Young people are among the major driving forces of society’s development. They are the capital on which tomorrow’s world is built. It is not the young people per se that enhance tomorrow’s quality of life but their ideas, creativity, motivation and energy to move things forward; these are all aspects that are closely intertwined with health and wellbeing. Young people’s health and wellbeing is multi-faceted and several aspects contribute to it such as their physical condition, being overweight, injuries, physical activity, having a good relationship with their parents, not being bullied or stressed by school-related issues, safe sexual intercourse and—most of all—being free of physical or mental complaints and satisfied with life in general. It is one of this supplement’s strengths to bring many of these aspects together in one volume.

But where are we standing in terms of adolescent health and wellbeing and related factors? What can possibly or realistically be achieved in the near future? These questions are crucial for policy makers in charge of improving young people’s health and wellbeing. However, in a world in which most if not all conditions were found to be relative, it is impossible to answer these questions without a ‘fixed point’ or ‘stand point’ for comparison. In this respect, this supplement offers two valuable anchors. First, all contributions include multiple countries. This allows to see where a given country is standing in comparison to the neighbouring countries or to countries in different regions of Europe or even overseas. Second, all contributions include multiple survey years. This allows the comparison of a given age group, e.g. 15-year-olds, surveyed in 2010 with the same-aged peers living in the same country is standing in comparison to the neighbouring countries or to countries in different regions of Europe or even overseas.

Moreover, both aspects contribute to the assessment of differences in changes of prevalence (differences in trends) of health behaviours and social determinants across different countries. While it is difficult to link a policy measure implemented in a given country at a certain time point or differences in a country-specific policy to observed differences in adolescent health behaviours or related factors, the results presented here nevertheless offer valuable insight on which evidence-based policy can and should be based.

What this supplement has to offer

General aim

As mentioned above, in addition to multiple countries and multiple survey years, the aim of this supplement was to provide evidence on various aspects of young people’s health, wellbeing and related factors. To be able to do so, most contributions are in short report format. In this way, the reader can easily get an overview of prevalence changes across countries for selected outcomes, e.g. fruit and vegetable consumption, overweight, injury-related mortality and morbidity, physical activity, parental communication, bullying, early sexual intercourse and condom use, weekly alcohol consumption and the co-occurrence of tobacco and cannabis use, and life satisfaction, just to name a few of the outcomes included. Full-length papers offer examples of how time trends can be interpreted and explained when dealing with perceived school pressure and health complaints.

Results in a nutshell

Altogether, this supplement consists of 20 contributions. After a general introduction into the Health Behaviour in School-aged Children (HBSC) project by Currie and Aleman-Diaz and its impact over time, Schnoor et al. describe some historical aspects of the HBSC. Their paper also briefly reviews previously published trend papers that emerged from this collaboration. It also describes methodological considerations and analytical strategies on how to produce reliable trends based on an international study. In the paper by Cavallo et al., adolescents were asked to assess their current health condition. The results show that over the last decade an increasing proportion of adolescents rated their health as excellent. Analyses conducted by Vereecken et al. reveal an increase in daily fruit and vegetable consumption between 2002 and 2010 in a majority of countries, with a decrease noted in only five countries. Honkala et al. demonstrate that the prevalence of recommended tooth brushing (i.e. more than once a day) increased in all countries except in Scandinavia, where it was already high in 1994. This also means that differences between the countries diminished from 2004 to 2010.

Analyses conducted by Ottová-Jordan et al. show that trend patterns in recurrent health complaints vary considerably across countries; i.e. nine countries showed no linear or quadratic trend, seven a linear decrease, five a linear increase, four a U-shape curve, six an inverted U-shape curve and four an unstable trend. Ahluwalia et al. document an increase in overweight prevalence (including obesity) predominantly in Eastern Europe. In other countries, overweight rates remained stable albeit at high levels. Also noteworthy is that no decreases from 2002 to 2010 were found in any of the countries. The paper by Molcho et al. reveals that in the same timespan injury-related mortality, but not morbidity, declined over time across all the included 30 countries. Interestingly, risky behaviours such as substance use, physical activity or fighting were...
consistently and significantly associated with injury morbidity, but
did not explain the observed temporal trends. Kalman et al.9
demonstrate that despite a slight overall increase in physical activity from
2002 to 2010 across the 32 included countries nine showed a sig-
nificant decrease.

Bonie-Nissim et al.10 document an increase in electronic media
communication from 2002 to 2010 in most of the 30 included
countries. Electronic media communication was also linked with
communicating easily with friends in general and with the
opposite sex in particular. In the same vein, analyses conducted by
Brooks et al.11 show, in the majority of the 32 countries, an increase
in the proportion of adolescents who find it easy to talk to their
mother or father about the issues that are of importance to them,
and this was mostly pronounced for the communication with the
father. A decreasing trend was found only in France, Slovenia and
Poland. The paper by Klinger et al.12 reveals that the overall
proportion of students who felt under pressure due to the amount
of schoolwork they had did not change, with the levels reported in
1998 being similar to those reported in 2010 across all gender and
age groups. Students in North America report the highest percep-
tions of school pressure, followed by Great Britain, Eastern Europe,
Nordic countries and Germanic countries in a descending order.
Analyses conducted by Moor et al.13 show that, in the majority of
countries, schoolchildren who perceived their family wealth as low
reported significantly higher rates of multiple health complaints
(1994: 12 out of 19 countries; 1998: 17 out of 25 countries, 2002:
26 out of 32 countries, 2006: 30 out of 37 countries, 2010: 32 out of
36 countries). In the majority of countries, there was no change in
social inequalities in health complaints across the survey years.

