European Region

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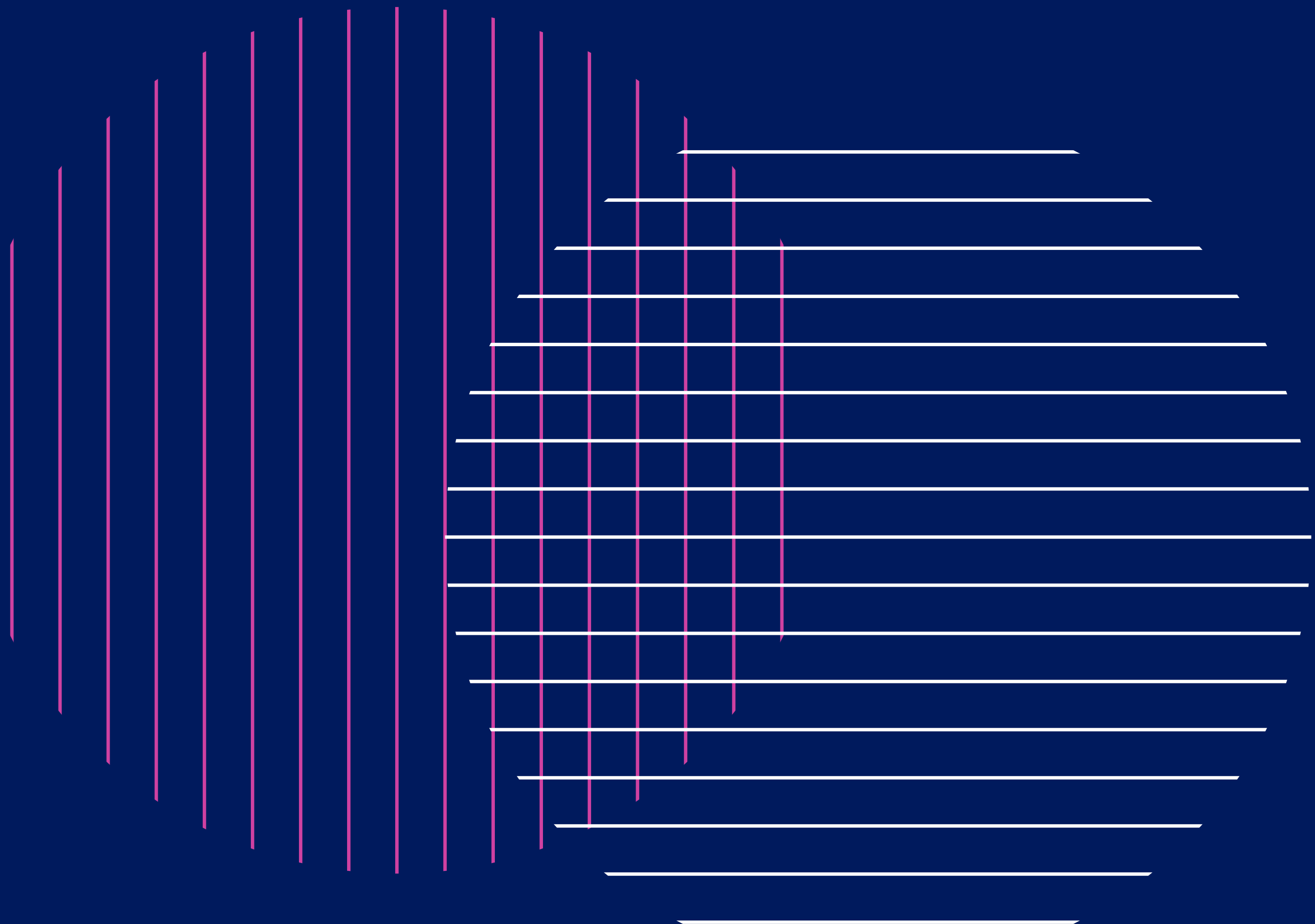
HEALTH BEHAVIOUR IN SCHOOL-AGED CHILDREN

A focus on adolescent sexual health in Europe, central Asia and Canada

Health Behaviour in School-aged Children international report from the 2021/2022 survey

Volume 5



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Abstract
The Health Behaviour in School-aged Children (HBSC) study is a large school-based survey carried out every four years in collaboration with the WHO Regional Office for Europe. HBSC data are used at national/regional and international levels to gain new insights into adolescent health and well-being, understand the social determinants of health and inform policy and practice to improve young people's lives. The 2021/2022 HBSC survey data are accompanied by a series of volumes that summarize the key findings around specific health topics. This report, Volume 5 in the series, focuses on adolescent sexual health, using the unique HBSC evidence on the sexual health of adolescents aged 15 years across 42 countries and regions in Europe, central Asia and Canada (two of the 44 countries and regions in the study could not collect data on sexual behaviours). It describes the current sexual health status of adolescents by analysing their sexual initiation, contraceptive pill and condom use (or non-use) at last sexual intercourse, the role of gender, age and social inequality, and how adolescent sexual behaviour has changed over time. Findings from the 2021/2022 HBSC survey provide an important evidence benchmark for current research, intervention and policy-planning.

Keywords
HEALTH BEHAVIOR
HEALTH STATUS DISPARITIES
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GENDER EQUITY
ADOLESCENT HEALTH
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SEX EDUCATION

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Foreword

Young people around the world face many challenges. Research shows that acceleration of climate change, migration, and economic and political instability – to name just three factors – are having profound effects on their health and well-being. The coronavirus disease 2019 (COVID-19) pandemic and, more specifically, the mitigation measures put in place by countries around the world to stop the spread of the virus, changed the way children and young people live their lives. And now, for the first time in decades, war is being waged in Europe.

Colossal global events like these inevitably have huge effects on young people. But it is the narratives of young people's everyday lives – their relationships with family, friends and teachers, self-image, levels of physical activity, what they eat and drink and their experiences at school, for instance – that determine to a large extent their overall sense of mental and physical health and well-being.

It is vital that we understand the impacts of all these issues on young people and identify what countries and regions can do to further promote adolescent health and positive health behaviours.

In this regard, we are so fortunate in the WHO European Region to have the Health Behaviour in School-aged Children (HBSC) study. HBSC is a school-based survey carried out every four years in collaboration with the WHO Regional Office for Europe. It tracks, monitors and reports on self-reported health behaviours, health outcomes and social environments of boys and girls aged 11, 13 and 15 years. The most recent survey (2021/2022) was conducted across 44 countries and regions of Europe, central Asia and Canada, and included an optional set of questions that measured the perceived impacts of the COVID-19 pandemic.

This report, Volume 5 in the series, focuses on findings from the HBSC survey on adolescent sexual health, as reported by 15-year-old boys and girls in 42 countries and regions.

While results varied widely across the countries and regions, the most important observed trend since the HBSC survey in 2014 is of declines in some countries and regions in condom use among sexually active 15-year-olds. This is worrying, as not using condoms during sexual intercourse exposes adolescents to higher risks of unintended pregnancy and sexually transmitted infections. It emphasizes the need for supportive prevention and intervention strategies that target young people's sexual health, and highlights the vital importance of age-appropriate, youth-friendly sexuality education that allows young people to learn about and explore sexual feelings, relationships and behaviours.

This high-quality evidence suggests that countries and regions should redouble their efforts to ensure young people can access the right education, support and health advice to practise sexual behaviours safely within respectful and noncoercive relationships. Efforts to ensure young people can explore their sexuality without having to face prejudice and victimization in their communities should also be strengthened.

I congratulate and thank those responsible for the HBSC/WHO Regional Office for Europe collaborative study for once again providing timely, reliable and clear evidence that countries and regions can use as a springboard to step-up existing initiatives and develop new policies to counter the ongoing challenges young people face.

Hans Henri P. Kluge
WHO Regional Director for Europe

Preface

The Health Behaviour in School-aged Children (HBSC) study provides unique insights into the health and well-being of adolescents across Europe, central Asia and Canada. In this, the study's 40th anniversary year, we are delighted to be launching the findings from the 11th consecutive international survey in a series of topic-based volumes.

Over the past four decades, the study has grown to include over 50 countries and regions. The scope of the study has broadened over this time to encompass emergent priorities for adolescent health, while also seeking to maintain the ability to monitor longer-term trends that provide invaluable insights into how the lives of adolescents have changed over recent decades. The 2021/2022 survey included a wide range of measures of adolescent health and health behaviours and the social context in which they grow up, including family and peer relationships, school experience and online communication. As the first HBSC survey since the coronavirus disease 2019 (COVID-19) pandemic, measures were included to understand the ongoing impact of the pandemic on adolescent health. A special focus was placed on mental health, with new measures of mental well-being, loneliness and self-efficacy.

For the first time, the HBSC international report is also presented online through a new data browser that allows users to view the data through a series of interactive charts and figures. The release of the new data is accompanied by a series of volumes that summarize the key findings around specific health topics. This report, Volume 5 in the series, focuses on adolescent sexual health. It presents some challenging findings, including reduced use of condoms by sexually active 15-year-olds in some countries and regions.

HBSC involves a wide network of researchers from all participating countries and regions. The data collection in each country or region is funded at national/regional level. We are grateful for the financial support and guidance offered by government ministries, research foundations and other funding bodies for the 2021/2022 survey round. We would also like to thank our valued partners, particularly the WHO Regional Office for Europe, for their continuing support, the young people who took part in the survey and shared their experiences with us, including those who provided the quotations that feature in the report, schools and education authorities for making the survey possible, and all members of the national HBSC teams involved in the research.

High-quality, internationally comparable data continue to be essential to support international policy development and monitor progress towards global targets such as the United Nations Sustainable Development Goals. At national/regional level, HBSC data provide key scientific evidence to underpin health improvement initiatives and can be used to track progress on health priorities. With its long-term trends, the HBSC study enables us to monitor the impact of wider societal change and individual lifestyles on health outcomes for the adolescent age group. Importantly, it lets us hear from young people themselves about the issues that matter to them and the factors that affect their health and well-being. While there are many challenges to address, the data also highlight the importance of providing caring and supportive environments in which adolescents can thrive.

Jo Inchley
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Key findings and implications

Key findings

- In 2022, one in five (20%) 15-year-old boys and one in seven (15%) 15-year-old girls reported having had sexual intercourse. The proportion of adolescents who reported having had sexual intercourse remained relatively stable since 2014, but boys showed a slight decline compared to 2018 (one in four).
- Between 2018 and 2022, the percentage of boys who reported having had sexual intercourse declined in 11 countries and regions. The percentage of girls who reported having had sexual intercourse declined in three countries and regions and increased in three.
- Among adolescents who reported having had sexual intercourse, 61% of boys and 57% of girls reported using a condom at last sexual intercourse.
- Around a third of adolescents (30% of boys and 36% of girls) did not use a condom at last sexual intercourse and a further 9% of boys and 7% of girls did not know if they or their partner had used a condom. These rates varied widely across countries and regions.
- A decline in condom use since 2014 was observed among both boys (nine percentage points) and girls (six percentage points).
- Among girls who had had sexual intercourse, 26% reported having used the contraceptive pill at last sexual intercourse. For boys, 25% reported that their partner had used the contraceptive pill at last sexual intercourse.
- A large proportion of adolescents (57% of boys and 68% of girls) reported not using the contraceptive pill at last sexual intercourse. A further 18% of boys and 6% of girls reported not knowing if they or their partner had used the contraceptive pill. There was large variation in these rates across countries and regions.
- Reports of contraceptive pill use during last sexual intercourse remained relatively stable between 2014 and 2022.
- Thirty per cent of sexually active boys and 31% of sexually active girls reported using neither condom nor contraceptive pill at last sexual intercourse. This is similar to rates observed in 2018.
- Socioeconomic differences in sexual behaviour were seen in only a few countries and regions, and there was no consistent pattern among girls. For boys, there was some evidence that those with high affluence were more likely to have had sexual intercourse and were also more likely to have used a condom at last intercourse than those with low affluence.

