of school health services

16:45 ESSOPs Annual General Meeting

18:30 End of Conference

20:30 Conference dinner in Kaffi Reykjavík, Vesturgata 2, Reykjavík

Guest speakers

Early childhood development and school readiness
Dr. Clyde Hertzman

Thursday October 9, 09:20 AM

Clyde Hertzman, MD, FRCPC, is the Director of the Human Early Learning Partnership (HELP) and is a professor in the School of Population and Public Health at the University of British Columbia. Nationally, he is a Fellow of the Canadian Institute for Advanced Research (CIfAR), a Canada Research Chair in Population Health and Human Development, and President of the Council on Early Child Development.

Clyde was born and grew up in Vancouver, BC. He completed his training in medicine, community medicine, and epidemiology at McMaster University in Hamilton, Ontario in 1985, and has been on faculty at UBC since that time. He has played a central role in developing the conceptual framework for the "determinants of health" and elucidating the special role of early childhood development as one of those key determinants. His research has contributed to international, national, provincial, and community initiatives for healthy child development.

Identifying children likely to have school problems: Using information from parents
Dr. Francis Glascoe

Friday October 10, 08:30 AM

Frances Page Glascoe is a professor of Pediatrics at Vanderbilt University and a pediatric educator with more than 20 years experience in working with pediatric residents, faculty, and community providers. She spent 10 years teaching special education in the public school before joining the faculty at Vanderbilt University where she directed the rotation in developmental pediatrics and served as educational specialist on the neuropsychology, school performance, autism and developmental diagnostic teams. Her research focuses on the accuracy of developmental and behavioral screening measures and she is the author of more than 100 journal articles and chapters. Dr. Glascoe is the author or co-author of several screening tests including Parents' Evaluation of Developmental Status (PEDS) and PEDS: Developmental Milestones both brief screening, surveillance and decision-support tools focused on detecting and addressing developmental and behavioral needs in children 0–8 years (www.pedstest.com), the Brigance Infant and Toddler Screens, and the Safety Word Inventory and Literacy Screener (SWILS). In October, 2000, she received the Dale Richmond Award for contributions in child development from the American Academy of Pediatrics.

SESSIONS WITH BIOSKETCHES AND ABSTRACTS

THURSDAY OCTOBER 9, 2008

Chairperson of Morning Session:
Dr. Guðjón Magnússon, Professor of Public Health, School of Health and Education, Reykjavík University

Guðjón obtained his MD from the University of Iceland and did postgraduate and specialist training in Scotland and Sweden before obtaining specialist degree and PhD from Karolinska Institutet in Stockholm in public health. He was the Director of the Division of Health Programmes at the World Health Organization Regional Office for Europe in Copenhagen, Denmark in 2002-07 and the Dean of the Nordic School of Public Health in Gothenburg 1996-2002. In his professional career he has, among other positions, served as Deputy Chief Medical Officer of Iceland and Deputy Secretary General in the Icelandic Ministry of Health and Social Insurance. He has done research and published numerous articles on public health and health services research. He is an Honorary Member of ASPHER (Association of Schools of Health in the European Region) and has been active as volunteer for the Red Cross Red Crescent Movement for more than 20 years, both as President of the Icelandic Red Cross and Vice-President of the International Federation of Red Cross and Red Crescent societies.

09:20 Early childhood development and school readiness

Dr. Clyde Hertzman, Director of the Human Early Learning Partnership, Department of Health Care and Epidemiology, University of British Columbia, Vancouver, Canada

In 2004, British Columbia (BC), Canada became the first jurisdiction in the world to collect complete population-based data on children's state of development at entry to school. This was done using the Early Development Instrument (EDI) developed by Offord and Janus at McMaster University. Collected at age five, EDI data cover development on physical, social, emotional, language/ cognitive, and communication scales. We have mapped them by residential neighbourhood, to reflect the context in which children spend their first five years. Mapping has brought the issue of early child development into the public eye. Variations in the proportion of children who are vulnerable (behind) on one or more developmental scale are huge: from a low of 5% to a high of 60% by neighbourhood.

Finding ways to reduce vulnerability and decrease inequality in vulnerability is now very much on the policy agenda. More than 500 initiatives have been taken across the province to address this issue since these data were produced. Meanwhile, our ongoing data collection is tracking changes in developmental vulnerability over time and anchoring developmental trajectories for all BC children. The approach being taken in BC is now being applied in more than a dozen other wealthy and developing countries and deserves to be considered globally.

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Session 1: School readiness

10:40 Age maturation and school performance

Júlíus Björnsson, Director of Educational Testing Institute, Reykjavík

Júlíus is trained in psychology, graduate in Clinical Psychology, and lecturer in psychometrics and ps-psychophysiology at the University of Iceland for ten years. Conducted research in psychophysiology and sleep and educational research of various types. The Educational Testing Institute is responsible for all national ed-educational tests in Iceland, for the 4th, 7th and 10th grades. Additionally the Institute participates in a nu-number of international comparative studies, such as the PISA, PIRLS, TALIS and others. The Educational Te-sting Institute also is the main publisher in Iceland of psychological tests and measurement tools, and has do-ne a number of Icelandic standardizations of large tests such as the WISC, WPPSI and others. Further, it pa-rticipates in a number of educational research projects, in cooperation with the Ministry of Education, and the universities in Iceland.

The differentiation between children based on their absolute age, leading to different teaching methods (individualized teaching) is perhaps not nearly enough in today's schools; in other words, individual differences due to maturation and readiness to learn within each school year are not well enough recognized. Current data show that small differences in age can be associated with relatively large differences in performance. Data from the PIRLS (Progress in International Reading Literacy Study) international comparative study and results from the Icelandic national tests will be used to illuminate the issue.

Careful analysis of the PIRLS data indicates that differences in age and maturation are not taken into account in this study, making the international comparisons based on it very difficult. Data is shown both from the PIRLS and from the Icelandic national tests, which underline the fact that even a difference of one or two months in age can explain a significant difference in reading performance in 9-10 year old students. This conclusion is reached after examining data from over 33-000 Icelandic fourth graders, and is also illuminated with PIRLS data from 4th and 5th graders in Iceland and Norway, thus making the data very robust and conclusive. Different methods of school intake, different methods of repeating grades and several other variables make this very prominent age effect invisible in most countries, thus leading to the fact that schools and teachers largely ignore maturation differences after the children have been assigned to a certain grade. The data indicates that this age effect is very prominent at least until the 7th or 8th grade, and that it has largely disappeared at 15 years of age. This very prominent effect should be better known in today's schools and taken into account when planning teaching and understanding the learning progress of differently aged pupils placed in the same grade.

11:10 Social influences on early childhood and school readiness

Nick J. Spencer, Professor Emeritus of Child Health, University of Warwick, UK

In addition to his academic appointment as Professor of Child Health, Nick was an Honorary Consultant Community Paediatrician with Coventry Primary Care Trust between 1990-2003. He has acted as a consultant for the World Health Organisation and has recently authored a background paper on 'Poverty and Child Health in the European Region' for WHO European Regional Office. He is currently President of the European Society for Social Paediatrics and Child Health. His research interests are the social influences on child health and he has undertaken wide ranging research in this area. Over his research career, he has obtained >£500,000 in research grants. He is the author of over 100 papers in peer-reviewed journals and has published two single author books and edited five others.

This presentation draws upon international data, particularly from the UK and USA, to examine the societal level influences on early childhood and school readiness. It will seek to show that socio-economic factors play a key role in relation to cognitive development in early childhood that contributes to children's readiness for school. For example, a UK study shows that children from low socio-economic status (SES) households who are in the top 10% for cognitive development at 22 months are overtaken by their high SES peers who were in the bottom 10% at 22 months by the time of school entry. A similar study in the USA shows that children living in deep poverty are on average 7 IQ points behind children in affluent households by age 7-8 years and this difference increases to 11 points by the age of 9-10 years. The paper will explore the possible mechanisms by which these social inequities develop and the public health and educational implications for societies.

11:40 Voices of Icelandic Children

Margrét María Sigurðardóttir, Children´s Ombudsman, Iceland

Margrét María graduated in 1990 with a law degree from the University of Iceland. She worked as a district court lawyer 1996-2004 and was Deputy of District Commissioners 1991-98. She was Director of the Centre for Gender Equality in Akureyri 2003-07. On July 1, 2007, she was appointed Ombudsman for Children in Iceland.

