



The National Health & Lifestyle Surveys

Results of National Health and Lifestyle Surveys
SLÁN [Survey of Lifestyle, Attitudes and Nutrition]
and
HBSC [Health Behaviour in School-Aged Children]



The National Health & Lifestyle Surveys

Survey of Lifestyle, Attitudes and Nutrition (SLÁN) &
The Irish Health Behaviour in School-Aged Children Survey (HBSC)

Centre for Health Promotion Studies

Drafting Team:
Cecily Kelleher, Saoirse Nic Gabhainn, Sharon Friel,
Helen Corrigan, Geraldine Nolan, Jane Sixsmith
Orla Walsh and Mary Cooke

April, 2003

Copyright:
Health Promotion Unit, Department of Health and Children, Dublin
Centre for Health Promotion Studies, National University of Ireland, Galway
Department of Public Health Medicine and Epidemiology, University College Dublin

contents

Foreword	4
Introduction	5
Summary	6
Methodology	8
Demographic representativeness of respondents	10
general health	15
SLÁN	16
HBSC	19
smoking	21
SLÁN	22
HBSC	24
alcohol	27
SLÁN	28
HBSC	31
drugs	35
SLÁN	35
HBSC	36
food & nutrition	37
SLÁN	38
HBSC	44
exercise	51
SLÁN	52
HBSC	55
accidents	57
SLÁN	58
HBSC	59
appendices	62
SLÁN	62
HBSC	65
Project team	67

foreword

As Minister for Health and Children I am delighted to be associated with the publication of this, the second National Health and Lifestyle Surveys, report. The report consists of data from two different surveys: the SLÁN or Survey of Lifestyle, Attitudes and Nutrition aimed at the Irish adult population and the HBSC or Health Behaviour in School-Aged Children survey which is part of a wider European initiative. It is generally accepted that until recently there has been a shortage of national lifestyle data categorised by gender, age and social class. These National Health and Lifestyle surveys were therefore commissioned by the Health Promotion Unit of my Department, at my request, as a direct response to this information gap and continue to provide invaluable information for policy and programme planning in the health services.

The value of these surveys is immeasurable in terms of the useful data that they provide. Since the publication of the first survey report in 1999 my Department, and indeed all other relevant stakeholders, have been able to avail of dependable baseline information on a range of lifestyle related health behaviours in the Irish population, like smoking, alcohol and exercise, with detectable differences across age, gender and social strata. These surveys also allow us to make direct comparisons with the health-related behaviours of our European neighbours as well as at global level.

It has always been envisaged that the National Health and Lifestyle surveys would be repeated on a four yearly basis in order that trends be identified and changes monitored to assist national and regional setting of priorities in health promotion activities. The first survey was the most comprehensive piece of research ever undertaken with around fifteen thousand respondents and enabled health service planners and the Health Promotion Unit to plan initiatives and interventions for particular population groups. The second phase of the process saw the refocusing of the questions of phase one to target and identify other behaviours and attitudes within sub-groups of the population and used a larger sample. This information is also invaluable in evaluating the success at ground level of various health promotion initiatives.

This report, and its sister report of 1999, lead the way for more strategic policy and programme planning for the health services. The information it provides allow us to effectively focus our efforts and promote better health among the Irish population. I would like to take this opportunity to thank all those persons who took the time to complete the SLÁN and HBSC questionnaires thereby giving us this very great opportunity. I also pay tribute to all those involved in preparing the report which marks a very important step on the road to making the healthier choice the easier choice.



Micheál Martin TD
Minister for Health and Children

introduction

Two baseline surveys of health related behaviours among adults and school-going young people were carried out across the Republic of Ireland in 1998 and again in 2002. The main aims of these surveys are to:

- Produce reliable data of a representative cross-section of the Irish population in order to inform the Department of Health and Children's policy and programme planning.
- Maintain a survey protocol which will enable lifestyle factors to be re-measured so that trends can be identified and changes monitored to assist national and regional setting of priorities in health promotion activities.

This report focuses on these two cross-sectional studies, SLÁN (Survey of Lifestyles, Attitudes and Nutrition), adults aged 18+ years and HBSC (Health Behaviour in School-aged Children), school-going children aged 10-17 years.

In keeping with the health and lifestyle surveillance system of many European countries a number of related factors were measured in both surveys. These include general health, smoking, use of alcohol and other substances, food and nutrition, exercise and accidents. These are interpreted in this report according to the Health Promotion Strategy document recommendations. Socio-demographic variations are reported.

This work was commissioned by the Health Promotion Unit, Department of Health and Children and carried out at the Centre for Health Promotion Studies, National University of Ireland, Galway.

summary

A summary of the main findings from SLÁN and HBSC is listed below:

General Health

Rates of excellent or very good self-reported general health have improved among both men (53.8% in 2002 compared with 48.2% in 1997) and women (56.5% in 2002 compared with 49.1% in 1998). Patterns continue to be inversely related to age and educational status. The top four requirements for improving general health are the same for men and women and are similar in rank order to 1998 but rates have changed slightly. Less stress is still the top rated factor (34% of men and 39% of women in 2002) but not as high as in 1998 (41% of men and 47% of women). More will-power, change in weight and more money are the next three ranked for both men and women. In turn the greatest factor preventing people from improving their health is financial problems (36.3% of men compared with 39.4% in 1998 and 45.4% of women compared with 45.8% in 1998). Rates of self reported disability and morbidity have not shifted appreciably since 1998 but more people now report having had their blood pressure checked or that they had a normal or low cholesterol. The general practitioner remains the highest ranked source of health related information, a strongly age-related pattern. A newly recorded feature is Internet usage to obtain information at 12% overall, and this is highly related to both educational status and social class. Among school-going children 87.4% of boys and 84.2% of girls rank their health as excellent or very good and 91.3% of boys and 87.0% of girls feel very or quite happy about their lives at present. Their mother continues to be the highest ranked confidante for three-quarters of children. Rates of perceived bullying have shifted slightly (27.6% of boys compared with 29.5% in 1998 and 22.4% of girls compared with 19.9% in 1998).

Smoking

There has been a fall in reported cigarette smoking rates in virtually every demographic category since the first survey in 1998. Overall 27% of the adult population reported being regular or occasional cigarette smokers compared with 31% in 1998. Rates have fallen among both men (28%) and women (26%). Marked age gradients continue to exist among both men and women, with highest smoking rates among younger people. There continues also to be an inverse relationship with level of education. Among school going children, 19% overall report they are current smokers down from 21% in 1998 and rates have dropped most particularly in the key 12-14 year age group, suggesting the possibility of delayed initiation, a key part of any successful health promotion strategy. While rates among boys in social class 5-6 appear to have risen, rates have dropped in all social class categories among girls. These findings in 2002 suggest a real decline in smoking rates, given the consistency of the trends. In addition there are positive trends in exposure to passive smoke. Rates of exposure at home, in the workplace, on public transport, in pubs or clubs and other places are all down among adult men and women, though exposure rates at work (29% men and 16.6% women) are much lower than in pubs and clubs (47.3% men and 31.6% women) suggesting the importance of legislation in regulating exposure.

Alcohol and other substances

Overall 83% of men and 74% of women reported alcohol consumption in the last month. There are still relatively high numbers of non-drinkers among the over 55's, with evidence of a direct class gradient. However less than 7% of the rest of the population are non-drinkers. There was a very slight change in the mean number of days per week on which alcohol was consumed, at 2.8 in men and 2.6 in women. The numbers drinking more than six drinks on an average session has increased from 34.7% to 41.4% of men and from 11.6% to 16.2% of women. Women (7.2%) were more likely than men (3.9%) to report experience of arguments with family and friends about drinking, a small decrease since 1998. Reported rates of driving having drunk at least two drinks were virtually unchanged since 1998 at 21.8% men and 8.6% of women. Overall 40% of school going children reported never having had an alcoholic drink, up from 31% in 1998. This effect was most marked in the youngest categories of 10-11 year olds, the rates among 15 to 17 year olds being virtually unchanged. Similarly the number of 10-11 year olds reporting having had a drink in the last month had fallen by two thirds, as had numbers of those who were really drunk at least 10 times from 15% boys in 1998 to 7% in 2002. Types of alcohol consumed were down in all boys' groups but spirits (3.8% to 6.8%) and alcopops consumption had increased among girls (3.1% to 8.1%). These reported drops could reflect heightened awareness of alcohol as an issue, especially among the very young group.

Lifetime use of marijuana or cannabis among adults has increased by 4.2% in men and 3.2% in women but use in the last 12 months is virtually unchanged. Cocaine usage has increased from 1.8% to 3.0% in men and from 0.6% in women to 1.9%. Ecstasy rates have also increased since 1998 from 2.9% to 3.9% and from 1.5% to 2.4% in women. Overall there was very little change in already low reported use of other drugs in the last 12 months. Cannabis use in last 12 months has not changed among boys (13.4% in 2002 and 14.0% in 1998) but has increased somewhat among girls (9.5% in 2002 compared with 6.7% in 1998). Rates of use of glue or solvents were 5.1% in boys and 4.1% in girls and use of any other drug was 5.6% in boys and 4.1% in girls.

Nutrition and diet

Reported rates of overweight and obesity have increased in both adult men and women. Obesity rates have risen by 3% from 11% in 1998 of men to 14% in 2002 and from 9% of women in 1998 to 12% in 2002. While 13% overall reported being on a weight reducing diet, this was three-fold more likely among women than men, though younger third level educated women were somewhat less likely to be on a diet than other women. Rates of dieting among both boys (2% to 6.7%) and girls (11.7% to 18.5%) have increased markedly. Those believing their body to be a bit too fat or much too fat or of above average weight had not changed significantly however. Overall 34% of adults reported eating the recommended 6 plus servings a day of cereals, breads and potatoes compared to 40% previously. The number of males consuming the recommended amount had declined in all educational groups but remained unchanged among women. There was also an increase in those consuming the recommended 4 or more servings of fruit and vegetables from 61% to 69%. The socio-economic gradient seen in 1998 was much less marked or absent on this occasion. Reported fruit consumption has declined sharply by almost half among school-going children. This is true of at least daily or more than once daily rates and applies across all age categories. Similarly, vegetable consumption has declined, but not as markedly, particularly among girls. Rates of fried food consumption continue to show marked gradients according to age and educational status in adults, being particularly high among younger men and women with less than complete second level education. Rates of butter consumption have also declined, particularly among younger age groups. Overall 37% of women report breast-feeding any of their children. There is a strong inverse relationship to educational status and the best rates are among mothers of higher education levels in the 35-54 age group. Initiation rates among third level educated women in this category reach 68% though only women in the youngest age group with primary level education fall markedly below the 30% initiation target, at 17%.

Exercise

Overall just over half of all adults (51%) reported some form of activity compared with 52% in 1998. As previously there are marked differences according to gender and educational status, with men more likely to be strenuously active than women and the most strenuously active being males in the 18-35 category, with a very marked inverse relationship to educational status in both sexes at all other ages. Numbers of those reporting no activity at all have increased among both men (from 21% to 30%) and women (from 20% to 25%). Trends towards inactivity are particularly marked among those with less than complete second level education and have climbed for instance from 37% to 56% of such 55 year old men and in all the female age groups. Among school-going children vigorous exercise rates are higher among boys than girls at all ages but as in 1998 the gender gap doubles by the age of 15-17 with a soaring in the number of girls reporting no activity at all.

Accidents

Seventeen percent of respondents (18% in 1998) indicated having had an injury in the past two years that interfered with their daily activities and 89% of these were accidental. Men were most likely to sustain injuries related to sport (31%), followed by work (28%) and home (21%), whereas women were most likely to sustain injury at home (41%). Patterns were highly age-related, with sport injuries more likely among younger men and work injuries most common among those aged 35-54 years. Most injuries were treated by accident and emergency services (40% in 2002 compared with 38% in 1998). There was a major rise in the numbers reporting always using the seatbelt when seating in the front of the car (79% of men and 90% of women compared with 61% of men in 1998 and 74% of women). Similarly seat belt usage among school-going children had risen considerably as well, with rates almost doubling among boys to 57% overall and improving from a higher base among girls to 65%. Cycle helmet usage among boys and girls with a bicycle continues to be very low at 8%, which is strongly inversely related to age.

SLÁN

The national health and lifestyle survey, SLÁN was first undertaken in 1998 and repeated again in the summer of 2002. As in 1998, a representative cross-section of the Irish adult population was surveyed, with a sample powerful enough to detect differences according to socio-economic status in key variables, smoking, exercise and percentage caloric intake from fat. Allowances were made for non-response and likelihood of ineligibility to participate. The sample was generated randomly from the Irish electoral register supplied by Precision Marketing Information (PMI) Ltd., a subsidiary of An Post.

The sampling procedures followed those used in 1998, whereby a national postal sample was generated randomly and proportionately distributed based on health board population size and urban rural breakdowns so that each county of the Republic of Ireland was represented. Final selection was at district electoral division level.

The self-completed questionnaires were posted from the National University of Ireland (NUI), Galway with freepost return envelopes enclosed. A helpline to deal with general queries on questionnaire completion was set up in NUI, Galway and respondents were entered into a prize draw unless they stated otherwise. Following a reminder letter and further reminder questionnaire, all remaining non respondents were followed up either by telephone where possible or by trained fieldworkers calling to the person's home for questionnaire collection. Excluding those not eligible (that is deceased or confirmed at the follow-up stage to be unavailable at that address) the total valid sample was 11,212 questionnaires. A national response of 5992 (53.4%) was obtained. Data entry was carried out by RES Ltd.

HBSC

The HBSC is a World Health Organisation (European) collaborative study. It runs on an academic 4-year cycle and in 2001/2 32 individual countries participated. Principal investigators from all countries co-operate in relation to survey content, methodology and timing and an international protocol is developed. Strict adherence to the protocol is required for inclusion in the International database and this has been achieved with the current study. The HBSC protocol aims for sample sizes of 1, 536 in each of three age groups, 11, 13 and 15 in order to approximate a 95% confidence interval of +/- 3%.

In the Republic of Ireland, sampling was conducted in order to be representative of the proportion of children in each Health Board. The objective was to achieve a nationally representative sample of school aged children. A sample of pupils from a range of year groups was required. Data from the 1996 census was employed to provide a picture of the population distribution across the Health Boards. The sampling frame consisted of primary and post-primary schools, lists of which were provided by the Department of Education. A two-stage process identified study participants. Individual schools within regions were first randomly selected and class groups within schools were subsequently randomly selected for participation. In primary schools both 5th and 6th class groups were included, while in post-primary schools all Junior Cycle and the first year post Junior cycle (Transition Year or the first year of Senior cycle) were sampled.