Implications

- Sustainable investments should be made in comprehensive and evidence-based sexuality education in schools so that adolescents can learn to openly discuss topics surrounding sexuality, including (but not limited to) the use of reliable contraceptive methods.
- Reproductive health services should be youth-friendly and tailored to young people’s developmental, cultural and logistical needs. They should be accessible to young people without any gatekeeping measures being imposed (such as requiring parental permission or a referral from a general practitioner).

Introduction

First experiences with romantic relationships and sex typically occur during adolescence. While romantic and sexual experiences can positively contribute to young people's well-being *(1)*, they also entail risks, such as unintended pregnancies and sexually transmitted infections. Encouraging young people to practise safer sex represents a major public health challenge that has had varying degrees of success worldwide *(2)*.

Sexual initiation is an integral part of adolescents' transition to adulthood. The timing and context of young people's first sexual intercourse can impact their health and well-being in the short term and later in life *(3)*. Adolescents who initiate sexual intercourse early (before the age of 15 years) may be less able to negotiate consent and contraceptive use and consequently are more likely to engage in risky sexual behaviours *(4)*. This results in increased risks of adverse sexual health outcomes such as coercive sexual experiences, unplanned pregnancy and sexually transmitted infections *(5)*.

The sexual behaviours in which adolescents engage and the attitudes they hold regarding sexual intercourse are shaped by cultural and contextual factors. Across a sample of European countries, for instance, national-level norms on the age regarded as appropriate for the onset of sexual activity were found to be associated with the age of initiation of adolescent boys and girls *(6)*. Sexually active adolescents living in countries with higher levels of gender equality were more likely to use condoms and the contraceptive pill than their peers in countries with lower levels of gender equality *(7)*. This effect was especially strong for girls.

Evidence suggests that young people nowadays initiate sexual behaviours at a later age than previous generations. National studies *(8,9)* and a recent international analysis *(10)* reported a decline in the proportion of sexually active adolescents in the two decades up to 2018. The coronavirus disease 2019 (COVID-19) pandemic and its related social distancing measures may have intensified this trend *(11)*.

The 2021/2022 Health Behaviour in School-aged Children (HBSC) survey provides unique evidence on the sexual health of 15-year-old adolescents in countries and regions in Europe, central Asia and Canada across a set of standard indicators used in the HBSC survey (Table 1 and the Annex). This report describes:

- the prevalence of sexual initiation among 15-year-olds;
- the prevalence of condom and contraceptive pill use (or non-use) at last sexual intercourse among adolescents who report having had sexual intercourse;
- the role of gender and social inequality; and
- how adolescent sexual health has changed over time since the 2013/2014 HBSC survey.

Table 1. Sexual health measures included in the report

Sexual intercourse	Young people were asked if they had ever had sexual intercourse. A short explanation was provided ("Sometimes this is called 'making love', 'having sex' or 'going all the way'"). Response options were yes or no. Those who answered no were instructed to skip the additional questions on sexual health. Rates of those who reported having had sexual intercourse are presented in the Annex.
Condom use at last sexual intercourse	Young people who said they had had sexual intercourse were asked whether they or their partner had used a condom the last time they had had sexual intercourse. Response options were yes, no and don't know. Findings presented here show the proportions who reported yes to this question and those who reported not using a condom or not knowing if they used a condom at last sexual intercourse.
Contraceptive pill use at last sexual intercourse	Young people who said they had had sexual intercourse were asked whether they or their partner had used the contraceptive pill the last time they had had sexual intercourse. Response options were yes, no and don't know. Findings presented here show the proportions who reported yes to this question and those who reported not using the contraceptive pill or not knowing if they used the contraceptive pill at last sexual intercourse.
Neither condom nor contraceptive pill use at last sexual intercourse	Rates of those who reported not using either condom or contraceptive pill at last sexual intercourse (or not knowing if they or their partner had used either) are presented in the Annex.

For trends analyses, the HBSC average is calculated for countries and regions present in all three survey rounds. The 2022 prevalence for the trends analyses may therefore differ from the 2022 prevalence set out elsewhere in this report because the baseline number of countries and regions is different.

I think that at the country level, we should put more emphasis on informing young people about how we can make the right decision to start our safe-sex life, which is those methods of contraception that can protect us from both an unplanned pregnancy and a sexually transmitted infection. (Girl, Republic of Moldova)

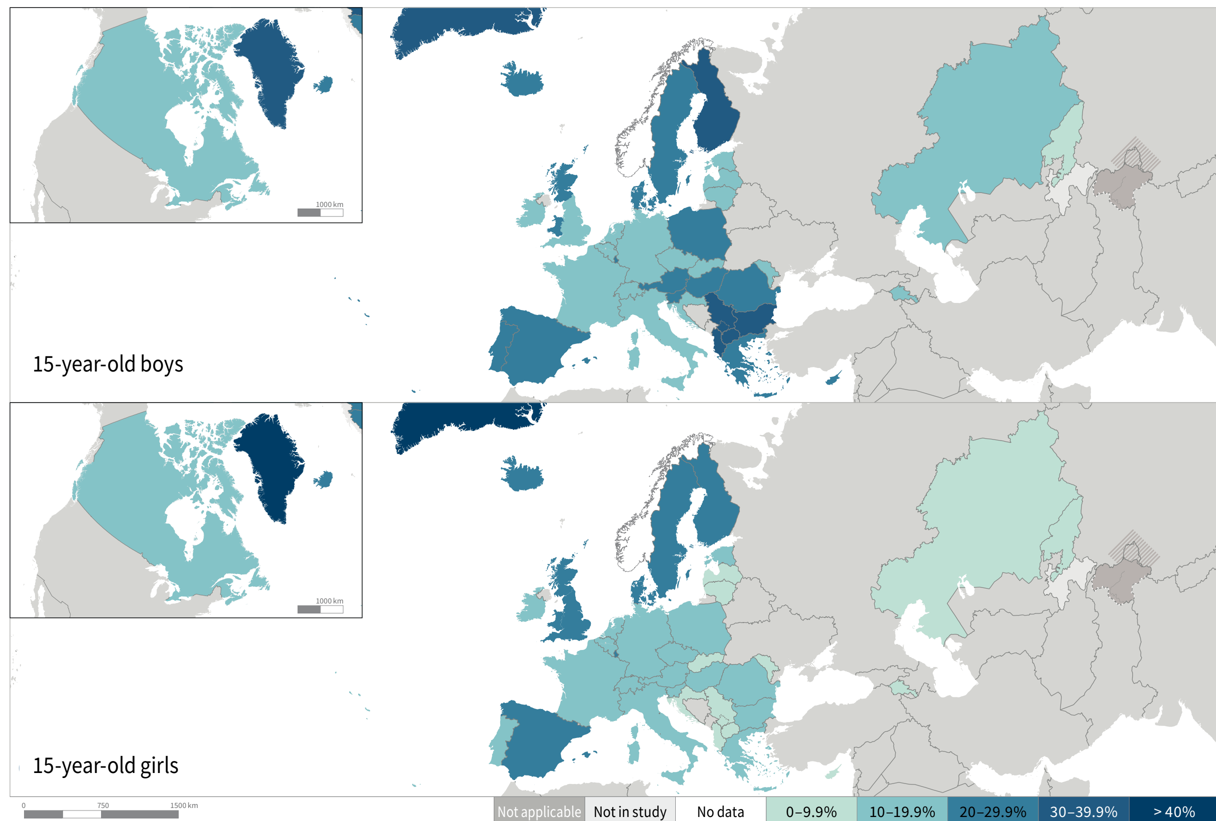
Insights into adolescent sexual health

Sexual intercourse

Boys were more likely than girls to report having had sexual intercourse at age 15 (20% versus 15%). The gender difference was significant in 22 of 42 countries and regions,[1] with the largest differences observed in Albania (30 percentage points) and North Macedonia (25 percentage points). A significantly higher proportion of girls reporting having had sexual intercourse was found only in Denmark (Greenland).

Wide cross-national/regional variation was observed, with different patterns for girls and boys (Fig. 1). In Armenia, Kazakhstan and Kyrgyzstan, prevalence of sexual intercourse among girls was 2% or fewer. The highest prevalence was observed in Denmark (Greenland) (49%) and Finland (29%). For boys, prevalence ranged from 5% in Kyrgyzstan to 38% in Bulgaria.

Fig. 1. Fifteen-year-olds who have had sexual intercourse by country/region and gender



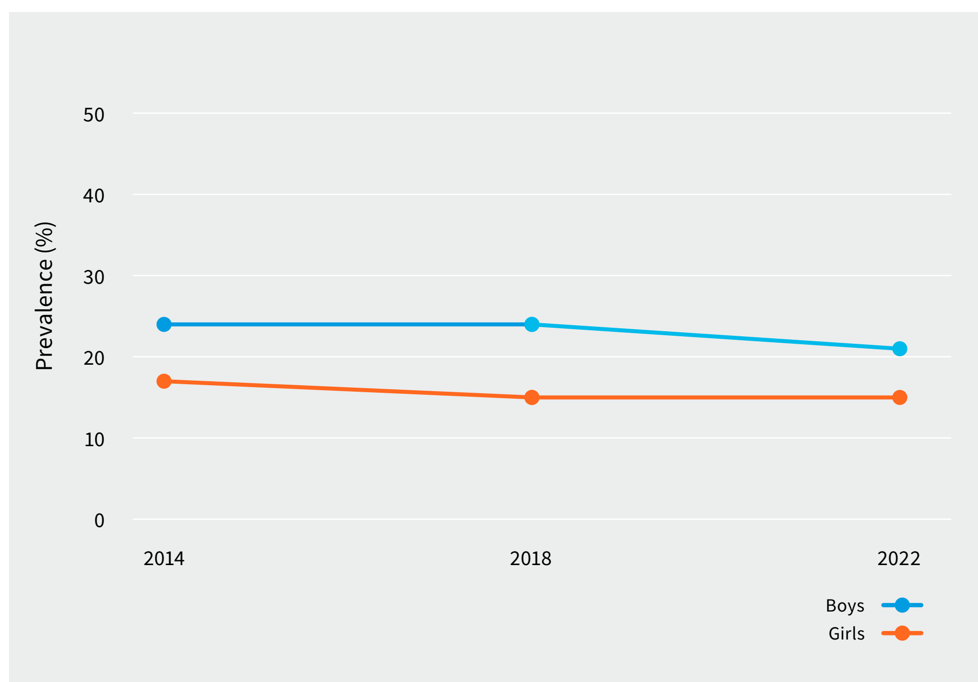
Note: no data were received from Norway and Tajikistan.

1 Two of the 44 countries and regions in the study (Norway and Tajikistan) could not collect data on sexual behaviours.

Social patterning in sexual intercourse overall was significant among boys but not girls. Broken down to country/region level, the difference was significant in 15 countries and regions for boys and seven for girls. Boys from high-affluence families in 13 of the 15 countries and regions were more likely to report having had sexual intercourse. Girls from low-affluence families were more likely to report this in four of the seven.

The proportion of adolescents who reported having had sexual intercourse remained relatively stable between 2014 and 2018 (Fig. 2). Boys showed a small decrease since 2018, but this was significant only in 11 countries and regions. The largest decrease was seen in Albania, Armenia, France and Greece. No overall change was observed among girls since 2018, but a significant decrease was seen in Bulgaria, Czechia and Greece, and a significant increase in France, Luxembourg and Spain.

Fig. 2. Trends in having had sexual intercourse among 15-year-olds, from 2014 to 2022 by gender



Note: the HBSC average for this figure does not include Armenia (girls), Cyprus, Denmark (Greenland), Kazakhstan, Kyrgyzstan, Norway, Serbia and Tajikistan, as data were not available for all three survey years.