The role of the Ombudsman for Children is to further the wellbeing of children and to look after their interests, rights and needs in all walks of life. The Ombudsman for Children is expected to be a protector of all children up to the age of 18.

One of the main goals of the Convention on the Rights of the Child is to give each and every child the opportunity to develop and be an informed and responsible individual. The ombudsman for children has worked on getting the voices and views of children in Iceland heard. In the presentation you will get a brief overview of that work.

12:00 *Lunch*

Chairperson of Afternoon Session:

Dr. Ragnar Grímur Bjarnason, Chairman of the Icelandic Pediatric Association

Ragnar Grímur took his medical degree 1985 at the University of Iceland. He did his training in pediatric endocrinology at Sahlgrens University Hospital in Göteborg, Sweden from 1991. PhD in paediatrics, Medical Faculty, Göteborg University with the thesis: Molecular markers for growth hormone sensitivity in man - Focus on growth hormone-binding protein and insulin-like growth factor I gene expression. Supervisor: Lena Carlsson, Kerstin Albertsson Wikland. Associate professor at Göteborg University in 2001. Post doc fellow, St Bartholomew's Hospital London 1998-1999, MFR/Welcome Trust. Senior consultant paediatric endocrinology between 1999 and 2002, Göteborg, Sweden. Senior consultant paediatric endocrinology from 2002, Reykjavik, Iceland. Supervisor of PhD students and Post doc fellows.

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Session 2: Late childhood and early adolesence

13:15 Research, policy and practice for adolescents

Dr. Inga Dóra Sigfúsdóttir, Dean of School of Health and Education, Reykjavík University

Inga Dóra is the founder and director of research at the Icelandic Centre for Social Research and Analysis, that is an organization with emphasis on youth research, education and innovation. She received her PhD in sociology in 2004 from Pennsylvania State University, USA. She has co-authored numerous books in Icelandic, as well as articles in peer reviewed journals. Her most recent articles appeared in Social Compass, Journal of Forensic Psychiatry and Psychology and Social Forces.

Adolescent substance use is a growing health related problem in western and particularly eastern-European countries. Decades of research, has shown that rapid societal change may reduce social integration and contribute to a higher frequency of delinquent behavior, such as substance use. Out of 28 countries participating in the ESPAD surveys, in 23, there was a constant and substantial increase in substance use among primary school students between 1995 and 2003. In Iceland, the situation was similar. Through the nineties, alcohol use, smoking and the use of other drugs increased constantly among 15 and 16 year olds.

In 1996, *an aim* was set forth to make an attempt to fight this vicious upward trend, by trying out a new approach in prevention in Iceland. In the presentation, I will describe the development, implementation, and results of this approach; the Icelandic Model of Adolescent Substance Use Prevention. The Icelandic Model is a theoretically-grounded, evidence-based approach to community adolescent substance use prevention that has grown out of collaboration between policy makers, behavioral scientists, field-based practitioners, and community residents in Iceland. The intervention focuses on reducing known risk factors for substance use, while strengthening a broad range of parental, school, and community protective factors.

13:50 Adolescent at risk in a global environment

Dr. Thórólfur Thórlindsson, Professor of Sociology, University of Iceland and Director of the Public Health Institute, Reykjavík

Thórólfur has been a professor of sociology at the University of Iceland for more than 30 years. He has a PhD from the University of Iowa, USA. His research has been in the area of youth, sociology of science and knowledge and health. He has published about hundred professional publications, including nine books and monographs and about 60 research articles in refereed journals.

In this presentation, I argue that increased globalization calls for a radically different approach to central issues pertaining to the welfare of children and adolescents. Increased globalization of the adolescent society has undermined some key social institutions, weakened traditional relationships and attachment to traditional norms and values. At the same time, it has strengthened the peer group and brought it to the center of the adolescent life-world. Thus, processes of globalization have shifted the balance of power from traditional institutions such as the family, church, and school to the adolescent society. The weakening of social control that is embedded in these changes leaves youth more free to seek excitement and fun, form subcultures, and develop lifestyles, which are in contrast to the dominating adult culture. The emergence of international, commercially driven popular youth cultures makes the peer group a profitable target. The entertainment industry, heavily geared toward peers, offers adolescents more freedom to choose lifestyles, values, and norms outside the direct guidance and control of family

and school. Furthermore, organized crime, the distribution of illegal drugs, and child and adolescents based sex trafficking, are increasingly organized on international level.

One of the consequences of these social changes is that the local community has become more important in public discourse, catching the attention of policy-makers, politicians and practitioners. Thus, politicians across the political spectrum that speak of the "third way" and the role of voluntary associations, educational leaders that endorse the proverb "It takes a village to raise a child", and youth workers and prevention experts that emphasize community based prevention, all assume the important role of community in social organization and individual well-being. The rise of theories of social capital, social networks, inequalities and related conceptual frameworks have renewed interest in community. They have, however, not inspired theoretical analyses of this important theoretical concept. In fact, the concept of community has been absorbed into these theories treating community as merely a transitory phenomenon.

In this presentation, I discuss the globalization of the adolescent life world. I focus on the interplay of the two opposing sets of local and global factors the context of youth research, policy and practice. I argue that focusing on the concept of community in the context of globalization helps to bridge the gap between research on one side and health promoting and preventive youth work on the other. Focusing on community also helps to integrate the theoretical perspectives. In order to illustrate this point, I discuss the relationship of research to 1) the family; 2) specific youth programs and leisure; 3) school; and 4) grassroots movements and community based networks.

14:30 Health indicators for school aged children

Dr. Mitch Blair, MBBS, BSc (hons), MSc., FRCP, FRCPCH, FRIPH, FFPH (hon), FHEA**,** Consultant and Reader in Paediatrics and Child Public Health, Imperial College, London, UK

Mitch qualified in medicine MBBS from UCH, London in 1983 with a BSc in Sociology and Philosophy of Medicine and went on to paediatric training posts at Stoke Mandeville, Charing Cross Hospital, Great Ormond Street, Northwick Park, and Nottingham. After obtaining an MSc in Community Paediatrics from the Institute of Child Health in London, he moved to Nottingham as Lecturer and then Consultant Senior Lecturer in Community Paediatrics which he held between 1990 and 1998. He worked in inner city community practice in health centres, schools, day nurseries and specialist out-reach to single handed and group practices. He carried out teaching and research into the national child health screening programme and community paediatric out-reach to primary care. He moved back to London in 1998 and is currently Consultant and Reader in Paediatrics and Child Public Health at Imperial College London and Honorary Professor at Thames Valley University. The River Island Academic Centre for Paediatrics and Child Health at Northwick Park Hospital, Harrow opened in July 2005. His current research interests include early identification of developmental impairment, the use of complementary medicine in children, international child health indicators, child public health monitoring, and health service evaluation.

How can we best measure, the health of school age children? Healthy children are healthy learners. This presentation focuses on two main aspects. The first part of the presentation will review some of the current data that is available on measures of children's health in the school period. It will critique the current situation, and suggest ways in which methods might be improved. The second part will focus on a process that took place in the UK in London, which aimed to bring stakeholders together and develop a consensus on what and how health should be measured at school entry. The process that led to the development of a specific tool (Child Health at School Entry - CHASE), which is administered to parents and completed by teachers and school

nurses. CHASE is currently being incorporated into the city wide health Information Systems (RIO) The data available from the pilot of this tool in 10 schools will be presented as a possible model for other countries with some discussion about limitations and improvements.

References

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Edmunds S, Garratt A, Haines L, Blair M. Child Health Assessment at School Entry (CHASE) Project: evaluation in ten London primary schools. *Child: Care, Health and Development* 2005;31(2):143-154.

FRIDAY OCTOBER 10, 2008

Chairperson of Morning Session:
Anna Björg Aradóttir, Chief Nursing Officer and Chief of Division of Clinical Quality and Public Health, Directorate of Health

Anna has B.Sc. (1980) and M.Sc (2003) in nursing from the University of Iceland, with emphasis on children´s nutrition and public health. Career mainly in children´s nursing and primary health care. For the last decade the emphasis has been on quality of the health care services, i.e. nursing education and clinical services, clinical guidelines, patient safety and, quality supervision of the health care services.