School principals were first approached by post and when positive responses were received, HBSC questionnaires in Irish or English were offered, along with blank envelopes to facilitate anonymity, parental consent forms, information sheets for teachers and classroom feedback forms. All returns were facilitated through the provision of FREEPOST envelopes. In order to maximise response rates, two postal reminders were sent to schools, followed by telephone calls from research staff from the Centre for Health Promotion Studies, NUI Galway. Data entry was conducted according to the International HBSC protocol by Research and Evaluation Services, Ltd.

A total of 351 schools were initially contacted across the 10 Health Boards. The total valid number of schools was 347. Overall, there was a final response rate of 51% (176 schools). This reflects a total n of 8316. Only the 5712 responses received by end of summer term are included in this report to maintain seasonal comparability with the previous report.

Three percent of parents of primary school children, and 1% of parents of secondary school children refused their child permission to complete the questionnaire. Two percent of primary school students and 1% of secondary school students forgot to return the parental consent form, and so were not allowed to complete the questionnaire. 10% of primary school students and 15% of secondary school students were absent on the day the questionnaire was completed. Therefore, 82% of primary school students and 83% of secondary school students returned the questionnaire.

Table 1: Summary of Methodologies

	SLÁN	HBSC
Population	Adults aged 18+	School going children aged 10-18
Sampling frame	Electoral register	Department of Education School lists
Sample	Multistage sample, drawn by district electoral division	Cluster sample of pupils in a given classroom
Stratification	Proportionate distribution across each of the 26 counties, locality, gender	Proportionate to the distribution of pupils across the 10 Health Boards
Survey Instrument	Self-completion questionnaire	Self-completion questionnaire
Delivery / Reminders	Postal, letter reminder, telephone reminder, fieldworker follow-up, telephone helpline	Postal delivery via principals and teachers, letter and telephone reminders
Return	Freepost addressed envelope, fieldworker collection	Freepost addressed envelopes provided
Obtained sample	5,992 adults	176 schools / 5,712 pupils
Data Quality	Data were entered and validated according to preset protocol	Data were entered according to the HBSC international protocol

demographic representativeness

SLÁN

The age and gender profile of respondents in both SLÁN 1 and 2 is compared with that of the 1996 Census in Table 2 below.

Table 2: Gender and age distribution of Census 96, SLÁN 1998 and SLÁN 2002

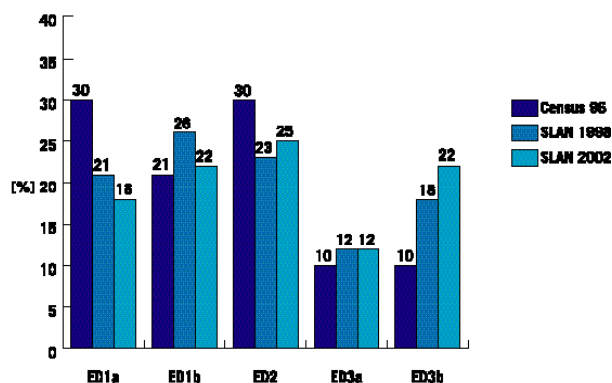
	Census 1996	SLÁN 1998	SLÁN 2002
MALE			
18-34 years	38	38	24
35-54 years	36	36	44
55+ years	26	26	32
Total	49	47	41
FEMALE			
18-34 years	36	36	27
35-54 years	35	38	46
55+ years	29	26	27
Total	51	53	59

The gender distribution of the overall respondents was 41% (2,448) male and 59% (3,526) female. There are relatively less younger people than previously.

Educational status was categorised based on highest level of education achieved reported by the respondent. Social class was categorised based on stated occupation of respondent or principal household wage earner. General Medical Services (GMS) eligibility was also recorded. Twenty seven percent (29% in 1998) were GMS cardholders compared to 34% in the general population. Of the 5,992 respondents, 90% could be classified accurately into the three educational groups and 82% could be classified accurately into the six social class groups.

Figure 1 shows the comparison between educational status of respondents and the 1996 Census educational status data. Figure 2 shows the comparison between social class of respondents and the 1996 Census social class data.

Figure 1: Educational status distribution of Census 96, SLÁN 1998 and SLÁN 2002



ED1a: No schooling/primary school education only

ED1b: Some secondary education

ED2: Complete secondary education

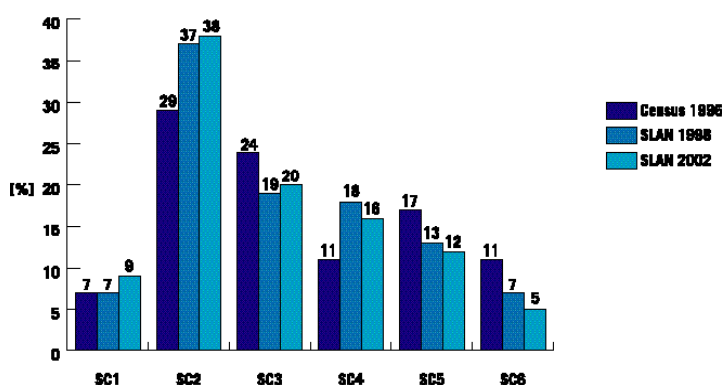
ED3a: Some third level education at college, university, RTC/IT

ED3b: Complete third level education at college, university, RTC/IT

of respondents

The Census 1996 figures exclude those currently in education, while SLÁN includes them. The Census 1996 includes individuals from 15 years of age upwards, while SLÁN includes individuals of 18 years of age upwards. This would account for some of the difference in distribution of education, with a lower number of individuals in ED2 and ED3 in the Census in comparison to SLÁN.

Figure 2: Social Class distribution of Census 96, SLÁN 1998 and SLÁN 2002



SC1: Professional workers
 SC2: Managerial and technical
 SC3: Non-manual
 SC4: Skilled manual
 SC5: Semi-skilled
 SC6: Unskilled

This shows SLÁN 1 and SLÁN 2 to be very similar in distribution to each other, with some over-representation of social classes 2 and 4, a feature of other comparable surveys.

Table 3 below presents the final numbers from each Health Board area and the percentage of the total sample that this represents. The sixth column presents the percentages of adults recorded in the regions during the 1996 Census.

Table 3: Comparison of the location of 1998 and 2002 SLÁN respondents to the 1996 Census					
Health Board	N		%		Census 1996 %
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	
South West Area HB	-	710	-	12	-
East Coast Area HB (EHB 1998)	1994	534	31	9	32
Northern Area HB	-	555	-	10	-
North Eastern HB	1048	562	16	10	10
Southern HB	852	799	13	14	15
Western HB	605	494	9	9	10
South Eastern HB	677	605	10	11	12
Mid Western HB	552	477	8	8	9
Midland HB	354	543	6	10	6
North Western HB	389	405	6	7	7

demographic representativeness

This shows a very good regional distribution of respondents, both in relation to SLÁN 1 and the 1996 Census. Note that the Eastern Regional Health Authority has been created since the last survey.

Finally, Table 4 below presents the percentages of SLÁN respondents across gender, age and educational status and Table 5 presents the percentages of SLÁN respondents across gender, age and social class.

Table 4: Distribution of 1998 and 2002 SLÁN participants by age, gender and educational status

	ED1		ED2		ED3		Total N	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
MALES								
18-34 years	27	20	28	25	44	55	995	523
35-54 years	53	45	19	22	28	34	1061	979
55+ years	81	75	7	10	12	15	729	731
FEMALES								
18-34 years	21	13	29	27	50	60	1176	848
35-54 years	44	30	31	36	26	34	1151	1458
55+ years	77	65	15	20	9	15	814	865

Table 5: Distribution of 1998 and 2002 SLÁN participants by age, gender and social class

	SC1-2		SC3-4		SC5-6		Total N	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
MALES								
18-34 years	22	41	43	38	35	21	851	534
35-54 years	23	43	36	35	41	21	840	943
55+ years	33	37	38	38	29	25	360	536
FEMALES								
18-34 years	18	52	41	36	42	12	1093	865
35-54 years	14	52	37	36	48	12	972	1451
55+ years	25	48	39	36	36	15	320	561

HBSC

The gender breakdown of the HBSC participants revealed that 44% were male and 56% female. Those who participated were compared to data from the 1996 census for region and social class. Table 6 below presents the final numbers from each Health Board area and the percentage of the total sample that this represents. The sixth column presents the percentages of 10-14 years olds recorded in the regions during the 1996 census. Clearly the data are representative of the population distribution across regions with only slight variations from the 1996 census.

of respondents

Table 6: Comparison of the location of 1999 and 2003 HBSC respondents to the 1996 Census

Health Board	N		%		Census 1996 %
	HBSC 1998	HBSC 2002	HBSC 1998	HBSC 2002	
Eastern HB	2255	1765	28	31	32
North Eastern HB	716	377	9	7	10
Southern HB	1399	826	17	15	15
Western HB	892	544	11	10	10
South Eastern HB	988	565	12	10	12
Mid Western HB	412	573	8	10	9
Midland HB	716	412	9	7	6
North Western HB	519	586	6	10	7

In addition, the social class of the fathers of the participants was compared with those presented in the 1996 census. It should be noted that slight variations would be expected here in that the census does not report proportions for whom social class is unknown and the database differs. Not all men included in the census would be fathers of children in these age groups and therefore some variability would be expected.

Table 7: Comparison of the social class of 1998 and 2002 HBSC respondents to the 1996 Census

Social Class	Father of Participants		Census 1996 %
	HBSC 1998	HBSC 2002	
Professional	4	4	7
Managerial	26	25	23
Non-manual	9	11	17
Skilled Manual	25	28	27
Semi-skilled	14	10	15
Unskilled	4	4	11
Unknown	17	17	not reported

Finally, Table 8 below presents the percentages of HBSC respondents across gender, age and social class.

Table 8: Distribution of 1998 and 2002 HBSC participants by age, gender and social class

	SC1-2		SC3-4		SC5-6		Total N	
	HBSC 1998	HBSC 2002	HBSC 1998	HBSC 2002	HBSC 1998	HBSC 2002	HBSC 1998	HBSC 2002
BOYS								
10-11 years	21	31	40	51	39	18	611	353
12-14 years	24	32	38	50	38	18	1754	1039
15-17 years	30	42	41	43	29	15	1016	668
GIRLS								
10-11 years	23	30	38	47	39	23	764	379
12-14 years	26	36	37	47	37	16	1809	1219
15-17 years	31	36	35	47	34	17	1057	1028

THE NATIONAL HEALTH PROMOTION STRATEGY 2000-2005

The second national health promotion strategy was published in 2000. In this report we concentrate primarily on these variables, as they vary according to age, sex, educational status and social class and in relation to trend changes, if any, between 1998 and now. As indicated earlier, both sample populations are regionally representative and reflect well the education and social class distribution.

Table 9: Health promotion targets in the Republic of Ireland

Area	Target
Being Smoke Free	Strategic Aim: to increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoke. Objectives include: to increase the percentage of children and young people who remain non-smokers (especially young girls).
Sensible Drinking	Strategic Aim: to promote moderation in alcohol consumption for those who wish to drink and to reduce the level of alcohol-related problems. Objectives include: to promote moderation in alcohol consumption with the message that less is better To delay the onset of alcohol consumption among children and adolescents, especially those in the under 15 year age group To contribute to a decrease in the number of young people and adults who drink to excess on any one occasion
Eating Well	Strategic Aim: to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight. Objectives include: to promote health eating habits and healthy body image amongst school-going children and young people.
Being More Active	Strategic Aim: to increase participation in regular, moderate physical activity. Objectives include: to identify models of good practice which encourage young people (especially young girls) and older people to participate in regular, moderate physical activity.
Safety and Injury Prevention	Strategic Aim: to contribute to a reduction in the percentage of the population affected by fatal and non-fatal injuries. Objectives include: to work in partnership to promote safety and injury prevention (especially amongst children and older people) with a particular focus on fall prevention, accidents in the home and on the road and farm.
Avoiding Drug Misuse	Strategic Aim: to support models of best practice which promote the non-use of drugs and minimise harm caused by them.
Breastfeeding	Targets: an overall breastfeeding initiation rate of 35% by 1996 and 50% by the year 2000 A breastfeeding initiation rate of 20% among lower socio-economic groups by 1996 and 30% by the year 2000. A breastfeeding rate of 30% at 4 months by the year 2000.

Sources: *The National Health Promotion Strategy 2000-2005, A National Breastfeeding Policy for Ireland 1994*

Interpretation of Results:

For both 1998 and 2002 SLÁN datasets, all variables have been stratified by sex and then age standardised to the 1996 census population. This allows for valid comparisons over time between the two surveys and also adjusts appropriately for variations in age and sex distribution of both surveys relative to the general population. All overall results and those according to education and social class have therefore taken account of age and sex differences in responses.

Data reported are rounded to the nearest percentage. Where means have been calculated standard deviations are reported in brackets. The valid response for each question has been used (i.e. those who did not answer the question(s) under consideration are excluded in all figures and tables). In some questions respondents were asked to choose all applicable options. These responses are not mutually exclusive and the presented results for those questions therefore may not add up to 100%.

general health





general health

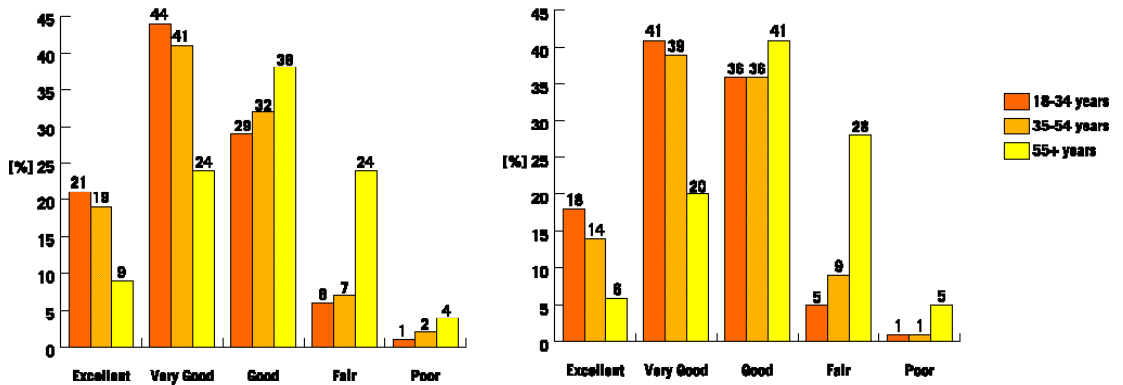
SLÁN

Overall, 55% (49% in 1998) of the respondents thought their general health was excellent or very good, 54% (48% 1998) men and 56% (49% 1998) women

Table 10: Percentage response for perceived general health by educational status

	ED1		ED2		ED3	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Excellent	9	10	16	18	19	22
Very good	27	28	41	42	41	43
Good	41	38	36	31	33	29
Fair	20	19	6	8	6	5
Poor	3	4	1	1	1	1
Total n	2738	2160	1335	1332	1768	1846

Figure 3: Perceived General Health by Age 2002



It can be seen in both SLÁN 1 and 2 that older people are less likely to rate their health well than younger respondents. There were a number of requirements indicated by respondents as being necessary for bettering their health. The top five are shown in Figure 4 below.