Condom use at last sexual intercourse

Adolescents who reported having had sexual intercourse were asked if they had used a condom at last intercourse. Boys were more likely than girls to report condom use at last sexual intercourse (61% versus 57%). The gender difference was significant in 12 of 42 countries and regions. Of these, boys were more likely to report condom use in eight; girls were more likely to report it in the remaining four countries (Lithuania, Poland, Serbia and Slovenia).[2] The largest differences were observed in Albania (37 percentage points) and Malta (22 percentage points).

Wide cross-national/regional variation was observed, with different patterns for girls and boys. Condom use among girls was lowest in Albania (24%) and highest in Serbia (81%) and the Republic of Moldova (75%). For boys, the lowest rate of condom use was reported in Sweden (43%), while boys were most likely to report condom use in Switzerland (77%). No clear geographical pattern was evident, but the lowest condom use overall was reported in Albania, Denmark (Greenland), Kyrgyzstan, Sweden and United Kingdom (Scotland).

There was some evidence of social patterning of condom use among boys. Overall, boys from high-affluence families were 10 percentage points more likely to report condom use than those with low affluence. This difference, however, was significant only in seven countries and regions.[3]

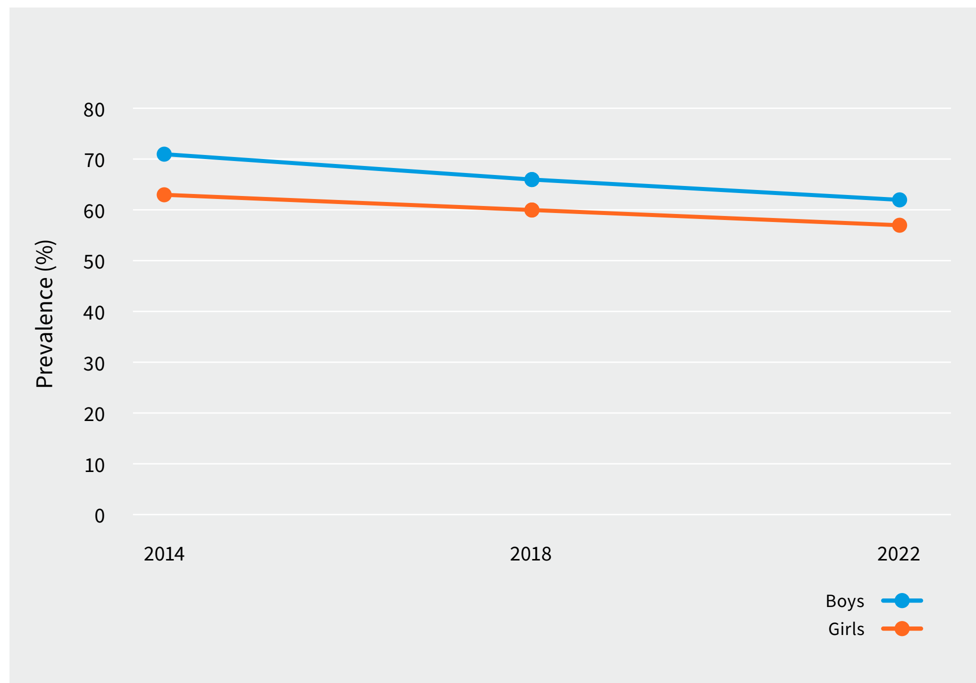
Between 2014 and 2022, a linear pattern of decreasing condom use at last sexual intercourse among both boys and girls has been seen. Compared to 2014, there has been an overall decrease of nine percentage points for boys and six for girls (Fig. 3). Since 2018, this decrease has been significant in five countries and regions for boys and five for girls. Conversely, a significant increase has been found in Armenia and Malta for boys and in Czechia and the Republic of Moldova for girls.

Thirty per cent of boys and 36% of girls reported not having used a condom at last sexual intercourse. Rates ranged from 14% in Armenia to 52% in United Kingdom (Scotland) among boys, and from 14% in Serbia to 68% in Sweden for girls. Nine per cent of boys and 7% of girls did not know whether they or their partner used a condom at last intercourse. Rates of boys not knowing whether they used a condom ranged from fewer than 0.5% in United Kingdom (England) to 20% in Cyprus. Among girls, lowest rates were found in Italy and United Kingdom (England) (both fewer than 0.5%); the highest proportion was found in Kyrgyzstan (38%).

2 Girls from Armenia and Kazakhstan were excluded from the analysis, as numbers having had sexual intercourse were not sufficient for a reliable estimate of condom prevalence to be established.

3 It was not possible to produce reliable estimates of condom use across family affluence groups for some countries and regions with very low numbers of young people reporting having had sexual intercourse.

Fig. 3. Trends in condom use among 15-year-olds who reported having had sexual intercourse, from 2014 to 2022 by gender



Note: the HBSC average for this figure does not include Armenia (girls), Cyprus, Denmark (Greenland), Kazakhstan, Kyrgyzstan, Norway, Serbia, Switzerland and Tajikistan, as data were not available for all three survey years.

Contraceptive pill use at last sexual intercourse

Adolescents who reported having had sexual intercourse were asked if they had used the contraceptive pill at last intercourse. No overall gender difference in contraceptive pill use at last sexual intercourse was seen (26% of girls and 25% of boys). Girls were most likely to report contraceptive pill use in Netherlands (Kingdom of the) (61%), Sweden (52%) and Denmark (51%), and least likely in Greece (6%) and Slovakia (7%). The highest proportion of boys reporting contraceptive pill use was found in Belgium (Flemish) (50%), Finland and United Kingdom (England) (44% in both), while the lowest rates were in Spain, Denmark (Greenland) and North Macedonia (10% in all three).

Significant gender differences were detected in only eight countries: Austria, Bulgaria, Denmark, Ireland, Kyrgyzstan, Netherlands (Kingdom of the), Slovakia and Sweden. Boys were more likely to report contraceptive pill use in three of these countries and girls in the other five.[4]

Socioeconomic differences in contraceptive pill use at last sexual intercourse were found in only a very small number of countries and regions[5] (three for boys and two for girls). Across all countries and regions combined, however, contraceptive pill use was higher among girls and boys from higher-affluence families.

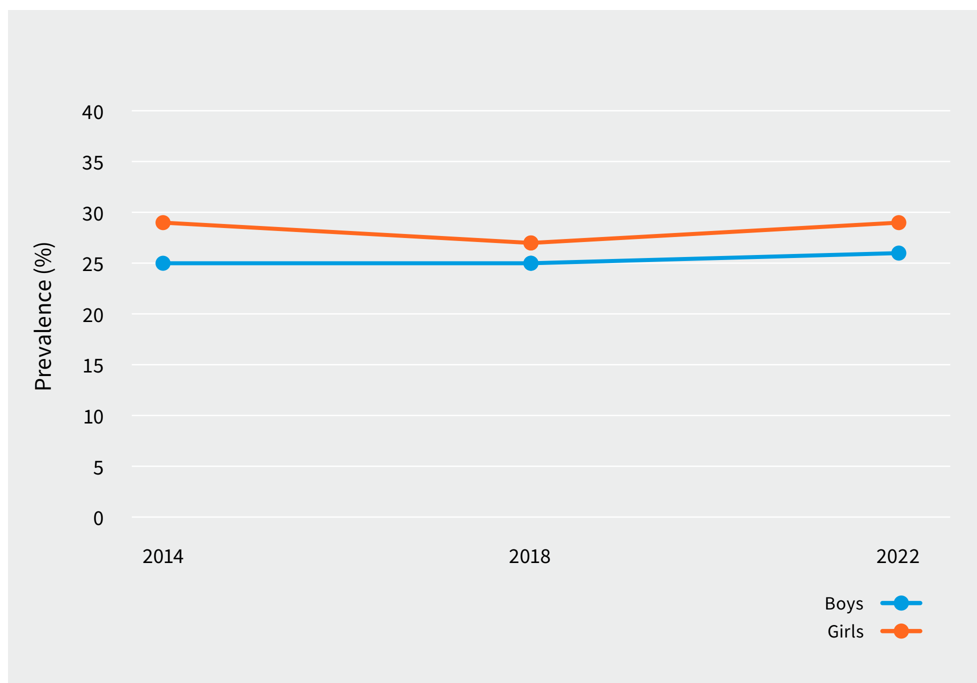
4 Girls from Armenia and Kazakhstan were excluded from the analysis, as numbers reporting having had sexual intercourse were not sufficient for a reliable estimate of contraceptive pill use prevalence to be established.

5 It was not possible to produce reliable estimates of contraceptive pill use across family affluence groups for some countries and regions with very low numbers of young people reporting having had sexual intercourse.

No significant change in contraceptive pill use at last sexual intercourse was seen in either gender between 2014 and 2022 (Fig. 4). At country/region level, however, there was variation in the direction and magnitude of change. For girls, a significant decrease was observed in Belgium (French) and Canada, and a significant increase in Czechia, Ireland, Malta and Portugal. Among boys, reported contraceptive pill use decreased in Canada but increased in Malta, United Kingdom (Scotland) and United Kingdom (Wales).

Fifty-seven per cent of boys and 68% of girls reported not having used the contraceptive pill at last sexual intercourse. Rates ranged from 34% in Belgium (Flemish) to 81% in Italy among boys and from 37% in Netherlands (Kingdom of the) to 93% in Greece for girls. Eighteen per cent of boys and 6% of girls did not know whether they or their partner had used the contraceptive pill at last intercourse. Rates of boys not knowing whether they had used the contraceptive pill ranged from fewer than 0.5% in United Kingdom (England) to 52% in Denmark (Greenland). Among girls, lowest rates were found in Austria, Ireland, Italy and United Kingdom (England) (all fewer than 0.5%) and the highest in Kyrgyzstan (39%).

Fig. 4. Trends in contraceptive pill use among 15-year-olds who reported having had sexual intercourse, from 2014 to 2022 by gender



Note: the HBSC average for this figure does not include Albania (girls), Armenia (girls), Cyprus, Denmark (Greenland), Kazakhstan, Kyrgyzstan, Norway, Poland, Serbia, Switzerland and Tajikistan, as data were not available for all three survey years.

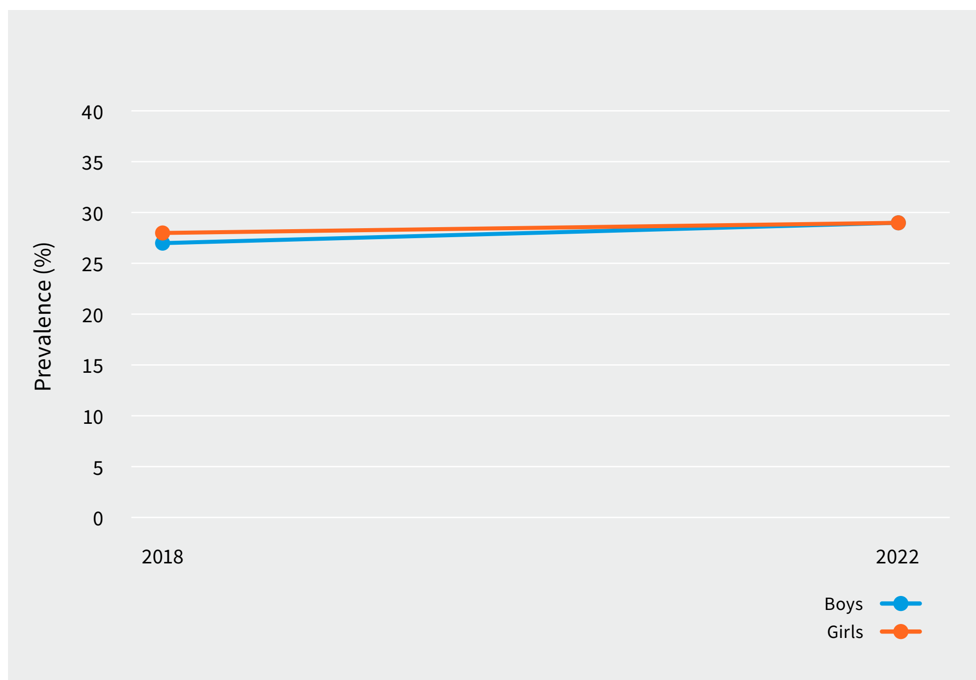
Neither condom nor contraceptive pill use at last intercourse

There was very similar prevalence in reporting using neither contraceptive method at last intercourse across genders (30% among boys and 31% girls). Significant gender differences were seen in only six countries and regions.[6] Girls in Albania and Hungary were more likely than boys to report that they had used neither condom nor pill at last sexual intercourse. The opposite pattern was found in Austria, Lithuania, Serbia and Slovenia.