Session 3: Development screening of young children

08:30 Identifying children likely to have school problems
Francis Glascoe, Professor of Pediatrics, Vanderbilt University, USA

Difficulties in school performance have numerous precursors first arising in the early childhood years. These include a range of developmental and behavioral problems and psychosocial risk factors. Intervention prior to school enrollment can prevent school failure and the mental health problems that almost inevitably follow. Detecting young children in need of intervention is fraught with challenges. Informal methods (e.g., milestones checklists, clinical observation) miss about 70% of those with needs. Measurement using evidence-based measures is essential. Efficient measurement in busy health care settings is best conducted using quality tools that depend on information from parents.

09:25 Identification of young children with developmental problems in Iceland
Geir Gunnlaugsson, Professor of Public Health, Reykjavík Unversity and Director of the Centre for Child Health Services, Iceland

Geir graduated with a MD from the University of Iceland and PhD in paediatrics and MPH from the Karolinska Institute, Stockholm, Sweden. Teacher and Director of Studies in the Section for International Maternal and Child Health, Uppsala University Hospital in 1998-2000. Lived and worked in Guinea-Bissau, West-Africa, in 1982-85 and 1993-1998. Consultant to the Icelandic International Development Agency (ICEIDA) in health projects in Malawi and Mozambique. Participant in Nordic, European and international

working groups on child health (e.g., CHILD, NOMESCO and Arctic Council) and breastfeeding. Research and publications within the field of paediatrics, primary health care and public health in Iceland, Guinea-Bissau and Malawi. This work includes, e.g., publications on breastfeeding, infant and child mortality, development, child abuse, measles, cholera, and health systems. First chairman of the Icelandic Public Health Association in 2001-07.

Preventive child health services in Iceland stand on three pillars: maternity care, care to infants and young children (0-5 years) and school health services (6-15 years), based on guidelines from the Directorate of Health. Most if not all parents (or parents-to-be), irrespective of socio-economic background, attend the services that are state-run and free of charge.

Services to infants and young children include on average 2-4 home visitations after birth and regular visits to the neighbourhood health centre from the age of 6 weeks. During the first 18 months of life the parents are offered eight scheduled visits to nurses, supported by medical practitioners, and more in case of need. The compliance is good, e.g., illustrated with about 99% of all children being vaccinated acccording to schedule at 2 years of age except for MMR (~90%). In addition to regular preventive health centre visits during the first 18 months of life, the families are offered to attend with their children at 3,5 and 5 years of age. These two visits have however been criticised by professional staff as lacking proper guidelines and for being ineffective. Parents also often complain that the two years interval is too long.

After extensive consultation among professionals it is now decided to change the current programme and offer regular visits at the age of 2,5 and 4 years of age. In addition, the tools PEDS and BRIGANCE Screen will be applied in the visits to improve focus on development and mental health of the child. The tools have now been translated and slightly adapted to the Icelandic setting and are currently being pilot tested in five health centres, and are expected to be implemented on a nation-wide basis from January 2009. The implemention will be continously monitored and data collected and analysed in collaboration with the Educational Testing Institute in Reykjavík. On the basis of the results, the application of the tools will be revised and improved, if neccessary. One of the options to be scrutinized is whether PEDS would be sufficient as a screening tool, followed by BRIGANCE Screen in case of parental worries. Implementation in the setting of day-care services is also one of the options to be looked into.

Preventive child health services in some high-income countries, e.g. Sweden and UK, have in recent years been criticized for lack of evidence for the services offered. Rather than curtail current services, we seek ways to improve child focused universal preventive services that are appreciated and sought after by parents. The visits are an excellent entry point with age-adapted health promotion and support to parents and children. They are also one of the means the state has to support children to be successful learners, both in the pre-school and compulsory school setting, and later, to be healthy and productive individuals.

Session 4: School health services

10:25 School health services – what for?

Olivier Duperrex, MD, MSc, Medical Director, Unité des Éscoles en Santé du Canton de Vaud, Switzerland

Olivier is trained as a paediatrician in Lausanne, Vevey and Geneva and completed an MSc in community paediatrics at the Institute of Child Health in London 10 years ago. He also collaborated and taught with the Centre for Evidence-based Child Health at the same institution. He has spent the last ten years conducting

projects and research in school settings and contributed to bring a better informed approach in school health in Geneva with Paul Bouvier. Olivier is also the medical reference for a home visiting programme by nurses. With his academic hat, he teaches in an MPH programme and conducts systematic reviews in the injuries field.

Where are school health services coming? What were they set up for? Reviewing a bit of history should help put in perspective the current questioning about what is done in schools for promoting health and preventing diseases. Exploring some organisational models in different systems will lead to the discussion about how to respond to the evolving needs of children and adolescents in schools.

10:55 6H–Cube for health promotion in Icelandic compulsory schools

Ragnheiður Ósk Erlendsdóttir, Head of Section of School Health Services, Centre for Child Health Services, Iceland

Ragnheiður Ósk has a BSc in Nursing (1993) from University of Akureyri, MSc in nursing (2000), Faculty of Nursing and MA in human resources (2004), Faculty of Economics, University of Iceland. She worked 1995-2004 at the Children´s Hospital in Reykjavík. In her current position, her main role is to develop, lead and coordinate national school health services.

Health promotion is one of key strategies in the healthcare services for children of school age. In Iceland, school nurses from primary healthcare centres work in all compulsory schools. Their work includes health promotion but hitherto it has not been standardized or coordinated.

The 6H Cube is a collaborative project of the Centre for Child Health Services and the National Public Health Institute (PHI). The objective is to prepare educational materials for healthcare staff to use in health promotional activities for pupils aged 6-16 years. The project commenced in the autumn of 2005, and is due to end in the autumn of 2008, when the material for all age groups will be ready. About thirty people were involved. They worked in teams of professionals from the PHI and primary healthcare centres. An editorial board standardized and published the fruits of the teams' work, after testing it in several schools. On the completion of each part of the project, training was offered to school health professionals in order to reinforce the contents of the material and prepare standardized and coordinated health promotion in the school setting. The creation of the educational material was guided by clear objectives for each health promotion session in class with positive and empowering instructions for the pupils, including activities reinforcing learning by doing and involvement of parents.

Six concepts, each beginning with the letter **H**, comprise the framework for the 6H Cube: ***H****ollusta* (nutrition), ***H****reyfing* (physical activity), ***H****amingja* (mental health), ***H****ugrekki* (courage), ***H****víld* (relaxation and sleep) and ***H****reinlæti* (hygiene). The seventh concept is puberty, which leads to discussion of sex, which also happens to be the Icelandic word for six.

The success of the project is evaluated by the following variables: (1) proportion of primary healthcare centres which have purchased the 6H promotional material; (2) proportion of children attending 6H classes; (3) views and experience of users of the educational material; (4) parents' views and experience of letters children bring home to them after each class; and (5) children's lifestyle.

11:25 380° Prevention that works! LazyTown - The only brand dedicated to kids health

Magnús Scheving, Creator and CEO of LazyTown

Magnús is a writer, world-class athlete, entrepreneur and producer. He has been the producer and host of popular health-related children´s TV shows as well as producing and acting in other TV productions and commercials. Magnús also produced and hosted his own talk show, being a well-known comedian and public entertainer in Iceland. Among his many sports awards and trophies, he was the two-times European Champion of aerobics in 1994 and 1995 as well as a silver medalist in the World Championships of aerobics in 1994. He created LazyTown in 1991, in response to frequent questions from parents about exercise and nutrition for children, with the aim to help parents raise healthy kids, and to inspire kids to lead healthier lives. The company has been delivering pro-health and positive social messages in an entertaining and nonviolent way and produces only material which can stand up to scrutiny from an artistic point of view as well as an ethical one.

LazyTown is a funny, fresh show that blends movement, music, comedy and great storytelling in a colourful, fast-paced, upside-down world. The unique look of Lasy Town combines the worlds of CGI (computer generated imaginary), puppets and live characters. The stories are always lively and entertaining, motivating solid values. LazyTown may have the laziest name on Earth, but it is jam-packed with action, energy and powerful message that tells all kids they have the will to succeed. The show is now on air in 103 countries and is available in American/British English, French, German, Italian, Spanish (Latin-America & Spain), Portuguese (Brazil), Korean, Flemish, Danish, Swedish, Norwegian, Finnish and Icelandic.