Figure 4: Top five requirements for bettering health

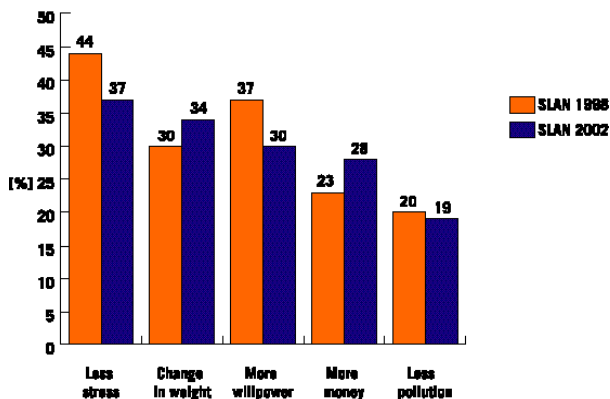
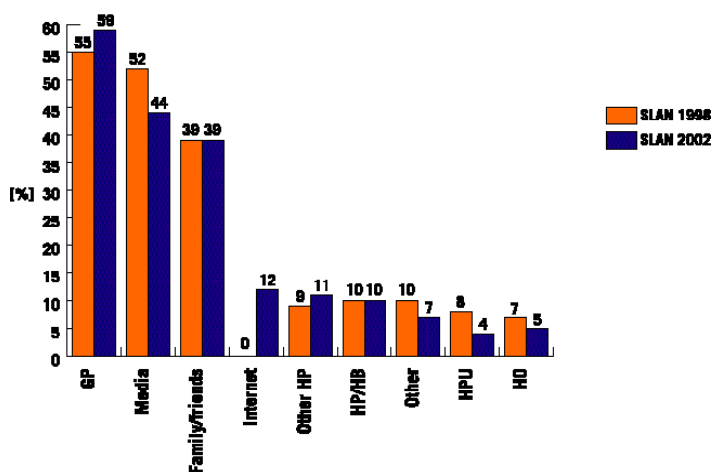


Table 11: Top five ranked requirements for better health					
MALES	SLÁN 1998 %	SLÁN 2002	FEMALES	SLÁN 1998 %	SLÁN 2002
Less stress	41	34	Less stress	47	39
More willpower	32	27	More willpower	41	32
Change in weight	28	32	Change in weight	32	35
More money	23	29	More money	23	27
Less time in smoky places	23	26	Less international / national pollution	20	19

Males and females had similar priorities in requirements for better health. Though both sexes ranked stress first in both 1998 and 2002, the absolute numbers ranking stress top had fallen. Change in weight and more money were both ranked more highly on this occasion.

Figure 5: Sources of Information



HO: Health organisations
 HPU: DoH Health Promotion Unit
 HP/HB: Health Promotion unit in Health Board
 Other HP: other health professionals

Note: The internet was not given as an option in the 1998 questionnaire and therefore has no comparable data.

The General Practitioner continues to be the most important point of contact with the health service. While the health promotion departments are ranked relatively low, it should be noted that a significant proportion of their health education initiatives are conducted through the media and primary care so they may be having an indirect impact in this way.

Table 12: Percentage response of sources of health information by age

Age Group (years)	SLÁN 1998 18-34	SLÁN 2002	SLÁN 1998 35-54	SLÁN 2002	SLÁN 1998 55+	SLÁN 2002
GP	44	53	55	58	75	72
Other HP	8	11	9	12	10	12
HP/HB	11	10	13	15	7	6
HPU	9	5	10	7	6	2
HO	8	5	8	6	5	4
Internet	-	19	-	13	-	3
Family/friends	49	51	37	39	25	21
Media	59	50	56	50	33	26
Other	10	8	11	7	10	6

There is a clear age gradient in relation to the general practitioner as a source of information, as there is with the Internet, an option not included previously but availed of particularly by younger respondents.

Table 13: Percentage response of sources of health information by educational status

Educational status	SLÁN 1998 ED1	SLÁN 2002	SLÁN 1998 ED2	SLÁN 2002	SLÁN 1998 ED3	SLÁN 2002
GP	67	68	52	57	43	56
Other HP	6	7	9	11	12	18
HP/HB	9	8	11	12	12	14
HPU	6	3	8	4	12	8
HO	5	3	7	5	11	7
Internet	-	3	-	8	-	24
Family/friends	30	27	41	36	48	49
Media	38	30	57	48	67	54
Other	7	4	11	6	14	10

The patterns according to education level are particularly notable. Those with less education were more likely to cite the general practitioner, reflecting both the means-tested GMS scheme and the fact that older people are more likely to have a medical card. However, the more highly educated individuals were, the more likely they were to cite the Internet, family and friends and the media, the latter rates having dropped from 1998, perhaps because of competition from the Internet.

Table 14: Percentage response of sources of health information by social class

Social class	SLÁN 1998 SC1-2	SLÁN 2002	SLÁN 1998 SC3-4	SLÁN 2002	SLÁN 1998 SC5-6	SLÁN 2002
GP	48	57	54	60	52	63
Other HP	12	17	7	9	5	9
HP/HB	12	14	11	10	12	9
HPU	11	8	8	4	7	4
HO	9	7	8	4	7	4
Internet	-	19	-	9	-	5
Family/friends	44	44	42	39	36	31
Media	62	52	56	45	51	38
Other	15	9	10	6	9	6

The social class effect for the general practitioner is not as marked as for education, again related to the age factor in GMS eligibility. However, both Internet and media are more commonly cited the higher the social class.

Children were asked a number of general questions concerning their lives and perceived health. The first of these asks how they would rate their health. Overall, 28% report that they would say their health is excellent and a further 58% would say their health is good. However, collapsing these response options masks some gender differences. For example, 32% of boys and 24% of girls think their health is excellent, while 55% of boys and 60% of girls think their health is good. The figures presented below are for those who report that they would say their health is excellent.

Figure 6: Percentages of boys who report their health is excellent (1998 – they are very healthy)

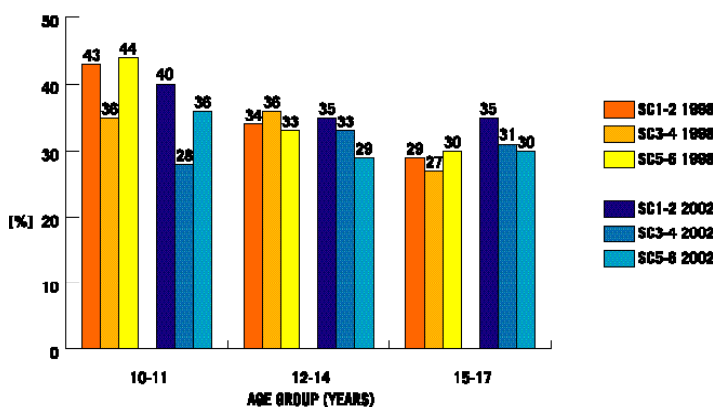
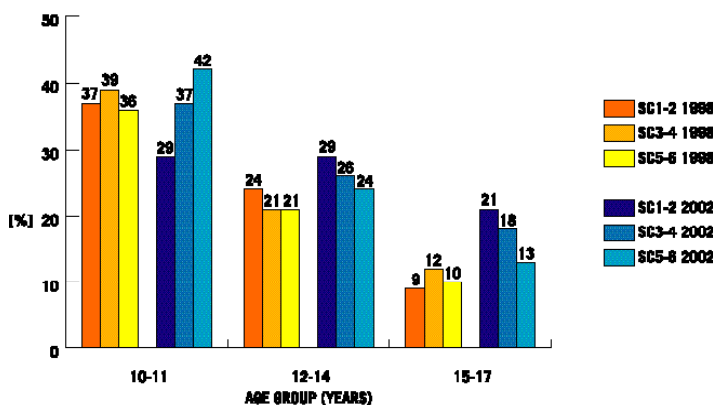


Figure 7: Percentages of girls who report their health is excellent (1998 – they are very healthy)



The second aspect of general health to be reported here concerns how children feel about their lives at present. Overall, 43% report that they are very happy and a further 45% that they are quite happy with their lives. The remaining 11% report that they are not very or not at all happy.

Figure 8: Percentages of boys who report feeling very happy about their lives at present

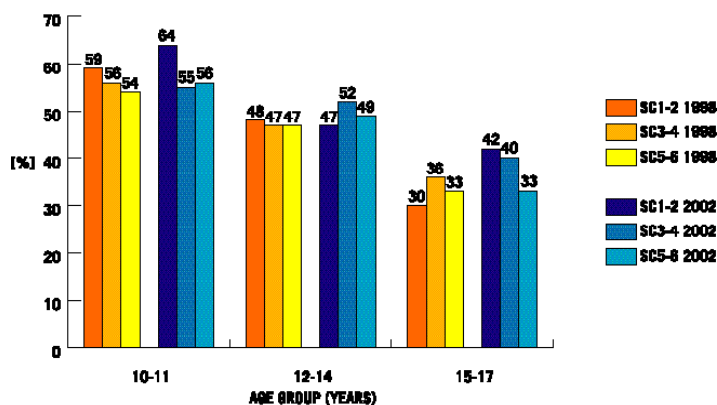
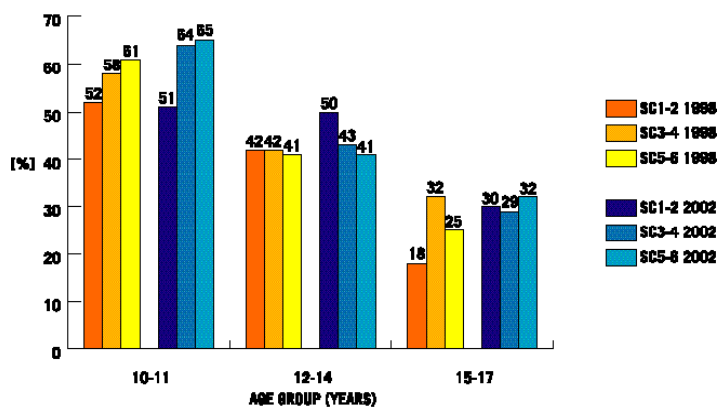


Figure 9: Percentages of girls who report feeling very happy about their lives at present



smoking



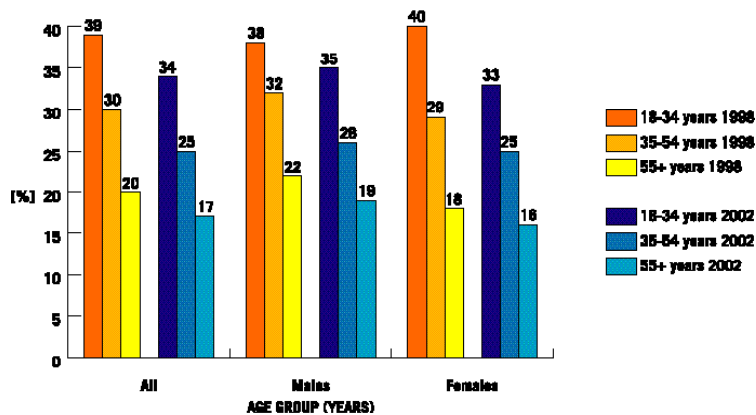


Health Promotion Strategy Target

To increase the percentage of the population who remain non-smokers with a particular emphasis on narrowing the gap across social classes and to protect non-smokers from passive smoke.

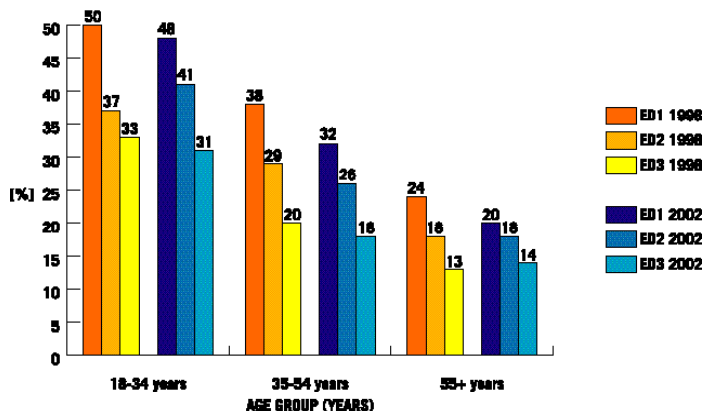
Overall 27% (31% in 1998) of respondents reported being regular or occasional cigarette smokers; 28% (32% in 1998) men and 26% (31% in 1998) women. In addition, a further 100 people were regular or occasional cigar/pipe smokers.

Figure 10: Age & Gender Distribution of Smokers



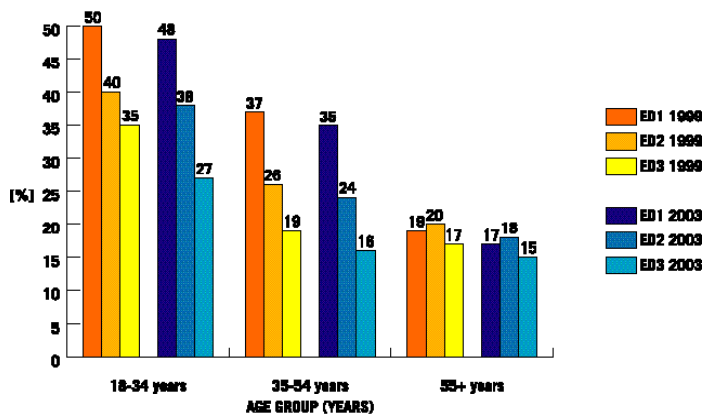
As in 1998, there continue to be marked age related patterns to smoking, with highest rates among both younger males and females. However there have been consistent falls in reported rates in every demographic category. There has also been a small narrowing in the gradient, particularly among females.

