

Foreign-born Children in Europe: An Overview from the Health Behaviour in School-Aged Children (HBSC) Study

International Organization for Migration (IOM)

Background Paper

*Developed within the framework of the IOM project
“Assisting Migrants and Communities (AMAC): Analysis of
Social Determinants of Health and Health Inequalities”
Co-funded by the European Commission DG Health and Consumers’ Health Programme,
the Office of the Portuguese High Commissioner for Health and IOM*



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Executive Summary

Introduction

The background paper presented here is based on findings from the Health Behaviour in School-Aged Children (HBSC) Study. The HBSC research network is an international, multidisciplinary alliance of researchers working together since 1982. In 2005/6, 41 countries and regions in Europe and North America collected data as part of the HBSC Study. The overall aim of the study is to gain new insights and increase understanding of adolescent health behaviour. Twelve countries of the network (Flemish-speaking Belgium, Germany, Denmark, Spain, Greece, Ireland, Iceland, Italy, Scotland, Sweden, Wales and Portugal) included questions on children's immigration status and these are included in the situation analysis of this paper. Additionally, five of these countries provided in-depth national case studies.

Situation Analysis

The proportion of child immigrants in the participating countries ranged from 4% in Wales to 11% in Ireland. In all countries, child immigrants were similar to their native peers in relation to age and gender distribution; however, in all countries, child immigrants were more likely to live in low socio-economic households. No clear cross-national patterns are found in relation to general health, relationship with parents and friends, school perceptions or involvement in risk behaviours. In some countries child immigrants fared better than their native peers; in other they are similar to their peers, and in some they fare worse.

National Case Studies

The background paper includes five national case studies, allowing for a more detailed analysis of child immigrants' experiences. Iceland has analysed cultural and linguistic predictors of difficulties in school and of involvement in risk behaviours among child immigrants. Ireland reviewed health inequalities in three groups of children in Ireland: child immigrants from the UK, child immigrants from non-UK countries and children from the Irish Traveller communities. Italy explored risk behaviour in immigrant children and the effect of family monitoring on such behaviours. Portugal looked at nationality versus poverty, looking at findings and recommendations regarding interventions on migrant adolescents. Finally, Spain focused on policies and practices for migrant children.

Conclusions

The findings highlight mainly two different issues. The first is that child immigrants across the board are more likely to live in low socio-economic households, and thus are more disadvantaged than their native peers. Child immigrants are also at a higher risk for social exclusion. The second issue is the lack of one clear message regarding child immigrants' health and experiences. Findings in this paper highlight the complexity of the immigration phenomenon and its different aspects predicting health and health behaviour (e.g. country of origin, country of residence, fluency in the language of country of residence and more). These findings strongly stress the need for more focused studies on child immigrants, looking at different groups, at country of origin and country of residence, potentially by comparing specific immigrant groups across countries.



Introduction

Facts, figures and migration trends in EU countries – brief review

Immigration is a world-wide phenomenon, involving many millions of people and most countries (United Nations, 2002). In 2006, an estimated 3.5 million people settled as new residents in the 27 EU countries, with the largest increase in immigration evident in Spain and Ireland. The majority of the new residents were from non-EU countries. Of these immigrants, more than half were younger than 29 years of age, and there are more men than women (Herm, 2008).

In some countries, the percentage of migrants is as low as 1%, while nearly 40% is reported as the highest proportion of migrants in one EU country. Western European countries report levels of 10–15% of the total population. In terms of numbers, the largest populations of migrants are found in five countries: Germany (10.1 million), France (6.5 million), the United Kingdom (5.4 million), Spain (4.8 million) and Italy (2.5 million) (Gushulak, Pace, Weekers, in press).

Immigrant children – literature review

There are many definitions used to define children as immigrants but the two most common definitions are first and second generation immigrants. Children are defined as first generation immigrants if they were not born in the country of residence (foreign-born), and as second generation immigrants if one or two of their parents were not born in the country of residence, even if they are born in that country. In both cases, children are imposed with the process of immigration which can be rather challenging: immigrants leave their homeland and settle in a new country, often with different norms and morals, and need to adapt to a sometimes markedly different culture and socioeconomic conditions, often facing discrimination and racism (Pantin et al., 2003; Berry, 1997; Ward, Bochner, & Furnham, 2001). It is therefore important to study the experiences of immigrant children. Most of the studies on this age group were conducted in the US and Canada, with fewer studies conducted in Europe (Stevens et al., 2003; Vollebergh et al., 2005; Storhmeier & Schmitt-Rodermund, 2008). Studies on child immigrants mostly described their socio-demographics circumstances, and involvement in risk behaviours, language fluency, school performance and mental health of these children, compared to native children.

All the literature on child immigrants points towards the overall poor living circumstances experienced by this group. A review of immigrant children in the US revealed that 54% of immigrant children live in low-income households compared to 36% of natives, with

parental wages being substantially lower than those of parents of native children. Immigrant children are also more exposed to food insecurity, crowded housing, and are less likely to have medical insurance. Having no legal status, some immigrants are also less likely to receive cash welfare compared to native children (The Urban Institute, 2006). These findings were echoed in Hernandez et al.'s study (2008), adding that immigrant children tend to live with both parents, with siblings and with other relatives, and their fathers tend to have lower level of education and lower paying jobs. Similar findings have been reported among immigrant children in the Netherlands (Vollebergh et al., 2005).

Another issue that is commonly addressed in relation to child immigrants is the level of fluency in the language spoken in the host country. US studies show that immigrant children are very likely to be fluent in English and become bilingual. However, approximately one fourth of child immigrants live in households with no one over age 13 being fluent in English (Hernandez et al., 2008). These children may experience a high degree of isolation from English-speaking society. These children also act as the primary intermediary between adult family members and professionals in various settings, a role that may expose them to more stress (Hernandez et al., 2008). The language spoken in the home appears to have a direct influence on the well-being of immigrant youth, although the pattern is not clear. Gonzales et al. (2006) found that among Mexican immigrant adolescents, speaking English at home predicted behavioural and emotional problems; while Yu et al. (2003) found that US adolescents are more likely to be bullied if they do not speak English at home.

The process of migration is not an easy one, according to various studies assessing child immigrants' mental health. Child immigrants are usually compared to either native children, or children of the same age group in the country of origin. In Italy, one study concluded that immigrant children experienced more psychosomatic symptoms and reported lower levels of life satisfaction; self-reported health; social integration; and victimization compared to their native peers (Vieno et al., 2009). Another study explored the mental health of Turkish immigrants in the Netherlands. The study found that compared to Dutch Children, Turkish immigrant children were more likely to report behavioural problems, both internalised and externalised, with depression as the leading problem. Immigrant boys presented more attention problems, delinquent behaviours and aggressive behaviour. Girls presented more somatic complaints, anxious/depression, and withdrawn behaviour. However, when compared to children of the same age group in Turkey, Turkish immigrant children in

the Netherlands had similar levels of mental/behavioural problems but scored higher on a competence scale (Bengi-Arslan et al., 1997). This was echoed in the work of Janssen and colleagues (2004).

Other studies in the Netherlands that did not focus on Turkish immigrants, did not find differences in the mental health of immigrants compared to their native peers (Vollebergh et al., 2005). Similarities between child immigrant and native peer were also reported in Canada (Ma, 2002), Australia (Davies & McKelvey, 1998) and the US (Blake et al., 2001; Beiser et al., 2002). This lack of differences between immigrant children their peers is known as the “immigrant paradox” (Fuligni, 1998; Gracia Coll, 2005; Berry et al., 2006). The immigrant paradox refers to lack of differences between immigrant children and their native peers, or to immigrant children faring better than native peers in relation to psychological and socio-cultural adaptation (Beiser et al., 2002; Crosnoe, 2005; Harker, 2001; Mullan Harris, 1999; Acevedo-Garcia et al., 2005; Georgiades et al., 2006; Sampson, Morenoff, & Raudenbush, 2005), despite being exposed to worse-off socio-economic circumstances (Beiser et al., 2002; Heisz & McLeod, 2004; Schellenberg, 2004).

Interestingly, it is immigrants’ parents that are worried about the mental health of their children, as, irrespective of other evidence, they perceive their children to be at higher risk for marginalisation (Vollebergh et al., 2005). Storhmeier & Schmitt-Rodermund (2008) summarised this aspect of immigrant children lives, stating that immigration experience per se does not necessarily lead to adaptation problems.

Case studies produced through an evidence review process on “Social cohesion for mental wellbeing among adolescents”, facilitated by the WHO Regional Office for Europe and partners including the HBSC network, explored the relation between mental well-being and socioeconomic status, gender, migrant status, geography and family structure. The studies from Germany, Portugal, Moldova and Spain explored issues related to migrant children’s mental health and wellbeing; some of these findings are further elaborated in the next section of this paper. The above-cited work highlights the importance of studying several risk factors occurring simultaneously (e.g. low socioeconomic status, one-parent household, migrant status with lesser levels of social cohesion) in relation to mental wellbeing (WHO Regional Office for Europe, 2008).

It is also important to note that when problems in adaptation and delinquent behaviour among immigrant youth do exist, they appear to be strongly moderated by levels of social cohesion, exposure to discrimination/exclusion based on ethnicity (or conversely, similar ethnic background), fluency in the language of the country of residence, the norms and expectations in the country of origin and in

the country of residence, and the actual process of adaptation. Being fully integrated into the new society does not necessarily lead to fewer problems among adolescents. Research among Lebanese immigrants in Canada showed that those with a strong Lebanese national identity experienced less depression and fewer problems in daily life compared to those with a strong Canadian national identity (Gaudet et al., 2005). Greater adaptation to American culture was associated with increased sexual risk-taking among Russian immigrant girls in the United States (Jeltova et al., 2005). A cross-national study of Turkish immigrants found that fluency in Turkish and a strong Turkish identity were associated with fewer behavioural problems in Sweden but not in the Netherlands (Vedder & Virta, 2005). The researchers explained these results referring to the differences in immigration policies between these two countries: while Swedish immigration policies emphasise strengthening the ethnic roots of immigrants, policies in the Netherlands emphasise adaptation to Dutch language and culture.

As with mental health, findings in relation to involvement in risk behaviours are divided: immigrant children in the US and Canada, even when living in families with lower socioeconomic status, are less likely to smoke, drink, use drugs or engage in delinquent behaviour, as described by the “immigrant paradox” (Georgoades, 2006; Haris, 2004). However, Russian immigrant youth in Israel, for example, report higher rates of substance use compared to their native peers (Israelowitz & Slonim-Nevo, 2002). Such findings were also previously reported by Bengi-Arslan et al., (1997) and by Pawliuk et al. (1996).

Another aspect of migrant children lives that has been explored is academic achievement and attainment. Here also, findings vary between countries of origin and countries of residence. In general, students from low- and middle-income countries and politically unstable countries tend to do worse in school compared to their native peers (Levels, Dronkers & Kraaykamp, 2008). However, in many Western countries, students of Asian background have better academic achievements than their native peers. This has been reported in Finland (Liebkind et al., 2004), Australia (Cardak & McDonald, 2004) and the United States (Glick & White, 2004). Latino students in the US, on the other hand, have rather consistently been found to perform worse in school (Harris et al., 2008). To complicate things further, immigrant youth in Sweden are disproportionately represented among both high-achieving students and among early school leavers (Westin, 2003).

Although many studies on immigrant children were conducted in the US and Canada, much less is known on immigrant children in European countries (Stevens et al., 2003; Vollebergh et al., 2005; Storhmeier & Schmitt-Rodermund, 2008). Even fewer studies have



presented international comparisons. One effort to make such comparisons was carried out by Berry and colleagues (2006) examining immigrant children in 13 countries. However, the samples per country were very small. Using data from the 2006 Health Behaviour in School-Aged Children (HBSC) Study, this background paper presents a situation analysis of immigrant children in a number of countries in Europe, supplemented by more in-depth studies undertaken in five of the HBSC countries. The situation analysis will explore child immigrants' relationship with parents and peers, school perceptions and involvement in risk behaviour compared to their native peers. The situation analysis will also explore differences in age, gender and family affluence between immigrant children and their native peers in the twelve participating countries. The case studies that follow provide a more in-depth exploration of HBSC data in five countries, allowing for a better understanding of the experiences of child immigrants in those countries. The background paper will then discuss the results of the situation analysis and of the five case studies and will draw conclusions and highlight gaps in knowledge.

Situation Analysis

Overview of the HBSC Study

The HBSC research network is an international alliance of researchers and research teams from different disciplines including sociology, pedagogy, paediatrics, psychology, epidemiology, clinical medicine, human biology and public health. The alliance dates from 1982, when researchers from three countries (England, Finland and Norway) agreed to develop and implement a shared research protocol to survey schoolchildren with the aim of collaborating cross-nationally. By 1983, researchers from Austria and Denmark had joined, and the HBSC Study was adopted by the WHO Regional Office for Europe as a collaborative study. The early success of the study led to an agreement to continue to survey schoolchildren on a cyclical basis. The next survey round, conducted in the academic year 1985/86, included a total of 13 countries. Independent cross-sectional surveys have continued every four years since that time. In 2005/6, 41 countries and regions in Europe and North America collected data as part of the HBSC Study. The overall aim of the study is to gain new insights and increase understanding of adolescent health behaviour.

In recent years, there has been an increased emphasis on adolescents' perceptions of the social environments in which young people live, which can influence health and health behaviour. The following aspects of the social environment are explored:

- Family: communication with parents;
- Family: monitoring style;
- Peers: close friendships;
- Peers: evenings with friends;
- Peers: electronic media contact;
- School: liking school;
- School: perceived school performance;
- School: pressured by schoolwork;
- School: classmate support;
- School: participation in decision making.

In recent years, the emphasis on inequalities has also increased. The study permits disaggregation of data by gender, age, geography, socioeconomic status and, in some cases, by foreign-born status (Currie et al, 2008). The crossing of these variables by health, health behaviour and risk behaviour allows for the identification of health inequalities and health inequities.¹ As such, the study can provide useful insight to social determinants of health inequities. A focus on the adolescent age group is an important part of a life-course approach to health inequities, and HBSC data can be used in this context.

The HBSC study is the product of the international network of researchers who work on topic-focused groups and collaborate to develop the conceptual underpinnings of the study, identify research questions, decide the methods and measurements to be employed and work on data analyses and the dissemination of the findings. The evidence produced from HBSC is therefore able to inform a wide range of policy and practice agendas.

Methods

The international questionnaire is developed by the network in English and is subsequently translated into national and sub-national languages. Questionnaires are then translated back to English for checking by the International Coordinating Centre. The questionnaires are self-administered in classrooms with methods to ensure confidentiality and anonymity. Sampling is conducted in accordance with the structure of the national education systems within countries and is sometimes stratified by region or school type. The sampling unit in this study is school class or the whole school where a sample frame of classes is not available. The non-independence of students within a classroom is considered in the procedures for sample-size calculation. Children aged 11, 13, and 15 years are the target for the international study. These age groups represent the onset of adolescence, the challenge of physical and emotional changes, and the middle years when important life and career choices are beginning.

Additional to the standard mandatory questionnaire, topic-focused working groups develop topic-based packages that are used in the countries that choose to focus on these topics. Questions on immigration were developed by the Social Inequality working group. These included four questions: 'Where you born in [country of residence]?'; 'In which country was your mother born?'; 'In which country was your father born?'; 'What language do you most often speak at home?'. The answering categories for the first question are 'yes' or 'no'. The latter three questions are open-ended (i.e. students specified the country and language).

For the purposes of the situation analysis, children were identified as immigrants if they were born outside of country of residence, and will be referred to as 'foreign-born children'. Information on foreign-born children was collected in twelve European countries and regions: Flemish-speaking Belgium, Germany, Denmark, Spain, Greece, Ireland, Iceland, Italy, Scotland, Sweden, Wales and Portugal.



Findings

Demographic background

The demographic distribution of foreign-born children was examined. In most countries (with the exception of Spain and Wales), foreign-born children were older than their native peers. Foreign-born children are similarly distributed in both genders.

