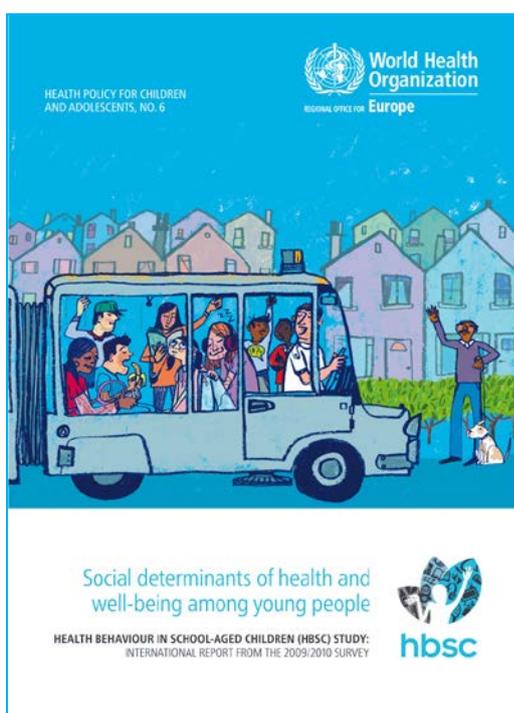


## Social determinants of health and well-being among young people

### Key findings from the Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey

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This report summarizes findings from the most recent HBSC survey. The survey covered 39 countries and regions across Europe and North America,<sup>1</sup> examined more than 60 topics and involved over 200 000 children and young people.

HBSC, a WHO collaborative cross-national study, collects data on 11-, 13- and 15-year-old boys' and girls' health and well-being, social environments and health behaviours every four years. The international report, which is written and produced by the HBSC Research Network and is published by the WHO Regional Office for Europe, presents the world's most comprehensive picture of young people's health and well-being.

### Key findings

The report states that while young people enjoy better health and development opportunities than ever before, many are involved in behaviours that compromise their health (such as smoking, drinking and having an unhealthy diet) and report poor self-rated health. They are therefore failing to achieve their full health potential.

Focusing on the social determinants of health and well-being, the report demonstrates wide health inequalities between and within countries and regions. It shows that:

<sup>1</sup>The following countries and regions are included in the HBSC 2009/2010 international report: Armenia, Austria, Belgium (Flemish), Belgium (French), Canada, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Greenland, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, the former Yugoslav Republic of Macedonia, the Netherlands, Norway, Poland, Portugal, Romania, the Russian Federation, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, United Kingdom (England), United Kingdom (Scotland), United Kingdom (Wales), and the United States.

- health-compromising behaviours show increasing prevalence with age and with decreasing family affluence;
- boys and girls adopt different healthy and unhealthy behaviours, with some differences emerging or increasing during adolescence and potentially contributing to gender inequalities in adulthood; and
- health patterns vary across countries, suggesting that social, cultural and economic contexts within countries may influence young people's health and health behaviours and consequently create health inequalities between countries and regions.

## Adolescence: an age of opportunity

Adolescence is an “age of opportunity”<sup>2</sup> for action on addressing health inequalities. The health profile of young people changes during this period, with differences highlighting the need for age-differentiated interventions to promote young people's health and well-being.

The following examples use comparisons between 11- and 15-year-olds, unless otherwise indicated.

### Relationships with peers and school change with age

The prevalence of young people having three or more close friends of the same gender decreases between ages 11 and 15, possibly because of increases in intimacy of friendships. Older students in most countries and regions are more likely to spend evenings out with friends and use electronic media communication. They are also more likely to hold negative perceptions about their school – the overall average for liking school falls by almost 20% and is 21% for girls in Italy.

### Health and healthy behaviour declines during adolescence

Negative health indicators (such as health complaints, poor self-rated health and low life satisfaction) increase in prevalence during adolescence, particularly among girls. The decline in self-rated health is above 20% for girls in Scotland, Hungary and Ukraine and reported multiple health complaints in Greece increase by 30%. Fewer girls report high life satisfaction at age 15.

Eleven-year-olds are more likely to report health-promoting behaviours. Eating breakfast and fruit daily decreases with age in almost all countries and regions (eating breakfast daily by 20% among girls in Austria and fruit consumption by over 20% among girls in Hungary), with the difference in both genders being around 10%. Daily consumption of soft drinks tends to increase, with a stronger trend among boys.