Figure 11: Smoking prevalence by gender, age and educational status
MALE



There is also a clear gradient according to educational status, both in 1998 and now, in keeping with the International literature. Again there is a consistent downward trend in reported rates in those with least level of education, though that is not true of younger respondents with completed second level education, the only group where the trend appears upwards.

FEMALE



Among females the inverse trend according to level of education is also clear in both 1998 and 2002. However here the trend is universally downwards, though as with males, the youngest group, with second level education only, exhibit a more modest drop. Among over 55s, all groups are under the target of 20% non smokers, albeit with more modest drops, as might be expected for long established smokers. The smoking prevalence differed significantly between GMS and non GMS respondents. Thirty seven percent (42% in 1998) of those with a medical card reported smoking regularly/occasionally compared to 24% (30% in 1998) of those without.

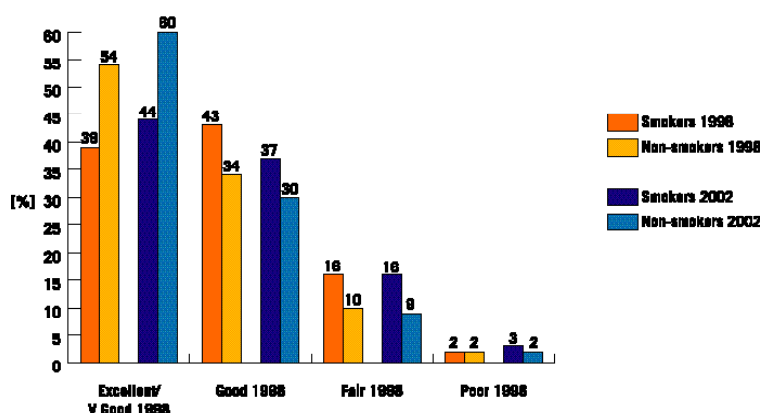
The mean number of cigarettes smoked daily ranged from 9.9 (7.1) for 18-34 year old females in ED3 up to 20.5 (11.1) for 35-54 year old males in ED1. Fifty eight percent (62% in 1998)* of smokers smoked more than 10 cigarettes per day. *65% (66% in 1998) men *50% (59% in 1998) women

Table 15: Mean number of cigarettes smoked by gender, age and educational status (standard deviation in brackets)

	MALES						FEMALES					
	ED1		ED2		ED3		ED1		ED2		ED3	
	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN
	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002
18-34 years	18.5 (9.4)	16.8 (8.6)	16.2 (9.2)	18.6 (11.4)	12.3 (8.7)	14.0 (9.0)	17.6 (7.5)	15.9 (8.7)	13.1 (6.7)	10.8 (6.9)	11.5 (7.1)	9.9 (7.1)
35-54 years	20.4 (10.7)	20.5 (11.1)	19.4 (13.6)	18.9 (11.4)	17.3 (9.9)	17.6 (11.4)	17.5 (8.6)	18.2 (11.3)	17.2 (9.2)	14.1 (8.0)	15.3 (8.4)	13.2 (7.9)
55+ years	17.0 (12.0)	16.0 (9.9)	15.5 (12.2)	18.3 (4.9)	15.1 (8.5)	16.8 (10.7)	13.1 (8.7)	13.1 (8.3)	15.8 (5.6)	14.1 (9.3)	14.8 (10.4)	15.6 (7.7)

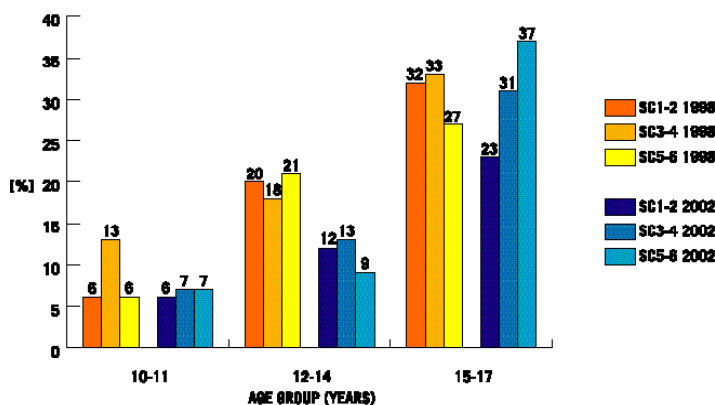
As seen in Figure 12 below smokers tended to rate their health slightly less well than non smokers generally in both the 1998 and 2002 surveys, though the trend to improved self rated health overall is maintained.

Figure 12: Perceived General Health



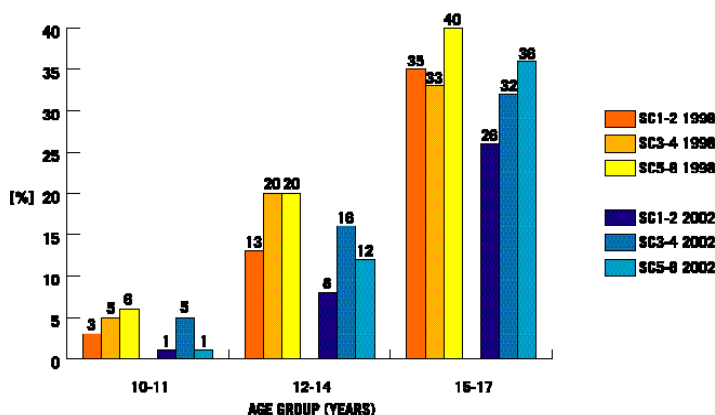
Overall, 41% of the children report that they have ever smoked a cigarette (40% boys and 42% girls). In 2002 19% report that they are current smokers compared with 21% in 1998 (17% boys in 2002 and 21% in 1998 and 20% girls in 2002 compared with 21% in 1998). The following figures present this information by gender, age and social class.

Figure 13: Percentages of boys who report that they are current smokers



The two most notable findings here are the sharp drops in prevalence of reported smoking among 12-14 year olds, a critical point for intervention to prevent initiation and a widening of the social class gradient among the 15-17 year olds. These patterns suggest the importance of health education initiatives in primary school and early secondary school education.

Figure 14: Percentages of girls who report that they are current smokers



As with boys, there is again a sharp drop in reported smoking prevalence in the critical 12-14 year age group and a widening in the social class gradient in the 15-17 year age group, though overall the trend is consistently downwards. Again, as with adults, the trend in those in the middle group of social class 3-4 is less marked.

smoking

alcohol & drugs





Health Promotion Strategy Target

To promote moderation in alcohol consumption for those who wish to drink and to reduce the level of alcohol-related problems. To promote moderation in alcohol consumption with the message that less is better

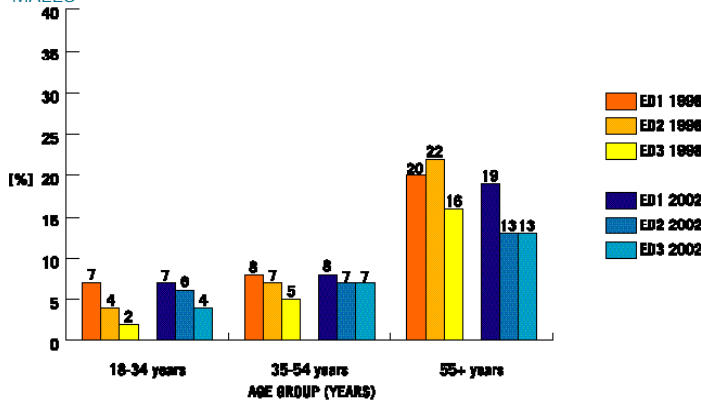
To delay the onset of alcohol consumption among children and adolescents, especially those in the under 15 year age group

To contribute to a decrease in the number of young people and adults who drink to excess on any one occasion

Overall 78% (76% in 1998) of the respondents had consumed alcohol in the previous month, 83% (82% in 1998) men and 74% (70% in 1998) women.

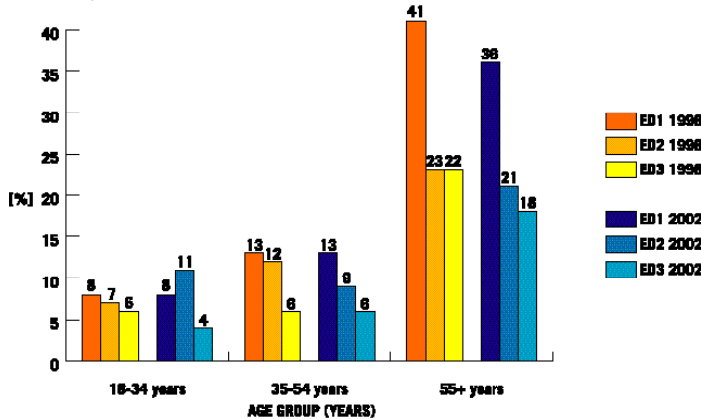
Figure 15: Percentage of non-drinkers by gender, age and educational status

MALES



There is a slight inverse gradient according to educational status with those in the lowest educational category tending to report non-drinking more frequently. There is a clear age effect with the over 55s being more likely to report non-drinking, though prevalence rates are downwards since 1998.

FEMALES

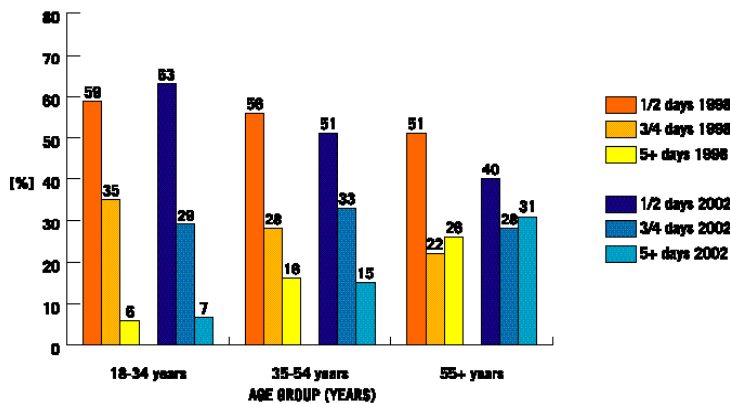


Among females the inverse educational gradient is much more marked, particularly among the over 55s and again prevalence of non drinking is higher among older women of all levels of educational attainment.

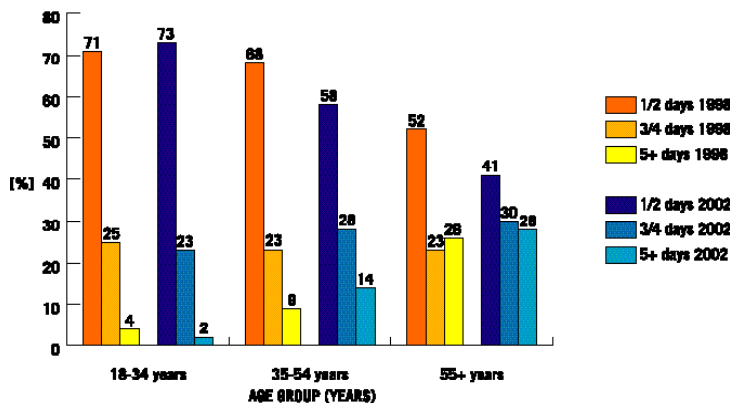
Fifty seven percent of respondents (61% in 1998) normally drank alcohol on one or two occasions in a typical week; 53% (56% in 1998) men and 59% (65% in 1998) women. However 14% (13% in 1998) had an alcoholic drink 5+ days of the week; 15% (14% in 1998) men and 13% (11% in 1998) women. Those reporting that they drank more than six drinks on an average drinking day had increased since 1998 (41.4% of men compared with 34.7% previously) and 16.2% of women, compared with 11.6% previously.

Figure 16: Number of days drinking alcohol in a typical week by gender and age

MALES

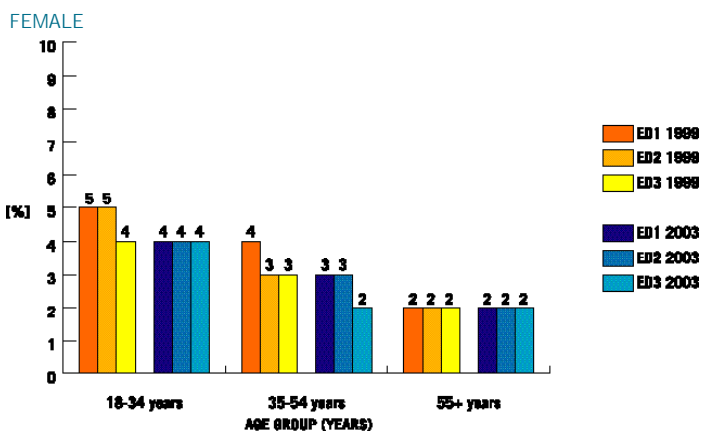
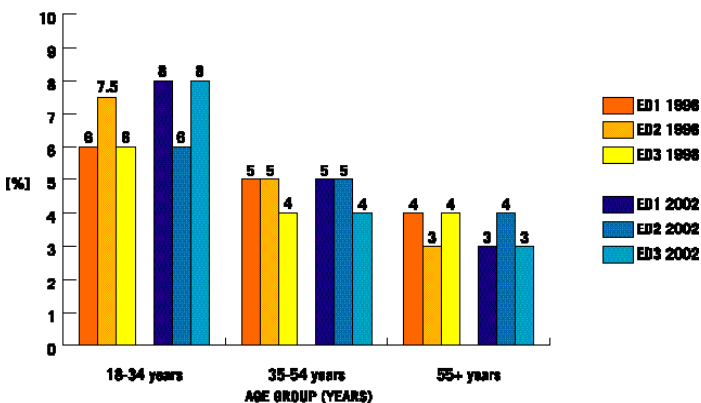


FEMALES



Of those who did regularly drink alcohol, on a typical drinking occasion male respondents consumed on average 6.6 (4.7) alcoholic drinks (median: 6). In 1998 they were 6.6, 5.0 and 5 respectively. Females consumed on average 3.7 (2.3) drinks (median: 3). In 1998 they were 4.2, 3.1 and 4 respectively.