Table 1: Percentage distribution of foreign-born children by country, gender and age group (in brackets: number of children)

Country	All	Boys	Girls	11 y	13 y	15 y
Belgium (Flanders)	4.8 (206)	5.1 (111)	4.5 (95)	3.2 (41)	5.6 (78)	5.4 (87)
Denmark	5.5 (313)	5.6 (153)	5.4 (160)	4.1 (85)	5.4 (110)	7.2 (112)
Germany	6.5 (468)	6.5 (237)	6.4 (231)	5.1 (114)	6.6 (160)	7.3 (187)
Greece	7.2 (265)	6.0 (106)	8.1 (159)	4.3 (47)	7.9 (93)	8.8 (124)
Iceland*	6.5 (122)	6.1 (58)	6.9 (64)			6.5 (121)
Ireland	11.0 (536)	10.5 (260)	11.5 (276)	10.1 (138)	10.5 (187)	12.2 (206)
Italy	4.8 (190)	5.0 (100)	4.6 (90)	3.6 (45)	4.7 (63)	5.8 (77)
Portugal	5.8 (235)	4.8 (103)	5.8 (132)	5.3 (68)	5.5 (82)	5.2 (85)
Scotland	8.3 (515)	8.3 (253)	8.4 (262)	6.6 (111)	8.6 (194)	9.4 (205)
Spain	8.6 (737)	8.2 (358)	8.4 (379)	9.8 (292)	7.9 (223)	7.3 (222)
Sweden	4.7 (207)	5.1 (111)	4.3 (96)	3.9 (58)	4.2 (57)	5.8 (88)
Wales	4.0 (177)	3.9 (84)	4.2 (93)	4.7 (70)	3.9 (59)	3.3 (45)

* Data collected for 15 year olds only.

¹ Health inequities involve more than inequality in exposure to health determinants or outcomes, or in access to the resources needed to improve and maintain health; health inequities involve a failure to avoid or overcome such inequality that infringes human rights norms or is otherwise unfair. A characteristic common to groups that experience health inequities is lack of power in political, social and/or economic terms. The term “social determinants of health inequities” refers to the social aspects that influence the inequitable distribution of health (WHO, 2009).

Socio-economic background

HBSC uses primarily two measures of socio-economic background or status (SES). The more traditional one is based on parental occupation as reported by the children. Whereas occupation is considered to be the standard SES measure, within the context of HBSC, it has been found that many children do not report their parents' occupation or do not provide sufficient details for their parental occupation to be codified (Currie et al., 2008). To overcome this difficulty, the Family Affluence Scale (FAS) was developed, reflecting affluence and consumption patterns. FAS is comprised of four easily answered, non-sensitive component items, including family car ownership, children having their own bedroom, the number of family holidays, and the number of family computers. FAS is used as a sum score and as a continuous

variable or recoded to a categorical variable identifying low, middle and high family affluence (Currie et al., 2008). Table 2 presents the FAS distribution of foreign-born children compared to their native peers.

Findings presented in table reveal that in most countries, foreign-born children live in less affluent families compared to their native peers. The level of inequality is different between the different countries, but with the exception of Ireland and Scotland, such disparities are significant in all countries. All subsequent analyses are therefore controlled for age, gender and FAS, presenting estimates that are over and above age and gender difference, and differences in level of family affluence that was found to be associated with health, risk behaviours and relationships.

Table 2: Distribution of FAS by foreign-born status (%)

Country	Foreign-born			Natives			Significance level
	High FAS	Mid FAS	Low FAS	High FAS	Mid FAS	Low FAS	
Belgium (Flanders)	FAS	Mid	17.8	47.2	42.7	10.0	P<0.01
Denmark	FAS	Low	17.9	51.4	41.4	7.3	P<0.001
Germany	FAS	High	30.9	48.5	39.5	12.0	P<0.001
Greece	FAS	Mid	47.1	28.6	47.7	23.6	P<0.001
Iceland	FAS	Low	8.6	70.7	27.5	1.8	P<0.001
Ireland	FAS	54.9	21.5	20.0	56.4	23.6	N.S.
Italy	27.0	37.4	35.3	32.2	46.1	20.4	P<0.001
Portugal	22.6	40.1	32.9	32.0	43.4	24.4	P<0.005
Scotland	48.0	38.2	13.8	42.8	40.8	16.3	N.S.
Spain	22.3	42.7	35.0	40.9	46.1	13.1	P<0.001
Sweden	33.5	43.8	22.7	57.0	37.3	5.7	P<0.001
Wales	31.6	41.8	26.6	45.6	41.4	13.0	P<0.001

Self-rated general health

Health is an asset that could affect the ability of an individual to experience life to its full. Experiencing good health and high levels of life satisfaction are important aspects of life and a cornerstone for all other life spheres. Children were asked questions on their general health and life satisfaction. Children were asked "Would you say your health is . . . ?" with answering categories 'excellent', 'good', 'fair', 'poor'. For the purpose of this paper, response categories were dichotomised to 'excellent health' vs. 'good, fair and poor'. Children were also asked about their perceived life satisfaction: "Here is a picture of a ladder, the top of the ladder '10' is the best possible life for you and the bottom '0' is the worst possible life. In general, where on the ladder do you feel you stand at the moment?" For the purpose of this paper, answers were dichotomised to 9-10 as high level of life satisfaction vs. 0-8. Overall,

no differences were found between foreign-born children and their native peers in relation to general health. The two exceptions were Ireland and Wales. Foreign-born children in Wales 1.5 times more likely to experience excellent health compared to their native peers (Odds Ratio (OR): 1.5, $p<0.05$); foreign-born children in Ireland, on the other hand, were less likely to report high life satisfaction compared to their native peers (OR 0.78, $p<0.05$).



Relationships with parents and friends

Many studies have indicated the importance of relationships with parents and peers in the life of adolescents. Healthy relationships with parents can act as a protective factor against adverse health and risky behaviours, whereas healthy peer relationships can help enhancing positive health (Molcho et al., 2007). Children were asked three questions on their relationships with peers and with their parents: children were asked “How easy is it for you to talk to the following person about things that really bother you?”. Among the listed people were father, mother and best friend. Answering categories comprised of ‘very easy’, ‘easy’, ‘difficult’, ‘very difficult’, ‘don’t have or see this person’. In most countries (with the exception of Flemish-speaking Belgium) child immigrants were significantly more likely to report that they do not have or do not see their father compared to their native peers. In Belgium, Spain and Sweden child immigrants were also more likely to report that they do not have or do not see their mother. In Spain, Iceland, Italy and Wales child immigrants were more likely to report that they do not have or do not see their best friends. Since the numbers of immigrants children reporting that do not see their father, mother or best friends were overall low, answering categories in the situational analysis were dichotomised to ‘easy’ vs. ‘difficult’, with those reporting that they do not have or do not see that person excluded from the analysis. Table 3 presents the odds ratios of positive relationships by immigration status.

Findings presented in table 3 suggest that in most countries there are no differences between foreign-born children and their native peers

regarding relationships with parents with the exception of Greece, where foreign-born children are less likely to find it easy or very easy to talk to their mother and father; and in Spain, where foreign-born children are less likely to find it easy or very easy to talk to their mother. A more mixed pattern is found regarding peer relationships. Only in Germany (significant) and Sweden (not significant) were foreign-born children more likely to find it easy to talk to their best friend, whereas in Denmark and Ireland (but also in most other countries, albeit not statistically significant) foreign-born children were less likely to report that they find it easy to talk to their best friend.

School life

School is the place where children spent a large part of their time. In school children gain their education, but school is also an important socialization agent, and negative school perceptions have been associated with lower levels of well-being and with increased risk for involvement in risk behaviours (Bonny et al., 2000; Rasmussen et al., 2005). Presented here are three questions regarding school life, examining perceived academic performance, overall school perception and relationship with classmates.

Children were asked: “In your opinion, what does the class teacher(s) think about your school performance compared to your classmates?” with answering categories: ‘very good’, ‘good’, ‘average’, ‘below average’; “How do you feel about school at present?” with answering categories: ‘I like it a lot’, ‘I like it a bit’, ‘I don’t like it very much’, ‘I don’t like it at all’; and “Please show how much you agree with the statement

Table 3: Models of logistic regression: odds ratios of relationships with parents and friends predicted by foreign-born status, by country

Country	Easy to talk to father	Easy to talk to mother	Easy to talk to best friend
Belgium (Flanders)	1.22	0.83	1.02
Denmark	0.96	1.00	0.67*
Germany	1.04	1.00	1.86**
Greece	0.57***	0.68*	0.85
Iceland	0.85	0.82	0.72
Ireland	1.16	1.06	0.75*
Italy	0.96	0.73	0.75
Portugal	0.96	1.03	0.72
Scotland	0.96	0.93	0.81
Spain	0.94	0.80*	0.88
Sweden	1.01	1.50	1.39
Wales	0.98	1.02	0.89
Wales	31.6	41.8	26.6

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

All analyses are controlled for gender, age and family affluence.

other students accept me as I am” with answering categories: ‘strongly agree’, ‘agree’, ‘neither agree nor disagree’, ‘disagree’ ‘strongly disagree’. Answers were dichotomized to ‘above average school performance’ vs. ‘average performance or less’; ‘like school’ vs. ‘do not like school’; and ‘agree’ vs. ‘do not agree’. Table 4 presents the odds ratios of positive school perception by immigration status.

Findings presented in table 4 suggest that different aspects of school life are perceived differently in different countries. Foreign-born children in Iceland (significant) and Sweden (not significant) were more

likely to perceive their school performance as above average. Foreign-born children in Greece and Italy, on the other hand, were significantly less likely to perceive their school performance to be above average. In all other countries foreign-born children did not differ from their native peers. In Belgium and Spain foreign-born children were much more likely to report that they like school, but no such differences were found in the remaining 10 countries. Lastly, in Ireland, Scotland, Spain and Wales foreign-born children were less likely to agree that other students accept them as they are, but in all other countries this pattern did not emerge.

Table 4: Models of logistic regression: odds ratios of school perceptions predicted by foreign-born status, by country.

Country	Above average school performance	Liking school	Students accept me
Belgium (Flanders)	0.87	1.41*	0.80
Denmark	1.15	1.13	0.97
Germany	1.16	0.95	1.14
Greece	0.73*	1.22	0.89
Iceland	1.49*	1.07	0.95
Ireland	1.00	1.01	0.74*
Italy	0.65**	1.07	0.88
Portugal	1.56**	1.27	1.02
Scotland	1.13	1.15	0.74*
Spain	1.06	1.92***	0.78*
Sweden	1.32	0.87	1.19
Wales	1.18	1.14	0.66*

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$
All analyses are controlled for gender, age and family affluence.

Involvement in risk behaviours

Risk behaviours could be the outcome of poor family and peer relationships and of poor school perceptions but are also predictors of poor academic performance and poor mental and physical health among other adverse outcomes. HBSC includes many questions on involvement in risk behaviours, of which five are presented here.

Violence

Children were asked: “During the past 12 months, how many times were you in a physical fight?” with answering categories: ‘I have not been in a physical fight’, ‘1 time’, ‘2 times’, ‘3 times’, ‘4 times or more’. This question was dichotomized to ‘never been in a fight’ vs. ‘1 time or more’.

Bullying

Following a short explanatory introduction, children were asked: “How often have you been bullied at school in the last couple of months?” with answering categories: ‘I haven’t been bullied at school at the past couple of months’, ‘it has only happened once or twice’, ‘2 or 3 times’, ‘about once a week’, ‘several times a week’. Children were also asked “how often have you taken part in bullying another student(s) at school in the last couple of months?” with answering categories: ‘I haven’t bullied other student(s) at school at the past couple of months’, ‘it has only happened once or twice’, ‘2 or 3 times’, ‘about once a week’, ‘several times a week’. The questions were dichotomised to ‘more than twice’ vs. ‘twice or less’.



Smoking

Children were asked “How often do you smoke tobacco at present?” with answering categories: ‘every day’, ‘at least once a week, but not every day’, ‘less than once a week’, ‘I do not smoke’. This question was dichotomised to ‘weekly or more’ vs. ‘less than weekly’.

Alcohol use

Children were asked “Have you ever had so much alcohol that you were really drunk?”, with answering categories: ‘no, never’, ‘yes, once’, ‘yes, 2–3 times’, ‘yes, 4–10 times’, ‘yes, more than 10 times’. The question was dichotomised to ‘twice or more’ (presented as ‘been drunk’) vs. ‘never or once’.

Table 5 presents the odds ratios of involvement in risk behaviours by immigration status.

As presented in table 5, foreign-born children in Germany, Greece, Italy, Spain and Sweden were more likely to be involved in a physical fight; foreign-born children in Ireland, Scotland and Spain were more likely to report that they have been bullied; foreign-born children in Italy, Spain and Sweden were more likely to report bullying others; and foreign-born children in Greece were more likely to report a history of drunkenness. However, fewer foreign-born children in Greece reported bullying others, fewer foreign-born children in Spain reported weekly smoking, and fewer foreign-born children in Wales and Denmark reported history of drunkenness. No other significant differences between foreign-born children and their native peers emerged.

Table 5: Models of logistic regression: odds ratios of involvement in risk behaviours predicted by foreign-born status, by country.

Country	Was in a fight	Been bullied	Bullied others	Weekly smoking	Been drunk
Belgium (Flanders)	1.24	0.89	1.54	1.10	0.93
Denmark	1.20	0.87	1.36	0.88	0.37***
Germany	1.93***	0.79	0.93	0.90	1.27
Greece	1.56**	0.89	0.69*	0.87	1.60*
Iceland	0.78	0.70	0.44	0.64	0.88
Ireland	1.00	1.39*	1.24	1.13	0.85
Italy	1.59**	1.12	1.89**	0.83	1.07
Portugal	1.13	1.33	1.38	1.08	1.10
Scotland	1.02	1.44*	1.05	1.24	0.92
Spain	1.27**	1.98***	1.67***	0.65*	1.08
Sweden	1.50*	1.23	2.53***	1.31	1.05
Wales	0.79	1.30	1.03	0.60	0.54**

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

All analyses are controlled for gender, age and family affluence.

Limitations

The HBSC Study provides a unique opportunity to gain a cross-national information on child immigrants, through using similar methods and a standardised questionnaire across a range of countries in different regions in Europe. Yet, the HBSC has its limitations. First and foremost, the study is aimed at the general population and not at immigrants, resulting in a rather low numbers of immigrant children in the study. The numbers of immigrants in the sample do not allow us to stratify the international analysis by country of origin or to try to un-

derstand cultural differences between different groups of immigrants. Concentrating countries of origin hinders our understanding of potential conflicts between country of residence and country of origin, and prevents us from making recommendations regarding specific ethnic minorities. The situation analysis gives an overview at large and does not allow for an in-depth exploration of the complex phenomena of immigration. Some of these limitations are addressed in the national case studies that are presented in this paper and provide a more in-depth analysis in these countries. Lastly, the study is based on self-reporting and this can be prone to social desirability bias.

National Case Studies

The cross-national analyses presented so far are limited to the mandatory HBSC questionnaire and to a single definition of immigrant status (foreign-born children) that was common to all twelve countries. However, five countries have provided more in-depth, varied and sophisticated analysis of adolescent migrants' health, based mainly on HBSC national data sets. These national case studies provide an opportunity to learn more about the experiences of migrants from different countries

of origin in the different countries, using the same study design. The more in-depth data that exist in those countries also allows expanding the definition of immigrant children, to include first generation migrants, second generation migrants and 1.5 generation migrants in one country (Spain). The precise definitions used in each country are stated in the corresponding case study.

Case study 1: Iceland

Cultural and linguistic predictors of difficulties in school and risk behaviour

Thoroddur Bjarnason

Introduction

In the second half of the twentieth century the population of Iceland doubled from about 140,000 inhabitants in 1950 to about 280,000 in 2000 (Statistics Iceland, 2009a). This population growth was almost entirely due to natural population growth, as immigration remained very low throughout this period. In 2000, the proportion of foreign citizens in the national population was 2.6%, compared to 1.9% in 1950 (Statistics Iceland, 2009b). In the first eight years of the 21st century Iceland experienced a surge in immigration, in large part due to the free movement of labour with the establishment of the European Economic Area in 2004 (EFTA 2008; European Commission, 2008). By 2008, the proportion of foreign citizens in Iceland had risen to 7.4% and a total of 14.3% of the Icelandic population were either first or second generation immigrants, or had at least one foreign parent (Statistics Iceland, 2009c).

The reaction of Icelanders towards immigrants has generally been rather positive. For instance, a 2005 Gallup survey found that 19% of Icelanders aged 15–75 believed that immigration from other countries had raised their own living standards, while only 5% believed that their living standards had deteriorated because of immigration (Ragnarsdóttir, Árnason & Thorvaldsson, 2005). However, there are some indications that adolescents have become less tolerant of immigrants in recent years. In 2003, about 41% of 14–16 year old students in Iceland believed that there were too many immigrants in the country, compared to 24% in 1997 (Sigfúsdóttir et al., 2005). There is also some qualitative evidence that suggests that adolescents of foreign descent in Iceland are more likely to suffer from various emotional, social and academic problems than their peers of Icelandic descent (Gyedu-Adomako et al., 2000).

The objective of the current case study is to explore the situation of immigrant youth in Iceland. While Polish immigrants were 4% of the Icelandic population in 2008 and accounted for almost half of the immigrant population, immigrants were also found from 124 other countries (Statistics Iceland, 2009). The case study will examine well-being in school and risk behaviours among students who are foreign-born, have parents of foreign origin, or live in a household where a foreign language is spoken. In particular, the case study will attempt to establish differences in student outcomes by world region of origin and the role of language in such outcomes.