Adolescents from low-affluence families were more likely to report using neither condom nor pill at last sexual intercourse. Socioeconomic differences nevertheless were small in most countries and regions and only reached significance in six for boys and one for girls.

Overall, the rates of using neither condom nor pill at last sexual intercourse did not change significantly between 2018 and 2022 (Fig. 5).[7] When disaggregated for country/region and gender, an increase was found in seven for boys and two for girls. There was a significant decrease in three countries (Armenia, Czechia and Malta) for boys and three (Czechia, Malta and the Republic of Moldova) for girls.

Fig. 5. Change in percentage using neither condom nor pill among 15-year olds who reported having had sexual intercourse, from 2018 to 2022 by gender



Note: the HBSC average for this figure does not include Albania (girls), Armenia (girls), Cyprus, Denmark (Greenland) (boys), Kazakhstan (girls), Kyrgyzstan, Norway, Switzerland and Tajikistan, as data were not available for both survey years.

6 Girls from Armenia and Kazakhstan were excluded from the analysis, as numbers reporting having had sexual intercourse were not sufficient for a reliable estimate of prevalence to be established.

7 This variable was not calculated in the 2014 survey.

Policy implications

This report demonstrates notable gender differences in some countries and regions and wide geographical variation in prevalence of sexual initiation and condom and contraceptive pill use (or lack of).

Compared to 2018, slightly fewer boys in 2022 reported sexual initiation, and those who had had sexual intercourse – both girls and boys – were also significantly less likely to report using a condom at last intercourse.

Notably, the decline in condom use between 2018 and 2022 was preceded by an already ongoing decline between 2014 and 2018, resulting in a nine percentage-point decline in condom use for boys and a six percentage-point decline for girls between 2014 and 2022. Contraceptive pill use, on the other hand, remained relatively stable between 2014 and 2022. No significant shift between 2018 and 2022 in using neither a condom nor the contraceptive pill at last intercourse was observed. These findings highlight the need for supportive prevention and intervention strategies targeting young people's sexual health.

The results of the survey have important policy implications that countries and regions may wish to consider and address.

- → Countries and regions should consider the benefits of investing in programmes that aim to improve adolescent sexual health, based on their national/regional HBSC results.
- → Sustainable investments could be made in comprehensive school-based sexuality education. The focus of sexuality education should not be limited to preventing risks; it should also entail the discussion of topics such as consent, respect, gender equality, and lesbian, gay, bisexual, transgender, intersex, queer/questioning and asexual diversity.
- → Supporting adolescent development of communication skills with sexual partners is an essential component of a comprehensive sexual and reproductive health approach.
- → There is a need for sustained educational and health interventions to promote condom use, combined with other highly effective contraceptive methods.
- → Schoolteachers should receive additional training to enable them to provide high-quality sexuality and relationships education and help their students to develop skills in these areas.
- → Reproductive health services should be youth-friendly, tailored to young people's developmental, cultural and logistical needs, and available to young people without any gatekeeping measures being imposed (such as requiring parental permission or a referral from a general practitioner).

Conclusions

It is seen as shameful for boys not to be sexually active, but for the girls [it] is on the contrary, it is shameful to be sexually active, and to talk about it. (Girl, North Macedonia)

This report shows wide variation across countries and regions in the proportion of adolescents who reported having had sexual intercourse and those who reported condom and contraceptive pill use at last sexual intercourse. The geographical variation may reflect varying cultural norms and values regarding sexuality, which may impact young people's sexual behaviour and the way they answer questions on this topic.

Overall, girls were less likely to report having had sexual intercourse than boys. They were also less likely to report condom use at last sexual intercourse, but there were no overall gender differences in reported contraceptive pill use. It should be noted that gender differences are especially large in eastern European and central Asian countries and are smallest in northern European countries and regions. These findings are in line with previous HBSC reports and suggest that the social and cultural context in which boys and girls grow up may impact the extent to which they engage in or report specific sexual behaviours.

The data are based on individuals' self-reported behaviours. Reasons for contraceptive use (or lack of it) at last sexual intercourse were not sought. The reasons for gender differences in condom and pill use therefore should not be inferred. It may be that boys (at least in some countries and regions) are more likely to report condom use than girls, as this is one of the few methods available to boys to prevent pregnancy and sexually transmitted infections. Condom use is also traditionally regarded in many cultures as a male-dominated method – one that men should take care of *(7).* Many girls report having had sexual intercourse with partners who were older than them, especially if they had first had intercourse at an early age *(12)*, and this may affect their contraceptive choices. These assumptions warrant further qualitative studies.

Of concern is the proportion of both girls and boys who reported not knowing if they or their partner had used a condom at last intercourse. This again underlines the need for comprehensive sexuality education and the promotion of sexual literacy among adolescents. Not using a condom or not remembering if one was used might be related to adolescents having sex under the impact of alcohol *(13)*, psychoactive substances *(14)*, stealthing (removing the condom during the sexual intercourse without the recipient's knowledge and consent) *(15)*, or unwanted or nonconsensual sex *(16).*

While the lack of a gender difference in reported contraceptive pill use could reflect good communication between sexual partners, it is also possible that some boys confuse the contraceptive pill with other (long-term) forms of contraceptives that girls may use. This might also be one of the reasons why more boys than girls reported not knowing if the contraceptive pill was used at last sexual intercourse. Use of other long-term contraceptive methods is on the rise *(9)* but is not investigated in many HBSC countries and regions; data therefore are not presented here.

It is important to note that while sexual initiation for many adolescents refers to first-time penile-vaginal intercourse, this explicit definition was intentionally not provided in the questionnaire and some adolescents may have interpreted sexual initiation to include other forms of sex. The sample included adolescents attracted to (and probably having sex with) same-gender partners, which may also have impacted their reporting of condom and contraceptive pill use *(17).* For instance, in the sexual intercourse of two (cisgender) girls, neither a male condom nor the contraceptive pill will provide a relevant choice for contraception or protection against sexually transmitted infections. Similarly, if the sexual partners are two (cisgender) boys, using the contraceptive pill is not relevant to them.

The most important observed trend between 2014 and 2022 is the decline in some countries and regions in condom use among adolescents who reported having had sexual intercourse. This trend is concerning, as not using a condom exposes young people to the risk of sexually transmitted infections and – especially if no other forms of contraception are used – unintended pregnancy. The patterns highlight the urgent need to invest more in evidence-based sex education and youth-friendly sexual health services.

The declining trend in a number of countries and regions in the proportion of boys who reported having had sexual intercourse is in line with a more widespread decline in adolescent risk behaviours (including smoking, alcohol use, drug use and juvenile crime) since the early 21st century *(18).* It is also in line with the notion that today's young people may be growing up slower and are delaying taking up adult behaviours *(19).* National responses to the COVID-19 pandemic, such as the closure of schools, clubs and restaurants, may have intensified this trend by affecting young people's opportunities to form romantic relationships *(20).*

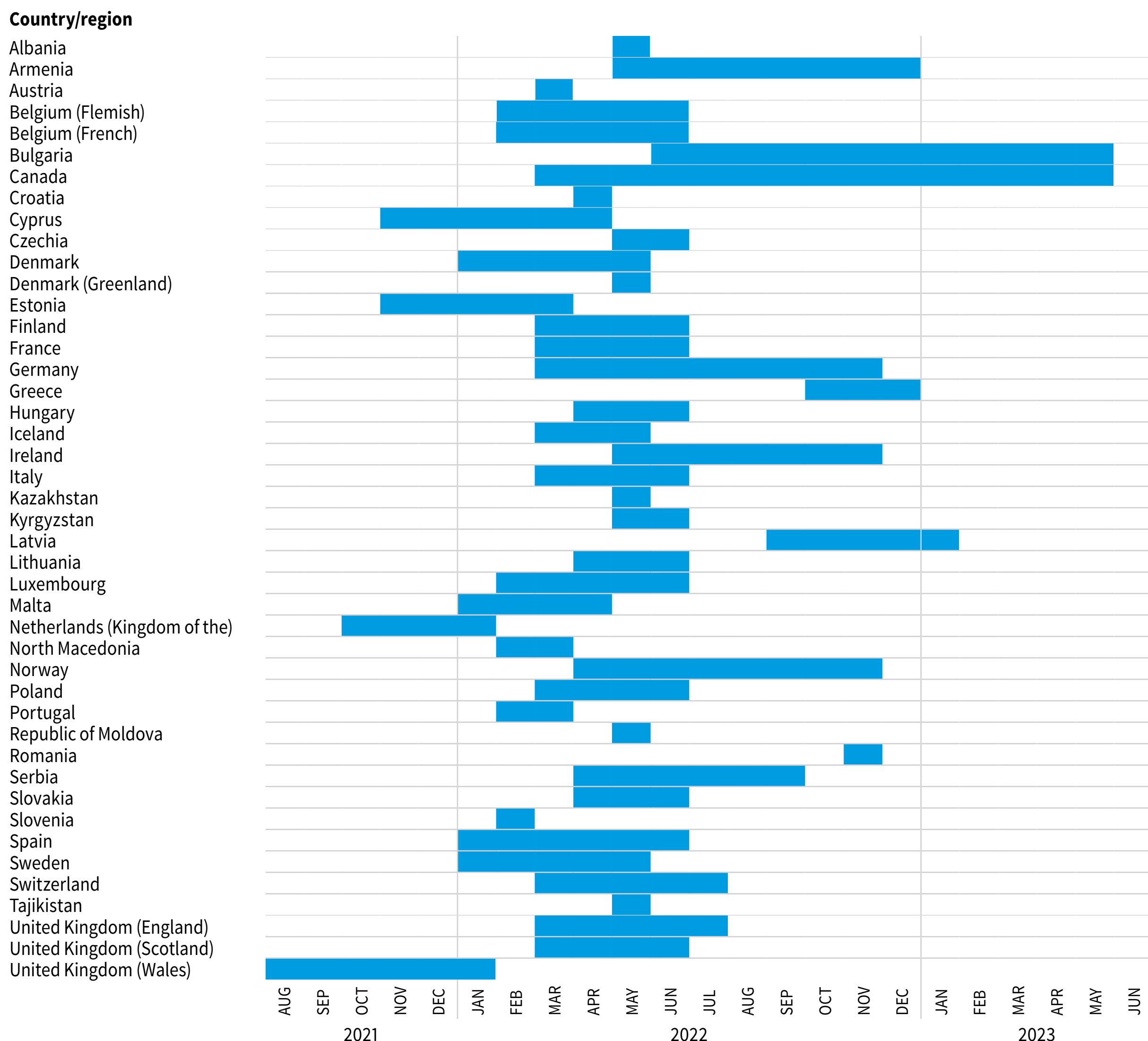
HBSC study

The HBSC study is a large school-based survey carried out every four years in collaboration with the WHO Regional Office for Europe. The study collects data on the health behaviours, health outcomes and the social environments of adolescents aged 11, 13 and 15. Since the mid-1980s, HBSC data have been used to gain new insights into young people's health and well-being, better understand the social determinants of adolescent health, and inform policy and practice to improve young people's lives.

The most recent HBSC survey (2021/2022) was conducted across 44 countries and regions in Europe, central Asia and Canada and included an optional set of questions that measured perceived impacts of the COVID-19 pandemic. Of these countries and regions, 42 included questions on sexual health in their national HBSC questionnaire.