Figure 17: Median number of drinks per typical occasion by gender, age and educational status



1 drink = half pint/glass beer, lager, stout or cider
 a single measure of spirits
 a single glass of wine, sherry or port

Recommended sensible weekly limits = 21 units males, 14 units females

Overall, 30% (27% in 1998) of males and 22% (21% in 1998) of females consumed more than the recommended weekly limits for alcohol. It must be noted that just 2,966 people responded to this question.

Table 16: Percentage consuming more than recommended limits by gender, age and educational status

	MALES						FEMALES					
	ED1		ED2		ED3		ED1		ED2		ED3	
	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN
	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002
18-34 years	33	44	37	34	29	35	25	27	27	27	29	26
35-54 years	25	25	28	30	20	21	15	25	9	20	15	20
55+ years	22	28	16	20	26	34	15	8	17	20	21	22

Continual, excessive alcohol use can contribute to a variety of physical and mental health problems. Respondents were asked if they had experienced any of a number of problems as a result of their own or someone else's drinking in the last 12 months. It should be noted here that the question in 2002 had a number of extra response options in comparison to 1998. The top three problems resulting from one's own drinking were as follows - 35% of respondents reported being drunk, 14% felt they should cut down, and 14% felt the effects of alcohol while at work. Positive responses to these three questions increased with age. The top three problems resulting from someone else's drinking were as follows – 6% have had arguments with family and friends about drinking, 6% (9% in 1998) report being verbally abused, and 3% (7% in 1998) report having family / marital difficulties.

Overall, 40% (31% in 1998) of children report that they have never had an alcoholic drink. These rates have risen in all categories, most particularly in the youngest group of 10-11 year olds. There is little evidence of a class effect in these reported rates.

Figure 18: Percentages of boys who report never having had an alcoholic drink

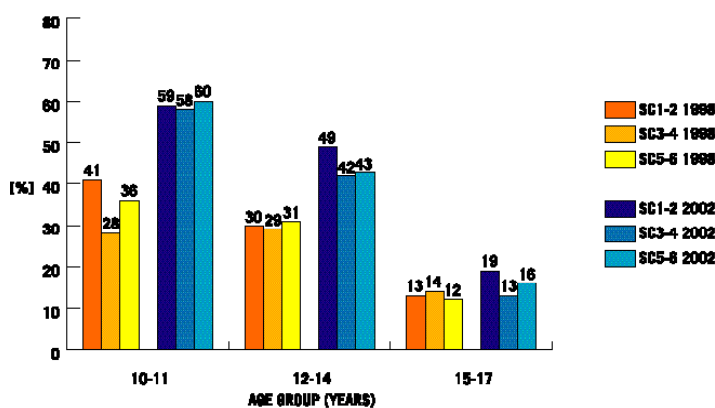
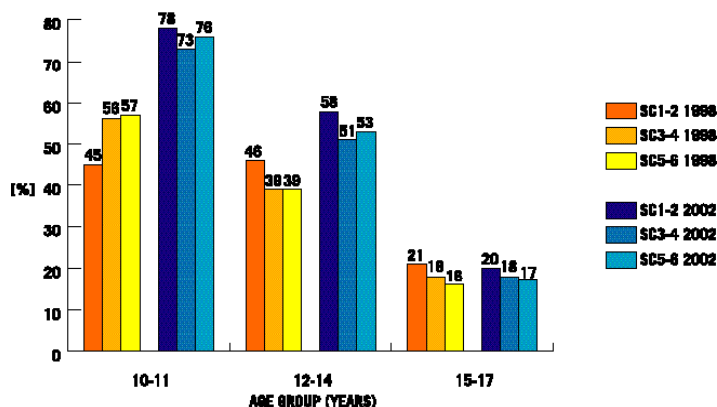


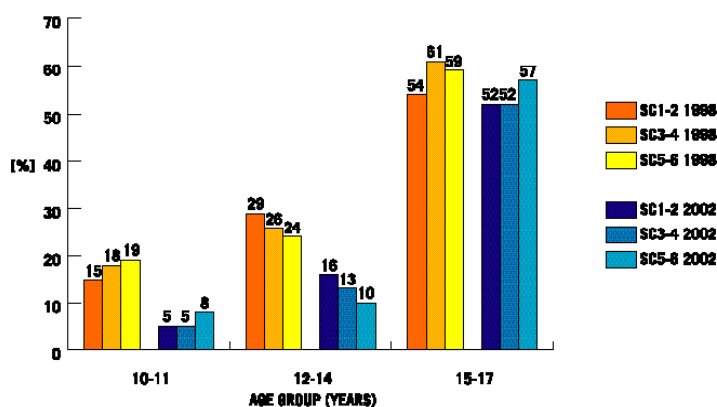
Figure 19: Percentages of girls who report never having had an alcoholic drink



As with the boys, the reported rates of non drinkers have risen considerably since the 1998 survey, though levels in 1998 were in any case higher than for boys. Only the 15-17 group shows little change and again there is little evidence of a class effect.

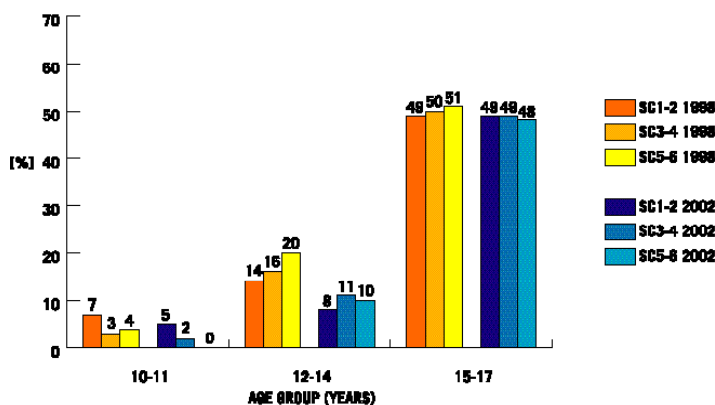
Current drinkers are defined here as those who report having had an alcoholic drink in the last month. They represent a more actively drinking group than those who have ever had a drink. Overall, 25% of the children report having had a drink in the last month. Unlike the 1998 data, there is no gender difference, with 25% of boys and 25% of girls reporting that they had an alcoholic drink in the last month.

Figure 20: Percentages of boys who report having had an alcoholic drink in the last month



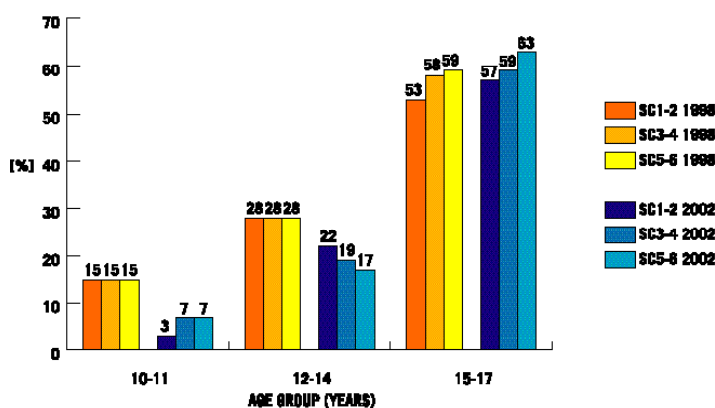
Although the oldest group show a change downwards, it is in the two younger groups that those trends are most marked, most particularly among the 10-11 year olds.

Figure 21: Percentages of girls who report having had an alcoholic drink in the last month



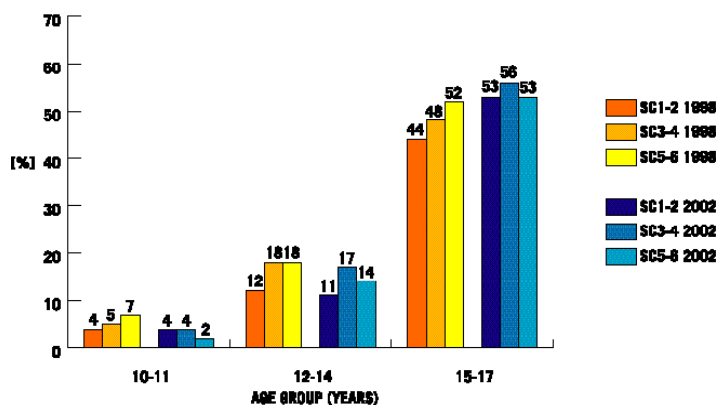
Again the trend is downwards in the two younger age groups though little different among the 15-17 year olds. In addition to alcohol consumption, children were asked if they had ever had so much alcohol that they were 'really drunk'. This is considered to be more risky alcohol consumption. In total, 30% of the children report having been really drunk. As previously, there was no gender difference with 31% of boys and 30% of girls reporting having been 'really drunk'. A gender difference was found in the 1998 report.

Figure 22: Percentages of boys who report having been "really drunk"



Again the number reporting being really drunk has dropped markedly among the younger two groups, particularly for the 10-11 year olds while not shifting appreciably in the oldest group. A class gradient has started to emerge in the oldest group.

Figure 23: Percentages of girls who report having been "really drunk"



As with the boys, the numbers reporting being really drunk have fallen, though less markedly and from a lower base level in the previous survey. Seven percent of boys and 5% of girls report being drunk more than 10 times, and this increases across the age groups with less than one percent of 10-11 year olds, 2% of 12-14 year olds and 12% of 15-17 year olds reporting being really drunk. There are no significant social class differences.

The marked change in reported drinking pattern, particularly among the two younger groups, between 1998 and 2002 is important and requires some interpretation. It is not an artefact of sampling since the two data-sets are very similar in demographic terms. Clearly it could be a real effect and the data from the 15-17 year olds have not altered so much as to imply major bias in self-reporting. It may reflect deliberate under-reporting on this occasion or over-reporting on the first occasion. Another possibility is that the considerable public and media attention to the issue of irresponsible drinking has caused younger respondents either to reflect more accurately on their own behaviour or to provide the expected appropriate response. Both are consistent with an assimilated health education message that could be built upon to foster more responsible behaviour later.

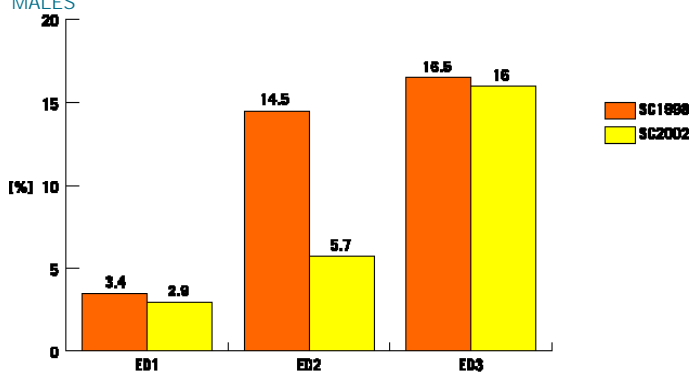
Health Promotion Strategy Target

Strategic Aim: to support models of best practice which promote the non-use of drugs and minimise harm caused by them.

Overall, nine percent of respondents (8% in 1998) report using cannabis in the past twelve months. A gender difference is clear with 12% (11% in 1998) of men and 7% (6% in 1998) of women reporting cannabis usage in the past 12 months. The rates of cannabis use are notably higher among third level educated people.

Figure 24: Percentage reporting cannabis use in the last 12 months by gender and educational status

MALES



FEMALES

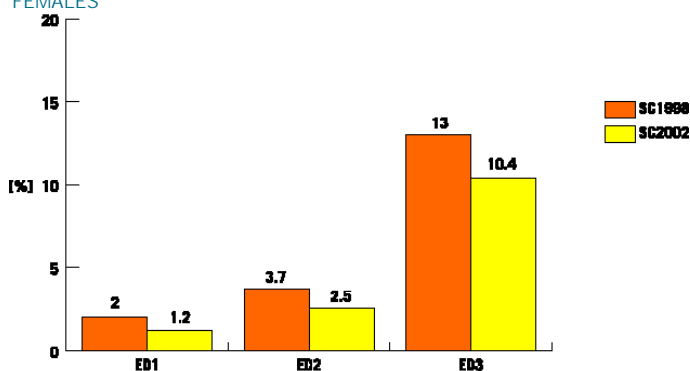


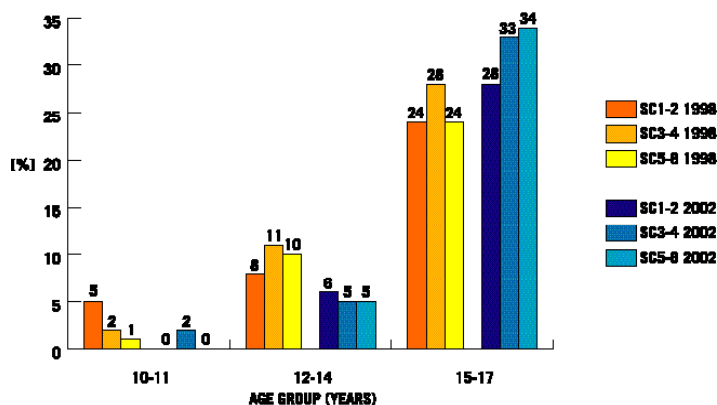
Table 17: Percentage reporting ecstasy use in the last 12 months by age

	SLÁN 1998	SLÁN 2002
18-34 years	4.9	6.4
35-54 years	0.3	0.5
55+ years	0	0.5

Ecstasy use is almost completely confined to younger respondents.

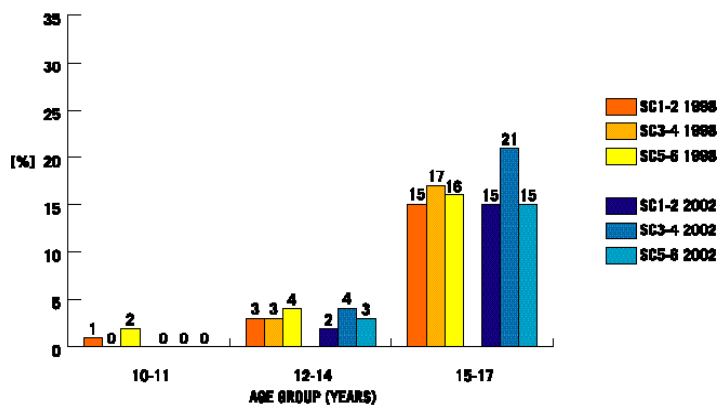
Overall, twelve percent (12% in 1998) of children report using cannabis during their lifetime, with 11% (10%) reporting using in the past 12 months.