Methods and data

The current case study is based on data from the HBSC survey in Iceland (Bjarnason & Jonsson, 2006; Currie et al., 2008). Standardised questionnaires were administered to all 6th, 8th, and 10th grade students who were present in class on the day of administration in February and March 2006. This research is based on the responses of 3,949 students in the 10th grade, which is 83% of all registered 10th grade students in the school year 2005–2006.

Table 1 shows that 93% of 10th grade students were born in Iceland and 7% abroad. This is consistent with official statistics indicating that 7% of all 15 year old residents of Iceland in December 2005 were born abroad (Statistics Iceland, 2009c). About 91% of the respondents said that both their parents were born in Iceland but 6% said that at least one of their parents was born in a Western country (Western Europe, United States, Canada, Australia or New Zealand). Eastern European countries are defined as a separate category, since the recent wave of immigration from these countries may be a source of some stigma towards students of Eastern European origin. About 1% of the students said that at least one parent was born in an Eastern European country and 2% said that at least one parent was born in Central or South America, Asia or Africa. Icelandic was the only language spoken in 95% of all homes while foreign languages were spoken in part or exclusively in 5% of the homes.



Table 1: Origin of students

Country of birth	
Iceland	93.3%
Abroad	6.7%
Origin of parents	
Both parents born in Iceland	91.0%
Parent(s) born in Western country ¹⁾	6.3%
Parent(s) born in Eastern Europe	1.2%
Parents born elsewhere ²⁾	2.1%
Language spoken in home	
Icelandic	94.9%
Other languages	5.1%
Difficulties in school	
Do not like school	4.6%
Other students are unkind	6.4%
Bullied in past month	12.4%
Risk behaviours	
Daily smoking	11.3%
Drinking	43.2%
Sexual intercourse	32.4%

1) *Western Europe, United States, Canada, Australia and New Zealand.*

2) *Africa, Asia, Central- and South-America.*

Three measures of problems in school are used in this study. Students were asked how they liked school and 5% reported that they did not like it very much or that they did not like it at all. Students were also asked if they thought most of their fellow students were kind and helpful and 6% disagreed or strongly disagreed. Finally, 12% of the students reported that they had been bullied in the past couple of months.

Three measures of risk behaviours were also included in the study. Students were asked how often they smoked tobacco and 11% reported that they smoked every day. About 43% reported having been drunk in their lifetime. Finally, 32% of the respondents indicated that they had ever had sexual intercourse.

Results

Table 2 shows the proportion of students experiencing problems in school by different categories of origin. There are no significant differences between students born in Iceland and those born abroad in the prevalence of disliking school, finding other students to be unkind or having been bullied. However, it should be noted that this measure does not distinguish between those born to foreign parents and those born to Icelandic parents temporarily living abroad. There is also no difference in the proportion of students who find other students to be unkind by parents' country of birth. Those who have two parents born in Iceland do like school significantly more and are significantly less likely to have been bullied. Importantly, while having parents of foreign descent is associated with more adverse outcomes, the region

Table 2: Proportion of students experiencing problems in school

	Dislike school	Other students unkind	Bullied in past month
Country of birth			
Iceland	.046	.063	.121
Abroad	.043	.074	.150
Origin of parents			
Both parents born in Iceland	.042*	.062	.110***
Parent born in Western country ¹⁾	.064	.078	.272***
Parent born in Eastern Europe	.068	.114	.295***
Parent born elsewhere ²⁾	.082	.095	.256***
Language at home			
Icelandic	.044**	.060***	.113***
Other language	.092**	.150***	.325***

* $p < .05$ ** $p < .01$ *** $p < .001$

1) *Western Europe, United States, Canada, Australia and New Zealand.*

2) *Africa, Asia, Central- and South-America.*

of the world from which the parents originate does not appear to matter in this respect.

Finally, Table 2 shows that adolescents living in a home where a foreign language is spoken are twice or three times as likely to dislike school, find other students to be unkind or to have been bullied. These differences are statistically significant for all school-related outcomes.

Table 3: Odds ratios of experiencing problems in school, best model

	Dislike school	Other students unkind	Bullied in past month
Boy	---	---	1.27*
Born Abroad	---	---	---
Parent born in Western country ¹⁾	---	---	2.30***
Parent born in Eastern Europe	---	---	---
Parent born elsewhere ²⁾	---	---	---
Icelandic not spoken at home	2.24**	2.79***	3.10***

* $p < .05$ ** $p < .01$ *** $p < .001$

1) Western Europe, United States, Canada, Australia and New Zealand.

2) Africa, Asia, Central- and South-America.

Table 3 shows the results of a logistic regression analysis of the same variables as were shown in Table 2. This shows that adolescents in homes where other languages are spoken are 2.2 times as likely to dislike school, 2.8 times as likely to think other students are unkind and 3.1 times as likely to have been bullied. Children whose parents were born in Western Europe, US, Canada, Australia or New Zealand are 2.3 times as likely to have been bullied.

Table 4 shows that adolescent risk behaviour does not significantly differ between those born in Iceland or abroad. However, students who have two parents born in Iceland are significantly less likely to smoke daily, have been drunk or have had sexual intercourse compared to first- and second-generation immigrant children.

Table 4: Proportion of students engaged in risk behaviours

	Daily smoking	Been drunk	Sexual intercourse
Country of birth			
Iceland	.111	.428	.322
Abroad	.128	.455	.326
Origin of parents			
Both parents born in Iceland	.104***	.424**	.317***
Parent born in Western country ¹⁾	.215***	.485	.406**
Parent born in Eastern Europe	.178	.523	.209
Parent born elsewhere ²⁾	.275***	.608**	.413***
Language at home			
Icelandic	.103***	.427**	.315***
Other language	.297***	.536**	.549***

* $p < .05$ ** $p < .01$ *** $p < .001$

1) Western Europe, United States, Canada, Australia and New Zealand.

2) Africa, Asia, Central- and South-America.



Table 5 shows the results of a logistic regression analysis of the same variables as shown in Table 4. The results show that adolescents in homes where language other than Icelandic is spoken are 3.1 times as likely to smoke daily, 1.4 times as likely to have been drunk and 2.3 times as likely to have had sexual intercourse by the end of compulsory school. In addition the students are 1.7–2.0 times more likely to have done these things, if they have parents born in Africa, Asia, Central- or South-America. Girls who have at least one parent born in a Western country are 2.4 times as likely to smoke daily and 1.5 times as likely to have had sexual intercourse than their counterparts who have two parents born in Iceland.

These complex patterns of results from previous studies suggest that in addition to the social, economic and psychological strain associated with immigrant status, research should take into account the normative behaviours in the country of origin as well as in the country of residence. In this respect it is surprising that this study does not find differences in risk behaviour by country of origin but rather by linguistic status. Disliking school and poor relations with other students appear to be associated with linguistic problems and those who are not native speakers of Icelandic appear to be at a substantially greater risk of being bullied. Qualitative research based on focus group interviews of adolescents of Icelandic and foreign descent in Iceland similarly

Table 5: Odds ratios of engaging in risk behaviours, best model

	Daily smoking	Been drunk	Sexual intercourse
Girl	---	1.17*	1.39***
Born Abroad	---	---	---
Parent born in Western country ¹⁾	---	---	---
Parent born in Eastern Europe	---	---	---
- girl	2.43***	---	1.52*
Parent born elsewhere ²⁾	1.80*	1.97**	1.74*
Icelandic not spoken at home	3.07***	1.38*	2.33***

* $p < .05$ ** $p < .01$ *** $p < .001$

1) Western Europe, United States, Canada, Australia and New Zealand.

2) Africa, Asia, Central- and South-America.

Discussion

The results of this study show that adolescents of foreign descent in Iceland experience more difficulties in school and are more likely to engage in risk behaviours. Difficulties in school appear to be associated with being of foreign origin in general rather than being from culturally distant or dissimilar cultures. In contrast, while adolescents of foreign descent are more likely to engage in risk behaviours, students from more distant cultures appear to be particularly affected.

Children living in homes where a foreign language is spoken are particularly likely to experience problems in school and engage in risk behaviours. Their school status is worse than would have been expected from studies conducted in the other Nordic countries (Liebkind et al., 2004; Vedder & Virta, 2005; Westin, 2003), the US (Glick and White, 2004) and Australia (Cardak & McDonald, 2004). Similar to Russian immigrants in Israel (Israelowitz and Slonim-Nevo, 2002), students of foreign descent in Iceland are more likely to use drugs. This is contrary to results obtained in Canada (Ma, 2002), Australia (Davies & McKelvey, 1998) and the US (Blake et al., 2001). Similar to the US, they are more likely to engage in risky sexual behaviour (Jeltova et al., 2005) and to be bullied (Yu et al, 2003).

revealed that language is a crucial device for talking about problems associated with immigration and adjustment of both Icelanders and immigrants to the emergent multicultural society (Bjarnason & Gunnarsson, 2008).

These strong effects of language could be indicative of different processes. First, limited adolescent proficiency in the Icelandic language is likely to be a direct cause of difficulties in school work as well as difficulties in establishing and maintaining relations with peers. Second, limited proficiency by parents in Icelandic may also, in a more subtle way, result in weaker ties between the home and the school as well as parents being less likely to benefit from public health prevention efforts directed at parents. Third, it is possible that the language spoken in the home is simply a better measure of immigrant status and social marginalisation than country of birth or origin of parents. These results strongly suggest that the role of linguistic competence must be clearly addressed in public policy in the field of immigration as well as, more generally, in the field of public health. Future research must further explore these different potential links between language and risk behaviours.

Case study 2: Ireland

Inequalities in health among migrant school children in Ireland

Michal Molcho, Colette Kelly, Aoife Gavin and Saoirse Nic Gabhainn

Introduction

In the last two decades, Ireland has experienced a change in migration trends, with more immigration than emigration. In 2006 15% of the population residing in Ireland were foreign-born. The national profile of immigrants in Ireland reveals that about half of the non-Irish Nationals are from the UK and the rest are from countries in central and Eastern Europe, the Americas, Asia and Africa. Of the child population (under 18 years of age), 6.1% are non-Irish nationals. Additional to non-Irish nationals, there is another ethnic minority group in Ireland: the Travelling community (or Travellers). Irish Travellers are an indigenous minority who have been part of Irish society for centuries. They have a value system, language, customs and traditions that make them an identifiable group both to themselves and to others. Their distinctive lifestyle and culture, based on a nomadic tradition and emphasising the importance of the extended family, sets them apart from settled people. According to the 2006 Census, there were 22,435 Travellers living in Ireland, comprising 0.5% of the population in the country. This figure may be an underestimation of the actual number of Travellers due to potentially lower response rates in this population. Overall, the Travelling community has lower level of education, substantially lower life expectancy and higher rates of unemployment (Nolan & Maitre, 2008). This case study presents the health status and health behaviours of child migrants and Traveller children living in Ireland. The case study utilises data collected in the 2006 Irish Health Behaviour in School-Aged Children study.

The case study presented here is based on an Irish national report, "Inequalities in health among school-aged children in Ireland" (Molcho et al., 2008). This report explored four groups in the Irish society that are deemed more disadvantaged. The report covered issues of importance identified in the Irish National Health Promotion Strategy (Department of Health and Children, 2000), and the Health Strategy: Quality and Fairness (Department of Health and Children, 2001). These include general health, smoking, use of alcohol and other substances, diet and food behaviour, physical activity and sedentary behaviour, injuries and bullying.

Methodology

The Irish HBSC study was carried out using a two-stage sampling process was conducted to achieve a representative sample of 10-17 year old school children. A total of 10,334 school children were

sampled from 215 schools, with response rate of 63.1% at the school level.

This case study focuses on Traveller children and immigrant children. Travellers were identified using a simple question "are you a member of the Traveller community?". Children answered 'yes' to that question, and whose parents were from Ireland or the UK were defined as members of the Travelling community. In the 2006 survey, 233 (2.3%) of respondents were identified as Travellers. Children were identified as immigrants if they were either born outside of Ireland or if both parents were born outside of Ireland. In the 2006 HBSC survey, 562 (5.4%) of respondents were immigrants according to this definition. In order to take into account any potential differences between the immigrant population, the Traveller population and the general population in terms of geographical location, or socio-demographic characteristics, immigrant children were matched to a sub-sample of respondents. All cases in the comparison group were matched by gender, age and social class, resulting in a sub-sample with similar socio-demographic characteristics. Where possible, the matching was done within the same classroom (69% of both groups). When this was not possible, a matched respondent was sought within the same school (8% of both groups) or within the geographical region (23% of both groups). In addition to the general immigrant sample this report also presents a breakdown of the immigrant group into: those for whom either parent is from the UK (UK immigrants), and those for whom neither parent is from the UK (non-UK immigrants). The two groups are similar in size (276 UK immigrants and 286 non-UK immigrants).

Findings

Socio-demographic status

Table 1 presents the socio-demographic distribution of the HBSC sample, the immigrant sample and that of the immigrants' sub-groups and the Travellers' sample. No gender differences are evident among the groups but the non-UK immigrants and Travellers are slightly younger than the HBSC sample and the UK immigrant sample. In relation to social class, the non-UK immigrants have a smaller proportion of children in social class 3-4 (middle), Travellers have a smaller proportion of children in social class 1-2 (high), and both groups have a much higher proportion who had not reported on their parental occupation and therefore have missing data for social class. However, the bigger demographic difference between UK and both non-UK immigrants and Travellers is in relation to location of residence. Only 35% of UK immigrants live in urban areas compared to 71% of the non-UK immigrants and 61% of Travellers. Thus, all further analyses are controlled for location of residence.

Table 1: Socio-demographic distribution of the HBSC Ireland sample-



Table 1: Socio-demographic distribution of the HBSC Ireland sample compared to the immigrant and Travellers sample (%)

		General sample	Travellers	All Immigrants	UK Immigrants	Non-UK Im-migrants
Gender	Boys	51	52	51	49	53
	Girls	49	48	49	51	47
Age group	10-11 years	13	23	11	11	11
	12-14 years	48	46	50	46	54
	15-17 years	39	31	39	43	35
Social class	SC1-2 (High)	29	18	30	28	31
	SC3-4 (Middle)	40	32	34	43	26
	SC5-6 (Low)	19	22	18	18	18
	Missing SC	12	28	18	11	25
Urban/Rural	Urban	42	61	53	35	71
	Rural	58	39	47	65	29
<i>N</i>		<i>10101</i>	<i>233</i>	<i>561</i>	<i>276</i>	<i>286</i>

Self-rated general health

Children were asked a number of general health and life satisfaction questions. They were asked to rate their health; to report how they feel about their lives at present; to report on a scale of 0 to 10 how they feel at the moment and to report on the frequency with which they experience headaches.

A third of immigrant children (35%) reported that their health is excellent (34% of matched group). Significantly fewer immigrant children reported that they are very happy with the lives at present (43%, compared to 53% of matched group; $p < 0.001$). The percentage of immigrants reporting high life satisfaction was lower compared to the matched group (74% and 80% respectively; $p < 0.05$), especially among boys (75% of immigrant boys compared to 83% of matched group; $p < 0.05$). More immigrant children reported weekly headaches (29%) compared to the matched group (22%). No differences were evident between Travellers and the matched group in relation to self-reported health and feeling very happy, but fewer immigrants reported high life satisfaction (71% vs. 82% of matched group, $p < 0.01$) and more Travellers reported frequent headaches (33% vs. 21% of matched group, $p < 0.01$) (table 2).

Further differences emerge when comparing the immigrant sub-groups. Fewer UK immigrant children reported that their health is excellent compared to non-UK immigrant children, and more UK immigrant children reported frequent headaches. Overall, both UK and non-UK immigrant children were less likely to report that they are very happy compared to their respective matched group, but some

different gender patterns emerged. Among UK immigrant children, girls were less likely to report feeling very happy (38% compared to 53% of matched, $p < 0.001$), while among non-UK immigrant children, boys were substantially different from the matched group (45% and 58% respectively, $p < 0.05$). Additionally, fewer UK immigrant children reported high life satisfaction (table 2).

Risk behaviours

Children were asked a number of questions about their involvement in risk behaviours. They were asked to report about their current smoking status; their frequency of alcohol consumption; if they have ever been "really drunk"; and if they used cannabis in the last 12 months.

Overall, the involvement of immigrants in risk behaviours is similar to that of the matched group. The only exception is that immigrant boys are less likely to report that they have been 'really drunk' compared to the matched boys (28% vs. 36%, $p < 0.05$). Comparing the sub-groups suggests that fewer Non-UK boys were involved in most risk behaviours compared to their matched group and nearly twice as many Traveller children reported involvement in all risk behaviours compared to the matched group (Table 2).