The paper by Chester et al.14 reveals a decrease in occasional and
chronic bullying victimization between 2002 and 2010 in the
majority of the 33 included countries. Although there was no
linear trend across countries from 2002 to 2010, Ramiro et al.15
demonstrate differences in sexual intercourse among adolescents
in different European regions. There was a tendency of increased
initiation among girls in eastern Europe and decreased very early
initiation (i.e. younger than 13) among girls in northern Europe,
along with a general increase in condom use in boys and most
notably in girls. Analyses conducted by De Looze et al.16 reveal
that between 2002 and 2010 weekly alcohol use declined in 20
of the 28 European and North American countries included and
in all geographical regions. The authors conclude that, although
the declining trend was remarkably similar across countries,
prevalence rates still differ considerably, from highest to lowest in
eastern Europe (10.1%), southern Europe (9.9%), western Europe
(7.8%), Anglo-Saxon countries (6.1%) and northern Europe (4.1%).
Consistent with alcohol consumption, the paper by Hublet et al.17
shows a decrease from 2002 to 2010 in concurrent use of tobacco
and cannabis in all European and North American regions,
(a decrease in tobacco-only use in all European regions and a
decrease in cannabis-only use in all regions except in eastern
European countries. Holstein et al.18 document that the prevalence
of medicine use for headaches increased in twelve out of twenty
countries, most notably in the Czech Republic, Poland, Russia,
Sweden and Wales.

Concerning general life satisfaction, Cavallo et al.19 found no
consistent trends across all countries. Between 2002 and 2010, six
relatively affluent western countries (Austria, Canada, Switzerland,
Denmark, Finland and Greenland) and two eastern European
countries (Hungary and Macedonia) decreased. In contrast,
increasing life satisfaction was observed in six eastern European
countries (Estonia, Croatia, Lithuania, Latvia, Russia and Ukraine),
and in four western European countries (Spain, Norway,
Portugal and Belgium). Finally, analyses by Ottóva-Jordan et al.20
reveal that individual factors, especially being a female, being bullied,
experiencing school pressure and smoking, were more strongly
associated with health complaints in the different survey years
than country characteristics, such as national wealth or income
inequality.

Conclusion: is there nothing to worry
about anymore?

What emerges as a general picture of the 19 contributions included
in this supplement is that, across countries, contemporary adoles-
cents are better off than their counterparts were about a decade ago.
In 2010, a higher proportion of adolescents ate healthily in terms of
fruit and vegetable consumption, had a good dental hygiene, did not
suffer from injury, were physically active on a daily basis,
communicated with friends electronically, found it easy to talk to
their mother or father about important personal issues, were not
victimized in terms of occasional or chronic bullying, used a
condom when having sex, did not drink alcohol on a weekly basis
and lived tobacco and cannabis free. Consistently and as a kind of
general summary, Cavallo et al.13 report a higher proportion of ado-
lescents who rated their health as excellent.

The overall optimistic picture seems surprising considering that
many countries in Europe and North America faced a severe
economic crisis in the last decade. At the same time, however,
policies and actions to improve public health were implemented
in many countries such as the ban of selling cigarettes to minors
and smoking in public buildings including bars and restaurants or
the policies aiming to increase physical activity and healthy eating in
school children to counteract excess weight and obesity develop-
ment. However, one has to bear in mind that such trends over
time are never the result of a single measure but reflect changes in
fashions, behavioural norms, societal values, etc., as well as the
diversity of the policy actions that were taken. This is what makes
it particularly difficult to come up with sound explanations for the
observed trends.

While the overall picture indicates improvements in adolescent
health and social determinants this was not the case for all the
countries. For example, in Greenland, Norway, Poland and
Denmark an increase in multiple recurrent health complaints was
observed from 1994 to 2010.10 In the Czech Republic, Denmark, Italy,
Lithuania, Russia, Scotland, Slovenia, Switzerland and USA in 2010,
there was a lower proportion of adolescents who were physically
active on a daily basis compared to 8 years ago.9 In the same time
span, less adolescents found it easy to talk to their mother or father
about important personal issues in France, Slovenia and Poland.11
Also, in French-speaking Belgium and Finland, there were increasing
trends of bullying victimization.14 Thus, it is not only important to
consider the evidence of single countries or groups of countries, but
the multiple evidence presented in the various articles included in
this supplement can help to better understand the development in a
given country in the light of the others.

The fact that not all the examined variables developed positively
across the years is something to be concerned about. Despite the
results showing that a higher proportion of adolescents ate healthily
in terms of fruit and vegetable consumption and were physically
active on a daily basis, overweight prevalence including obesity
increased from 2002 to 2010, predominantly in Eastern Europe, or
remained stable in the best case.7 Furthermore, although a higher
proportion of adolescents did not suffer from any injuries, did not
experience bullying victimization, did not drink alcohol on a weekly
basis, lived tobacco and cannabis free, and rated their health as
excellent, the prevalence of medicine use for headaches increased
from 1986 to 2010 in 12 out of 20 countries.18 More research is
clearly needed to gain a better insight into these seemingly contra-
dictory trends.

Another major concern is that many if not the majority of ado-
lescents living in Europe and North America still do not meet the
recommendations for healthy living despite the improvements
described above. For example, large proportions of adolescents do
not meet the recommendations for physical activity (at least 60 min per day), for time spent in front of electronic screens (no more than 2 h per day), or for fruit and vegetable consumption (daily basis). This demonstrates the need for continued advocacy, policy implementation, and a strengthening of efforts to motivate adolescents and their parents to behave in healthy ways. It is imperative to work with policymakers from various countries to implement health strategies for children and adolescents that take into account social determinants for health cross-nationally.

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