Figure 25: Percentages of boys reporting cannabis use in the last 12 months



Numbers reporting cannabis use are higher than previously and do reflect a positive class gradient, unlike the inverse pattern seen among younger adults.

Figure 26: Percentages of girls reporting cannabis use in the past 12 months







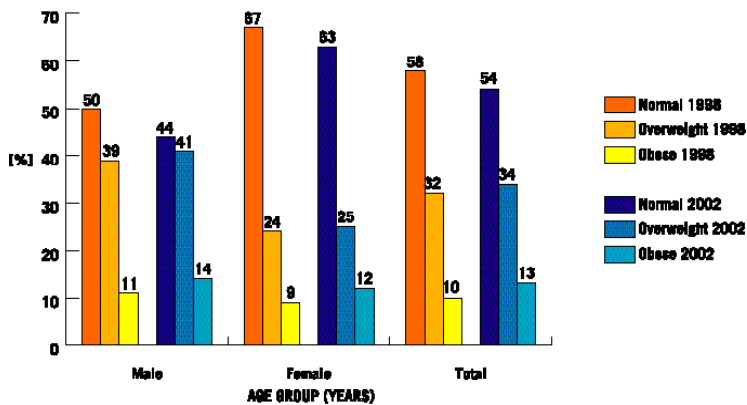
Health Promotion Strategy Target

Strategic Aim: to increase the percentage of the population who consume the recommended daily servings of food and maintain a healthy weight.

Objectives include: to promote health eating habits and healthy body image amongst school-going children and young people.

Using reported height and weight, the body mass index (weight /height ²) was calculated and used as a measure of normal weight, overweight or obesity.

Figure 27: Gender distribution of BMI



Since 1998 numbers of both men and women reporting acceptable weights have dropped and rates of obesity have risen by 3% in both men and women. Overall, thirteen percent of respondents reported being on a weight reducing diet compared with twelve percent in the previous SLÁN study. Women were more likely to report being on a weight reducing diet with some evidence that those with the highest level of education were less likely to be on a diet.

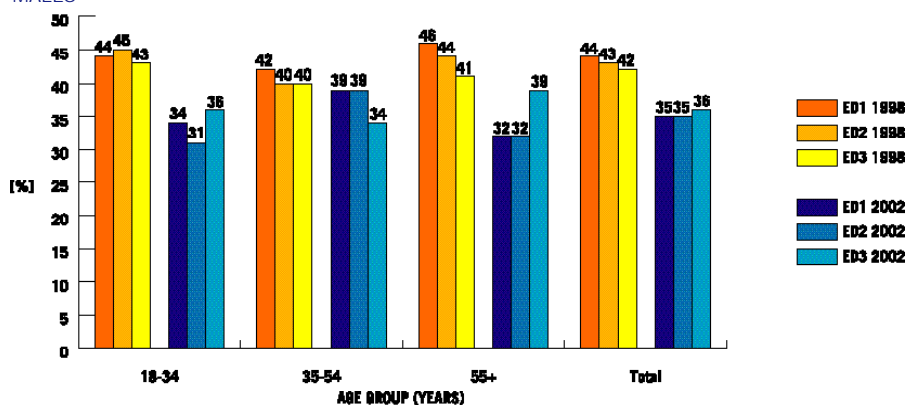
Table 18: Percentage of respondents on weight reducing diets by gender, age and educational status

	None/primary/ some secondary 1998	Complete secondary 1998	Tertiary 1998	None/primary/ some secondary 2002	Complete secondary 2002	Tertiary 2002
MALES						
18-34 yrs	5	5	4	7	2	4
35-54 yrs	5	5	6	4	6	6
55+ yrs	7	9	6	7	8	6
FEMALES						
18-34 yrs	21	22	15	22	26	20
35-54 yrs	24	26	18	25	26	21
55+ yrs	12	9	13	11	13	13

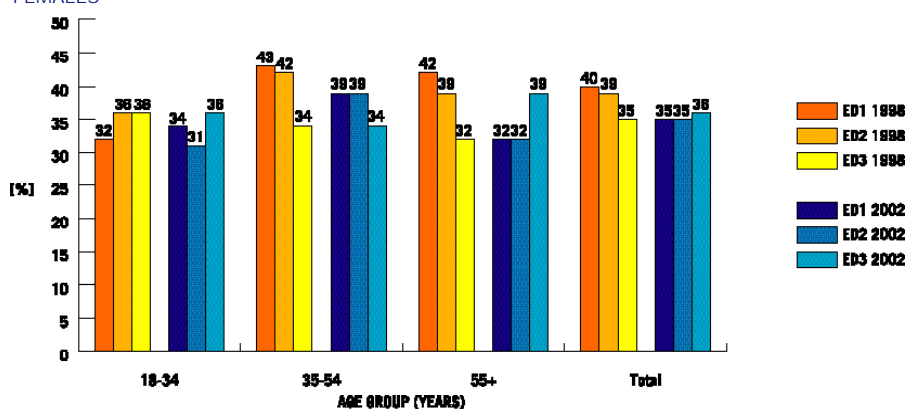
The bottom shelf of the pyramid relates to breads, cereals and potatoes. Six or more servings from this shelf are recommended for the general adult population. Thirty four percent of respondents reported eating the recommended number of servings compared to forty percent in the previous SLÁN. Consumption patterns have fallen overall and for all educational groupings and age groups since the last survey in 1998.

Fig 28: Percentage consuming recommended 6+ servings per day of cereals, breads and potatoes by gender, age and level of education

MALES



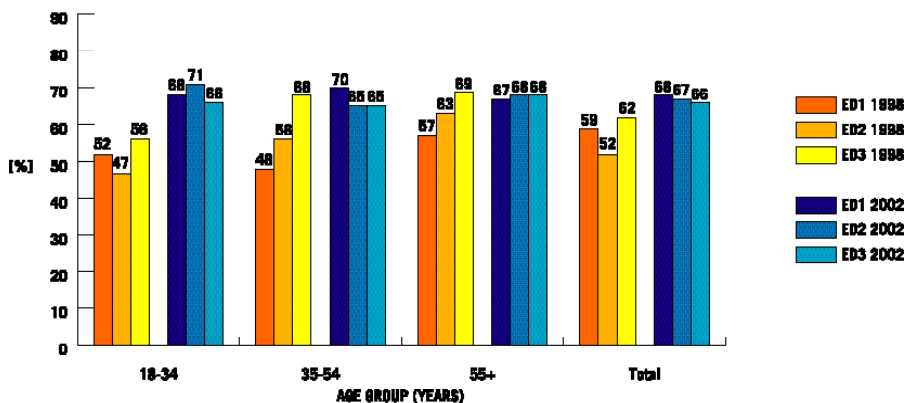
FEMALES



The pattern is less marked for women than for men, though overall levels are down, though with some evidence that those in the highest educational group have maintained or increased consumption.

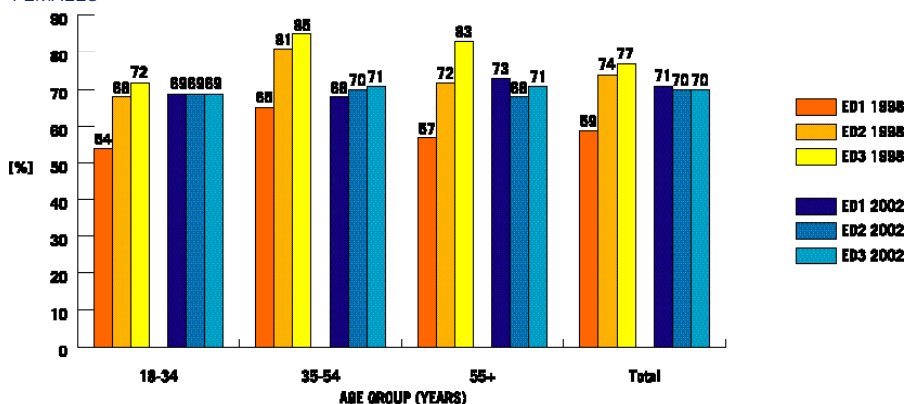
It is recommended that 4+ servings per day of fruit and vegetables be consumed. Sixty nine percent of respondents reported consuming the recommended amounts compared to sixty one percent four years ago.

Fig 29: Percentage consuming recommended 4+ servings of fruit and vegetables by gender age and level of education
MALES



Rates overall have improved among men with a less marked gradient according to educational status than was seen previously.

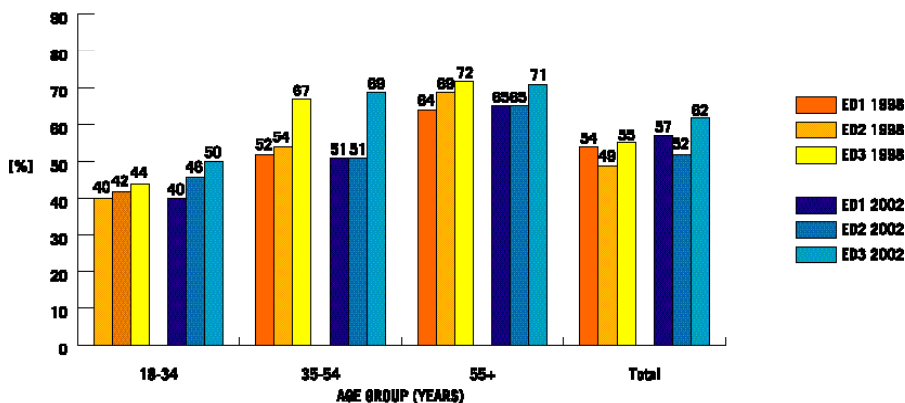
FEMALES



Among women the most striking pattern is the uniformity of reported consumption according to age and educational grouping, by contrast with the educational and age gradients seen previously.

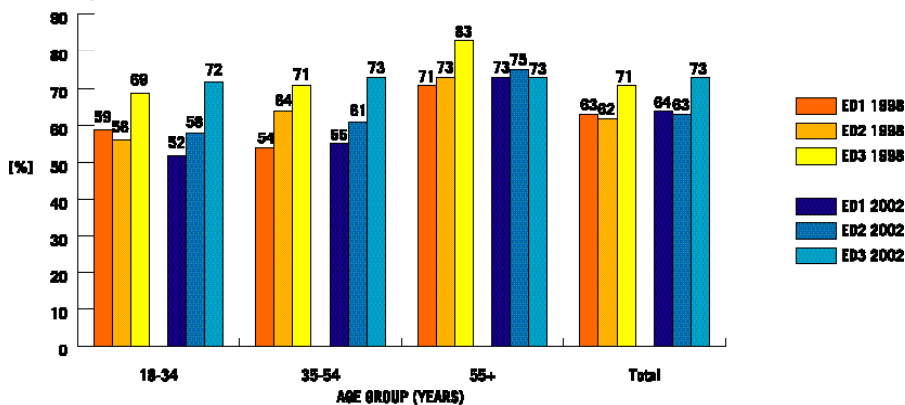
Two servings per day are recommended from the meat, fish and alternatives group. Overall sixty one percent of respondents reported consuming within the recommended amount (of the sixty one percent, thirty eight percent reported consuming the recommended two servings per day and the remaining 23 percent consumed less than 2 servings).

Fig 30: Percentage consuming 2 or less servings of meat, fish and alternatives by gender, age and level of education
 MALES



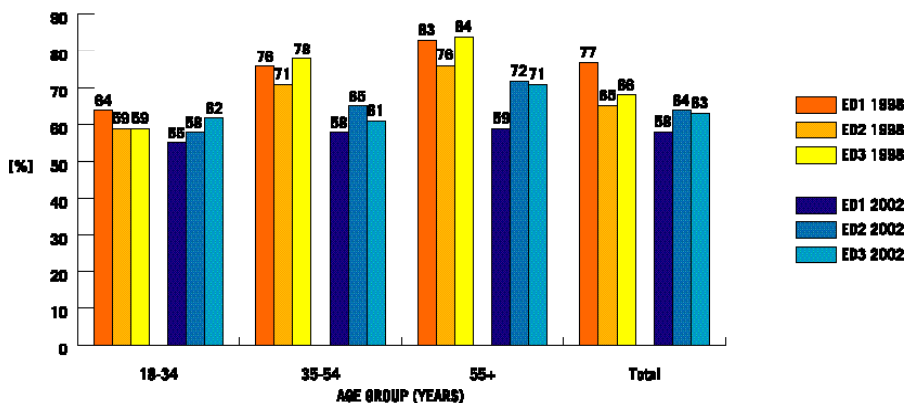
Overall there has been an increase in those reaching the recommended levels, again with a less marked educational gradient than was seen previously. Rates in the youngest group are comparable with the others in the 2002 data-set. And show improvement since 1998

FEMALES



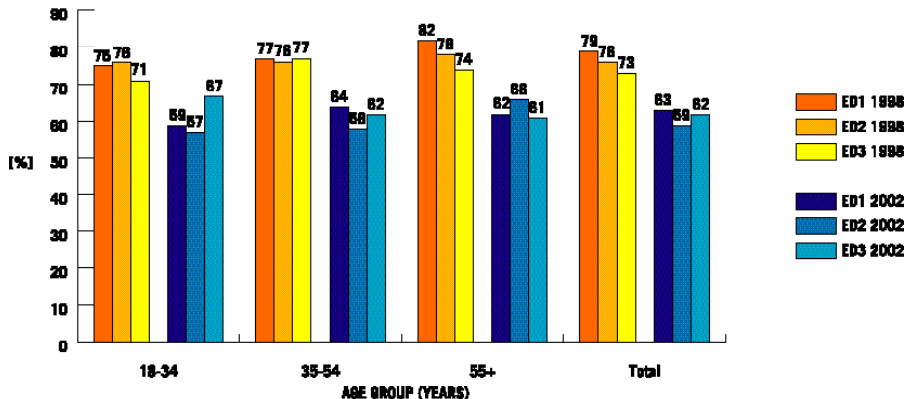
It is recommended that 3 servings per day of foods from the dairy shelf on the pyramid be consumed. Overall sixty one percent of respondents consumed within the recommended number of servings (of the sixty one percent, twenty nine percent reported consuming three servings and the remaining thirty two percent consumed less than three servings).