Food and dietary behaviour

Children were asked a number of questions in relation to foodstuff consumption and dietary behaviours. They were asked about daily consumption of fruits, vegetables, sweets and soft drinks. Children were also asked to report if they had breakfast on weekdays, if they

Table 2: Behaviours and attitudes among immigrant and Travellers sample compared to matched groups (%)

	UK	Matched	Non-UK	Matched	Travellers	Matched
General health						
Excellent health	29	34	40	34	38	38
Very happy	42*	52	44*	53	51	53
High life satisfaction	71**	81	76	79	71**	82
Headaches at least weekly	30**	19	27	24	33**	21
Risk behaviours						
Current smokers	19	19	11*	16	25*	17
Alcoholic drink in the last month	31	25	17*	25	32***	18
Ever been "really drunk"	35	30	22**	35	40**	26
Cannabis in the last 12 months	18	13	9*	15	21**	12
Food and dietary behaviours						
Fruit more than daily	18	20	33**	22	22	18
Vegetables more than daily	17	20	20	18	18	20
Sweets at least daily	38	37	30	32	43	35
Soft drinks at least daily	24	21	25	22	34*	26
No breakfast on any weekday	20*	12	16	14	21**	12
Food poverty	19	15	16	15	28*	19
On a diet	17*	10	14	9	14*	8
Injuries, fighting and bullying						
Injury in the last 12 months	40	41	36	41	43	49
Been bullied in the past couple of months	30*	21	29	24	29	22
Bullying others in the past couple of months	21	19	22	23	28	24
Fight in the past 12 months	38	36	35	42	50	46
School perceptions						
Liking school	67	71	76	72	58	66
Students enjoy being together	70*	79	69	73	77	81
Students are kind and helpful	62*	71	62	65	68	73
Other students accepting them as they are	74*	83	72**	81	80*	86
Social relationships						
Easy to talk to father	57	59	66	62	56	63
Easy to talk to mother	79	76	79	79	71*	80
3+ evenings with friends	55	53	56**	68	66	66
3+ same sex friends	86	90	79***	92	83	90

* $p < .05$ ** $p < .01$ *** $p < .001$
All analyses are controlled for social class and rural/urban status.



ever went to school or to bed hungry because there was no food at home (food poverty) and if they were on a diet.

About a quarter of Traveller children reported eating fruit more than once a day (22%, vs. 18% of matched group); 18% reported eating vegetables more than once a day (20% of matched group); 43% reported eating sweets more than once a day (35% of matched group); 21% reported not having breakfast in any weekday (12% of matched group, $p < 0.01$); 28% reported that they experienced food poverty (19% of matched group, $p < 0.05$); and 14% reported that they are on a diet (8% of matched group, $p < 0.05$).

A quarter of immigrant children (26%) reported eating fruits more than once a day (21% in matched group) and 18% reported eating vegetables more than once a day (19% in matched group). A third of immigrant children and matched children reported eating sweets more than once a day and a quarter of both groups reported drinking soft drinks more than once a day. More immigrant girls report that they do not have breakfast on weekdays (23% vs. 14% in matched group, $p < 0.01$) and that they are on a diet (21% vs. 12% in matched group, $p < 0.01$).

Further differences are evident when comparing the immigrant sub-groups. More non-UK immigrant children reported that they eat fruit more than once a day, and this difference was particularly evident among non-UK immigrant girls (37% vs. 22% in matched, $p < 0.01$). In contrast, fewer UK immigrant girls report eating vegetables more than once a day (12%) compared to matched (21%, $p < 0.05$) and to non-UK immigrant girls (23%). Skipping breakfast on weekdays was more common among UK-immigrant girls, with 26% reporting that they never have breakfast on weekdays, compared to 11% in the matched group ($p < 0.001$). More non-UK immigrant girls reported that they are on a diet (24%) compared to their matched group (15%, $p < 0.05$).

Injuries and bullying

Children were asked to report if they had an injury that required medical attention in the past 12 months, if they were bullied or if they bullied others in school in the last couple of months and if they had been in a physical fight in the past 12 months.

More immigrant children reported that they were bullied at least once in the last couple of months (30%) compared to the matched group (23%, $p < 0.01$). No other overall differences were evident between immigrants and the matched group. Further differences emerged when comparing the immigrant sub-groups. More UK immigrant children reported that they were bullied in the last couple of months, with 29% of non-UK immigrant children reporting so (24% of matched group, not significant). No significant differences were

found between Traveller children and the matched group, although slightly more Traveller children reported being bullied and bullying others (see table 2).

Social context of health

Children were asked a number of questions about their perceptions of school life and their relationships with their parents and peers, all which contribute to the social context of health in children's lives. In relation to school, children were asked to report how much they like their school; if they agree that students in their classes enjoy being together; if they agree that students in their classes are kind and helpful; and if they agree that other students in their classes accept them as they are. In relation to relationship with parents, children were asked to report how easy it is for them to talk to their father and how easy it is for them to talk to their mother. With regard to relationships with peers, children were asked to report how many evenings per week they spend time with their friends; and how many same sex friends they have.

Overall, immigrant children were less likely to report positive school perceptions. Fewer immigrant girls reported that students in their classes enjoy being together (68% vs. 77% of matched group, $p < 0.05$); that students in their classes are kind and helpful (62% vs. 68% of matched group, $p < 0.05$); or that students in their classes accept them as they are (73% vs. 82% of matched group, $p < 0.001$). When comparing the two immigrant sub-groups it becomes apparent that fewer UK immigrant children reported positive school perceptions, but fewer children in both groups reported that other children accept them as they are. Fewer Traveller children reported positive school perception on all measures compared to the matched group, but none of these differences were statistically significant.

Immigrant children were also less likely to report positive peer relationships: fewer immigrant children reported spending three or more evenings with friends (53% vs. 69% of matched group, $p < 0.05$); and having three or more friends of the same sex (83% vs. 91% of matched group, $p < 0.001$). Among non-UK immigrants, fewer children reported positive relationships with their peers: fewer non-UK immigrant children reported spending three or more evenings with friends; and having three or more friends of the same sex. This pattern was most evident among girls.

Unlike immigrant children, Traveller children were less likely to report that they find it easy to talk to their parents, and less likely to report having 3 or more same-sex friends (Table 2).

Conclusions

The findings are very different for the three groups. UK immigrants are less positive about school and are more involved in risk behaviours compared to their native peers. Non-UK immigrants are less likely to report having many friends or spending time with their friends compared to their native peers. Traveller children report poorer health and high rates of involvement in risk behaviours compared to the settled community. The only aspect of school life that seems less positive among non-UK immigrants compared to their native peers relates to the feeling that other students accept them as they are, whereas far fewer of the Traveller children report positive school perceptions. Poor dietary habits are more common among UK immigrants and Traveller children (compared to their native peers and to the settled community respectively). However, findings on non-UK immigrants and on Traveller children suggest that they are experiencing social exclusion, an experience that is known to have an affect on mental health and well being.



Case study 3: Italy

At-risk behaviour in immigrant and non-immigrant young adolescents: immigrant paradox?²

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Background for the study

The number of immigrants in Italy has been constantly increasing during recent years: on 1st January 2008 the number of immigrants in Italy was 3,432,651; compared to the previous year, the number of immigrants increased by 493,729 (+16.8%). The proportion of immigrants increased from 2.7% at the end of 2002, to 5.8% at the beginning of 2008 (ISTAT, 2008). The increase in the number of immigrant youth is consistent with the increasing number of immigrant population. As of the 1st January 2008, the number of underage youth was about 767,000, accounting for 22.3% of the immigrant population in Italy. Most of them, about 457,000, were born in Italy (about 64,000 during 2007; +10.9% compared to the previous year) and are second generation immigrants. The remainders were immigrant youth who arrived in Italy for the re-unification of the family, as their parents arrived in Italy earlier.

Recently, approaches to adolescent development (for example: Schwartz et al., 2007) underlined the importance of testing the applicability of models of risk factors, protective factors and assets for adolescents from diverse ethnic and cultural backgrounds. This research question is particularly relevant in Italy because of the growing level of immigration and the growing birth rate of children from immigrant families (Lo Coco, 2000; ISTAT, 2008; Caritas/Migrantes, 2008).

In this case study we focused on analysing risk behaviours of immigrant youth in particular as regard to tobacco use. Findings from previous studies about risk behaviour of immigrant youth are inconsistent. Some studies indicated that immigrant youth reported higher risk for problem behaviours than non immigrants (e.g. Bengi-Arslan, Verhulst, & van der Ende, 1997; Pawliuk et al., 1996). Recently, other studies conducted mainly in North America showed that immigrant youth reported better adaptation and less problem behaviours than their national peers, in spite of the fact that they lived under challenging conditions and higher socioeconomic risk. This phenomenon was called “immigrant paradox” (e.g. Fuligni, 1998; García Coll, 2005).

We focused particularly on tobacco use, as a relevant at-risk behaviour during early adolescence and adolescence to compare immigrant and Italian native adolescents. Additionally, we aimed to test the influence of risk and protective factors for tobacco use among immigrants and Italian native adolescents. On

the one hand, we analysed the influence of the quality of communication with parents and of parental monitoring on tobacco use; previous studies showed that these variables are protective factors against tobacco use (Dishion & Loeber, 1985; Duncan, Duncan, & Hops, 1994; Hill et al., 2005). On the other hand, we analysed the influence of family socio-economic status on tobacco use, because research outlined that low socio-economic level is a risk factor for tobacco use (Chen, Matthews, & Boyce, 2002).

Objectives of the case study:

- 1) To examine whether immigrant adolescents are less likely to use tobacco when compared with Italian-born adolescents of Italian-born parents (as it is hypothesized by the immigrant paradox);
- 2) To examine whether immigrant status moderates the association between Family Affluence Scale (FAS) and tobacco use;
- 3) To examine whether characteristics of adolescent-parent relationship (i.e. parental monitoring, quality of adolescent-parent communication) moderate the association between immigrant status and tobacco use.

Method

Sample

We used HBSC data collected in the Veneto region (Italy). The sample was composed of 6,744 students (Ages: 11, 13, 15). The average age of each of the three age groups is: 11.93 years (N = 2,097); 13.98 years (N = 2,067); and 16.07 years (N = 2,580). The 11- and 13-year-old cohorts were in middle schools and the 15-year-olds were in high schools.

The sample consists of 3,398 boys (50.4%) and 3,346 girls (49.6%). For the present study, we excluded students who could not be categorised for immigrant status. The sample for the present study was comprised of 6,116 students (male=50.2%, female= 49.8%; primary=30.6%, secondary 2=30.7%, secondary 4=38.7%). As regard to immigrant status, the sample was divided into the four groups shown in the **Table 1**.

² This study will be published as a chapter of an Italian book. The original Italian chapter was developed by Massimo Santinello,* Francesca Cristini,** Luca Scacchi,** Gianmarco Altoè,* Michela Lenzi,* Daniela Baldassari***

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Table 1. Groups of students based on birth country of student and parents

Students born in Italy from both Italian native parents	Students born in Italy from one Italian native parent and one foreign-born parent	Students born in Italy from both foreign-born parents	Students foreign-born from at least one foreign born parent
N=5,343	N=347	N=92	N=334

Measure

We analysed the following variables:

- *Demographics (age and gender) and immigrant status.* Students reported their sex and year of school (grade). Native or immigrant status was based on the country where the child and his/her parents were born, analysed by the following items: "Were you born in Italy?"; "In which country was your mother born?"; "In which country was your father born?";
- *Family Affluences.* It was measured by the Family Affluence Scale (FAS; Currie et al. 2008; Wardle, Robb, & Johnson, 2002).
- *Tobacco use.* We used three items, each recoded as dichotomous item to respectively distinguish: students who have tried to smoke versus students who have never tried to smoke; students who smoked recently versus students who did not smoked recently; students who smoke daily versus students who do not smoked daily.
- *Communication with parents.* We used two items "How easy is it for you to talk to the following persons about things that really bother you?", respectively for mother and for father.
- *Parental monitoring.* It was assessed by five items, respectively for mother and for father.

Analysis

Differences in terms of risk and protective factors for tobacco use (family affluence, communication with parents and parental monitoring) between the four groups were compared using ANOVA and χ^2 statistics. To evaluate the influence of immigrant status on tobacco use, and to test if this relation is attributable to other characteristics (family affluence, communication with parents and parental monitoring), a series of logistic regression equations were conducted.

Results

Descriptive analysis (**Table 2**) indicated statically significant differences between the four groups with regards to:

- FAS ($F=21.15$; $p<.001$), indicating lower levels of FAS for group 4 (students foreign born from at least one foreign born parent) and for group 3 (students born in Italy from both foreign born parents);
- Parental monitoring (for father: $F=13.84$; $p<.001$; for mother: $F=26.41$; $p<.001$), indicating lower levels of monitoring for group 4 (students foreign born from at least one foreign born parent) and for group 3 (students born in Italy from both foreign born parents);

We did not find significant difference between the four groups with regards to communication with parents.

To evaluate the influence of immigrant status, risk and protective factors on tobacco use, we conducted three logistic regression equations. None of these analyses showed statistically significant differences on tobacco use levels between the four groups distinguishing immigrant and non immigrant adolescents

Table 2. Differences between the four groups as regard to FAS, parental monitoring, communication with parents

		Group 1 ¹	Group 2 ²	Group 3 ³	Group 4 ⁴	
FAS	Mean	2.32	2.37	2.20	2.14	F=21.15***
	SD	0.43	0.42	0.49	0.48	
Monitoring from father	Mean	2.35	2.32	2.08	2.19	F=13.84***
	SD	0.54	0.55	0.63	0.57	
Monitoring from mother	Mean	2.65	2.63	2.48	2.45	F=26.41***
	SD	0.39	0.38	0.45	0.46	
Communication with father	Mean rank	3059.02	3064.21	3007.11	3058.45	$\chi^2=0.71$
Communication with mother	Mean rank	3056.25	3028.02	3170.85	3095.26	$\chi^2=0.09$

1. Students born in Italy from both Italian native parents.

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.



Table 3. Predictors of experimenting smoking: models of logistic regression

	B	E.S.	Wald	df	Sig.	Odd Ratio	95.0% CI for Odd Ratio	
							Lower	Upper
Gender (female)	-0.15	0.07	4.61	1	p<.05	0.86	0.75	0.99
Age			887.92	2	p<.001			
Age (13)	1.64	0.13	167.28	1	p<.001	5.16	4.03	6.62
Age (15)	3.17	0.12	666.54	1	p<.001	23.90	18.78	30.41
Immigrant status			1.25	3	ns			
Group 2 ²	0.14	0.14	0.97	1	ns	1.15	0.87	1.52
Group 3 ³	-0.16	0.33	0.23	1	ns	0.86	0.45	1.63
Group 4 ⁴	0.03	0.16	0.03	1	ns	1.03	0.76	1.40
FAS	0.16	0.08	4.24	1	p<.05	1.18	1.01	1.38
Communication with father	-0.05	0.05	1.12	1	ns	0.95	0.87	1.04
Communication with mother	-0.12	0.05	6.73	1	p<.05	0.89	0.81	0.97
Monitoring from father	-0.29	0.08	11.79	1	p<.01	0.75	0.64	0.88
Monitoring from mother	-1.01	0.11	80.11	1	p<.001	0.36	0.29	0.45

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.

Table 4: Predictors of recent smoking: models of logistic regression

	B	E.S.	Wald	df	Sig.	Odd Ratio	95.0% CI for Odd Ratio	
							Lower	Upper
Gender (female)	0.03	0.08	0.17	1	ns	1.03	0.89	1.21
Age			509.70	2	p<.001			
Age (13)	2.019	0.21	89.86	1	p<.001	7.53	4.96	11.44
Age (15)	3.50	0.21	290.25	1	p<.001	33.10	22.13	49.51
Immigrant status			7.51	3	Ns			
Group 2 ²	-0.02	0.95	0.00	1	Ns	0.98	0.15	6.29
Group 3 ³	-0.939	2.32	0.16	1	Ns	0.39	0.00	37.08
Group 4 ⁴	-2.395	0.88	7.38	1	p<.01	0.09	0.02	0.51
FAS	0.025	0.10	0.07	1	Ns	1.03	0.85	1.24
Communication with father	-0.046	0.05	0.76	1	Ns	0.96	0.86	1.06
Communication with mother	-0.047	0.05	0.86	1	Ns	0.95	0.86	1.05
Monitoring from father	-0.20	0.09	4.64	1	p<.05	0.82	0.68	0.98
Monitoring from mother	-1.148	0.12	89.84	1	p<.001	0.32	0.25	0.40
FAS * Immigrant status			8.01	3	p<.05			
FAS * Group 2 ²	0.02	0.39	0.00	1	Ns	1.02	0.47	2.20
FAS * Group 3 ³	0.20	1.02	0.04	1	Ns	1.23	0.17	9.06
FAS * Group 4 ⁴	1.087	0.39	7.98	1	p<.01	2.97	1.40	6.31

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.