### Health inequalities emerge or worsen

Emerging or worsening health inequalities in adolescence may translate into inequalities in adulthood. There is no difference between boys' and girls' average life satisfaction at age 11, but it declines by an average 10% for girls by age 15. The reduction is around 15% for girls in Sweden and Poland and 5% for boys. Increases in gender health inequalities are also seen in girls' attempts to lose weight (2% difference at age 11, rising to 13% by 15) and in the rise in health complaints among girls (7% difference at age 11, 18% by 15).

### Health compromising behaviours increase

Health-compromising behaviours seem to increase, particularly between ages 13 and 15. Eighteen per cent of 15-year-olds report smoking on a weekly basis and 21% report drinking, with 26% being sexually active. The pattern of increase varies by country or region, indicating that social, cultural and economic contexts may play an important role.

<sup>2</sup>*The state of the world's children 2011. Adolescence: an age of opportunity.* New York, United Nations Children's Fund, 2011.

## Gender: it does matter

Gender differences in young people's health and well-being persist, despite social changes and narrowing gender gaps in many areas. Country/regional variation in the extent of gender differences suggests that social and cultural factors play an important role. Gender differences for some health indicators increase significantly between ages 11 and 15: this is therefore a crucial period in which to prevent the development of gender inequalities in adulthood.

Understanding gender differences is a prerequisite for designing successful and targeted interventions. Gender differences in adulthood can be reduced by approaching young people's health from a gender perspective.

### **Girls adopt health-promoting behaviours but have more psychological and health complaints**

Girls are more likely to engage in health-promoting behaviours such as eating fruit, brushing their teeth and limiting soft drink intake, but almost 10% skip breakfast daily by age 15 and 40% are unsatisfied with their bodies – almost double the rate for boys. On average, 22% of 15-year-old girls are on a diet to control their weight, even though only 10% are overweight: 9% of boys report being on a diet, but 18% are overweight. Girls also have lower levels of self-rated health and life satisfaction and higher levels of health complaints.

### **Boys adopt health-compromising behaviours**

Boys are more likely to meet physical activity guidelines<sup>3</sup> but also engage in health-compromising behaviours more frequently. Boys across all ages have at least 10% higher prevalence of injuries: examining age, gender and cross-national differences, a 13-year-old Spanish boy is almost five times more likely to report an injury than a 13-year-old girl from the former Yugoslav Republic of Macedonia.

Boys are more likely to engage in risk behaviours such as drinking and smoking cannabis and/or tobacco. Wide gender differences arise here: for instance, Armenian boys of all ages are around three times more likely to have been drunk than girls, and the gender difference for ever using cannabis among 15-year-olds in Lithuania is 16%. Boys are also more likely to report fighting and bullying (perpetrating or being a victim). The likelihood of 15-year-old boys being in a fight is three times that of girls (16% compared with 5%) and they are more than twice as likely to be involved in bullying others (16% and 7%): in addition, a 15-year-old boy in Belgium (French) is more than 12 times more likely to be bullied than a girl of the same age living in Italy. Boys in some countries and regions, mostly in eastern Europe, are more likely to report having had sex by age 15: 48% of those in Romania report having sex, which is 31% more than for girls in that country.

### **Relationships**

Girls are likelier to have more positive school experiences, greater satisfaction with school and higher perceived academic achievement, but also report more school pressure. When asked about ease of communication with parents, boys are more likely to report that they find it easy to talk to their fathers about things that really bother them. No clear gender differences exist for communication with mothers.

### **Gender paradoxes**

Gender trends are reversed in some countries and regions. Girls have higher prevalence of drunkenness in some Scandinavian countries and the United Kingdom: this is significant among 15-

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<sup>3</sup> *Global recommendations on physical activity for health*. Geneva, World Health Organization, 2010.

year-olds in Scotland, Greenland, Finland and Sweden. Weekly smoking is significantly more prevalent among girls in the Czech Republic, England, Spain and Wales. Although not statistically significant, more girls report having had sex (by age 15) in the United Kingdom and Scandinavian countries: 71% of girls in Greenland report having had sex, compared with 46% of boys.

## **Family affluence: an important predictor of young people's health**

High family affluence is generally associated with more positive relationships, better health outcomes and health behaviours. The pattern for risk behaviours, however, is less clear.

### **Associations between low family affluence, poor health and health outcomes**

Young people living in low-affluence households are more likely to report fair or poor health: the difference is 20% for girls in Denmark and 18% for boys in Iceland. The gap between low and high family affluence in relation to high life satisfaction exceeds 20% for girls in Iceland, Turkey, Hungary, Romania, Luxembourg, Denmark and Switzerland.