Fig 31: Percentage consuming 3 or less servings of dairy produce by gender, age and level of education
MALES



Those achieving the recommendations have fallen since 1998 with the emergence of a more discernible class gradient than previously

FEMALES

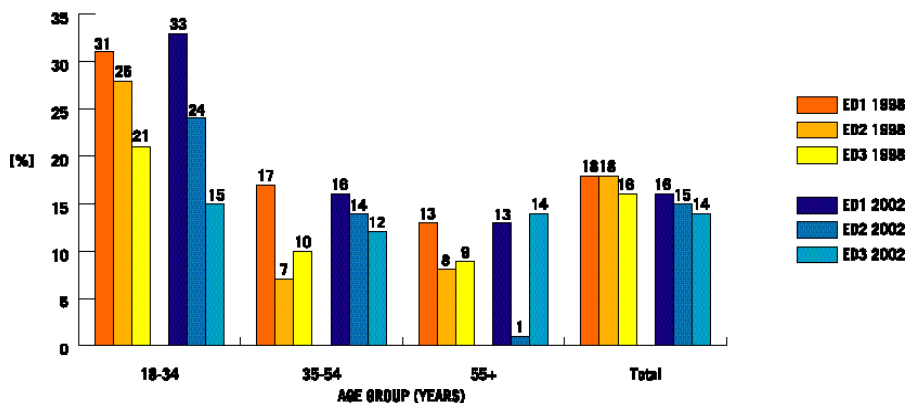


As with men those reaching the recommended rates have fallen since 1998 and the inverse class gradient is no longer notable.

Foods from the tops shelf of the pyramid are those which are high in fat and salt. It is recommended that these foods are used sparingly. Eighty three percent of respondents had at least three servings per day of these foods.

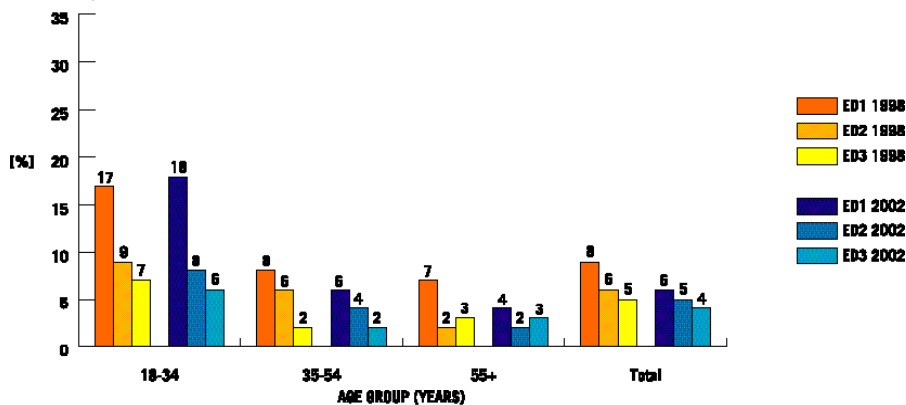
Eleven percent of respondents ate fried foods four or more times per week. As seen in figure 32 more males than females consumed fried food four or more times per week.

Fig 32: Percentage consuming fried foods more than 4 times per week
MALES



There is a marked age difference in fried food consumption, which is higher in younger adults and the distinct class gradient seen previously has widened in the young and middle-aged groups particularly. The 1% in the 55+ ED2 2002 males category can be explained by the very low N in this particular group.

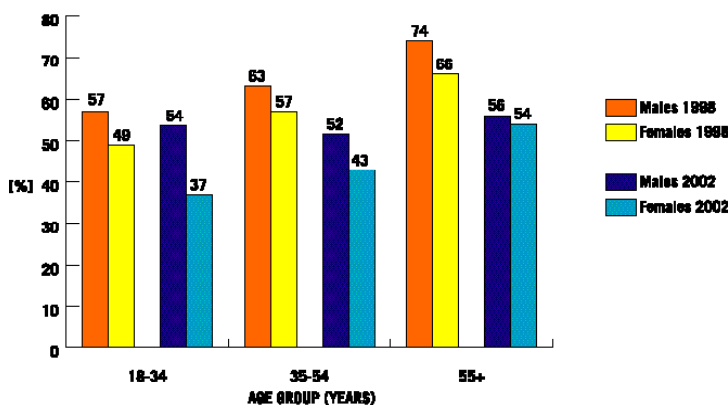
FEMALES



Fried food consumption is much lower among women than men and the overall trend is very slightly down. However the outstanding group are those in the lowest educational category aged 18-34 where rates have not improved since 1998 and are about double any other category of respondents.

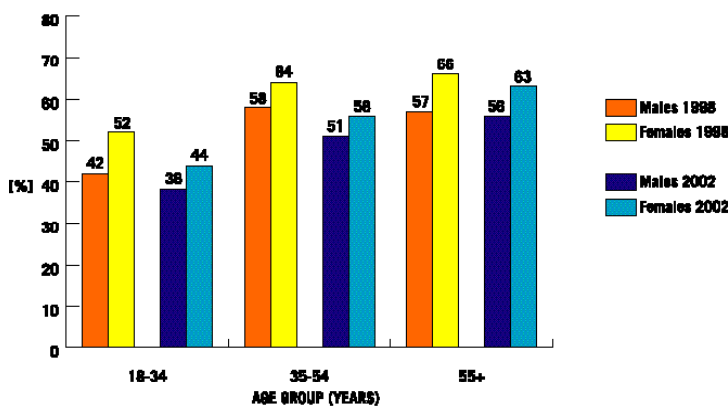
There has been a decrease in daily butter consumption since the previous SLÁN study was carried out. Overall forty eight percent of respondents used butter daily compared to fifty nine percent in the previous study.

Fig 33: Percentage consuming butter every or most days by gender and age



The rates of butter consumption remain highest in the oldest age group have fallen markedly since 1998. Forty nine now report using low fat, polyunsaturated spreads every or most days compared to fifty five percent in the previous study. Consumption of low fat spreads also show downward trends.

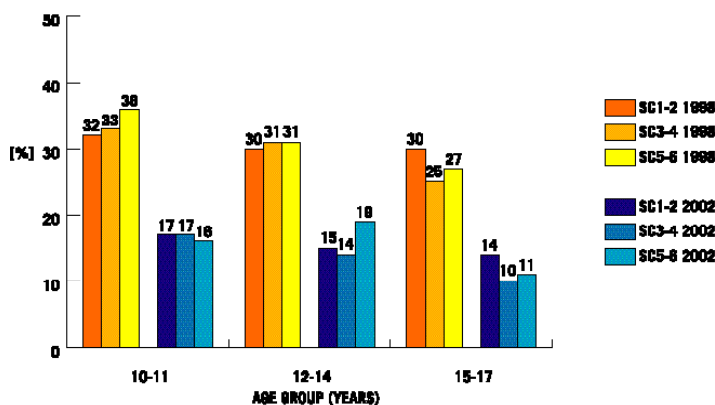
Fig 34: Percentage consuming low fat spread every or most days by gender and age



The children were asked about the frequency of their consumption of a variety of foodstuffs. These data illustrate less variability over socio-demographic groups than earlier sections. Nevertheless, both age and gender differences do emerge on the aggregate fruit data. Twenty percent of children aged 10-11 report eating fruit more frequently than daily and this decreases to 15% for those aged 15-17. Gender differences are minimal, with 15% of girls reporting they either never eat fruit or eat fruit less than weekly. Eighteen percent of girls report eating fruit more than once a day. The corresponding percentages for boys are 16% and 15% respectively.

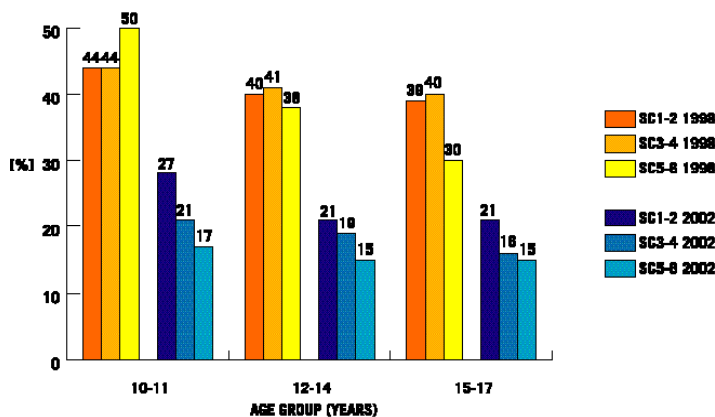
In interpreting these findings it should be noted that respondents in 2002 were given more frequency options than in 1998. However we examined these patterns for more than once a day and for once a day and more, without identifying any difference in the trends.

Figure 35: Percentages of boys who report eating fruit more than once a day



There are distinctly lower rates than in 1998 for fruit consumption with little evidence of a consistent class trend.

Figure 36: Percentages of girls who report eating fruit more than once a day



Though rates in girls were, and continue to be, higher than for boys, they have dropped considerably since the last survey and show an inverse trend according to social class.

The data for vegetable consumption show there are fewer global differences across socio-demographic groups. Gender differences are minimal, with 14% of boys and 17% of girls reporting that they eat vegetables more than once a day, while 14% of boys and 12% of girls reporting never eating vegetables or eating vegetables less than weekly.

Figure 37: Percentages of boys who report eating vegetables more than once a day

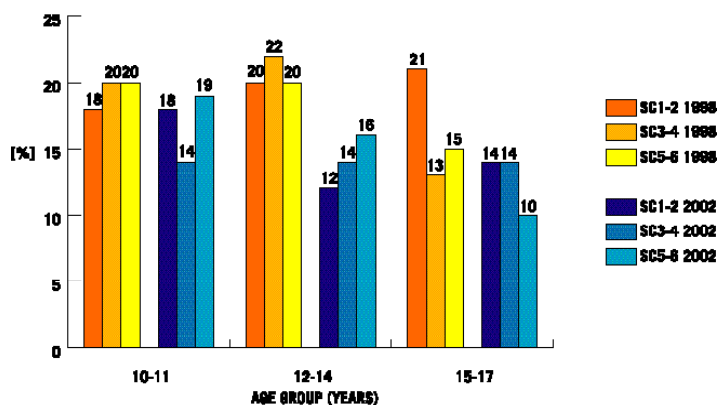
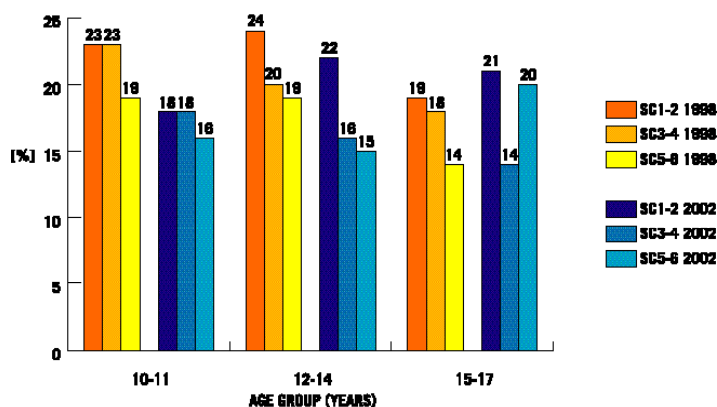


Figure 38: Percentages of girls who report eating vegetables more than once a day



Overall, 15% of children report that they never have breakfast during the week, and 8% report that they never have breakfast during the weekend. Seven percent of children report never having lunch during the week, and 17% at the weekend. Four percent of children report never having supper during the week, and the same percentage report never having supper at the weekend.

Figure 39: Percentages of boys reporting not having breakfast during the week or during the weekend

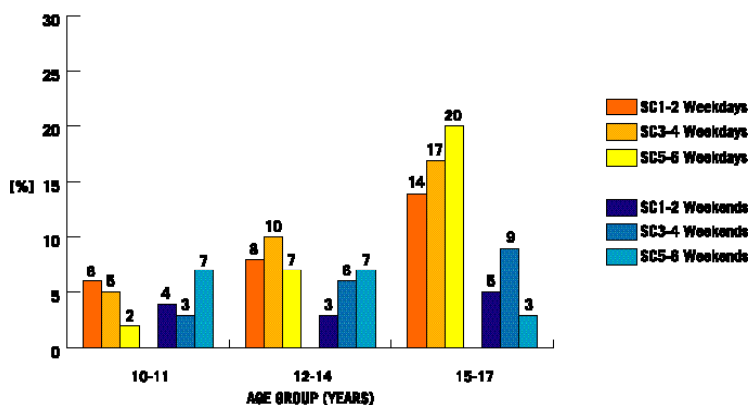
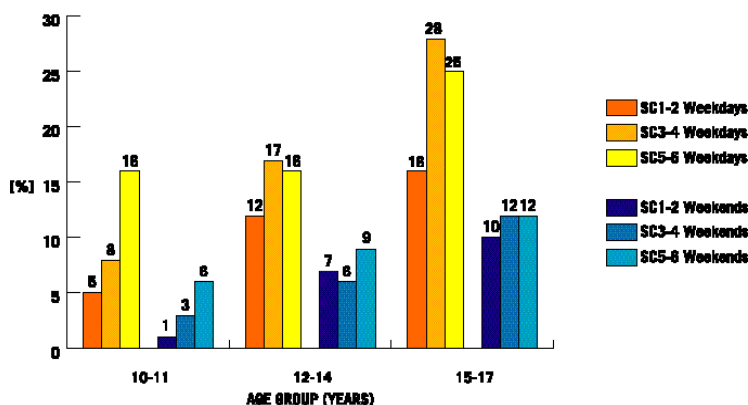


Figure 40: Percentages of girls reporting not having breakfast during the week or during the weekend



Children were asked whether they were on a diet to reduce weight or if they thought that they needed to lose weight (but were not currently on such a diet). Overall, 13% (7% of boys and 18% of girls) reported being on a weight reducing diet and an additional 22% (16% of boys and 26% of girls) reported that they need to lose weight. These percentages increased across the age groups, from 7% of 10-11 year olds through 13% of 12-14 year olds to 17% of 15-17 year olds who were on weight reducing diets and a further 17% of 10-11 year olds, 22% of 12-14 year olds and 24% of 15-17 year olds reporting that they should lose weight. Gender differences are clear, with 7% of 10-11 year olds girls reporting being on a weight reducing diet (boys in this age group were also 7%) and a further 17% of girls reporting that they needed to lose weight (boys in this age group also 17%). Eighteen percent of 12-14 year old girls report being on a diet, in comparison to 7% of boys, and a further 26% of girls in this age group reporting that they needed to lose weight (16% of boys). Twenty four percent of 15-17 year old girls report being on a diet (6% of boys in this age group), while a further 30% of girls report needing to lose weight (15% of boys). There is no consistent pattern for these variables across the social classes.