11:55 *Lunch*

13:00 Poster session

Session 5: Health for the future

Chairperson:
Gülbin Gökçay, Professor in Pediatrics and Child Health, Istanbul, Turkey.

Gülbin is a faculty member of Department of Social Pediatrics, Institute of Child Health and Head of Social Pediatrics Unit, Department of Pediatrics, Istanbul Medical School, Istanbul University. She is a researcher and lecturer/trainer in the field. She works as a consultant with a number of national and international organisations on well child health care, nutrition and immunization in the community. She coordinates interactive training courses for various levels of health personnel as well as trainers on breastfeeding counselling. She is in the editorial or advisory committee of many international and national journals on health sciences. She is a member ESSOP since 1988 and was its President 1997-1999. She is the founding and current president of the Turkish Society for Social Pediatrics.

13.30 School performance and health in youth

Anders Hjern, Professor, Centre for Epidemiology (EpC) , Stockholm, Sweden

Anders was trained as a paediatrican at Karolinska University Hospital in Stockholm. In his practice in an out-care clinic in an immigrant-dense suburb of Stockholm he became interested in child health in immigrant families. This interest led to the development of a series of child health programmes and follow-up studies of refugee children in Stockholm and other parts of Sweden during the early 1990's. In the mid 1990's Anders went to work with Sven Bremberg at the Centre for Child and Adolescent Health in the Stockholm county. There he continued his work with migrant children but also went into other child health fields such as injury prevention, perinatal health and inequality issues. Research collaborations with the National Board of Health and Welfare eventually led to a formal post there in 1999 where Anders has remained since, as responsible for Child and Adolescent Health at the Centre for Epidemiology. He also holds academic posts at Karolinska Institutet, Uppsala University and recently was appointed adjunct professor of Paediatric Epidemiology at the Nordic School of Public Health in Göteborg. His current research interest include migrant health, international adoptions, foster children, inequality, child cancer survivors and education as a determinant of health in a life course perspective.

Education is by far the greatest economic investment a society makes in its children. Despite Michael Rutter's pioneering studies that demonstrated that academic success on the school-level usually is accompanied by a favourable mental health situation, the educational system rarely is evaluated in a public health perspective. In this presentation some preliminary results from a Swedish research project about school performance as a determinant of health will be presented and discussed in a life course perspective.

13:50 Why we need to tackle climate change as a matter of urgency

Tony Waterston, Consultant Paediatrician and Senior Lecturer, Newcasle upon Tyne, UK

Tony´s chief interests are in child mental health and child public health. He also takes part in both undergraduate and postgraduate teaching and training and has edited a student textbook on paediatrics and a postgraduate text on child public health. Tony leads a research programme on Baby Express, a parenting newsletter designed to help parents understand their child's emotional needs. He is an editor of the Journal of Tropical Pediatrics and is project manager for the Royal College of Paediatrics and Child Health Palestine programme, which trains primary health care workers within the occupied Palestinian territories. Currently he chairs the RCPCH Advocacy Committee.

This presentation is intended to offer ESSOP members the reasons why we must place the issue of climate change as the number one priority for the health of children. This is not only because of its inherent risks, but also because our other concerns of child health inequity, road traffic accidents, obesity and environmental degradation are subsumed under the same heading. And yet few scientific meetings on child health include tackling climate change in their programme.

Irreversibility of climate change: Owing to the presence of positive feedback (such as the emission of carbon from soil as the metabolism of microbes speeds up, the loss of ice in polar regions and reduced reflectivity and the release of methane owing to melting permafrost), climate change is accelerating. The critical threshold of temperature for changes to become irreversible is thought to be 2 degrees C. At the present rate of warming, we will reach this point by 2030. To avoid this, we have to maintain emissions below 440 ppm of CO2. This means NO INCREASE from where we

are now. And yet in the UK, the NHS emits 18 million tonnes of CO2 every year: 60% on procurement and 18% on travel. The NHS is the biggest public sector contributor to climate change, and hence doctors have a particular responsibility to bring a change in attitudes.

Health impact on children: Children will be the first to suffer from climate change and are already doing so through increased vector-born disease and flooding of low lying areas. Food supplies will be affected leading to increasing malnutrition, migration will worsen and there will be direct deaths from the rise in temperature and other adverse weather events. Yet the potential health benefits of carbon reduction are huge: for example, fewer accidents, more exercise, less meat in the food system, and a reduction in cancer, heart disease, diabetes and air pollution.

Role of health professionals: Health professionals have led in the publicising of tobacco deaths and consequent political action; we have an obligation now to do the same for climate change. We can educate and inform, ensure that our health services become sustainable, and set a good example. The recent published strategy for the NHS shows what can be done in the health sector (www.sdu.nhs.uk/get_involved/carbon_reduction_feedback.php). An excellent conference was held at the Royal College of Physicians in London in January on climate change and health, see http://www.rcplondon.ac.uk/event/ArchiveEvent/0801Climate.aspx

What ESSOP members can do. ESSOP itself can set a lead by becoming carbon neutral as an organisation. Can we demonstrate that we can hold a conference without flying? Can we stimulate our national organisations to do the same? There is now abundant evidence that flying has to be curbed dramatically if we are to have any hope of human survival. And most important, can we as paediatricians model a low carbon lifestyle as well as lobbying our governments on the urgent need for sustainability?

Session 6: Free papers

Chairperson:
Gyða Haraldsdóttir, Head of Section of Development and Behaviour, Centre for Child Health Services, Reykjavík

Gyða is a clinical child psychologist with a BA from the University of Iceland in 1978. Postgraduate studies and PhD degree from the Hester Adrian Research Centre at Manchester University, UK. She was the head of Assessment and Counselling Department at the regional office for services of the handicapped in Akureyri 1985-1995, and lecturer at the University of Akureyri 1996-1998. Through the years she has held lectures, workshops for staff, professionals, parents, and in universities. She is the author of the parent workshop Parenting that Works and has translated various books on parenting and child behaviour into Icelandic.

14:15 Recent developments on school health services in Turkey

Serpil Uğur Baysal, Institute of Child Health, Istanbul University, Turkey

Issue/ Problem: Fifteen million students aged between 6 and 19 years, 700,000 teachers and staff attending over 60,000 schools, consist of approximately 20 per cent of the Turkish population. School- aged children cannot benefit from regular primary health care.
Description: This presentation gives an overview of the present state of school health of Turkey, and includes the history of the development of services, and some information on the School Based Health Services Project.
Results: Turkey's Ministry of Health is primarily responsible for School Health since February 2005, in collaboration with Ministry of Education. At present, school health services have four aspects: student's health, school environment, health education, and health of school staff. More than one million students are screened for health annually at primary schools. Health Promoting Schools and Safe Schools Programmes are recently being developed. The main issues regarding safety at schools are violence, bullying, unintentional injuries, traffic and other injuries on the way to or from school. "School Safety" approach is being conducted as a subtitle under WHO Safety Population Program. In 2006, a new online access to a comprehensive "Guidance on School Health for Primary Level Health Workers" was prepared by the Ministry of Health.
Lessons: In countries where social inequality is prevalent, school health care has particular importance in reaching out to children who do not have access to proper health care. We believe that this model can be applied widely and it may be very beneficial to develop community health. The involvement of the teachers, parents, social workers, volunteers, as well as health workers trained in school health is needed for efficacy of programmes. Nowadays, it is encouraging to observe that the topic of "school health" has gained interest among the managers and health workers in Turkey. Schools are the way to reach the population.

14:28 How can Community Paediatricians help to reduce school exclusion of young people with behavioural difficulties?

Anthony Tam, Southwark Children´s Services, London, UK

Introduction: In the United Kingdom, many young people are permanently excluded by their main-stream schools because of poor behaviour. Alternative education is usually costly with uncertain effectiveness.
Aim: To explore how community paediatricians can help this client group.
Objective: To retrospectively study our clinical cases to identify the diagnosis most frequent linked to young people at risk of school exclusion.
Method: Review of case-notes of young people aged over 10 years who have undergone assessment by our department over the past year. Only those with the following were included in the study: (1) behavioural problems; (2) at risk of school exclusion; or (3) already permanently excluded. The diagnosis and underlying causes of poor behaviour identified were categorized: the referrals originated by the assessment were categorized; the educational outcome as a result of intervention was noted.
Results: Conditions associated with frustration and/or poor behaviour, e.g. language disorder, dyspraxia, autistic spectrum disorder, etc. were found in the majority of the young people

assessed. The results of this study, together with how community paediatricians can help with school inclusion and transition-planning, will be presented.
Discussion: Paediatricians can help reduce education failure by identifying the underlying causes and advising on the management of poor behaviour.