Low family affluence predicts higher prevalence of overweight and obesity in western Europe and North America. Boys in the Netherlands, Italy and Belgium (Flemish), for example, show an almost 15% prevalence difference between high- and low-affluence families. The trend is reversed in some eastern European countries, such that in Armenia, higher family affluence predicts higher prevalence of overweight and obesity – the difference is 10%.

Lower prevalence of daily physical activity in Germany is associated with lower family affluence, with a 10% difference for boys, but injuries increase with higher affluence. The difference is almost 20% among boys in Finland and around 25% for girls in Luxembourg. An association with low family affluence and low prevalence of physical activity is found in a minority of countries and regions.

### **Associations between high family affluence and health-promoting behaviours**

High family affluence is associated with health-promoting behaviours such as higher fruit intake and daily breakfast eating. Girls from higher-affluence families in Armenia, Turkey and Ukraine report more than 20% higher fruit intake than their low-affluence peers. Young people from higher-affluence families have better communication with mothers and fathers, higher classmate support and more close friends. Higher affluence also tends to be related to lower prevalence of sedentary behaviour (TV watching).

### **Family affluence and risk behaviours: is rich riskier?**

The picture for risk behaviours is more complex, often presenting an absence of association with family affluence. There is nevertheless an association between higher rates of weekly drinking and high family affluence in some countries, such as Iceland and Ireland: rates in Iceland are 25% higher among boys.

Similarly, recent cannabis use is more prevalent among young people from high-affluence families in Iceland, Norway (boys only) and the United States. The prevalence difference between high and low groups is more than 50% in Iceland and over 20% in Norway.

Weekly smoking is significantly more prevalent among boys and girls from low-affluence families in most countries, but the reverse is true in Romania, where 11% more boys from higher-affluence families smoke on a weekly basis.

## Inequalities between countries and regions

The report reveals inequalities between countries and regions. Rates of overweight and obesity for girls, for example, range from 30% in the United States to only 5% in Switzerland. Smoking rates, although fairly similar at age 11 (less than 1%), differ dramatically across countries by age 15. Austria and Lithuania show smoking rates of over 25% for 15-year-old boys and girls, but the rate is 10% in Norway and Portugal, suggesting that the socioenvironmental context can be changed to benefit young people's health.

## Social environments create opportunities to improve young people's health

Health outcomes are differentiated not only by age, gender and socioeconomic status (SES), but also by the social environments in which young people grow up. The family, peers and school can provide supportive environments for healthy development in which young people can accumulate protective factors, increasing the likelihood of coping with adverse situations even within poorer life circumstances. Young people who have reported ease of communication with their parents in previous HBSC research are more likely to report a range of positive health outcomes, such as higher self-rated health, higher life satisfaction and fewer physical and psychological complaints.

Friendships are crucial to adolescents, helping them to form an identity, develop social skills and increase their self-esteem and independence. Young people who perceive their school as supportive are more likely to engage in positive health behaviours and have better health outcomes, including good self-rated health, high levels of life satisfaction, fewer health complaints and low smoking prevalence.

## Conclusions

Systematic differences related to age, gender and SES across health, health behaviour outcomes and experiences in different life settings produce inequalities in health that call for international and national policies and actions. These need to address the determinants of observed health inequalities in childhood and adolescence so that all young people have the opportunity to maximize their current and future health and well-being and that identified inequalities do not extend into adulthood, with all the negative consequences this may have for human life and societal development.

Health promotion programmes should be sensitive to age, gender and socioeconomic differences in adolescents' developmental trajectories and should aim to provide equal opportunities for all. They should address not only health and health behaviour outcomes, but also the social context in which young people live. Broad-scope actions such as these will help to prevent and diminish health inequalities and stimulate continued positive development for young people regardless of inequalities.

The evidence base around age, gender and socioeconomic inequalities in health and well-being must continue to develop to inform improvements in the effectiveness of health-promotion actions and policies. The unique HBSC data provide a rich resource for such work.

Professionals working in young people's health should not only address health problems directly, but should also consider how social environments support the development of health-promoting behaviours. The "asset model" provides a systematic approach to identifying a set of key assets for health and the most effective approaches to promoting health and development.

### **International report from the 2009/2010 HBSC survey**

The report presents findings from the 2009/2010 HBSC survey, which focus on demographic and social determinants of young people's health. It provides a strong evidence base to support national and international efforts to strengthen initiatives that affect young people's health and well-being.

Currie C et al., eds. *Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey*. Copenhagen, WHO Regional Office for Europe, 2012 (Health Policy for Children and Adolescents, No. 6) <http://www.euro.who.int/HBSC>, accessed 2 May 2012).