This report presents key findings on adolescent sexual health, including issues related to gender, socioeconomic factors and changes over time. It is the fifth volume in a series of reports that presents findings from the latest international HBSC survey and discusses what they mean for young people's health and well-being. Fig. 6 shows the dates on which the 44 countries and regions conducted the survey.

Fig. 6. Dates on which the 44 countries and regions conducted the 2021/2022 HBSC survey



Note: data from Israel were collected too late for inclusion in the report. No HBSC survey was undertaken in 2021/2022 in Azerbaijan, Georgia, Türkiye and Ukraine. HBSC membership of the Russian Federation was suspended in April 2022.

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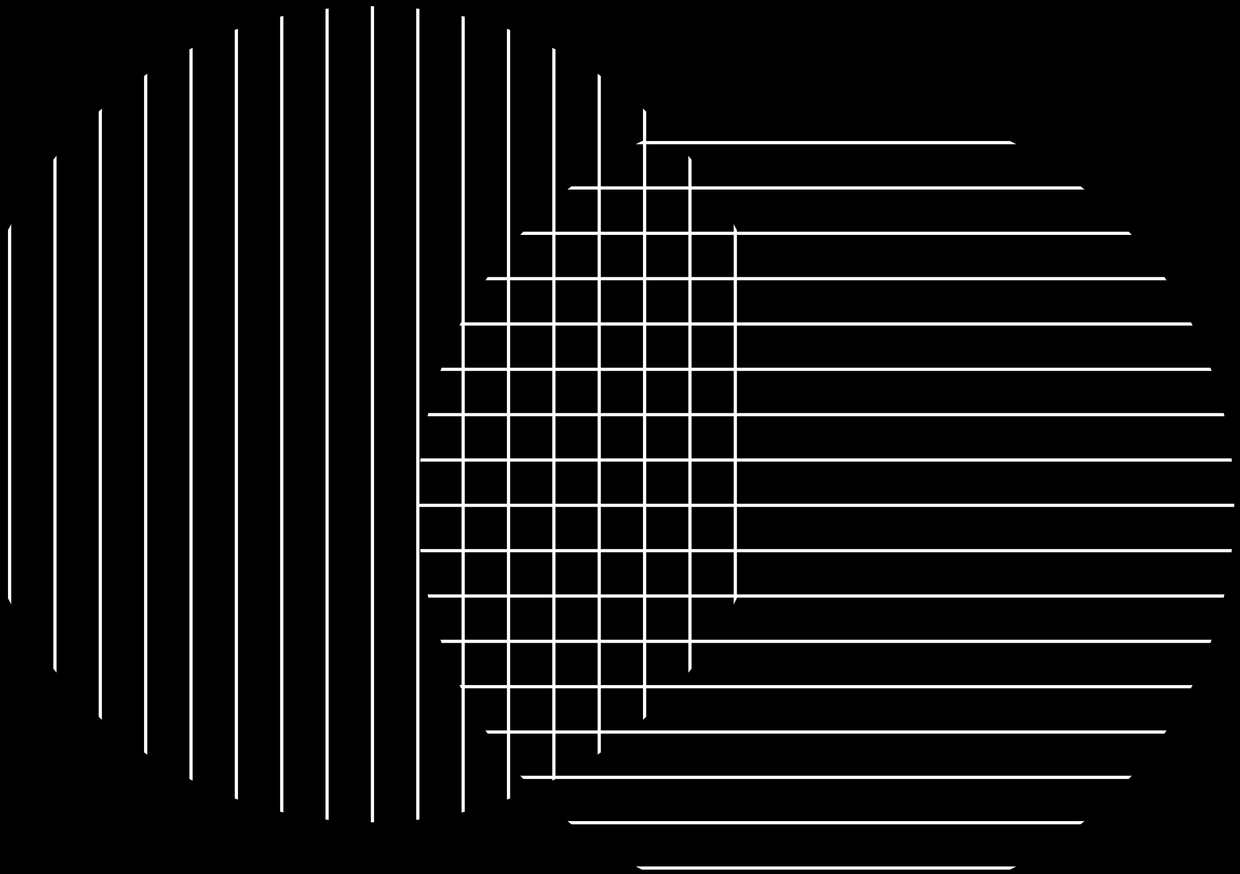
Annex



Key data

Introduction

This Annex presents the key data from the 2021/2022 Health Behaviour in School-aged Children (HBSC) study that underpin the summary of scientific findings presented in the main report – in this volume, related to adolescent sexual health.

A standard methodology for the study is used in each participating country and region. This is detailed in the HBSC 2021/2022 international study protocol *(1).*

Fieldwork took place mainly between October 2021 and June 2022. An extended fieldwork period was necessary in two countries to enable them to reach the required sample size.

Further information about the HBSC study is available online *(2).* Aggregate data from the 2021/2022 survey can be accessed as charts and tables via the HBSC data browser *(3)*, alongside comparable data from the 2017/2018 and 2013/2014 surveys where available.

Data presented

Key data on adolescent sexual health are presented disaggregated by country and region, gender and family affluence for young people aged 15 years[9] from 42 countries and regions (for sexual intercourse) and 40 (condom and contraceptive pill use) that participated in the 2021/2022 HBSC survey. Data are presented for each of the four indicators presented in this volume.

Data availability

Data are drawn from the mandatory component of the HBSC survey questionnaire, which was used in all countries and regions. Data for some indicators were not available from specific countries and regions; this is indicated in the footnotes to relevant charts.

Family affluence

Family affluence is a robust determinant of adolescent health, but children are not able to give the sort of information traditionally collected about job roles and salary that would give an indication of how rich or poor families may be.

HBSC uses the Family Affluence Scale (FAS) *(4–6)*, which asks young people about material assets in the household. The HBSC 2021/2022 survey used a six-item assessment of common material assets or activities, covering family vehicle ownership, house bedroom and bathroom/shower room capacity, holidaying abroad, and family computer and dishwasher ownership.

Responses are scored and summed to form an HBSC FAS summary score, which has been shown to provide a valid indicator of relative affluence *(4).* This summary score is used in the FAS charts to estimate relative socioeconomic position by comparing the individual's score for FAS with those of all other scores for the same gender and age group within their country or region. A relative affluence score *(6)* is then used to identify groups of young people in the lowest 20% (low affluence), middle 60% (medium affluence) (not shown in the charts in this Annex) and highest 20% (high affluence) in each country and region. This approach assesses relative, not absolute, health inequality.

9 While the wider HBSC survey includes 11-, 13- and 15-year-olds, measures on sexual behaviour are among those restricted to 15-year-olds.

Interpreting differences in prevalence

Each chart indicates where differences are statistically significant. Statistical analyses are included to help readers avoid overinterpretation of small differences. Statistical significance does not always indicate a difference that is considered important in terms of public health.

Prevalence in the charts is presented as a percentage, rounded to the nearest whole number. Average scores are presented to one decimal place.

Understanding the age–gender charts

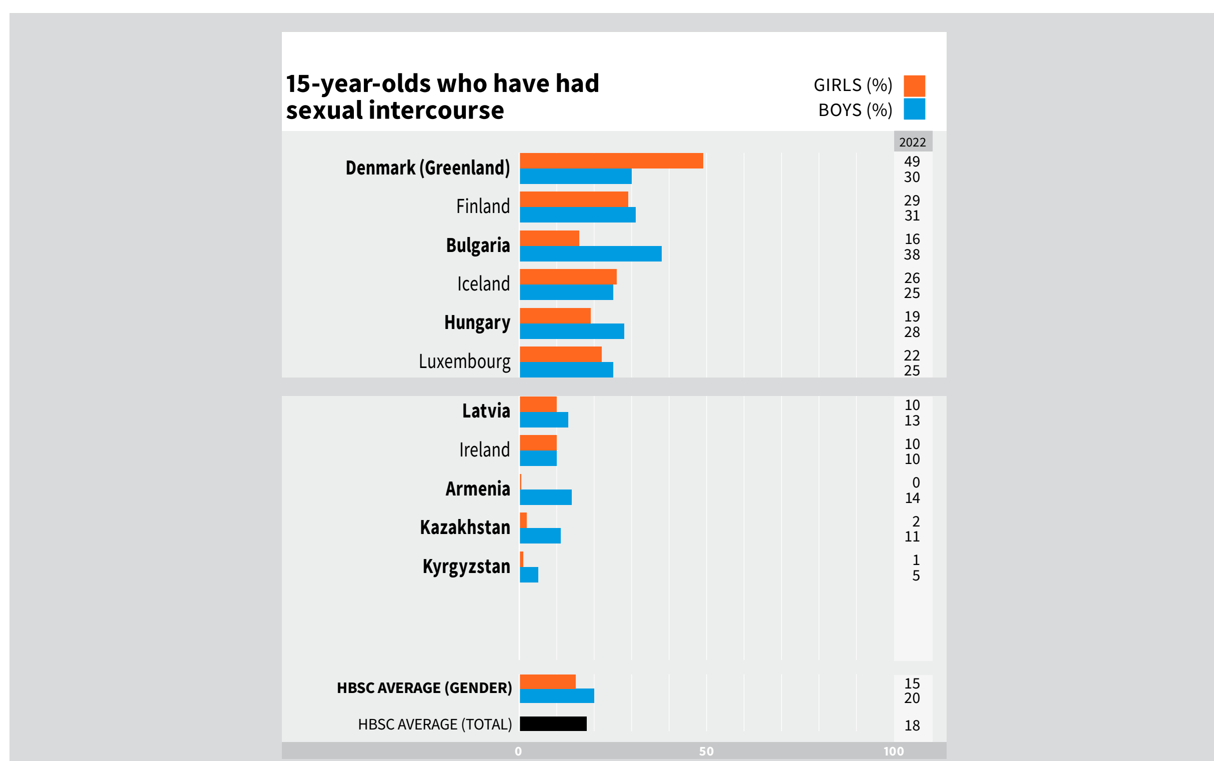
Bar charts present data for 2021/2022 for girls (orange bars) and boys (blue bars) in each age group separately for each country and region in descending order of prevalence (or average score) (for girls and boys combined). The percentage prevalence (or average score) in 2021/2022 (boys and girls separately) is also presented as a number down the right-hand edge of the charts. HBSC averages for each gender and combined are shown at the bottom of each chart.

Country/region names highlighted in bold in the age–gender charts are those in which there was a statistically significant gender difference in prevalence or average score in 2021/2022.

As an example, Fig. A1 shows that in an average HBSC country or region, 15% of 15-year-old girls and 20% of 15-year-old boys report that they have had sexual intercourse. Prevalence of having had sex is significantly higher among boys than girls in some countries and regions, including Bulgaria and Hungary, but prevalence of having had sex is significantly higher among girls than boys in Denmark (Greenland) (49% of 15-year-old girls and 30% of 15-year-old boys reporting having had sex).

For design reasons, the measures used to elicit the data from participants are described on the second (right-hand) page of each indicator spread.

Fig. A1. Example of age–gender bar chart



Understanding the family affluence charts

Charts of prevalence by FAS group illustrate the relationship between family affluence and each adolescent sexual health indicator. The FAS charts show the prevalence (or average score) of the indicators in the most affluent 20% of adolescents in each country or region (a solid circle) and the least affluent 20% (an open circle). The data are presented for each country and region for boys (blue circle) and girls (orange circle) separately, combined across the three age groups.

Prevalence (or average score) in the least and most affluent groups is linked by a line, the length of which indicates the difference in prevalence (or average score) between the two groups. HBSC averages for each affluence group are presented by gender at the bottom of the charts. The overall prevalence (or average score) for the indicator, combined over age groups and gender, is given as the final point at the bottom of the charts (black and white circle) and is shown as a line along the length of the charts.