14:41 How to handle death in the school?

Stella Tsitoura, 2nd Pediatric Clinic, University of Athens, Greece

Issue/Problem: Death touches the lives of all of us. Children are by no means immune. Death of parents, relatives, schoolmates, of school staff members, family pets are not so rare events. Youth suicide, life threatening illness and sexually transmitted diseases, violence in our society (including assault, rape and violent death) and war are some growing crises that children face. In school communities all these traumatic events have the potential to affect the mental health of those involved, the academic process of students, the work-life of teachers and the public perception of schools as safe, physical and psychosocial environments. Today an innovative holistic public health approach is advocated.
Description: This comprehensive approach, based on the health promoting schools framework, has a sequential curriculum, provision of training for teachers and active participation in learning by students. The curriculum is linked to the organizational structures and processes of the school environment that demonstrate the school's ethos. Loss and grief in this framework means that effort is placed on helping a large proportion of student population in a variety of ways. This involves critical incident management plans, pastoral care structures and links with outside agencies. This approach requires the involvement of those teachers who are trained and supported in their role. Within this model about 20-30% of students may need some additional help from support groups in the school of outside agencies.
Results: The curriculum of this comprehensive approach facilitates the normalization of grief through education. The orientation is to teach skills to enable individuals to be supportive. It establishes a role for school communities as social systems that have the capacity to support members and to meet the needs of teachers, parents and students in a proactive way.
Lessons: This approach emphasizes the role of the school as a social institution, because young people look to peers and teachers to help define the reality of their loss, express feelings associated with it, provide support and access to information and integrate the experience into their lives.

14:54 The effect of route of tobacco smoke exposure of breastfed and non-breastfed infants on urinary cotinine levels

Gonca Yılmaz, Department of Pediatrics, Keçiören Training and Research Hospital, Ankara, Turkey

Background: The rate of cigarette smoking in Turkey is 43.6 % now, but it was only 22% 30 years ago. 28% of women between the ages of 15 and 49 years are regular smokers. These figures imply that passive smoking of our children is increasing tremendously. Tobacco smoke has been shown to have negative consequences on infant's health, especially during the first year of life.
Methods: Tertiary referral center. Cross-sectional analysis on 254 six-to-seven-month-old healthy infants. Their mothers completed a questionnaire regarding the infant's history of nutrition and

tobacco smoke exposure. Urine samples were taken from infants for cotinine measurements. According to tobacco smoke exposure, infants were divided into 4 groups: 1. Infants free from any exposure; 2. those who were exposed to tobacco smoke via breast feeding; 3. those exposed via passive smoking; 4. those exposed via passive smoking besides via breast feeding.

Results: 35% (89/254) of the infants were not exposed to tobacco smoke at all, whereas 6% (15/254) were exposed only via breast milk, 46% (117/254) were exposed only via passive smoking, and 13% (33/254) were exposed via breast milk in addition to passive smoking. Their mean cotinine/creatinine ratios were 1.14 ±0.56, 1461.1 ±505.26, 108.93 ±63.70, 602.66 ±244.37 ng/mg, respectively. Tobacco smoke exposure groups led to statistically significantly different mean urinary cotinine/creatinine levels (P<0.001). Upon coupled comparisons of groups using the Student's t-test, the lowest average urinary cotinine/creatinine level was detected in the non-exposed group, and the highest mean cotinine/creatinine level was found in the breast-milk-exposed group (P<0.001).

Conclusions: Tobacco exposure via breast milk led to 13.4 times more nicotine exposure to the baby compared to passive exposure. The possible harmful effects to the infant of gastro-intestinally absorbed nicotine as opposed to nicotine absorbed via lungs remains to be determined.

15:07 Assessment of general health findings with relation to blood lead levels in school children in Kırıkkale, Turkey

Selda Bülbül Hızel, Şanlı C, Albayrak M, Kocak U

Kırıkkale University, School of Medicine, Department of Pediatrics, Turkey

Background: Kırıkkale is a place where lead contact is thought to be common. Several factors may affect the general health of adolescent in the puberty stage. Our study was performed to determine the physical growth, puberty development and the average arterial blood pressure of school children with relation to blood lead levels.

Methods: 905 students [451 male (49%) and 454 female (51%)], with a mean age of 10.98 ±2.2 years (min 7, max 15 years of age) were enrolled. Children were passed through a general physical examination and an anthropometric measurement process after face to face interviews. With the permission of the parents, venous blood samples were collected and blood lead was measured by Inductively Coupled Plasma Automic Emission Spectrometer.

Results: Among all, 9.2% of the students (83/905) were having 1st and 1.7% (15) 2nd degree malnutrition according to weight for height. 19 girls' (4.2%) and 20 (4.5%) boys' BMI was over 95%. Puberty (Tanner stage 2) was found to begin at a mean age of 11.4 ±1.0 years in girls and 12.5 ±1.3 years in boys. In 40 (4.4 %) children systolic hypertension, in 28 (3.1 %) children diastolic hypertension, and in 15 (1.6 %) children both systolic and diastolic hypertension were detected. The mean blood lead levels of girls and boys were 2.5 ±1.4 µg/dl. No significant relation was found between blood lead concentration and puberty development or blood pressure.

Conclusion: The blood lead levels are in normal range in Kırıkkale with no significant relation with onset of puberty or blood pressure. Despite the blood lead levels being in normal ranges, at present, it is known that desired lead level is "0" and these children should be controlled regularly for the long-term hazards of lead.

15:20 Psychosocial maladjustment influences symptoms severity and treatment efficacy in functional dyspepsia in children

Igor Radziewicz-Winncki, Department of Health Promotion and Environmental Nursing, Medical University of Silesia, Katowice, Poland

Introduction: Functional dyspepsia (FD) is a common compliant of convoluted biopsychosocial origin. Despite some evidence of depression, there is a lack of precise assessment of the psychosocial maladjustment in adolescents with FD.
Aim: Assess social competence, behavioural and emotional disorders in adolescents with FD and to evaluate the impact of psychosocial facets on the intensity of subjective sensations and their change after the implementation of pharmacotherapy.
Methods: 66 consecutive patients were diagnosed with FD following Rome criteria. The control group consisted of 86 healthy children. The severity of dyspeptic symptoms was measured with visual-analogue scales before and after 8 weeks of treatment. Psychosocial evaluation was completed using the Youth Self Report (CBCL-YSR).
Results: Patients with FD exposed increased levels of Anxiety and depression, Somatic complaints, Social and Thought problems, Internalisation (girls) and lowered externalisation (boys). Dysmotilities were more connected with elevated Internalisation. The severity of ulcer-like symptoms related in boys with strongly inhibited Externalisation (aggressiveness) and Total problems outcome. Somatic complaints, Internalisation and Total problems related positively with both ulcer- and dysmotility-like symptoms, while Anxiety and depression related positively to intensity of dysmotilities. Somatic complaints were conducive to release of Early satiety, while Externalisation components related positively with aggravation of ulcer- and dysmotility-like symptoms, despite implemented treatment.
Conclusion: FD is connected with other somatic complaints, elevated anxiety and depression, and internalisation disorders. Psychosocial factors influence the efficacy of treatment. Further longitudinal research is needed to determine the precise effectiveness of simultaneous pharmacological and psychosocial therapies.

POSTERS

I. INFANTS AND PRE-SCHOOL CHILDREN

Major problems in breastfeeding in Greece

Kostopoulou A, *Petrovalis Ch*
Serres General Hospital, Greece

Background: Breastfeeding is known to have protective effects against many diseases such as allergies, respiratory problems of children, cancer, diabetes mellitus, obesity, inflammatory bowel diseases, etc. Many young women are familiar with the positive effects of breastfeeding both for themselves and their children; however in practice they face many problems.
Methods: The methodology we employed consisted in 196 questionnaires given to women that gave birth and were hospitalized in the obstetrics clinic of our hospital.