Table 5. Mean of FAS as regard to immigrant status and smoking recently

	Group 1 ¹	Group 2 ²	Group 3 ³	Group 4 ⁴
Smoking recently	2.32	2.39	2.10	2.29
Not smoking recently	2.32	2.37	2.22	2.11

1. Students born in Italy from both Italian native parents.

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.

Results of the three logistic regression equations were as follows:

1. In comparing students who have tried to smoke versus students which have never tried to smoke (Table 3), we found that males were more likely to have tried to smoke than female ($B=-0.15$; $p<.05$); older students were more likely to have tried to smoke than younger students (for age 15: $B=3.17$; $p<.001$); students reporting higher FAS were more likely to have tried to smoke ($B=0.16$; $p<.05$); students reporting higher levels of communication with mother ($B=-0.12$; $p<.05$) and parental monitoring were less likely to have tried to smoke (father: $B=-0.29$; $p<.01$; mother: $B=-1.01$; $p<.001$).

2. In comparing students who smoked recently versus students who did not (table 4), we found that older students were more likely to report smoking recently than younger adolescents (for age 15: $B=3.50$; $p<.001$); and students reporting higher levels of parental monitoring were less likely to report smoking recently (father: $B=-0.20$; $p<.05$; mother: $B=-1.15$; $p<.001$). Analysis of the interaction between FAS and immigrant status showed that the relation between FAS and tobacco use was different for the 4 groups. As we can see in table 5, in group 4 (foreign-born students with at least one foreign born parent) recent smokers reported higher family affluence than students who did not smoke recently.

Table 6: Predictors of daily smoking: models of logistic regression

	B	E.S.	Wald	df	Sig.	Odd Ratio	95.0% CI for Odd Ratio	
							Lower	Upper
Gender (female)	-0.01	0.10	0.01	1	ns	1.00	0.81	1.21
Age			276.52	2	$p<.001$			
age (13)	1.59	0.35	21.01	1	$p<.001$	4.90	2.48	9.67
age (15)	3.56	0.33	119.68	1	$p<.001$	35.00	18.51	66.17
Immigrant status			7.15	3	ns			
Group 2 ²	-0.26	1.29	0.04	1	ns	0.77	0.06	9.59
Group 3 ³	-2.51	3.34	0.59	1	ns	0.08	0.00	55.90
Group 4 ⁴	-3.00	1.16	6.67	1	$p<.01$	0.05	0.01	0.49
FAS	-0.20	0.13	2.61	1	ns	0.82	0.64	1.04
Communication with father	0.05	0.07	0.51	1	ns	1.05	0.92	1.20
Communication with mother	0.03	0.07	0.14	1	ns	1.03	0.90	1.17
Monitoring from father	-0.23	0.12	3.72	1	ns	0.79	0.63	1.00
Monitoring from mother	-1.05	0.15	48.25	1	$p<.001$	0.35	0.26	0.47
FAS * Immigrant status			8.32	3	$p<.05$			
FAS * Group 2 ²	0.10	0.53	0.04	1	ns	1.11	0.39	3.13
FAS * Group 3 ³	1.03	1.42	0.53	1	ns	2.81	0.17	45.57
FAS * Group 4 ⁴	1.40	0.50	7.88	1	$p<.01$	4.07	1.53	10.84

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.



Table 7. Mean of FAS with regards to immigrant status and daily smoking

	Group 1 ¹	Group 2 ²	Group 3 ³	Group 4 ⁴
Smoking recently	2.29	2.38	2.35	2.30
Not smoking recently	2.32	2.38	2.20	2.13

1. Students born in Italy from both Italian native parents.

2. Students born in Italy from one Italian native and one foreign born parent.

3. Students born in Italy from both foreign born parents.

4. Students foreign born from at least one foreign born parent.

3. In comparing students who smoke daily versus students who do not (**table 6**), we found that older students were more likely to smoke daily than younger ones (age 15: $B=3.56$; $p<.001$); students reporting higher levels of maternal monitoring were less likely to smoke daily ($B=-1.05$; $p<.001$). The interaction between FAS and immigrant status showed that the relationship between FAS and daily tobacco use were different for the 4 groups. As we can see in **table 7**, in group 4 (foreign-born students with at least one foreign born parent) and group 3 (students born in Italy from both foreign born parents), daily smokers have higher FAS than students who did not smoke daily.

Discussion

Findings from the present study revealed that the phenomenon called “immigrant paradox” was not confirmed in relation to tobacco use among immigrant adolescents living in Italy. Our study did not found lower levels of tobacco use among immigrant adolescents in comparison with Italian native adolescence, as hypothesised by the “immigrant paradox” (Georgiades et al., 2006; Harris, 2004).

We hypothesised a negative association between FAS and tobacco use (Chen et al., 2002) and that these relationships were evident only for Italian born adolescents (Georgiades et al., 2006). Our findings indicated that the association between family affluence and tobacco use was evident only in relation to trying smoking, but not for recent or daily smoking. However, this relationship was in the opposite direction to that hypothesised: students reporting higher FAS were more likely to have tried to smoke. This positive relationship was found both for immigrant and non-immigrant adolescents.

In relation to recent and daily smoking, the association between family affluence and tobacco use differed by immigrant status: among foreign-born students with at least one foreign-born parent, and among students born in Italy to two foreign-born parents, those reporting recent and daily smoking report higher FAS than those did who did not report recent and daily smoking.

Regarding the influence of relationships with parents on tobacco use (Dishion & Loeber, 1985; Duncan et al., 1994; Hill et al., 2005; Georgiades et al., 2006), our results showed that: quality of communication with parents was a protective factor only for experimental tobacco use. Parental monitoring was a protective factor for recent smoking and maternal monitoring was a protective factor for daily smoking. The protective role of the relationships with parents did not differ between immigrant and Italian native adolescents.

Several methodological limitations need to be considered in this case study, in particular: we did not analyzed other variables that can influence tobacco use during adolescence, for example, tobacco use by peers and parents, and acculturation strategies adopted by the immigrant adolescents (Berry et al., 2006b); our data are not able to test the extent to which our results apply uniformly across specific cultural or ethnic groups among immigrants; our measure of family affluence was not a complete indicator of socio-economic level; this was a cross-sectional study and we need to test our results using a longitudinal design. We can hypothesise that short-lived economic adversity in the years after migration may not affect the development of problem behaviour, whereas prolonged economic hardship may have detrimental effects for immigrant families and youth (Georgiades et al., 2006). We need to test the effect of short-lived and prolonged economic hardship using longitudinal studies.

Despite the limitations, this case study contributes to the analysis of the influence of immigrant status on tobacco use and the influence of family and economic factors on tobacco use among immigrant and non-immigrant adolescents. We found that the “immigrant paradox” was not evident with regard to tobacco use for immigrant adolescents in Italy; additionally, our results showed a clear protective influence of family level variables on tobacco use. We did not found a strong influence of family affluence on tobacco use. These results point out that immigrant status per se should not be considered as a risk or protective factor; and hence it should not be used to orient selective prevention activities for tobacco use.

Case study 4: Portugal

Nationality versus poverty: highlights and recommendations regarding interventions with migrant adolescents in Portugal based on findings from the HBSC survey

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Background for the case study

Portugal is a country with historical relationships with some African countries and Brazil, countries that use Portuguese as their official language (CPLP countries). Many migrants from those countries live in Portugal, most of them living in very poor socio-economic conditions, and in specific neighbourhoods with poor hygiene, health and social conditions. Migrants are more prone to social and racial discriminations in several contexts, such as school contexts, work contexts and community contexts; these are often related to mental and psychosocial problems.

The HBSC Study, conducted in Portugal in 2002 and 2006 (Currie et al., 2000; Matos et al.; 2002, 2003, 2006), revealed that adolescents with other nationalities besides Portuguese reported inferior school results and involvement. This group feels unhappier, reports a more distant communication with parents and engages in sexual intercourse more frequently, namely unprotected sex and sex associated with alcohol and drugs use. Further analyses suggested that the association of migrant status to poor well being, school failure and family distance is mediated by poverty (Gaspar et al., 2005; Matos & Gaspar, 2003; Matos, Gaspar & Gonçalves, 2004; Matos, Gonçalves & Gaspar, 2005).

Mental and physical health are interrelated, adolescents that report higher life satisfaction also refer a better perception of physical health. Several personal and social issues, besides gender, age and father socio-economic status (SES), seem to be associated with health perceptions and happiness. Personal issues, (like health related behaviours, such as physical activity, food intake and risk behaviours) seem to have more impact on health perceptions, and physical complaints, while social issues (like social relationships in significant life contexts: family, friends, classmates, school), seem to have more impact on perception of happiness. Family affluence has a significant impact on feeling happy and on health perceptions (Simões, Matos, Batista-Foguet, 2007). Several studies highlight the importance of these issues, described as protective factors (Matos, Simões & Sacchi 2004).

Migrant adolescents living in Portugal

Specific HBSC-related Study, two waves (2002 and 2006)

To characterise migrant adolescents' positive health and health behaviours, we used HBSC (Currie et al., 2000; Matos et al., 2003; Matos et al., 2006) two waves, 2002 (n= 6,131) and 2006 (n= 4,877) with a total sample, n=11,008 (6th, 8th and 10th grades). Of the total sample, 3.1% came from Portuguese speaking countries (African Countries and Brazil), without Portuguese Nationality (CPLP). They were used to help identify differences between Portuguese adolescents and African Portuguese-speaking adolescents living in Portugal. This group was mainly of low-socio-economic status.

Bivariate analysis and simple associations were carried on between Nationality and a set of positive health variables. For all psychological symptoms (feeling depressed or low, feeling irritable or bad temper and feeling nervous) statically significant difference were found between Portuguese adolescents and foreign adolescents from African countries or Brazil (Tables 1-3).

Table 1. Feeling depressed or low – Differences between Portuguese and CPLP adolescents (%)

	Portuguese (n=9771)	CPLP (n=309)
Once a week	15.2	20.1
Every week / every month	25.5	18.8
Rarely / never	59.3	61.2

($\chi^2= 10.21$; $df. = 2$, $p<.006$). $n=10,080$

Table 2. Feeling irritability or bad temper – Differences between Portuguese and CPLP adolescents (%)

	Portuguese (n=9789)	CPLP (n=313)
Once a week	16.4	21.7
Every week / every month	33.5	28.8
Rarely / never	50.0	49.5

($\chi^2= 7.17$; $df. = 2$, $p<.028$). $n=10,102$



Table 3. Feeling nervous – Differences between Portuguese and CPLP adolescents (%)

	Portuguese (n=9811)	CPLP (n=312)
Once a week	23.1	21.5
Every week /every month	36.4	28.5
Rarely / never	40.5	50.0

($\chi^2= 12.13$; $d.f. = 2$, $p<.002$). $n=10,123$

Table 4. Life Satisfaction – Differences between Portuguese and foreign adolescents (%)

	Portuguese (n=9856)	CPLP (n=314)
Unsatisfied	2.8	5.1
Satisfied	44.7	44.6
Very satisfied	52.5	50.3

($\chi^2= 5.72$; $d.f. = 2$, $p=.057$). $n=10,170$

Foreign adolescents also tend to feel more often unsatisfied with their lives than Portuguese adolescents. (Table 4)

Qualitative in dept methodology - Focus groups

Focus groups were carried out, in order to get closer to migrant adolescent's perspective, professionals' perspectives (teachers, psychologists, nurses, social assistants) and parents' perspectives (opinions, attitudes, speech and understanding about adolescent's positive health and health behaviours; the influence of personal, social and economic issues). A total of 26 migrant

Portuguese-speaking adolescents (African) aged between 13-19 years old; 22 professionals (health and education professionals working with migrant (African) adolescents), and 6 parents (1 mother and 5 fathers migrant from African Portuguese speaking countries) were included in this in-depth qualitative study. Nine focus groups from four areas of Lisbon city were carried out (four adolescent groups, one parent group and four professional groups). Taped focus group interviews were analysed and category definition and codification carried on. Illustrative examples of each category are presented below.

Family

"My mother works a lot, she leaves home at 6 am and arrives home at night but she cares about us." (Adolescent)

"Most of them have single parent families, mothers work a lot, and an older sister often takes care of the younger ones." (Professional)

"They tend to have large families, lots of kids, grandmothers, uncles, stepfathers . . ." (Professional)

"I can not talk to my daughter, we have different concepts. I try to communicate with her and she always says that I am old fashioned." (Parent)

School

"At school, we feel discriminated. When we say that we live in this neighbourhood, everything goes wrong." (Adolescent)

"School it is not a protective factor . . . On the opposite, school seems to work like an exclusion factor, they tend to leave school too soon, it is a big problem." (Professional)

"Many times teachers build barriers against pupils, because they just don't know what to do." (Professional)

"Violence it is a big problem, not just in the street but inside the school." (Parent)

Peers group

"Friends are not important, I don't have friends, and I just have some people that I know." (Adolescent)

"They see the older ones breaking the social rules and they admire them. They want to be like them in order to be accepted, to feel integrated." (Professional)

"She always spends her leisure time with one friend or alone in her room." (Parent)

Well-being

"First they should take care of the younger ones, giving them places to play, to be happy, to feel good instead of engaging in violence, substance use and other risky things." (Adolescent)

"The discrimination reinforces the negative image that they have about themselves (. . .) They lose the hope that their life will ever be different." (Professional)

"Our children know that they have 'broken legs' since the beginning"; "They become very stressed because they do not have documents, first they don't exist, and then they become delinquents." (Parent)

Leisure time

"The worst thing is when we do not have anything to do." (Adolescent)

"We do not have adequate structures for physical activities, neither leisure parks in the neighbourhood." (Professional)

"Our children became more and more connected with internet, TV . . ."; "They are 'addicted' to the street. Every parent has this worry." (Parent)

Substance use

"I feel more comfortable. It's better to dance, and it's better to talk with the girls." (Adolescent)

"Alcohol use is common (. . .) many people abuse of alcoholic drinks at home and in the community. They are the role models for adolescents." (Professional)

"Some adolescents leave school, they have nothing to do. They traffic drugs, it is easy money. . . but most of them do not use drugs." (Professional)

"We are always worried with our children. The problem is not the people from the neighbourhood, the problem are those who come from other neighbourhoods and want to buy or sell drugs." (Parent)

Violence

"Some boys ruin everything, break everything. They do not understand that it is important have a good image." (Adolescent)

"They are aggressive among themselves, with the teachers, with parents and with themselves. It is difficult to understand and control them." (Professional)

"A black adolescent is kind of condemned. Many adolescents feel anger. We are raising delinquents, and we do not know what to do, or where to find help." (Parent)

Sexual behaviours / HIV

"We get information among friends and in the internet, never with our parents"; "I feel ashamed if my parents talk about that"; "If we can not learn at home, we should have sexual education at school." (Adolescent)

"They start their sexual activity too young (. . .) we have many pregnant adolescents"; "pregnancy is kind of an alternative to poor schooling and poor school expectancies." (Professional)

"All parents realize that HIV is a big problem, we and all the society have to fight against that huge problem." (Parent)

"Sexuality is a taboo . . . it is something that we could not talk about, we just do . . . but we should break this wall." (Parent)

Belonging to an ethnic minority, specifically migrant adolescents coming from African Portuguese-speaking countries and Brazil, and a low socio-economic status, are factors linked with mental health problems and more risk behaviours. Those are fundamental risks to address in health promotion research and intervention. However, at the moment, there are no specific interventions aimed at migrant adolescents that are based on adequate prevention and promotion skills.

A "migrant specific" HBSC based study

One health survey based on HBSC questions (Matos, Gonçalves & Gaspar, 2005) included adolescents from severely deprived areas, in the suburbs of Lisbon. A global sample of 1,037 adolescents, mean age 15 years old, participated in the survey, 24.3% were foreigners, from African Portuguese-speaking countries.

Results confirmed what was suggested during the National surveys: migrant status and low social and economic status are associated, and often co-exist with a higher level of adolescent risk behaviours and these adolescents reveal feeling socially unsupported and unhappy. Other in depth studies (Matos et al., 2002; Matos, Dadds & Barrett, 2006) suggested a co-occurrence of poor physical health, risk behaviours (namely substance use) and poor mental health, and stressed the importance of social settings, namely school ethos and family-school links.

Conclusions

These Portuguese studies (Matos, 2005) suggest the need for a global community intervention within adolescent contexts (family, school, community) in order to promote health knowledge and personal and social skills that lead to healthy choices and lifestyles. The specific case of poor adolescents living in poor neighbourhoods with mainly ethnic minorities, lacking Portuguese



language skills and facing increased social exclusion and social problems could obviously be better addressed not merely from the point of view of preventing risk behaviours but also from promoting well being, a sense of belonging and social support and inclusion (Matos, Gonçalves & Gaspar, 2005).