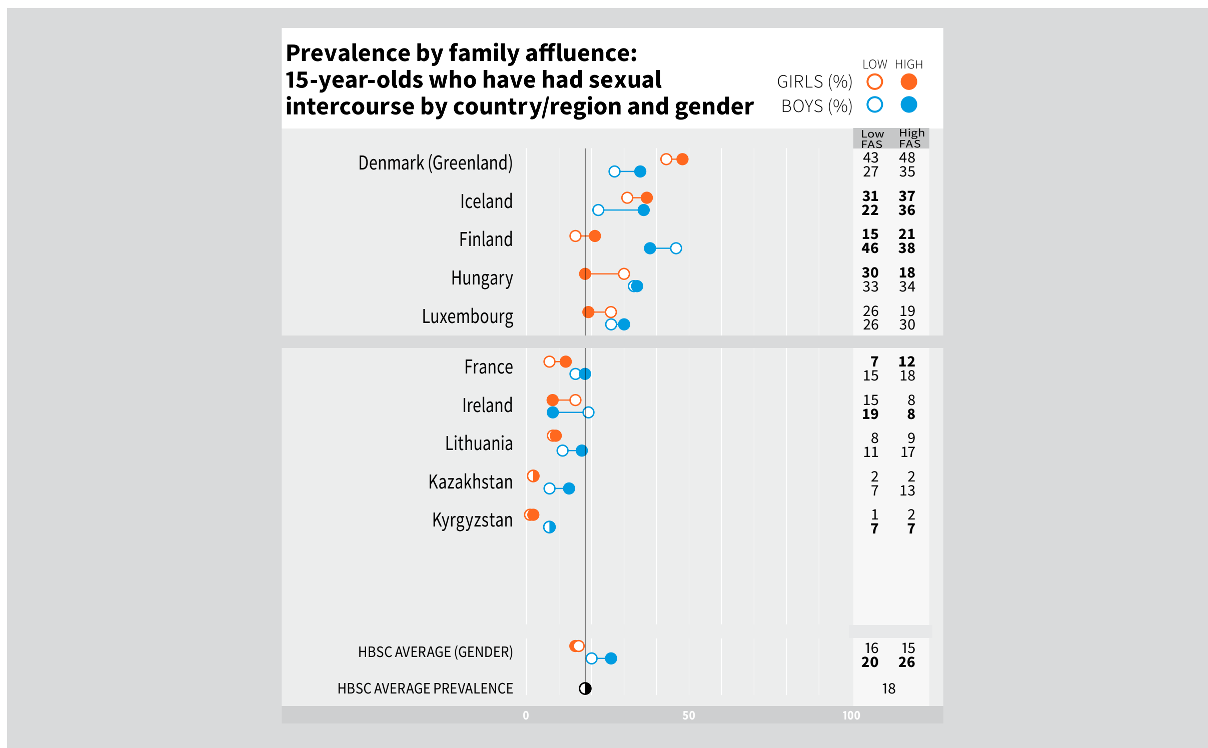
Countries and regions are ordered on the FAS charts by prevalence (or average score) averaged across genders.

Significance of differences in prevalence (or average score) by family affluence are indicated by the figures for prevalence (or average score) being bolded. Prevalence of the medium-affluence group is not presented in the charts, but the data from all three FAS groups are used when carrying out statistical analysis.

Significance is only marked where there is a linear trend in prevalence across the three groups. This may mean that some differences in prevalence that look large between the low- and high-affluence groups may not be marked as significant if, for example, the prevalence in the medium-affluence 60% is lower or higher than both presented numbers.

Fig. A2 presents an example family affluence chart. It shows that for some countries and regions, high-affluence boys and girls have higher prevalence of reporting having had sex than young people from low-affluence families. In Iceland, for example, 36% of boys in the 20% most affluent households report having had sex, while only 22% of boys in the 20% least affluent households do so. Prevalence of reporting having had sex is lower in Ireland (near the bottom of the chart), which is one of the few countries where prevalence of having had sex is significantly higher among low-affluence boys (19%) than high-affluence boys (8%).

Fig. A2. Example of family affluence chart



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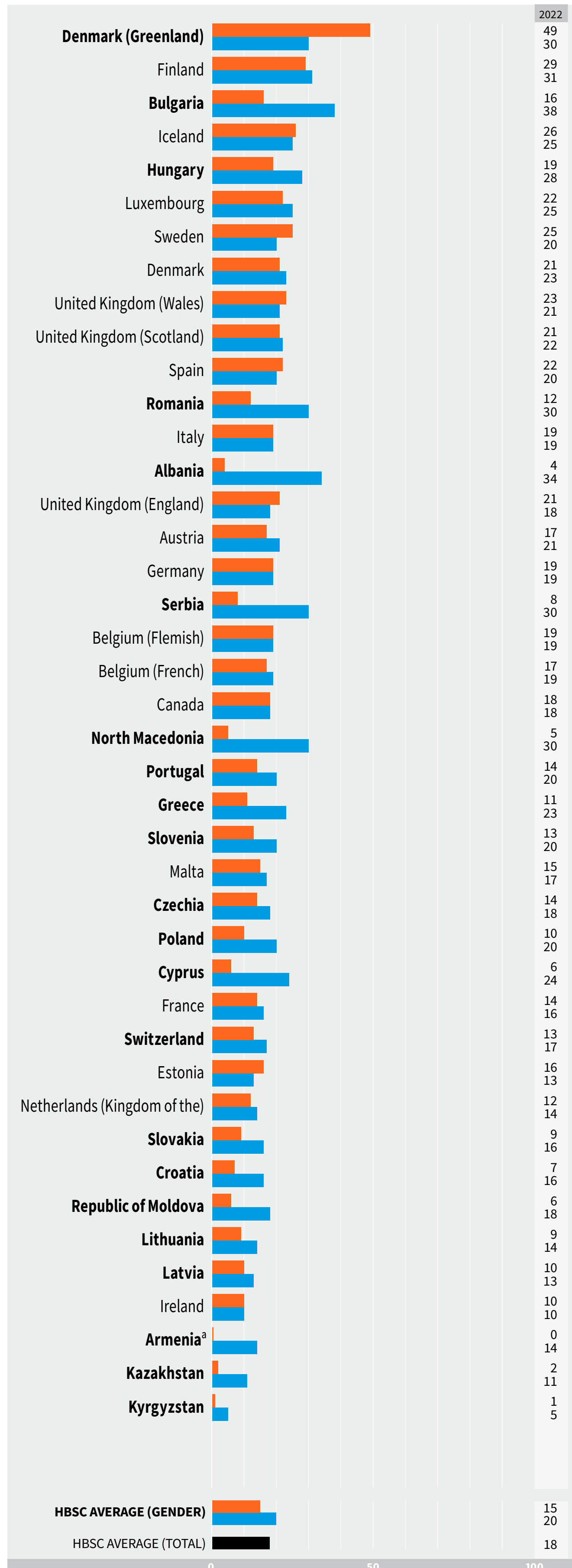
Sexual intercourse

MEASURE: 15-year-olds only were asked whether they had ever had sexual intercourse. The question was presented using colloquial terminology (such as "having sex") to ensure respondents understood it was about full penetrative sex. Findings presented here show the proportions who responded yes to having had sexual intercourse.

15-year-olds who have had sexual intercourse

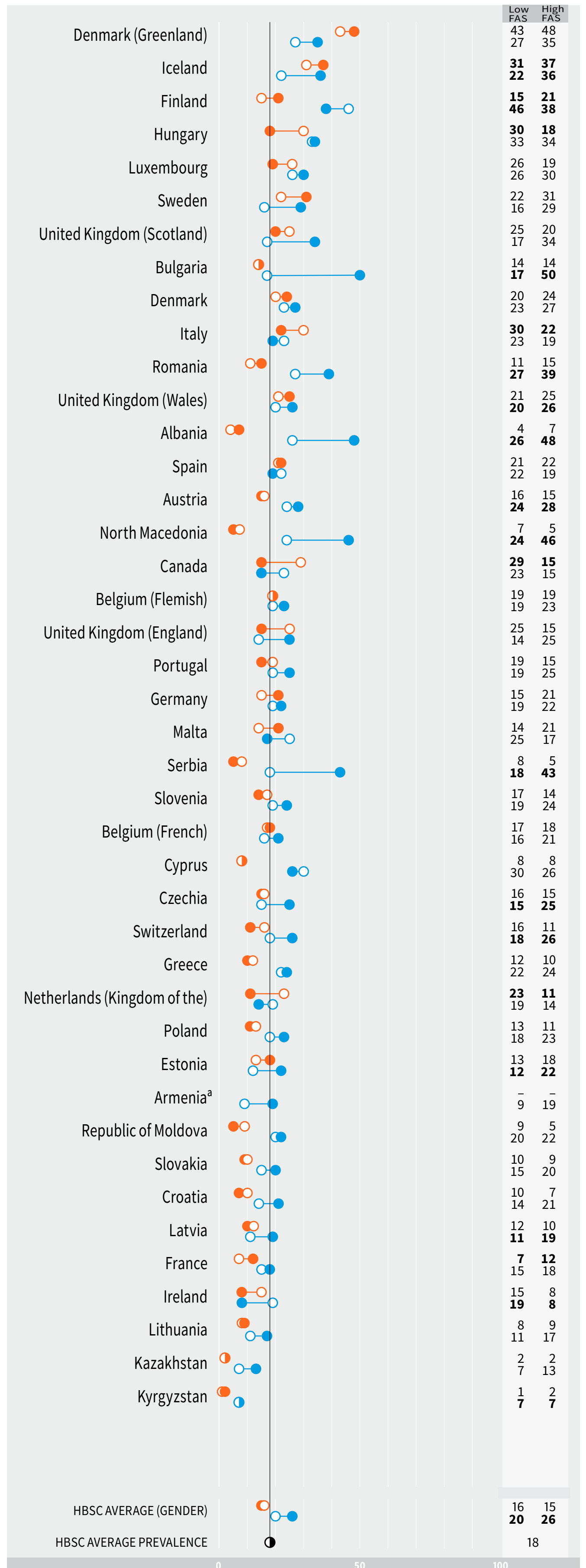
GIRLS (%) BOYS (%)



[a]Girls: < 0.5%. *Note:* country/region name in **bold** indicates a significant gender difference (at $P < 0.05$). No data were received from Norway and Tajikistan.

Prevalence by family affluence: 15-year-olds who have had sexual intercourse by country/region and gender

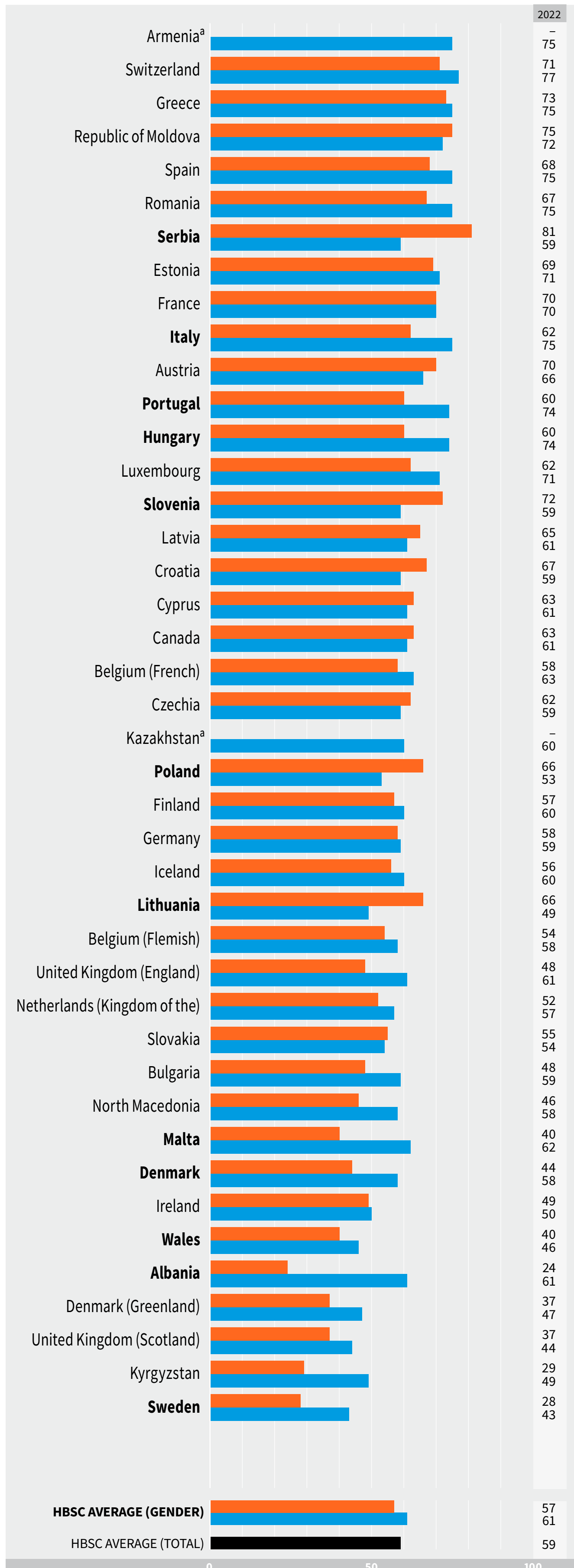
LOW HIGH
GIRLS (%) BOYS (%)