Results: Before labor, 89% of women gave a positive reply to breastfeed their child, 4% gave a negative reply, and 7% was indecisive. After labor 55% was exclusively breastfeeding, 26% used formula along with breastfeeding, 19% used only formula. The major problems that led women to quit breastfeeding according to their answers were: caesarian section (due to diabetes mellitus during pregnancy, hypertension, and preeclampsia), neonate's health problems (such as prem-prematurity, respiratory distress) and the mother's ignorance and fear about breastfeeding.
Conclusions: The major reasons for quitting breastfeeding according to our study are not counter indications to breastfeeding. The role of the medical and nursing personnel is important in supp-supporting the young mothers in order to increase the rate of breastfeeding.

Extremely low-birth weight infants in pre-schools in Iceland
E***inarsdóttir J***
Faculty of Social and Human Sciences, University of Iceland, Reykjavík, Iceland

Background: In North America and Western Europe premature birth is the leading cause of infant deaths and for those who survive the likelihood of disability is high. Extremely prematurely born children (<1000 g) have increased risk of cerebral palsy, blindness, deafness and severe hypotonia. Developmental delays persist into adulthood, illustrated with lower educational achievements than full-term age mates. In Iceland, children with developmental delays have priority to enter pre-schools and they get extra assistance in case of need.
Aim: Explore parental views on pre-schools for their extremely low birth weight infants.
Methods: Interviews were taken with parents of extremely low birth weight infants. The data presented stems from the research project *Abnormal birth: ethical questions and daily life*. The aim of the project is to examine how professionals and parents dealt with the birth of infants with a birth weight less than 1000g born during the period 1st September 1998 – 31st August 2002.
Results: Parents are overwhelmingly pleased with pre-schools and their work with the children. They claim their infants quickly demonstrate progress in language use as well as in the activities of daily life, such as table manners and dressing themselves. The children also learn to interact with other children. Parents praise pre-school teachers who take iniatives to address developmental delays and arrange special training.
Conclusions: Pre-schools can contribute to a positive development of extremely preterm children and are a good setting to give them opportunity to meet with agemates and adjust to normal life.

Relationship between the family socio-economic status and child health and development
Aszmann A
National Institute of Child Health, Budapest, Hungary

Background: One of the main goals of the National Program Combat Childhood Poverty is to decr-ease the gap of the psychosomatic development of children with different socio-economic (SE) backgrounds. A study was carried out to identify the developmental and health problems asso-ciated with the low SE status of families.
Method: On the basis of the documentations of 250 children (aged 3 and 5) provided by family doctors and public nurses, relationship between somatic, psychomotor, mental, social

development, the chronic diseases and diseases arising from parental carelessness and their mothers' education level and fathers' SES were analysed. Evaluation of somatic development was carried out according to Hungarian child growth standards, for the evaluation of psychomotor, mental developments a developmental milestone-scale was used. Data were analysed by bi- and multivariate analyses of the SPSS statistical software.
Results: There was a significant association between mothers' education, fathers' SE and their infants' birth weight and the rate of i.u. retardation, as well as between the family SE background and the psychosomatic, cognitive development of children at the age of 3 and 5. Higher rate of backwardness of height and weight was found among children with lower family SES though there was no difference in the BMI percents. Among them higher rate of backwardness of motor, speech, social developments was found and the rate of impetigo, which is a typical disease connected with carelessness, was also higher. Children who had unfavourable family background but were taken care of and educated in kindergarten at least for 2 years had less developmental problems than those who had shorter kindergarten stay.
Conclusion: Primary health care has a very important role and also chance to recognise the early developmental problems and refer children to proper correction. For the disadvantaged a favourable solution is to send them to kindergarten as early as possible, which provides not only healthy nourishment but also a stimulating environment.

II. CHILDREN AND ADOLESCENTS

Analysis of risk factors for child maltreatment in a Dutch paediatric mental health clinic

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[1]*Rivierduinen, Department of Mental Health and* [2]*Leiden University Medical Center, Leiden, The Netherlands*

Background: Child maltreatment in the Netherlands has received much attention as a result of new studies showing a higher prevalence than previous studies. Children confronted with maltreatment or violence have a greater risk of developing behavioral, psychosocial, psychiatric or medical problems. Structural attention should be paid to the relation between children with psychiatric problems and their experience with child maltreatment. The purpose of this study was to determine whether relevant risk factors for child maltreatment were adequately signalled and documented in Rivierduinen, an outpatient paediatric mental health clinic.
Methods: In a retrospective analysis of 100 patient charts we assessed whether relevant, known, risk factors for child maltreatment were documented. Examples of risk factors are parental psychiatric illness or drug abuse, parental history of maltreatment, financial problems and illness of the child. The DSM-IV diagnosis of the children was assessed.
Results: In most children (51 girls and 49 boys, median age 11 (5-18) years) the majority of relevant risk factors for child maltreatment were not documented. In 39% of children there was a strong suspicion of maltreatment or proven maltreatment ("maltreated group"). This group showed a higher number of documented risk factors than the non-maltreated group (in maltreated group 12 children had >6 risk factors compared to 0 children in non-maltreated group). In the maltreated group, the majority of children suffered from different forms of maltreatment. The principal psychiatric diagnosis in these children was ADHD.

Conclusions: Improvements in the documentation of risk factors for child maltreatment in children presenting at our clinic are needed. Structured risk assessment lists could be useful to achieve this goal. In families with an increased risk, individual treatment and family support measures can be more adequately applied. This could be an effective tool in preventing (further) child maltreatment.

The most popular activities of school children and adolescents in Central Greece. An approach with the help of Achenbach-Questionnaire

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[1]Hellenic Society of Social Pediatrics and Health Promotion-Thessaly branch; [2]Achillopouleio General Prefecture Hospital, Volos; [3]Health Care and Education Society; [4]Surgery Clinic, General Hospital, Karditsa; and [5]Primary and secondary education school advisor, Thessaly, Greece

Background: The choice of extracurricular activities (ea) shows some characteristics of the children's personality and possibly indicates their future development.
Aim: To a) record the most popular extracurricular activities of the pupils; b) to determine if there are any differences between the choices of boys (B) and girls (G); and c) to point out these differences and comment on them.
Materials and Methods: The sample size was 115 children (B: 70%, G: 30%), 7-9 yo: 23%, 10-14 yo: 35%, 15+ yo: 20%, outside these ranges or unknown: 22%. The extracurricular activities were recorded based on an analytical Achenbach questionnaire that separates the children's activities in 4 categories.
Results: The three most popular: A) *sports activities* for boys was football (61.25%), cycling (40%), swimming (31.25%); for girls volleyball (40%), swimming (37.14%), cycling (28.57%). 9.57% of the children do not exercise at all. B) *hobbies* for boys: PC (65%), music-singing-theatre-dance (28.75%), reading books (23.75%); for girls: music-singing-theatre-dance (28.57%), reading books (18.57%), crafts and arts/painting (18.57%). 8.75% of the children do not have any hobbies at all. C) *participation in organizations /societies /clubs* for boys: sports clubs (33.75%), cultural/musical clubs (8.75%), theatre-dance club (7.5%); for girls: sports clubs (20%), cultural/musical clubs (7.14%), theatre-dance club (5.71%). 53.04% of the children do not take part in any club. D) *house work* for boys: helping the parents (52.5%), cleaning up (45%), taking care of younger children (7.5%); for girls: cleaning up (32.86%), helping the parents (22.86%), and taking care of younger children (7.14%).
Conclusions: The children's responses as far as concerns the sports and non-sports activities were expected. However, it is surprising that ~10% of the children is not exercising at all, 1 in 2 does not participate in any team activity. PCs are the main object of entertainment among the boys. These are characteristics of our era that should give food for thought and comments.

Left-handedness and right-handedness in relation to simple daily activities. A study in a representative sample of children of Lycea in Thessaly, Central Greece

*Giovanetto KP,[1,2] Katsiardanis K,[1,2,3] **Anastassiou A,**[1,2] Mitsiou-Dactyla G,[1,2] Anastassiou D,[1] Giovanetto M-F,[1] Daktylas K,[1] Tassiou I,[1,2] Daktyla S,[1] Tsikoulas I[4]*

[1]Health Care and Education Society, [2]Hellenic Society of Social Pediatrics and Health Promotion-Thessaly branch; [3]Medical School, National Kapodistriako University of Athens; and [4]Medical School, Aristotle University of Thessaloniki, Greece

Background: Hand dominance constitutes an important characteristic of every individual that is determined genetically, it is expressed as early as the time of birth, and remains unchanged through life. Right handedness (RH) or left handedness (LH) is not simply a matter of "preference" in the way that we use our hands. It is the result of largely unknown procedures taking place inside the CNS.