Hobbies and other leisure activities like music, sports, drama, arts and dance have come to constitute very important spheres of living and learning, emphasising the importance of leisure in adolescents' lives. Thus, leisure activities have partly taken over educational roles formerly performed by schools and parents (Aittola, 1998). Further, it is well known that leisure activities provide enriching opportunities for children to interact with peers (Telama et al, 2005), which are the most important socialisation agents in physical activity. This entire context suggests the relevance of a selective preventive intervention in order to create alternatives to better cope with life (social exclusion, feeling unhappy, interpersonal relationships) and search for well being, personal competence and social participation.

Promotion of protective factors should be the essence of health promotion. For this current conception contributed a lot the concept of resilience and the research beyond it, which had privileged the search of protective factors and processes and self competence and self regulation skills.

It seems that any individual preventive work must approach life contexts, to get an effective decrease of risk, an activation of resources and the promotion of personal and social abilities. Individuals that have these kinds of abilities present a greater capacity to adapt to different situations and to deal with adversity (Matos, Simões & Sacchi, 2004; Simões, 2005; Matos, 2005).

Belonging to an ethnic minority, specifically migrant adolescents coming from an African Portuguese speaking country and Brazil (CPLP), and a low social and economic status, are factors linked to mental health problems and more risk behaviours. Effectively, these are fundamental risks to address in health promotion research and intervention. It is believed that this issue must be mainly addressed from the perspective of promoting and assuring school success, as the only way to cut in pieces "the snowball" of "poverty-social exclusion- school failure-health compromising behaviours- school drop out-under or an employment- social exclusion-poverty " (Gaspar et al., 2005; Matos, Gaspar & Gonçalves, 2004).

Recommendations

School and leisure time are a good starter point for cross-cultural and inter-cultural health promotion. They foster the creation of alternatives to coping with life (thus moving away from social exclusion, stress, depression, irritability, nervousness, and lack of interpersonal relationships) and to look for well-being and pleasure. Adolescents, parents, school, group peers and the community must all be involved in such processes.

Such social and personal skills promotion programmes, which build alternatives and add positive aspects of health and life, are ways to help adolescents to:

- identify and solve problems;
- manage interpersonal conflicts;
- identify and manage emotions;
- develop interpersonal communication;
- advocate for personal rights;
- resist peer pressure;
- develop self-regulation skills;
- choose and maintain a healthy lifestyle.

There is also a need of a global community intervention within the adolescent contexts (family, school, community) in order to promote personal and social skills. The final aims are the promotion of well-being, competence, autonomy, sense of responsibility, sense of belonging and personal achievement, social participation and commitment. There are specific issues for poor adolescents that live in poor neighbourhoods with mainly ethnic minorities, as they are in a stronger danger of social exclusion, discrimination, stigmatisation and heavier social problems, highly related to mental health problems. All professionals involved need adequate skills and training in order to be aware of and to meet the specificity of these target-populations.

Case study 5: Spain

Policies and practice for migrants in Spain

Carmen Moreno, Antonia Jiménez-Iglesias, Francisco Rivera and Pilar Ramos

In Spain, the migratory policy defined by the Spanish Government is developed and put into practice by the National Government through the Secretary of State for Immigration and Emigration. According to the regulations with regards to this area in Article 149.1 Point 2 of the Constitution, the National Government has exclusive jurisdiction over nationality, immigration, emigration, aspects relating to foreign-nationals, right of asylum and measures for integration.

In the case of the regulations, it is necessary to state that when the authorities know of a minor with no adult of reference, and therefore, in a situation of complete abandonment, they are forced by the Law of Minors (Law 1/1995, dated the 27th of January, with regards to the protection of minors), to take charge of the said minor, taking on their guardianship, without applying the status of foreign-national to the minor. The first step is to document such minors, to obtain the child's personal information and proceed with medical examinations to determine their age. If the result of the examination indicates that the child is a minor, it is necessary for the corresponding administration to have the documentation and accept the guardianship of the child.

The Permanent Observatory of Immigration is attributed to the Ministry of Work and Immigration, by means of the Secretary of State for Immigration and Emigration. This is a collegiate body whose functions (laid out in Royal Decree 345/2001, dated 4th of April, by which the Permanent Observatory of Immigration is regulated) include:

- To act as a permanent body to collect, analyze and exchange quantitative and qualitative information that arrives at the National Government with regards to foreign nationals, immigration and asylum;
- To gather, promote and guide the diffusion of the information obtained;
- To promote, compile, share and distribute research, surveys, studies and publications;
- To compile an annual report and periodic reports about the reality of immigration;
- The creation and maintenance of a statistical database;
- To compile reports and provide statistical data for Europe and at the international level.

Another body is the Large Enterprise Unit, responsible for the administration of the authorisations for residence, temporary residence and work for others, and temporary residence and work within the framework of a trans-national services, which are requested for highly qualified executives, technicians, scientists, professors of public Spanish universities and internationally renowned artists, whose recruitment is in social, labour or cultural economic interest.

In addition, in an effort to promote the participation and integration of immigrants in Spanish society, the Forum for the Social Integration of Immigrants was constituted to propose, inform and channel actions towards these objectives. The forum is under the Ministry of Work and Immigration, by means of the General Office for the Integration of Immigrants, this being the body for consultation, information and advice in regards to the integration of immigrants.

Finally, in Spain there are various different national research/ information centres dedicated to the topic of immigration, as well as associations and NGOs.

Migrants' HBSC Study in Spain

Within the Health Behaviour in School Aged Children (HBSC) Study in Spain (supported by an agreement signed between the Spanish Ministry of Health and Consumer Affairs and the University of Seville), at the request of the Ministry of Health and Consumer Affairs, a report titled "*Adolescent development and the health of immigrants in Spain. Health Behaviour in School Aged Children Study (HBSC-2006)*" is being drafted.

This work identifies three different groups of school-aged children between 11 to 16 years of age:

- Spanish nationals, teenagers whose parents were born and reside in Spain. This group is composed of 14,248 adolescents;
- Second generation immigrants, with teenagers born and residing in Spain, but whose parents were immigrants; With a total of 122 adolescents and because its sparse population, this group will be not analysed in this work;
- First generation immigrants (adolescents and their parents were born outside Spain) make up a group of 1,045 adolescents; This group differs from the other three groups according to their country of origin: Latin

Table 1. Distribution by sex, age and Family Affluence Scale (FAS) of the different groups

	Sex		Age			FAS		
	Boy	Girl	11-12	13-14	15-16	Low	Medium	High
Native Spaniards	7030	7218	4648	4668	4932	1803	6517	5732
2 nd generation Immigrants	50	72	40	28	54	30	56	34
1 st generation Immigrants	512	533	418	313	314	402	450	175
Latin America	342	356	298	192	208	290	290	108
Arab-speaking country countries-	45	51	35	36	25	33	43	18
Eastern Europe	61	59	38	38	44	43	66	10



America (698 adolescents), Arab-speaking countries (96 adolescents) and Eastern Europe (120 teenagers).

This distribution only takes into consideration native Spanish adolescents and first generation immigrants, as well as comparisons among them, taking into account their sex, age and FAS.

This report is structured into five chapters that describe and analyze the adolescent development of immigrants in Spain. Chapters are:

- Introduction: this chapter discusses the HBSC Study in Spain and the distribution of adolescent immigrants in the sample;
- Life Styles: this comprehensive chapter discusses the lifestyles of immigrants and native Spanish adolescents in relation to their food and diet, oral/dental hygiene, physical and sedentary activity, substance use, sexual behaviour as well as accidents and injuries;
- Development contexts: Another major chapter discusses different variables of different adolescents' contexts: family (such as family structure, family communication, parental supervision, family satisfaction), peer and free time (including peer satisfaction, time to return home at night, peer abuse) and school (satisfaction with school, academic achievement, psychosocial school environment index);
- Health and psychological adjustment: this chapter discusses adolescents' overall health and psychological adjustment, including their perception of health, health complaints, self-esteem and life satisfaction;
- Conclusions: this chapter summarizes the main results of previous chapters.

As an example, the work currently being undertaken presents the data found in relation to the consumption of alcohol.

Figure 1. Percentage of native Spaniards and immigrant adolescents who currently do not consume alcohol

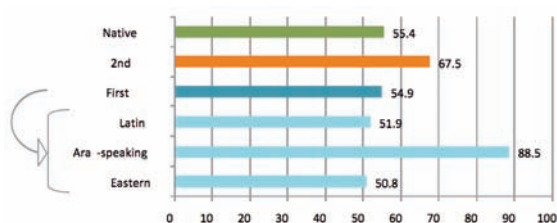


Figure 1 shows, according to the immigrant profile, that the percentage of no consumption is higher in 2nd generation adolescent immigrants (67.5 %), while in other groups, the percentage of no-consumption is very similar, 55.4% in native Spaniards and 54.9% in first generation immigrants. When taking into consideration the adolescent's country of origin, adolescents from Arab-speaking countries are least likely to consume alcohol (88.5%). However, adolescents from Latin America and Eastern Europe have no-consumption percentages that are very similar and lower (51.9% and 50.8% respectively).

When discussing the consumption of alcohol with different groups, taking into account gender, as indicated in Figure 2, in all groups, the no-consumption percentage is higher in girls, although differences are very small (1 to 2

percent points). The same is true when considering the place of origin, except in the Latin American group; in addition, in the Eastern European group, the differences between boys and girls are higher, 10 percent points.

Figure 2. Percentage of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to sex

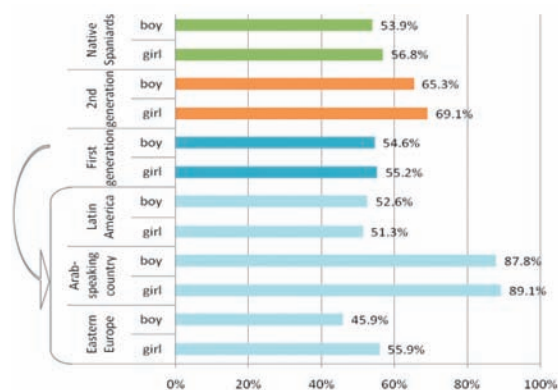


Figure 3 shows the differences of no-consumption between native Spaniards and migrants according to age. When studying immigrant profile data according to the place of origin, the percentage of no-consumption decreases with age. In other words, older adolescents consume more alcohol.

Finally, the percentage of no-consumption among native Spanish adolescents is similar to those from affluent (middle and high FAS) families (55.7% and 56.2% respectively) and is lower in low FAS (50.8%). Among 2nd generation adolescent immigrants, the percentage of no-consumption is higher in the average FAS families (72.2%), followed by low (65.5%) and finally high (62.5%) FAS. Among 1st generation immigrants, the percentages of no-consumption are very similar in low and average FAS (57.3 % and 55.9 % respectively) and greater than in high FAS (45.9 %) families.

Figure 3. Percentage of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to age

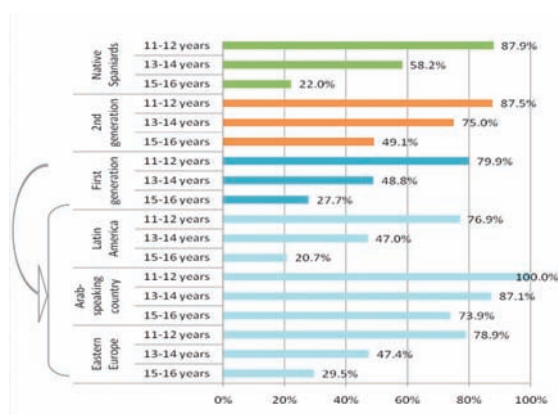
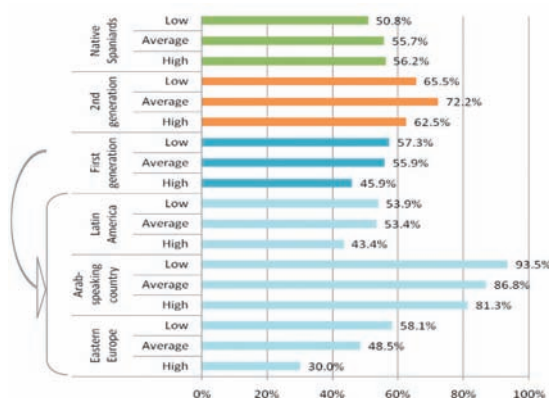


Figure 4. Percentage of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to FAS.



In reviewing adolescent immigrant data according to country of origin, the percentage of no-consumption in the three groups is lower among those adolescents from high FAS families and higher among adolescents from low FAS families (although in adolescents from Latin America, the difference between the low and average FAS families is very small).

Below are different tables indicating the frequencies of alcohol use.

Table 2. Frequencies of native Spaniards and immigrant adolescents who currently do not consume alcohol

		FREQUENCY OF CURRENT CONSUMPTION OF ALCOHOLIC BEVERAGES					
		TOTAL	EVERY DAY	ALL THE WEEKS	ALL THE MONTHS	RARELY	NEVER
			%	%	%	%	%
ADOLESCENT PROFILE	NATIVE SPANIARDS	13816	1.1%	10.1%	10.0%	23.3%	55.4%
	2 ND GENERATION IMMIGRANTS	117	.0%	6.0%	6.0%	20.5%	67.5%
COUNTRY OF ORIGIN	1 ST GENERATION IMMIGRANTS	1011	.7%	6.9%	7.2%	30.3%	54.9%
	LATIN AMERICA	676	.6%	6.2%	8.0%	33.3%	51.9%
	ARAB-SPEAKING COUNTRY	87	.0%	8.0%	1.1%	2.3%	88.5%
	EASTERN EUROPE	120	1.7%	7.5%	7.5%	32.5%	50.8%

Conclusions

In response to the policy objectives in Spain, this report carefully analyses lifestyles and their relationship to the health of adolescent immigrants in order to understand and safeguard the health of this population. Likewise, this study covers more in-depth the development of these young people within their developmental context: family, relationship with peers and school life. This allows us to obtain key interventions for adolescent immigrants. For example, according to the variable analysed as a sample for this report (alcohol consumption), relevant information has been obtained for use in intervention policies. These policies cover aspects such as the need to prevent the consumption of alcohol (especially among adolescent immigrants from first generation and from Latin America and Eastern Europe) and the influence of their socio-economic level on the consumption of alcohol.

Therefore, the statistics from the HBSC Study allow important information about the health of immigrant adolescents to be collected, while at the same time researches the processes involved in the development and maintenance of lifestyles that promote or jeopardise the health of these young people. Moreover, it analyses this matter from the international perspective and issues timely reports so that they can be analysed over time.