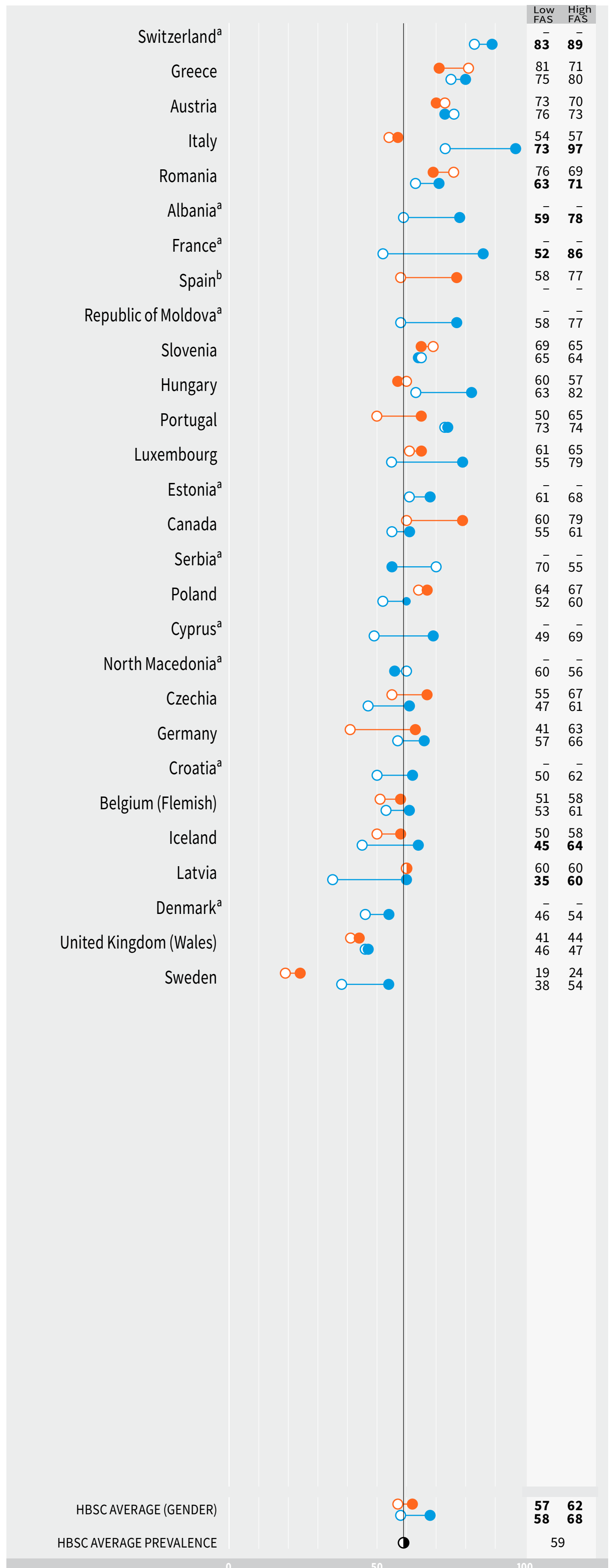
FAS: Family Affluence Scale. [a]Girls: < 0.5%. *Note:* **bold** indicates a significant difference in prevalence by family affluence group (at $P < 0.05$). Low- and high-affluence groups represent the lowest 20% and highest 20% in each country/region. No data were received from Norway and Tajikistan.

Condom use at last sexual intercourse

MEASURE: 15-year-olds who have had sex were asked whether they or their partners had used a condom at their last sexual intercourse. Findings presented here show the proportions who responded yes to this question.



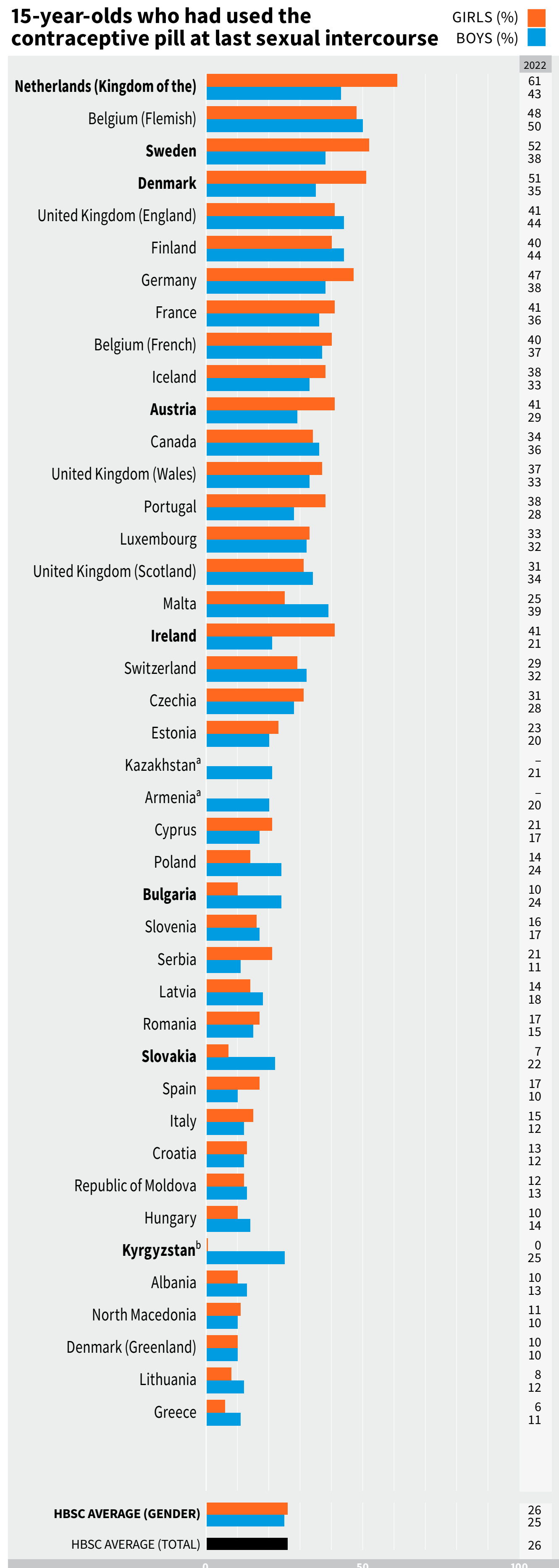
[a]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. *Note:* country/region name in **bold** indicates a significant gender difference (at $P < 0.05$). No data were received from Norway and Tajikistan.



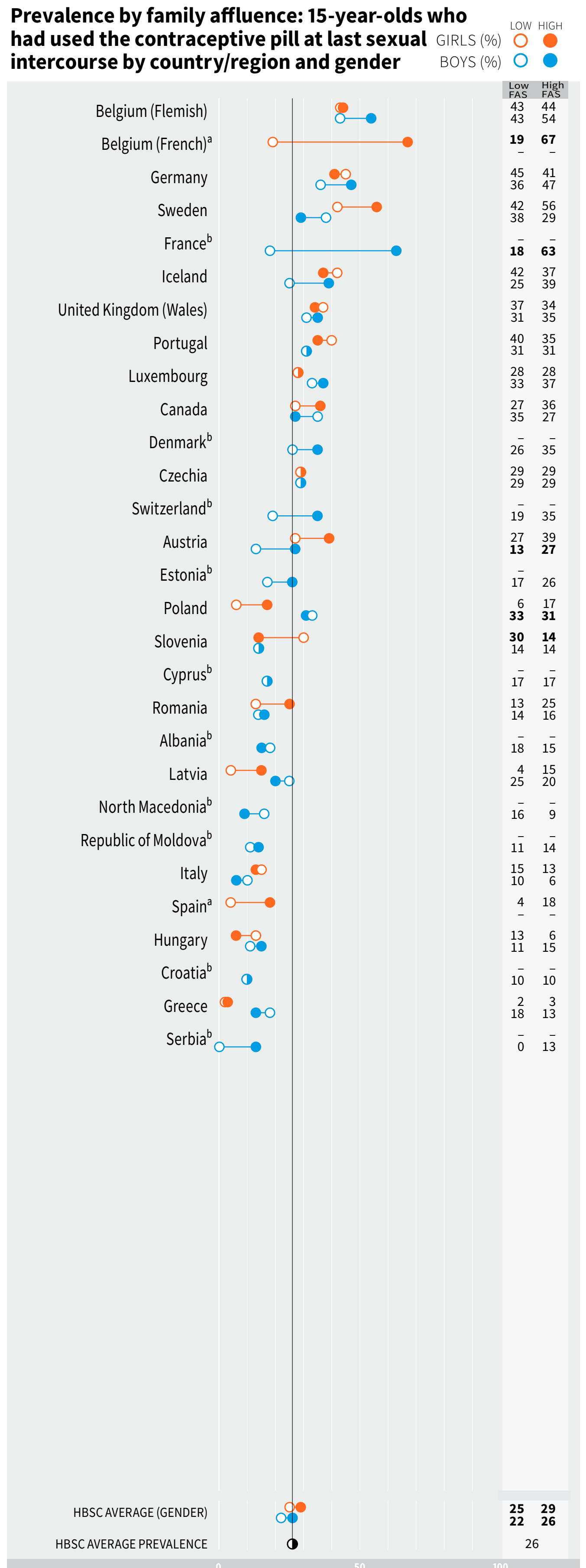
FAS: Family Affluence Scale. [a]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. [b]Data are not presented for boys as numbers reporting were too low for a reliable estimate of prevalence. *Note:* **bold** indicates a significant difference in prevalence by family affluence group (at $P < 0.05$). Low- and high-affluence groups represent the lowest 20% and highest 20% in each country/region. The following countries and regions provided data for girls and boys but in insufficient quantities to enable prevalence to be established: Armenia, Belgium (French), Bulgaria, Denmark (Greenland), Finland, Ireland, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Netherlands (Kingdom of the), Slovakia, United Kingdom (England) and United Kingdom (Scotland). No data were received from Norway and Tajikistan.

Contraceptive pill use at last sexual intercourse

MEASURE: 15-year-olds who have had sex were asked whether they or their partner had used the contraceptive pill at their last sexual intercourse. Findings presented here show the proportions who responded yes to this question.