Aim: To find if there is any relation between: a) hand dominance and b) performing simple daily activities that require the use of hands and to identify potential differences between RH and LH.

Materials and methods: 129 adolescents (ADS) of both sexes who were pupils at two different schools (Lycea) in two different regions of Thessaly answered to pre-written questionnaires (QS) that cover a wide spectrum of usual daily activities that require the use of both hands (based on the Edinburgh, Oldfield, Handedness Inventory test).

Results: 51% of the them (QS) were filled in by girls, 29% by boys and the remaining 20% by (ADS) who didn't want to mention their gender. The percentage of RH and LH was 94% and 6%, respectively. It is worth noting that 8.27% of boys were LH while the same percentage for girls was only 6.27%. ADS were questioned about the use of both hands in relation to simple daily activities: (1. Writing; 2. Painting; 3. Throwing a stone; 4. Using a pair of scissors; 5. Using a toothbrush; 6. Using a knife/spoon; 7. Using a broom; 8. Lighting a match; and 9. Opening a box). The hand used for writing determined hand dominance. RH(ADS): 55% of ADS in the RH group mentioned that the dominant hand in all of the above activities was only their right hand (no use of the left hand). 26.67% of them mentioned that they perform all of the above activities but one with their right hand. LH (ADS): 14.29% of ADS in the LH group mentioned that the dominant hand in all of the above activities was only their left hand (no use of the right hand). 57.14% of them mentioned that they perform all of the above activities but one with their left hand. The difference between the RH and LH ADS is statistically very significant ($p<0.0001$).

Conclusions: We confirmed that the percentage of LH is lower related to RH in the general population and that most LH individuals are males. There is no correlation between RH/LH and area of residence. Individuals in the RH group perform a greater number of activities only with their right hand than LH individuals do only with their left hand. It seems highly likely that an LH individual will also need to use the right hand in specific activities while an RH individual tends to use only his/her right hand in most activities without using the non-dominant hand at all. This special tendency of the LH group (to use both hands) is an important finding and it could possibly be attributed to indirect suppression of left hand preference at young age due to social or cultural reasons.

Handedness, learning difficulties and other problems among children and adolescents of special schools. A population-based study in Thessaly prefecture, Greece

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Background: Many theories have been reported on the increased frequency of left-handedness (LH) - ambidexterity (AX), learning difficulties (LD) and other problems in children and adolescents (CaA) attending special schools (SS) both in Greece and Internationally. However, in Greece there are no population studies correlating pathological handedness of CaA with LD and other problems.
Aim: To study the frequency and the rate of dominance of handedness in CaA of all SS in Magnesia in order to justify the increased incidence of LH-AX in this population and correlate them with their pre-perinatal and family record.
Method: During 2005-2006, having a written consent from the educational committee and in collaboration with the teachers and the parents, we recorded all the pupils attending a special school including those visiting the « ΕΛΕΠΑΠ » of our area. We used information based on personal interviews and information found on their personal health books, including all the possible factors that might have influenced their Mobile-Mental-Emotional situation. We identified their handedness using the Test Edinburgh Handedness Inventory (Oldfield, 1971).
Results: We concentrated in 89 SS pupils (P), 59 boys (B) and 30 girls (G) ≥5.5 y.o. We excluded 2 persons (age>20 y.o.), in order to estimate the median age (MA)=12 y.o. 50 P visited the «ΕΛΕΠΑΠ». We excluded 17P (12P <5.5 y.o. and 5P ≥20 y.o. and 21P already recorded at the SS). From a total number of 101 P (LD=100%), we concentrated our study in 89 P attending SS and analyzed extensively those originated from Magnesia, excluding from the test the quadriplegic ones. The incidence of LH was 16.10% (12,8% (B) and 21.7% (G)) and the incidence of AX: 17.8% (10,2% (B) and 30.4% (G)). Right-handed/Non-Right-handed= 2/1. High correlation was found between LH-AX and LD and positive perinatal history/record including: trauma and lesion on the left hemisphere in conditions like: preterm labor, perinatal hypoxia, infarct of the left median cerebral artery, the presence of the umbilical cord arround neck, low Apgar score, metabolic disorders (hypoglycemia, hypocalciemia), seizures, congenital uterus abnormalities and dysplasias related with syndromes (e.g. hypoplasia, mesolobus, etc). Pupils in SS presented higher frequency of nocturnal enuresis (36%). Learning difficulties were present in all pupils of SS.
Conclusions: We confirm the high frequency of pathologic handedness and LD in SS pupils. LD are reported more commonly in males. The theory of the correlation between the two conditions and positive/ perinatal (with problems) history is further enhanced with this study. The AX frequency was found to be quite high in the representative sample size studied especially among girls and those resulting from twin or multiple pregnancies.

The emotional impact of learning difficulties

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Introduction: Learning difficulties are of growing educational concern for parents, educators and pediatricians. In the last years, the understanding of learning difficulties has greatly improved. Yet, the associated emotional problems are not deeply understood.
Aim: The emotional impact of learning difficulties on children was the subject of our study.
Methods and materials: We followed-up 200 Greek children (43.18% boys), mean age 8.5 ± 2 years, with learning difficulties and 325 age and sex matched controls without, for a five-year period.
Results: All children with learning difficulties had at least one first degree relative with learning difficulties. Emotional problems that aroused during this period were determined via questionnaires. All children with learning difficulties had sleep disorders, compared to 30% of those without. Learning difficulties correlated with somatic complaints (OR: 3.9, 95% CI: 2.09-5.04), isolation (OR: 4.7, 95% CI: 2.79-6.53), anxiety and depression (OR: 5.3, 95% CI: 3.05-6.79), aggression (OR: 5.67, 95% CI: 3.44-7.39), inattention (OR: 2.28, 95% CI: 1.8-4.08), adaptation disorders (OR: 5.22, 95% CI: 3.39-7.05), social problems (OR: 8.05, 95% CI: 6.09-9.03), negative sense of identity (OR: 8.23, 95% CI: 6.8-9.56), lack of tolerance for frustration and failure (OR: 2.98, 95% CI: 1.93-4.34), inability to accomplish complex social interactions successfully (OR: 6.54, 95%, CI: 4.68-8.48) and disturbed self-perception (OR: 4.48, 95% CI: 3.48-6.58) and self-esteem (OR: 8.83, 95% CI: 6.72-9.03).
Conclusion: Our study showed that children with learning difficulties are at increased risk for emotional disorders, arousing mostly in our study group from language difficulties (OR: 4.07, 95% CI: 2.61-6.06) and lack of self-esteem (OR: 7.3, 95% CI: 5.08-8.96). Language difficulties are involved in social acceptance and self-esteem is implicated in affect and regulation of social behavior. Our study will continue in order to better identify the emotional problems of children with learning difficulties and find solutions.

Attention deficit hyperactivity disorder (ADHD) and learning difficulties

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Introduction: ADHD is one of the most common behavioral problems encountered during childhood. The prevalence of this disorder is estimated at 3% to 5% of the schoolage population.
Purpose: The purpose of the study is the recording of students with ADHD and possible correlation to learning difficulties.
Method and Materials: Specialized questionnaires were given to parents and teachers. 658 Greek students of elementary school (7-10 years old) were evaluated. 102 students were recorded having learning difficulties. The questionnaires were designed according to DMS-IV criteria for ADHD.
Results: Our findings are summarized in the following table.

		Group A (with learning difficulties)		Group B (without learning difficulties)		
		N	%	N	%	P
01	*Difficulty sustaining attention in tasks*	36	55,9	92	23,8	<0,001
02	*Asks to repeat the questions*	29	44,6	74	19,1	<0,001
03	*Easily distracted by noises*	47	69,1	196	52	0,003
04	*Shifts from one uncompleted activity to another*	21	31,3	31	21,4	0,073
05	*Does not pay attention to what is being said to him/her*	34	47,9	93	24,5	<0,001
06	*Difficulty sustaining in tasks*	28	41,8	30	21,5	<0,001
07	*Difficulty following instructions from others*	9	14,1	16	4,4	0,006
08	*Loses things necessary for tasks*	26	27,8	118	30,3	0,653
09	*Intrudes on others*	22	32,8	105	23,1	0,428
10	*Talks excessively*	22	32,4	141	36,2	0,546
11	*Answers to questions before they have been completed*	26	37,1	139	36,4	0,904
12	*Interrupts other people*	23	34,3	154	39,4	0,432
13	*Seems to be restless*	23	33,8	32	21,1	0,021
14	*Fidgets with hands or feet or squirms in seat*	24	34,8	32	21	0,015
15	*Engages in physically dangerous activities without considering consequences*	21	30,9	61	15,9	0,033
16	*Makes noise*	34	47,9	116	29,9	0,033

Conclusion: It is established that children with Learning Difficulties have statistically higher rates of Hyperactivity and Attention Deficit Disorder.