Table 3. Frequencies of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to sex

			FREQUENCY OF CURRENT CONSUMPTION OF ALCOHOLIC BEVERAGES					
			TOTAL	EVERY DAY	EVERY WEEK	EVERY MONTH	RARELY	NEVER
				%	%	%	%	%
ADOLESCENT PROFILE	NATIVE SPANIARDS	BOY	6819	1.7%	10.7%	9.7%	24.0%	53.9%
		GIRL	6997	.5%	9.6%	10.4%	22.7%	56.8%
	2 ND GENERATION IMMIGRANTS	BOY	49	.0%	10.2%	4.1%	20.4%	65.3%
		GIRL	68	.0%	2.9%	7.4%	20.6%	69.1%
	1 ST GENERATION IMMIGRANTS	BOY	491	1.0%	8.4%	6.9%	29.1%	54.6%
		GIRL	520	.4%	5.6%	7.5%	31.3%	55.2%
COUNTRY OF ORIGIN	LATIN AMERICA	BOY	327	.9%	6.1%	7.0%	33.3%	52.6%
		GIRL	349	.3%	6.3%	8.9%	33.2%	51.3%
	ARAB-SPEAKING COUNTRY	BOY	41	.0%	9.8%	.0%	2.4%	87.8%
		GIRL	46	.0%	6.5%	2.2%	2.2%	89.1%
	EASTERN EUROPE	BOY	61	3.3%	14.8%	9.8%	26.2%	45.9%
		GIRL	59	.0%	.0%	5.1%	39.0%	55.9%

Table 4. Frequencies of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to age

			FREQUENCY OF CURRENT CONSUMPTION OF ALCOHOLIC BEVERAGES					
			TOTAL	EVERY DAY	EVERY WEEK	EVERY MONTH	RARELY	NEVER
				%	%	%	%	%
ADOLESCENT PROFILE	NATIVE SPANIARDS	11 - 12	4562	.5%	.2%	.9%	10.5%	87.9%
		13 - 14	4442	1.0%	5.0%	6.8%	29.0%	58.2%
		15 - 16	4812	1.7%	24.3%	21.7%	30.3%	22.0%
	2 ND GENERATION IMMIGRANTS	11 - 12	40	.0%	.0%	2.5%	10.0%	87.5%
		13 - 14	24	.0%	4.2%	4.2%	16.7%	75.0%
		15 - 16	53	.0%	11.3%	9.4%	30.2%	49.1%
	1 ST GENERATION IMMIGRANTS	11 - 12	407	.5%	.2%	1.0%	18.4%	79.9%
		13 - 14	297	1.0%	5.1%	8.8%	36.4%	48.8%
		15 - 16	307	.7%	17.6%	14.0%	40.1%	27.7%
COUNTRY OF ORIGIN	LATIN AMERICA	11 - 12	290	.7%	.3%	1.0%	21.0%	76.9%
		13 - 14	183	.5%	3.3%	8.7%	40.4%	47.0%
		15 - 16	203	.5%	17.2%	17.2%	44.3%	20.7%
	ARAB-SPEAKING COUNTRY	11 - 12	33	.0%	.0%	.0%	.0%	100.0%
		13 - 14	31	.0%	9.7%	3.2%	.0%	87.1%
		15 - 16	23	.0%	17.4%	.0%	8.7%	73.9%
	EASTERN EUROPE	11 - 12	38	.0%	.0%	2.6%	18.4%	78.9%
		13 - 14	38	2.6%	7.9%	10.5%	31.6%	47.4%
		15 - 16	44	2.3%	13.6%	9.1%	45.5%	29.5%

Table 5. Frequencies of native Spaniards and immigrant adolescents who currently do not consume alcohol, according to FAS

			FREQUENCY OF CURRENT CONSUMPTION OF ALCOHOLIC BEVERAGES					
			TOTAL	EVERY DAY	EVERY WEEK	EVERY MONTH	RARELY	NEVER
				%	%	%	%	%
ADOLESCENT PROFILE	NATIVE SPANIARDS	LOW	1757	1.3%	12.3%	10.4%	25.2%	50.8%
		AVERAGE	6333	.9%	10.0%	10.0%	23.3%	55.7%
		HIGH	5545	1.1%	9.6%	10.1%	22.9%	56.2%
	2 ND GENERATION IMMIGRANTS	LOW	29	.0%	3.4%	6.9%	24.1%	65.5%
		AVERAGE	54	.0%	3.7%	3.7%	20.4%	72.2%
		HIGH	32	.0%	12.5%	6.3%	18.8%	62.5%
	1 ST GENERATION IMMIGRANTS	LOW	389	1.0%	6.2%	4.6%	30.8%	57.3%
		AVERAGE	435	.7%	6.0%	8.0%	29.4%	55.9%
		HIGH	170	.0%	10.0%	11.2%	32.9%	45.9%
COUNTRY OF ORIGIN	LATIN AMERICA	LOW	280	.7%	5.7%	5.4%	34.3%	53.9%
		AVERAGE	281	.7%	5.7%	8.9%	31.3%	53.4%
		HIGH	106	.0%	7.5%	12.3%	36.8%	43.4%
	ARAB-SPEAKING COUNTRY	LOW	31	.0%	6.5%	.0%	.0%	93.5%
		AVERAGE	38	.0%	5.3%	2.6%	5.3%	86.8%
		HIGH	16	.0%	18.8%	.0%	.0%	81.3%
	EASTERN EUROPE	LOW	43	2.3%	9.3%	4.7%	25.6%	58.1%
		AVERAGE	66	1.5%	6.1%	10.6%	33.3%	48.5%
		HIGH	10	.0%	10.0%	.0%	60.0%	30.0%



Conclusions

This section reviews findings from the situational analysis and from the different case studies, aiming to achieve an overall understanding of immigrant children's experiences.

All data reviewed suggest that there are few socio-demographic differences between child immigrants and their native peers. However, across all countries and groups, foreign-born/immigrant children are found to be over-represented in less affluent households and under-represented in more affluent households, with immigrant children in Portugal being particularly poor. This finding stands out as the strongest, most significant difference between child immigrants and the general population and are similar to findings previously reported in the US (the Urban Institute, 2006; Hernandez et al., 2008) and in the Netherlands (Vollebergh et al., 2005).

Overall, cross-national analysis suggests that the general health and life satisfaction of foreign-born children is similar to that of their native peers. However, the Irish case study reveals that immigrant children from the UK are less likely to report excellent health and high life satisfaction, and more likely to report frequent headaches compared to their native peers. These findings were not evident among non-UK immigrants.

In Greece, foreign-born children are less likely than their native peers to report that they find it easy to talk to their parents. This was not found in any of the other 11 countries studied. The Italian case study adds that the protective effect that good relationships with parents have on children's lives is evident for both immigrants and native children.

Findings regarding peer relationships are more complicated with no clear cross-national patterns. In some countries, foreign-born children are much more likely to find it easy to talk to their best friends. In others, the opposite was found. However, the data fall short of describing these friendships. Best friends could be made of other foreign-born children from the same background, from a different origin or natives. A couple of the case studies addressed peer relationships by country of origin. In Ireland, immigrant children originating from non-UK countries report weaker peer relations, but the opposite is reported by UK immigrant children. Among children in Iceland, there is an increase in racism toward children from Eastern Europe, but not towards children from other origins.

Integration in school could serve as an indicator for integration in society, hence it is broadly studied in relation to migrant status. The cross-national analysis did not reveal a clear pattern across countries and across variables. In some countries, foreign-born children were more likely to perceive their school performance as above average, in some they are less likely to perceive themselves as above the average, and other countries foreign-born children are similar to their native peers. In two countries,

foreign-born children were more likely to report that they liked school, but in all other countries such differences were not evident. The lack of one clear pattern coincides with the literature that points to different findings in different countries and between immigrants from different countries of origin (Levels, Dronkers and Kraaykamp, 2008; Liebkind et al., 2004; Cardak & McDonald, 2004; Harris et al., 2008; Westin, 2003).

In four of the countries, foreign-born children were less likely to agree that other students accept them as they are, but this was not evident in the other eight countries. In Iceland findings suggest that school related problems are associated with the level of fluency in language rather than solely with an immigrant status. Children leaving in houses where a foreign language is spoken are two-to-three times more likely to report disliking school and less likely to report that other students are kind to them. In Ireland, however, language itself could not serve as an explanation for such difference: in Ireland, UK immigrants (who are fluent in English) are less likely to report positive school perceptions and both UK and non-UK immigrant are less likely to report that other students accept them, compared to their native peers.

Bullying victimisation is more prevalent among foreign-born children in Ireland, Scotland and Spain, and bullying perpetration more prevalent among foreign-born children in Italy and Spain and less prevalent among foreign-born children in Greece. Involvement in physical fighting is more prevalent among foreign-born children in Germany, Greece, Italy, Spain and Sweden. In Iceland, adolescents in homes where other languages (not Icelandic) are spoken are 3.1 times more likely to have been bullied.

Involvement in risk behaviours also varies by type of behaviour and by country. Foreign-born children in Greece are more likely to report history of drunkenness; in Wales and Denmark fewer foreign-born children reported to have been drunk; and fewer foreign-born children in Spain reported weekly smoking. More in-depth information is provided in the national case studies. In Iceland, results show that adolescents in homes where a language other than Icelandic is spoken are 3.1 times as likely to smoke daily, 1.4 times as likely to have been drunk and 2.3 times as likely to have had sexual intercourse. Additionally, second generation children from African, Asian, Central- or South-American origin are 1.7-2.0 times as likely to smoke, drink or have early sexual intercourse. In Ireland, UK immigrant boys are more likely to be involved in risk behaviours, but this is not evident among non-UK immigrant children. In Portugal, immigrant children are much more likely to report involvement in all risk behaviours.

Challenges Identified

The compilation of evidence from the situational analysis and the national case studies suggest that immigration is a very complex phenomenon

that differs between and within the countries. There is no one clear pattern that allows concluding that immigrant children are faring better or worse. The culture of the country of origin, the culture in the country of residence, the policies that exist in a country in relation to migration and the level of inclusion in society all interplay to create this mixed picture, making it impossible to conclude with recommending a one-size-fits-all approach. The challenges that are therefore identified are many.

Although the data presented is fairly rich, it is not rich or deep enough to establish the needs of different migrant groups in different countries. More targeted data collection is, therefore, required.

One aspect of migrant life that seems substantial for immigrant children's lives is social inclusion. Children that are excluded seem to fare worse. Social inclusion does not necessarily mean that children need to shed their old sense of identity; diversity should be accepted and respected.

One of the only findings that seems to cut across countries and groups is the lower level of family affluence among immigrant families. Whereas in many cases this is only to be expected, it still puts these children under additional stress. This issue needs to be better studied and addressed.

The evidence presented calls for a global community intervention within the adolescent's contexts (family, school, community). Interventions are needed in order to promote health knowledge and personal and social skills that lead to healthy choices and lifestyles and to better social inclusion. The importance of fluency in the language spoken in the country is also highlighted and needs to be supported. In addition to promoting individual skills, there is a need to promote tolerance towards diversities in societies and to create mechanisms that allow for better integration of immigrant children in society.

Implications for research, policy and practice

Despite the limitations of the above analysis, it provides insights into issues that could have implications for research, policy and practice. Four examples of these are briefly highlighted below, and reflect a social determinants of health approach to the immigrant child's well-being.

- Noting that immigrant children are found to be over-represented in less affluent households, it is important that (a) migration policies provide migrant families with equitable access to social protection services, and (b) social protection policies foster equitable access to public services and opportunities. Of relevance here are the recommendations of the Commission on Social Determinants of Health regarding policies for social protection across the life course (WHO, 2008):
 - o Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, should build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living;
 - o Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, should use targeted approaches only as back up for those who slip through the net of universal systems.
- A positive family environment can be a protective factor for the health of all children, immigrant and native-born. There is evidence that programmes that foster effective parenting skills —including Early Child Development programmes that feature, among other services, parenting and caregiver support— can help to maximize children's development capacity (Irwin, Siddiqi & Hertzman, 2007). Such programmes can be particularly important for children from socioeconomically disadvantaged households, which are disproportionately represented in migrant populations, and are a tool in breaking the inter-generational transmission of poverty and social exclusion.
- Effective health information systems are central in enabling health systems to fulfil their goals of health, financial protection and responsiveness (WHO Regional Office for Europe, 2008a). The analyses in this paper highlight the need for these systems to monitor and measure the health of national populations, including migrant and ethnic minority populations, with data disaggregated according to the major social determinants in each context (such as age, gender, ethnicity, education, employment and socioeconomic status). This permits health inequities to be detected and the impact of policies and practices monitored (WHO, 2009a).
- Given the complexities of the migration phenomena —for instance, with differing socioeconomic conditions in countries of origin and different levels of integration in countries in destination— international comparison of data on migrant health is challenging and can lead to disparate results. While it is important nevertheless to continue these efforts at the international level, it is first and foremost essential to scale up investment in information systems at national and sub-national level that look at health inequities, including by migrant status. Such data can be taken into consideration in the design of policies and programmes, in the health sector and beyond, with particular usefulness for primary health care level in areas serving migrant communities and other populations that may face higher levels of social exclusion.



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References

- Acevedo-Garcia D, Pan J, Jun H, Osypuk TL, & Emmons, KM. The effect of immigrant generation on smoking. *Social Science & Medicine*, 2005, 61: 1223-42.
- Beiser M, Hou F, Hyman I, et al. Poverty, family process and the mental Health of immigrant children in Canada. *American Journal of Public Health*, 2002; 92:220-7.
- Bengi-Arslan L, Verhulst FC, van der Ende J, Erol N. Understanding childhood (problem) behaviour from a cultural perspective: comparison of problem behaviour and competencies in Turkish immigrant, Turkish and Dutch children. *Social Psychiatry and Psychiatric Epidemiology*, 1997, 32:477-484.
- Berry JW. Immigration, acculturation, and adaptation. *Applied Psychology: An International Review*, 1997, 46: 5-68.
- Berry JW, Phinney JS, Sam DL, Vedder P. Immigrant youth: acculturation, identity and adaptation. *Applied psychology: an International Review*, 2006, 55(3):303-32.
- Bond L, Butler H, Thomas L, Carlin J, Glover S, Bowes G, Patton G. Social and school connectedness in early secondary school as predictor of late teenage substance use, mental health, and academic outcomes. *Journal of Adolescents Health*, 2007, 40:357.e9-357.e18.
- Blake SM., Ledsky R. Goodenow C & O'Donnell L. Recency of immigration, substance use, and sexual behavior among Massachusetts adolescents. *American Journal of Public Health*, 2001, 91:794-798.
- Bonny AE, Britto MT, Klostermann BK, Hornung RW, Slap GB. School disconnectedness: Identifying adolescents at risk. *Pediatrics*, 2000, 106:1017-1021.
- Cardak BA & McDonald, JT. Neighbourhood effects, preference heterogeneity and immigrant educational attainment. *Applied Economics*, 2004, 36, 559-572.
- Crosnoe R. (2005). Double disadvantage or signs of resilience? The elementary school contexts of children from Mexican immigrant families. *American Educational Research Journal*, 2005, 42:269 – 303.
- Currie C, Gabhainn SN, Godeau E, Roberts C, Smith R, Currie D, Pickett W, Richter M, Morgan A & Barnekow V (eds.). *Inequalities in young people's health: HBSC international report from the 2005/2006 Survey*, 2008. Copenhagen: WHO.
- Davies LC, McKelvey RS. Emotional and behavioural problems and competencies among immigrant and non-immigrant adolescents. *Australian and New Zealand Journal of Psychiatry*, 1998, 32:658-665.
- Fuligni AJ. The adjustment of children from immigrant families. *Current Directions in Psychological Science*, 1998, 7:99-103.
- Gaudet S, Clement R, Deuzeman K. Daily hassles, ethnic identity and psychological adjustment among Lebanese-Canadians. *International Journal of Psychology*, 2005, 40:157-168.
- Georgiades K, Boyle MH, Duku E, Racine Y. Tobacco use among immigrant and non-immigrant adolescents: individual and family level influences. *Journal of Adolescents Health*, 2006, 38:443-7.
- Glick JE, White MJ. Post-secondary school participation of immigrant and native youth: the role of familial resources and educational expectations. *Social Science Research*, 2004, 33:272-299.
- Gonzales NA, Deardorff J, Formoso D, Barr A, and Barrera M. Family mediators of the relation between acculturation and adolescent mental health. *Family Relations*, 2006, 55:318-330.
- Gracia Coll C. The immigrant paradox: Critical factors in Cambodian students' success. Paper presented at the 2005 Biennial meeting of the Society for Research in Child Development. Atlanta, Georgia, 7-10 April 2005.
- Gushulak B, Pace P, Weekers J. Migration and health of migrants. In: Poverty and social exclusion in the European Region: Health systems respond. Follow-up to Resolution EUR/RC52/R7 on Poverty and Health [provisional title]. Copenhagen, WHO Regional Office for Europe, in press.
- Harker, K. Immigrant generation, assimilation, and adolescent psychological well-being. *Social Forces*, 2001, 79:969-1004.
- Harris KM. The health status and risk behaviours of adolescents in immigrant families. In: Henandez DJ, ed. *Children of Immigrants: Health, adjustment and public assistance*, 2004. Washington, DC: National Academy Press Pp. 286-322.
- Heisz, A., & McLeod, L. *Low-income in Census Metropolitan Areas, 1980 – 2000*. Statistics Canada No. 89-613-MIE, No. 001, 2004. Ottawa: Statistics Canada.