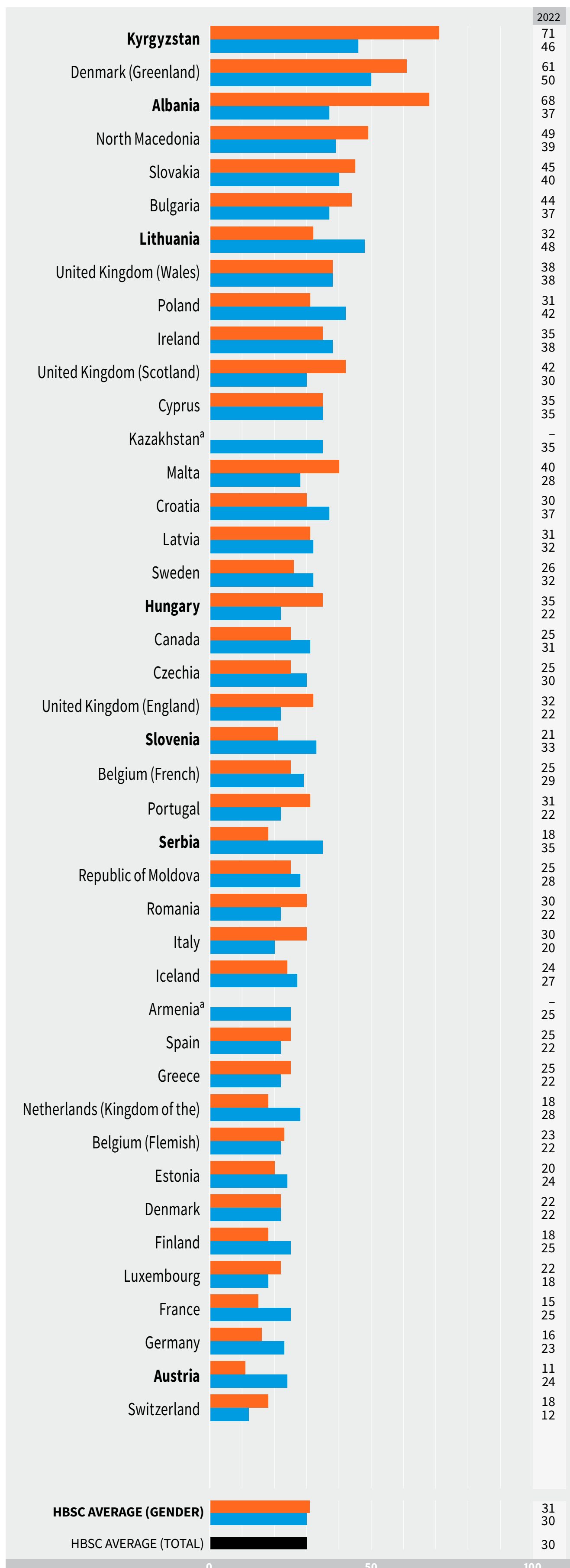
[a]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. [b]Girls: < 0.5%.
Note: country/region name in **bold** indicates a significant gender difference (at *P* < 0.05). No data were received from Norway and Tajikistan.



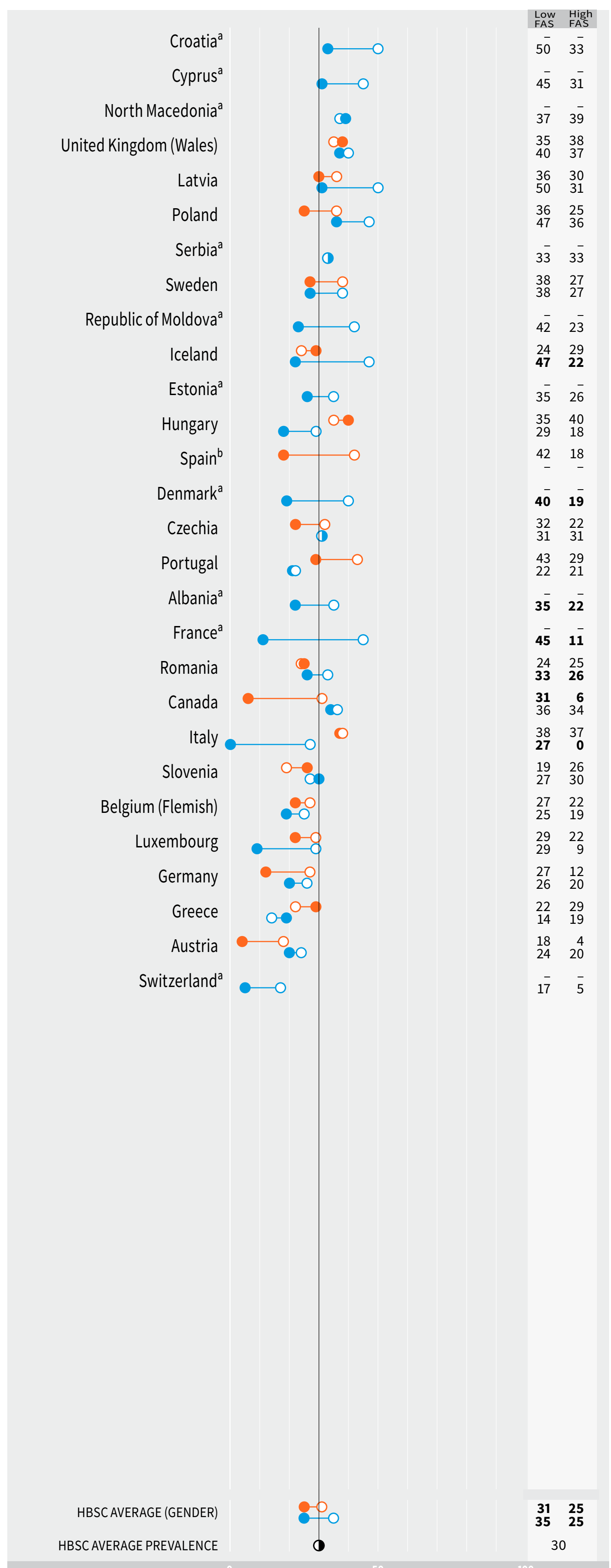
FAS: Family Affluence Scale. [a]Data are not presented for boys as numbers reporting were too low for a reliable estimate of prevalence. [b]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. *Note:* **bold** indicates a significant difference in prevalence by family affluence group (at *P* < 0.05). Low- and high-affluence groups represent the lowest 20% and highest 20% in each country/region. The following countries and regions provided data for girls and boys but in insufficient quantities to enable prevalence to be established: Armenia, Belgium (French), Bulgaria, Denmark (Greenland), Finland, Ireland, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Netherlands (Kingdom of the), Slovakia, United Kingdom (England) and United Kingdom (Scotland). No data were received from Norway and Tajikistan.

Neither condom nor contraceptive pill use at last intercourse

MEASURE: 15-year-olds who have had sex were asked whether they or their partner had used a condom or the contraceptive pill at their last sexual intercourse. Findings presented here show the proportions who reported that they or their partners had used neither a condom nor the contraceptive pill at their last sexual intercourse.



[a]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. *Note:* country/region name in **bold** indicates a significant gender difference (at $P < 0.05$). No data were received from Norway and Tajikistan.



FAS: Family Affluence Scale. [a]Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. [b]Data are not presented for boys as numbers reporting were too low for a reliable estimate of prevalence. *Note:* **bold** indicates a significant difference in prevalence by family affluence group (at $P < 0.05$). Low- and high-affluence groups represent the lowest 20% and highest 20% in each country/region. The following countries and regions provided data for girls and boys but in insufficient quantities to enable prevalence to be established: Armenia, Belgium (French), Bulgaria, Denmark (Greenland), Finland, Ireland, Kazakhstan, Kyrgyzstan, Lithuania, Malta, Netherlands (Kingdom of the), Slovakia, United Kingdom (England) and United Kingdom (Scotland). No data were received from Norway and Tajikistan.

No condom use at last sexual intercourse

MEASURE: 15-year-olds who have had sex were asked whether they or their partner had used a condom at their last sexual intercourse. Findings presented here show the proportions who reported that they or their partner had **not** used a condom at their last sexual intercourse, or they **did not know** if they or their partner had used a condom.

15-year-olds who ...	**did not use a condom at last sexual intercourse**		**did not know if they or their partner used a condom at last sexual intercourse**	
Country/region	BOYS (%)	GIRLS (%)	BOYS (%)	GIRLS (%)
Albania	31	56	8	20
Armenia[a]	14	–	11	–
Austria	25	28	9	2
Belgium (Flemish)	33	42	9	4
Belgium (French)	28	39	9	3
Bulgaria	26	27	15	25
Canada	33	35	6	2
Croatia	30	25	12	8
Cyprus	19	28	20	9
Czechia	30	30	11	8
Denmark	40	56	3	1
Denmark (Greenland)	42	59	11	4
Estonia	22	28	7	3
Finland	33	40	7	3
France	23	27	7	3
Germany	31	37	10	5
Greece	18	23	8	4
Hungary	19	36	7	4
Iceland	31	41	10	3
Ireland	44	49	6	2
Italy	23	38	2	< 0.5
Kazakhstan[a]	26	–	14	–
Kyrgyzstan	47	33	4	38
Latvia	26	28	13	7
Lithuania	37	24	14	11
Luxembourg	25	33	4	5
Malta	28	53	10	6
Netherlands (Kingdom of the)	31	47	11	1
North Macedonia	31	32	11	22
Poland	29	22	17	12
Portugal	17	33	9	7
Republic of Moldova	16	17	13	8
Romania	20	26	6	7
Serbia	28	14	13	5
Slovakia	35	33	11	12
Slovenia	30	25	12	3
Spain	17	30	8	2
Sweden	48	68	9	4
Switzerland	22	28	1	1
United Kingdom (England)	39	53	< 0.5	< 0.5
United Kingdom (Scotland)	52	56	4	7
United Kingdom (Wales)	49	56	5	4
HBSC total	**30**	**36**	**9**	**7**

[a] Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. *Note:* no data were received from Norway and Tajikistan.

No pill use at last sexual intercourse

MEASURE: 15-year-olds who have had sex were asked whether they or their partner had used the contraceptive pill at their last sexual intercourse. Findings presented here show the proportions who reported that they or their partner had **not** used the contraceptive pill at their last sexual intercourse, or they **did not know** if they or their partner had used the contraceptive pill.

15-year-olds who ...	**did not use the contraceptive pill at last sexual intercourse**		**did not know if they or their partner used the contraceptive pill at last sexual intercourse**	
Country/region	BOYS (%)	GIRLS (%)	BOYS (%)	GIRLS (%)
Albania	66	66	20	24
Armenia[a]	63	–	18	–
Austria	55	58	17	< 0.5
Belgium (Flemish)	34	50	16	2
Belgium (French)	43	56	20	4
Bulgaria	56	75	20	15
Canada	50	64	14	2
Croatia	68	82	20	5
Cyprus	56	70	26	9
Czechia	46	66	25	3
Denmark	47	49	18	1
Denmark (Greenland)	38	88	52	2
Estonia	63	72	16	5
Finland	45	56	10	4
France	49	57	15	1
Germany	49	51	14	2
Greece	77	93	12	2
Hungary	65	86	21	4
Iceland	48	60	19	2
Ireland	73	59	6	< 0.5
Italy	81	85	7	< 0.5
Kazakhstan[a]	58	–	21	–
Kyrgyzstan	57	61	18	39
Latvia	61	81	21	5
Lithuania	67	86	22	6
Luxembourg	48	63	20	3
Malta	46	63	15	12
Netherlands (Kingdom of the)	38	37	20	2
North Macedonia	57	62	33	27
Poland	55	74	21	13
Portugal	50	60	22	2
Republic of Moldova	53	73	34	15
Romania	68	72	17	11
Serbia	74	73	15	5
Slovakia	62	90	16	2
Slovenia	70	84	14	1
Spain	74	82	16	1
Sweden	43	46	18	2
Switzerland	59	70	10	1
United Kingdom (England)	56	59	< 0.5	< 0.5
United Kingdom (Scotland)	54	65	12	4
United Kingdom (Wales)	55	61	12	2
HBSC total	**57**	**68**	**18**	**6**

[a] Data are not presented for girls as numbers reporting were too low for a reliable estimate of prevalence. *Note:* no data were received from Norway and Tajikistan.

The WHO Regional Office for Europe

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