Psychometric evaluation of the *School-Children Health Promotion* instrument

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Background: Effective health promotion focused on 10-12 year old school children is an investment for the future. However, not much is known about how Icelandic children in this age group act to promote their health, and an instrument to capture the broad spectrum of health promotion behaviors of Icelandic preadolescents has been lacking. The purpose of this study was to perform psychometric evaluation on the instrument *School-Children Health Promotion Behavior*, which was shortened, modified and translated into Icelandic from the Taiwanese instrument *Adolescent Health Promotion Scale*.

Methods: The study is a part of a larger cross sectional secondary study, were data from 480 10-12 year old Icelandic children in 5th and 6th grade of 12 public elementary schools in Reykjavik were analyzed. Experimental factor analysis (principal factor analysis) was used to determine subscales (construct validity) of the instrument *School-Children Health Promotion Behavior.* Internal consistency (reliability) was measured using Cronbach´s α.
Results: Five factors emerged from the 21 items of the instrument, which were labeled: "Positive Thinking", "Diet and Sleep Patterns", "Seek Psycho-social Support", " Coping Behavior", and "Health Habits." The internal consistency of the total instrument was 0.86, and for the factors it ranged from 0.57 to 0.75.
Conclusion: The instrument *School-Children Health Promotion Behavior* is generally valid and reliable to measure health promotion behavior of 10-12 year old Icelandic school children. Recommended future research and clinical use will be discussed.

School based sexual and reproductive health education

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Introduction: Evidence indicates that most youth have sexual intercourse during their high school years. Literature demonstrate that no existing educational school based program can change this reality, but sexual education in school can effectively increase responsibility and reduce adolescent's sexual risk taking.
Methods: We explored sexual behavior of high school students [age 13–18] in our region, by questionnaire addressed to 500 students, concerning topics as: age of first intercourse, knowledge on sexual health and risks, use of contraception and prevention of sexually transmitted diseases [STD], prevalence of comportment related to sexual risk taking [alcohol etc], and critical views of students on school based sexual education.
Results: 60.2 % had experience of sexual intercourse. 75.3% had first intercourse around 16 years, 15.8% had first intercourse <15 years of age, and 8.9% >17 years. 60% did not use protection or effective protection at first intercourse. Only 30.3 % said they had their first intercourse as a result of a responsible decision. 45% of students consume alcohol one day per week. Lack of knowledge or misinformation was found in 60% of students. Students with manifest poverty and poor academic achievement where more likely to be exposed to sexual risks. Most where critical about school-based sex education that focused exclusively on fear and abstinence. They said they have not friendly access to special health services.
Conclusion: School based sexual education programs must be realistic, give arguments for intercourse delay - abstinence, but respect at the same time the right of youth in sexuality, focusing on responsibility and not on prohibition. Balanced, accurate and realistic sexuality education and confidential, affordable school health services is not only a need but a right of students. Programs must be differentiated according to the age of students and aim to increase school achievement and reduce school dropout, delay sex and reduce sexual risk taking.

ESSOP Annual Meeting 2008

Violence in secondary school aged children – Prevalence and safeguarding

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Background: Violence amongst children of secondary-school age is a topic high on the public agenda and an area of importance to health professionals. A relationship between youth violence and childhood adversity (including child abuse) has been recognised (1). Health professionals play a role in the treatment of injuries resulting from youth violence. They also have a responsibility to take a proactive approach to safeguarding the young people they treat (2, 3).
Objective: Our aim was to study the frequency of young people attending our emergency departments with injuries resulting from youth violence and to determine the safeguarding measures undertaken.
Method: We retrospectively reviewed the case notes of all children aged between 11 and 16 years presenting to the emergency department with an injury between May 2007 to April 2008. Cases were identified where injuries resulted from violence between young people and details of the injury and whether safeguarding measures were taken and recorded.
Results: 1042 children presented with injuries of which 120 cases resulted from violence between young people. Commonest age at presentation was 15 years with the majority of cases being male. The commonest mechanisms of injury were kicking and punching. The alleged perpetrator was known to the young person in 80% of cases. 67% of episodes of violence occurred at school. There were 8 recorded fractures. Incidence of concurrent child protection concerns was low. Communication with other agencies including school, social services and police was poor.
Conclusion: Children frequently present to the emergency department with injuries resulting from teenage violence. Presentations to hospital probably represent only a minority of cases with actual prevalence being significantly higher. Interagency communication regarding these presentations was poor and improvements are needed in this area

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The individual plan for school integration: results after three years of utilization in schools and pre-school institutions in Geneva

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Objectives: In September 2004 we introduced the Individual plan for school integration (projet d'accueil individualisé, PAI) in all schools and preschool institutions in Geneva. This document promotes quality of life through school and social integration of children and adolescents with chronic diseases, in defining the child's specific health needs, the treatments and measures necessary in the school, and the roles and responsibilities of the partners involved. We presented the first results during the annual meeting of the Swiss Pediatrics Society (SSP) in Montreux (June

2005). Its utilization has now been generalized and we present here the results for 2006-2007 after three years of experience.

Population and methods: The PAI is used for every child and adolescent who attends school, apprenticeship or preschool institution, with a chronic disease having an impact on his schooling. We now use two different types of PAI: the complete PAI which has been used since the beginning and the simplified PAI which was developed during year 2006-2007 for children with conditions having only few specific health needs at school (i.e. asthma). A monitoring sheet was filled by the school nurse or the school doctor for each child and adolescent with chronic conditions.

Results: From September 2006 to June 2007, 427 children and adolescents out of 75'232 benefited from a PAI (192 girls, 235 boys) representing a prevalence of 5.7/1'000. The median age was 9.1 years (1-21 years). The most frequent diagnoses were allergies (161), asthma (62), epilepsy (59) and diabetes (48). Most health needs regarded treatments (278), mobility (223), special diet (137), and sportive activities (120). For allergies, asthma and epilepsy, there were usually less than three different health needs, whereas for diabetes there were usually more than three. We filled 383 emergency protocols and 32 school evacuation protocols. Comparison with the previous year will also be provided.

Conclusion: The PAI is now well-known by all partners, and its utility acknowledged by the schools and the child/adolescent's doctors. It clarifies in lay language the problems that could happen in schools and provides solutions, while taking into account everybody's view. It reassures parents and teachers and develops a better knowledge of the children and adolescents with chronic diseases at school. The simplified PAI is especially adequate for more simple pathologies.

III. YOUNG ADULTS

Smoking habits among medical students in İzmir, Turkey

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Objective: The approach of future physicians as health care providers for tobacco-related diseases may be influenced by their smoking habits.

Aim: Evaluate smoking habits among medical students in Ege University Medical School, in İzmir, Turkey.

Method. The medical students were asked to complete a self-administered questionnaire evaluating smoking habits.

Results: A total of 391 medical students filled in the questionnaire. The median age of the students was 23 years. Of them, 54% were male and 46% were female. Seventeen percent of the students were current regular smokers while 5% of them former smokers. Also, 11% of the students defined themselves as occasional smokers. Students began to smoke at the mean age of 19.0 ±2.6 years and the mean duration of cigarette smoking was 4.8 ±2.8 years. Current smokers smoked a median of 19 cigarettes per day and 23% of them said that they smoked first cigarette within 5 minutes after wake up. Of the current smokers, about 70% said that they don't think to give up smoking in the near future.

Conclusion: The findings reveal that the prevalence of cigarette smoking is high among medical students and, the worst of them is that they don't plan to give up smoking. Therefore, more efforts are necessary for tobacco education in the medical curricula and the intervention for smoking cessation of medical students as future doctors.