- Herm A. Recent migration trend: citizens of EU-27 Member States become ever more mobile while EU remains attractive to non-EU citizens. *Eurostat Statistics in focus – 98/2008*.
- Hernandez DJ, Denton NA, Macartney AZ. Children in immigrant families: looking to America's future. Social Policy report. Society for Research in Child Development. Fordham University City, 2008.
- Irwin L, Siddiqi A, Hertzman C (2007). Early childhood development: a powerful equalizer. Final report of the Early Childhood Development Knowledge Network of the Commission on the Social Determinants of Health. Geneva, World Health Organization (http://www.who.int/social_determinants/resources/ecd_kn_final_report_072007.pdf, accessed 11 May 2009).
- Isralowitz RE & Slonim-Nevo V. Substance use patterns and problem behavior among immigrant and native-born juvenile offenders in Israel. *Addiction Research and Theory*, 2002, 10:399-414.
- Janssen MMM, Verhulst FC, Benghi-Arslan L, Erol N, Salter CJ, Crijnen AAM. Comparison of self-reported emotional and behavioral problems in Turkish immigrant, Dutch and Turkish adolescents. *Social Psychiatry and Psychiatric Epidemiology*, 2004, 39:133-140.
- Jeltova I, Fish MC, Revenson TA. Risky sexual behaviours in immigrant adolescent girls from the former Soviet Union: Role of natal and host culture. *Journal of School Psychology*, 2005, 43:3-22.
- Liebkind K, Jasinskaja-Lahti I, Solheim E. Cultural identity, perceived discrimination, and parental support as determinants of immigrants' school adjustments: Vietnamese youth in Finland. *Journal of Adolescent Research*, 2004, 19:635-56.
- Levels M, Dronkers J, Kraaykamp G. Immigrant Children's Educational Achievement in Western Countries: Origin, Destination, and Community Effects on Mathematical Performance. *American Sociological Review*, 2008, 73:835-853.
- Ma X. The first ten years in Canada: A multi-level assessment of behavioural and emotional problems of immigrant children. *Canadian Public Policy*, 2002, 28:395-418.
- Molcho M, Nic Gabhainn S, Kelleher C. Interpersonal relationships as predictors of positive health among Irish youth: The more the merrier. *Irish Medical Journal*, 2007, 100(8), 33-36.
- Mullan Harris K. The health status and risk behaviours of adolescents in immigrant families. In DJ Hernandez (Ed.), *Children of immigrants: Health, adjustment and public assistance*. Washington, DC: National Academy Press, 1999, pp. 286-322.
- Pantin H., Schwartz SJ, Sullivan S, Coatsworth JD, Szapocznik J. Parent-Centered Approach Preventing Substance Abuse in Hispanic Immigrant Adolescents: An Ecodevelopmental. *Hispanic Journal of Behavioural Sciences*, 2003, 25:469-500.
- Pawliuk N, Grizenko N, Chan-Yip A, Gantous P, Matthew J, Nguyen D. Acculturation style and psychological functioning in children and immigrants. *American Journal of Orthopsychiatry*, 1996, 66:111-121.
- Rasmussen M, Damsgaard MT, Holstein BE, Poulsen LH, Due P. School connectedness and daily smoking among boys and girls: the influence of parental smoking norms. *European Journal of Public Health*, 2005, 15: 607-12.
- Sampson RJ, Morenoff JD, Raudenbush S. Social anatomy of racial and ethnic disparities in violence. *American Journal of Public Health*, 2005, 95:224-232.
- Schellenberg G. *Immigrants in Canada's Census Metropolitan Areas*. Statistics Canada No. 89-613-MIE, No. 003, 2004. Ottawa: Statistics Canada.
- Stevens GWJM, Pels T, Bengi-Arslan L, Verhulst FC, Vollebergh WAM, Crijnen AAM. Parent, teacher, and self-reported problem behaviour in The Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 2003, 38:567-585.
- Strohmeier D, Scmitt-Rodermind E. Immigrant youth in European countries: The manifold challenges of adaptation. *European Journal of Developmental Psychology*, 2008, 5(2):129-37.
- The Urban Institute. Children of immigrants: fact and figures. *Fact sheet Office of Public Affairs Washington DC*, May 2006.
- United Nations (UN). International migration report 2002. Department of Economic and Social Affairs, Population Division. New York.
- Vieno A, Santinello M, Lenzi M, Baldassari D, Mirandola M. Health Status in Immigrants and Native Early Adolescents in Italy. *Journal of Community Health*, 2009, 34(3): 181-187.
- Ward C, Bochner S, Furnham A. *The psychology of culture shock (2nd ed.)*. Hove, UK, Routledge, 2001.
- Westin C. Young people of migrant origin in Sweden. *International Migration Review*, 2003, 37:987-1010.

World Health Organization (WHO) Regional Office for Europe (2008). Social cohesion for mental well-being among adolescents. Copenhagen. http://www.euro.who.int/socialdeterminants/hbsc/20080821_26, accessed 11 May 2009.

World Health Organization (WHO) (2008). Closing the gap in a generation: health equity through action on the social determinants of health, 2008. Geneva, World Health Organization (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf, accessed 11 May 2009).

World Health Organization (WHO) (2009). Web site. Health systems topics – Equity. Geneva <http://www.who.int/healthsystems/topics/equity/en/>, accessed 11 May 2009.

World Health Organization (WHO) (2009a). Executive Board resolution EB124.R6 on reducing health inequities through action on the social determinants of health. Geneva, World Health Organization, 2009 (http://www.who.int/gb/ebwha/pdf_files/EB124/B124_R6-en.pdf)

World Health Organization (WHO) Regional Office for Europe (2008a). The Tallinn Charter: health systems for health and wealth. Copenhagen, WHO Regional Office for Europe <http://www.euro.who.int/document/E91438.pdf>, accessed 11 May 2009.

Vedder P & Virta E. Language, ethnic identity, and the adaptation of Turkish immigrant youth in the Netherlands and Sweden. *International Journal of Intercultural Relations*, 29, 317-337, 2005.

Vollebergh WAM, Ten Have M, Dekovic M, Oosterwegel A, Pels T, De Winter A, Ormel H, Verhulst F. Mental health in immigrant children in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology*, 2005, 40:489-496

Yu SM, Huang ZJ., Schwalberg RH, Overpeck M & Kogan MD. Acculturation and the health and well-being of US immigrant adolescents. *Journal of Adolescent Health*, 2003, 33:479-488.

Case study - Iceland

Bjarnason T & Gunnarsson GM. *Adolescents of foreign descent in Iceland*. Paper presented at the 24th Conference of the Nordic Sociological Association, University of Aarhus, Denmark, 14-17 August 2008.

Bjarnason T & Jónsson, SH. *The effects of open vs. closed response categories on responses to the HBSC questionnaire: The results of a split-half experiment in Iceland*. Paper presented at the HBSC project meeting, Budapest, June 8–10 2006.

Blake SM, Ledsy R, Goodenow C, O'Donnell L. Recency of immigration, substance use, and sexual behaviour among Massachusetts adolescents. *American Journal of Public Health*, 2001, 91:794-798.

Cardak BA, McDonald JT. Neighbourhood effects, preference heterogeneity and immigrant educational attainment. *Applied Economics*, 2004, 36:559-572.

Currie C, Gabhainn SN, Godeau E, Roberts C, Smith R, Currie D, Pickett W, Richter M, Morgan A & Barnekow V (eds.). *Inequalities in young people's health: HBSC international report from the 2005/2006 Survey*, 2008. Copenhagen: WHO.

Davies LC & McKelvey RS. Emotional and behavioural problems and competencies among immigrant and non-immigrant adolescents. *Australian and New Zealand Journal of Psychiatry*, 32, 658-665, 1998.

EFTA. Agreement on the European Economic Area. http://secretariat.efta.int/Web/EuropeanEconomicArea/EEAAgreement/EEAAgreement/EEA_Agreement.pdf, retrieved June 2, 2008.

European Commission. The European Economic Area. http://ec.europa.eu/external_relations/eea/index.htm, retrieved June 2, 2008.

Glick JE, White MJ. Post-secondary school participation of immigrant and native youth: the role of familial resources and educational expectations. *Social Science Research*, 2004, 33:272-299.

Gyedu-Akomako AN, Sigfúsdóttir ID & Ásgeirsdóttir BB. 2000. *Social Condition of Immigrant Youth in Iceland*. Reykjavík: Rannsóknir og greining.

Isralowitz RE & Slonim-Nevo V. Substance use patterns and problem behaviour among immigrant and native-born juvenile offenders in Israel. *Addiction Research and Theory*, 2002, 10:399-414.

Liebkind K, Jasinskaja-Lahti I, Solheim E. Cultural identity, perceived discrimination, and parental support as determinants of immigrants' school adjustments: Vietnamese youth in Finland. *Journal of Adolescent Research*, 2004, 19:635-56.

Ma X. The first ten years in Canada: A multi-level assessment of behavioural and emotional problems of immigrant children. *Canadian Public Policy*, 2002, 28:395-418.

Ragnarsdóttir ÁG, Árnason JK & Þorvaldsson M. *Viðhorf til nokkurra minnihlutahópa*. [Attitudes towards a few minority groups]. 2005. Reykjavík: IMG Gallup.



Sigfúsdóttir ID, Ásgeirsdóttir BB, Kristjánsson ÁL. and Sigfússon J. *Félaglegir bakgrunnspættir og viðhorf ungs fólks til innflytjenda á Íslandi*. [Social background and attitudes of youth towards immigrants in Iceland]. 2005. Reykjavík: Rannsóknir og greining.

Statistics Iceland. 2009a. Population – key figures 1703–2009. <http://www.staice.is/Statistics/Population/Overview>, retrieved March 7, 2009.

Statistics Iceland. 2009b. Foreign citizens 1950–2008. <http://www.staice.is/Statistics/Population/Citizenship-and-country-of-birth>, retrieved March 7, 2009.

Statistics Iceland. 2009c. Population by origin, sex, age and citizenship 1996–2008 <http://www.staice.is/Statistics/Population/Citizenship-and-country-of-birth>, retrieved March 7, 2009.

Vedder P, Virta E. Language, ethnic identity, and the adaptation of Turkish immigrant youth in the Netherlands and Sweden. *International Journal of Intercultural Relations*, 2005: 29, 317–337.

Westin C. Young people of migrant origin in Sweden. *International Migration Review*, 2003, 37:987–1010.

Yu SM, Huang ZJ., Schwalberg RH, Overpeck M & Kogan MD. Acculturation and the health and well-being of US immigrant adolescents. *Journal of Adolescent Health*, 2003, 33:479–488.

Case study – Ireland

Department of Health and Children. *The National Health Promotion Strategy 2000–2005*, 2000.

Department of Health and Children. *Quality and fairness: a health system for you*, 2001.

Molcho M., Kelly C., Gavin A., Nic Gabhainn S. Inequalities in Health among School-aged Children in Ireland, 2008. Dublin: Department of Health and Children.

Nolan B, Maitre B. *A social portrait of communities in Ireland*. The Office for Social Inclusion, Dublin, 2008.

Case study – Italy

Bengi-Arslan L, Verhulst FC, van der Ende J. Understanding childhood (problem) behaviours from a cultural perspective: Comparison of problem behaviours and competencies in Turkish immigrant, Turkish and Dutch children. *Social Psychiatry and Psychiatric Epidemiology*, 1997, 32:477–484.

Berry JW, Phinney JS, Sam DL, Vedder P. Immigrant Youth: Acculturation, Identity, and Adaptation. *Applied Psychology: An International Review*, 2006, 55(3):303–332.

Caritas/Migrantes. *Immigrazione: dossier statistico 2008, XVIII rapporto sull'immigrazione. Lungo le strade del futuro*, 2008. IDOS.

Chen E, Matthews KA, Boyce TW. Socioeconomic differences in children's health: how and why do these relationships change with age?. *Psychological Bulletin*, 2002, 1, 128:295–329.

Currie C, Gabhainn SN, Godeau E, Roberts C, Smith R, Currie D, Pickett W, Richter M, Morgan A & Barnekow V (eds.). *Inequalities in young people's health: HBSC international report from the 2005/2006 Survey*, 2008. Copenhagen: WHO.

Dishion TJ, Loeber R. Adolescent marijuana and alcohol use: the role of parents and peers revisited. *American Journal of Drug & Alcohol Abuse*, 1985, 11:11–25.

Duncan SC, Duncan TE, Hops H. Analysis of longitudinal data within accelerated longitudinal designs. *Psychological Methods*, 1994, 1:236–248.

Fuligni AJ. The adjustment of children from immigrant families. *Current Directions in Psychological Science*, 1998, 7:99–103.

Garcia Coll C. The immigrant paradox: Critical factors in Cambodian students' success. Paper presented at the 2005 *Biennial meeting of the Society for Research in Child Development*. Atlanta, Georgia, 7–10 April 2005.

Georgiades K, Boyle MH, Duku E, Racine Y. Tobacco use among immigrant and non-immigrant adolescents: Individual and family level influences. *Journal of Adolescent Health*, 2006, 38:443.e1–443.e7.

Harris KM. The health status and risk behaviours of adolescents in immigrant families, in DJ Hernandez, (ed.) *Children of Immigrants: Health, Adjustment and Public Assistance*, 2004. Washington, DC: National Academy Press, pp. 286–322.

Hill KG, Hawkins JD, Catalano RF, Abbott RD, Guo J. Family influences on the risk of daily smoking initiation. *Journal of Adolescent Health*, 2005, 37:202–210

ISTAT. *La popolazione straniera residente in Italia al 1° gennaio 2008*. Sistema Statistico Nazionale, Istituto Nazionale di Statistica.

Lo Coco A. Identità etnica, sviluppo, relazioni sociali in Italia. *Età evolutiva* 2000, 66:64-107.

Pawliuk N, Grizenko N, Chan-Yip A, Gantous P, Matthew J, Nguyen D. Acculturation style and psychological functioning in children and immigrants. *American Journal of Orthopsychiatry*, 1996, 66:111-121.

Schwartz S, Pantin HJ, Coatsworth D, Szapocznik J. Addressing the Challenges and Opportunities for Today's Youth. *Journal of Primary Prevention*, 2007, 28(2):117-144.

Wardle J, Robb K, Johnson F. Assessing socioeconomic status in adolescents: the validity of a home affluence scale. *Journal of Epidemiology and Community Health*, 2002; 56:595-599.

Case study – Portugal

Aittola T. Unconventional learning environments of young people, in H. Helve (ed.) Unification and Marginalisation of young people. Youth Research, 2000 Programme, 1998. *Helsinki: The Finnish Youth Research Society*. pp. 151-160.

Currie C, Hurrelmann K, Settertobulte W, Smith R, Todd J. *Health and health behaviour among young people*. 2000. HEPCA series: World Health Organisation.

Gaspar T, Matos MG, Gonçalves A. Saúde dos Adolescentes Migrantes (Migrant adolescents' health) in M. Matos (eds.) *Comunicação, Gestão de Conflitos e Saúde na Escola*. (Communication, Conflict management and health in school) 2005, Lisboa, FMH.

Matos MG, Equipa do Projecto Aventura Social & Saúde. *A Saúde dos Adolescentes Portugueses (Quatro anos depois)*. (Portuguese adolescents' health: 4 years after), 2003. Edições FMH: Lisboa. Accessed at www.aventurasocial.com

Matos MG, Gaspar T. Differences in lifestyles between Portuguese adolescents and adolescents that "came from elsewhere" Do we have healthy alternatives promoting social inclusion? *Ces adolescents qui viennent d'ailleurs*, 2003. Fondation de France, International Association of Adolescent Health, Institut Curie: Paris.

Matos MG, Gaspar T, Gonçalves A. Adolescentes estrangeiros em Portugal: factores ligados ao risco e à protecção (Foreign adolescents in Portugal: risk and protection issues). *Psicologia, Doenças & Saúde*, 2004, 5(1):75-85, Accessed at www.sp-ps.org

Matos MG, Simões C, Sacchi D. Adolescenti, stile di vita e salute: Ricerca e intervento (Adolescents, lifestyles and health: research and intervention). *Psicoterapia Cognitiva e Comportamentale*, 2004, 10(2):133-150.

Matos MG, Gonçalves A, Gaspar T. *Aventura Social, Etnicidade e Risco: prevenção primária do VIH em adolescentes de comunidades migrantes*. (Social adventure, ethnicity and Risk), 2005. Lisboa: CMDT/IHMT/UNL & FMH/UTL Accessed at www.aventurasocial.com

Matos MG, Equipa do Projecto Aventura Social & Saúde. *A Saúde dos Adolescentes Portugueses hoje e desde há 8 anos*, 2006 (Portuguese adolescents' health: now and in the last 8 years) Accessed at www.aventurasocial.com

Matos MG, Barrett P, Dadds M, Short A. Anxiety, Feeling Depressed or low and peer relationships during adolescence: results from the Portuguese National Health Behaviour in School aged children survey, *European Journal of Psychology of Education*, 2002, XVIII(1):3-14

Matos MG, Dadds M, Barrett P. Family-school issues and the mental health of adolescents: post hoc analysis from the Portuguese National Health Behaviour in School aged children survey, *Journal of Family Studies*, 2006, 2:261-274

Matos MG (ed.). *Comunicação, Gestão de Conflitos e Saúde na Escola (Communication, Conflict management and health in school)*, 2005. Lisboa, FMH.

Simões C. Resiliência, Saúde e Desenvolvimento. (Resilience, health and development) In MG Matos (Ed.), *Comunicação e gestão de conflitos e saúde na escola*. (Communication, conflict management and health in schools, 2005. Lisboa: CDI/FMH.

Simões C, Matos MG, Batista-Foguet JM. *Personal and social features in adolescent's health*. Minutes from the 3rd European Conference on Positive Psychology, Braga, July, 2006.

Telama R, Nupponen H, Piéron M. Physical activity among young people in the context of lifestyle. *European Physical Education Review*, 2005, 11(2):115-137.



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