Figure 41: Percentages of boys who report being on a weight reducing diet

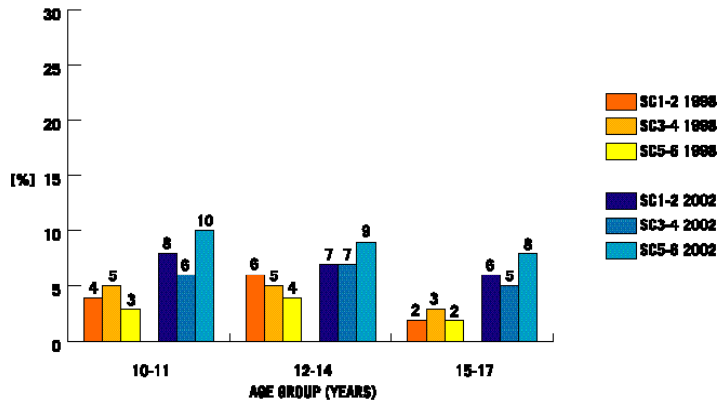
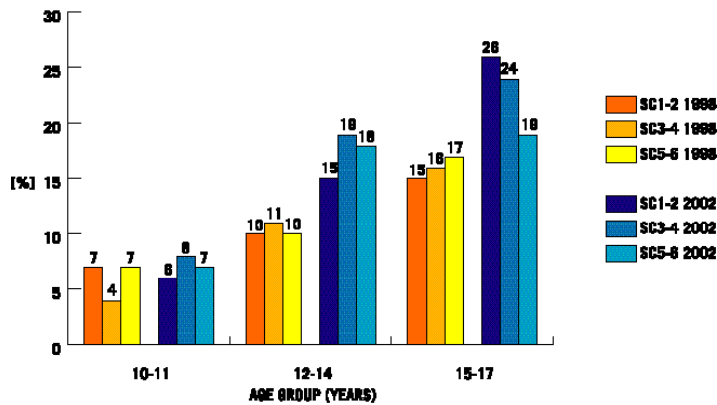


Figure 42: Percentages of girls who report being on a weight reducing diet

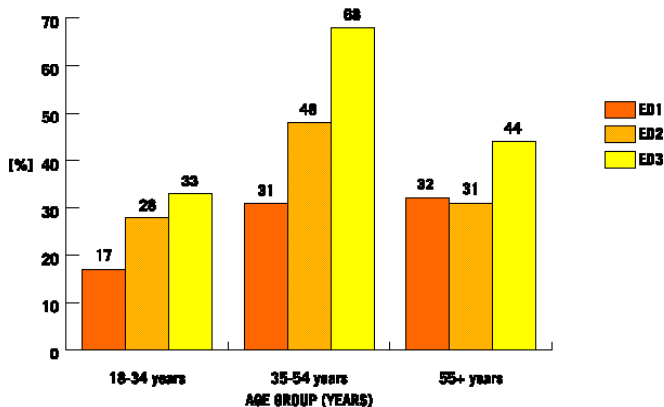


Breastfeeding

The aim of the Breastfeeding Strategy is for an overall breastfeeding initiation rate of 35% by 1996 and 50% by the year 2000. A breastfeeding initiation rate of 20% among lower socio-economic groups by 1996 and 30% by the year 2000. A breastfeeding rate of 30% at 4 months by the year 2000.

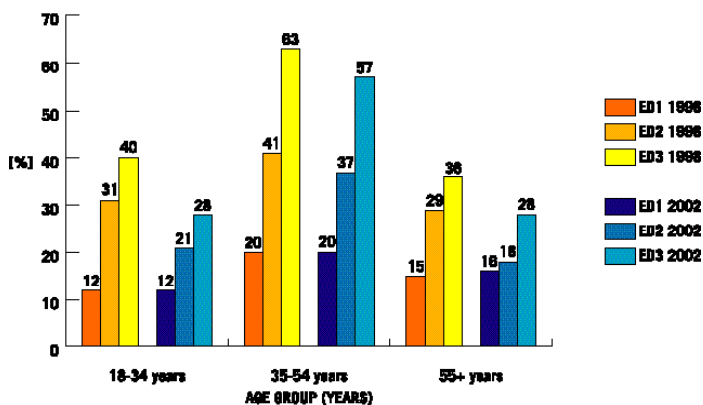
Overall, 37% of women report breastfeeding any of their children.

Figure 43: Percentage of women breastfeeding any of their children by age and educational status



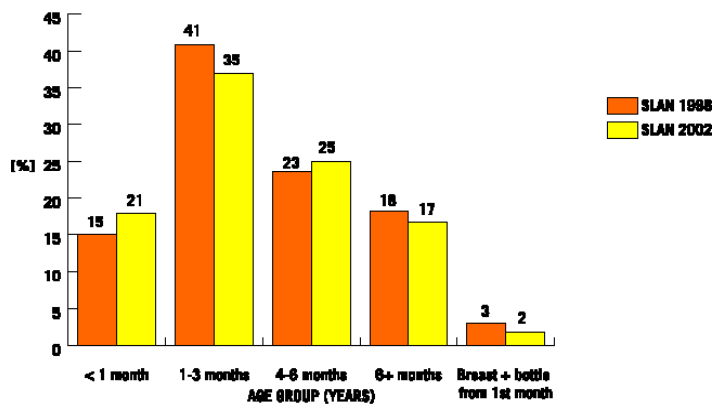
Eighteen percent (18% in 1998) of all women respondents report breastfeeding their last child. Twenty six percent (27% in 1998) of women with children report breastfeeding their last child. Seventy three percent of women who have breastfed any of their children report breastfeeding their last child.

Figure 44: Percentage of women with children who breastfed their last child by age and educational status



There continues to be a clear inverse gradient related to breast-feeding patterns seen both in 1998 and now. The wording of the question was altered slightly since 1998 which may have affected the denominator so this may be interpreted cautiously. However there is clearly a marked difference in initiation rates in all younger mothers compared to those in the 35-54 category.

Figure 45: Length of time women breastfed their last child for



The median age at which women reported their last child stopped breastfeeding was 4 (3 in 1998) months, mean 5.1 (5.3 in 1998) & standard deviation 5.2 (5.5 in 1998).

exercise





Health Promotion Strategy Target

Strategic Aim: to increase participation in regular, moderate physical activity.

Objectives include: to identify models of good practice which encourage young people (especially young girls) and older people to participate in regular, moderate physical activity.

Overall, 51% (52% in 1998) of respondents engaged in some form of regular physical exercise (mild exercise most days of the week and/or moderate exercise three or more days per week and/or strenuous exercise three or more days of the week).

Twenty-two percent (25% in 1998) reported doing mild exercise four times per week for at least 20 minutes, 32% (31% in 1998) did moderate exercise three or more times per week and 11% (10% in 1998) did strenuous exercise three or more times per week. Table 19 below gives this breakdown by gender.

Table 19: Percentage engaging in physical activity by gender

	MALES		FEMALES	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Some form of physical activity	50	48	54	53
Mild exercise	24	22	26	22
Moderate exercise	26	26	35	37
Strenuous exercise	14	15	6	7

Table 20 below shows the distribution of mild exercise participation by gender, age and educational status.

Table 20: Percentage engaging in mild physical exercise for at least 20 minutes most days of the week by gender, age and educational status

	MALES						FEMALES					
	ED1		ED2		ED3		ED1		ED2		ED3	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
18-34 years	14	20	20	16	32	25	24	12	25	21	28	22
35-54 years	19	16	22	18	22	20	21	18	23	18	23	23
55+ years	28	20	42	34	30	38	26	22	37	30	41	31

There is a strong inverse trend according to educational status at all ages, which is widest for the oldest group. As with males there is a clear and widening inverse trend according to educational status among women that has not improved since 1998.

Figure 46: Percentage engaging in moderate exercise for at least 20 minutes three or more times per week by gender, age and educational status

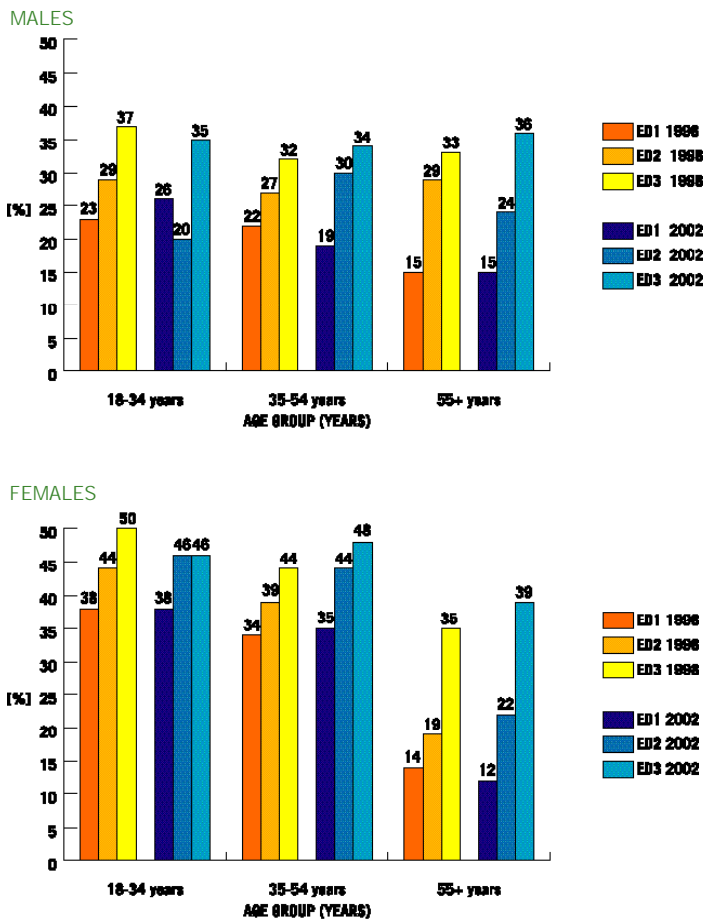


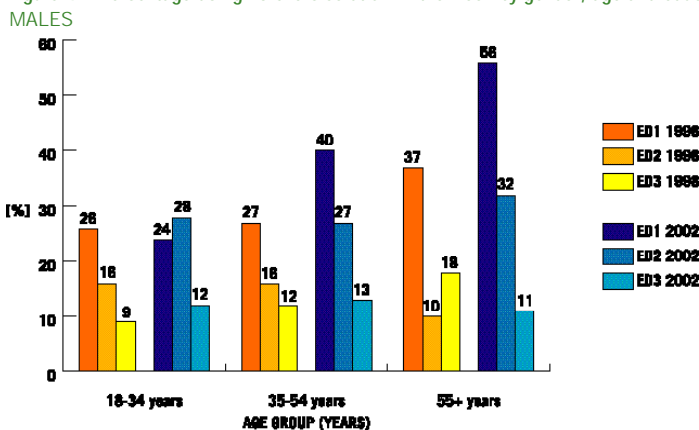
Table 21 over shows the distribution of strenuous exercise participation by gender, age and educational status.

Table 21: Percentage engaging in strenuous physical exercise for at least 20 minutes three or more times per week by gender, age and educational status

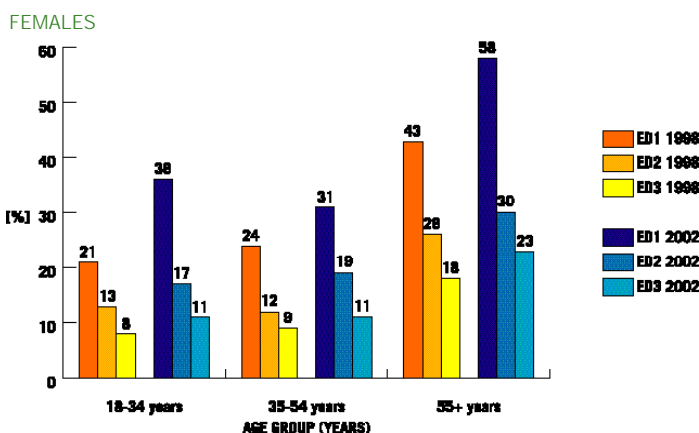
	MALES						FEMALES					
	ED1		ED2		ED3		ED1		ED2		ED3	
	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN	SLÁN
	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002	1998	2002
18-34 years	17	22	29	23	28	29	5	4	9	10	12	12
35-54 years	8	8	9	10	7	14	4	5	5	5	7	7
55+ years	3	2	2	4	2	4	1	1	1	2	-	2

The outstanding group engaging in strenuous exercise are younger males aged 18-34 and rates have fallen somewhat in all but the third level educated group since 1998. There is an inverse class trend too for younger women. Twenty-eight percent (21% in 1998)* of respondents reported doing no exercise at all; *30% (21% in 1998) men and 25% (20% in 1998) women.

Figure 47: Percentage doing no exercise at all in the week by gender, age and educational status

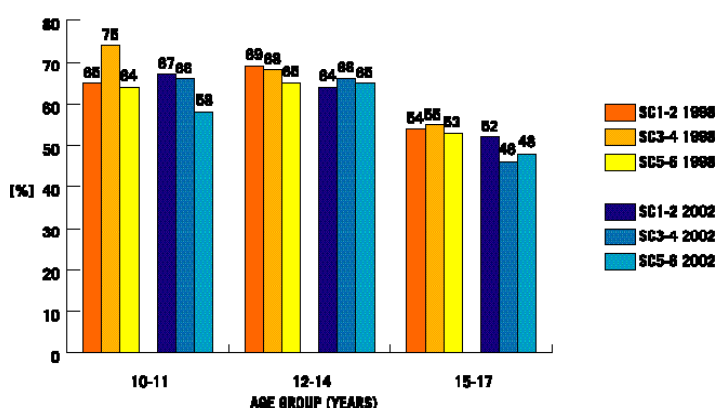


Again there is a strong inverse trend to inactivity in all age groups, which is worsening particularly among the less well educated and the oldest age group. As with the men the clearly established inverse trend persists, is deteriorating among the less well educated and the oldest age group.



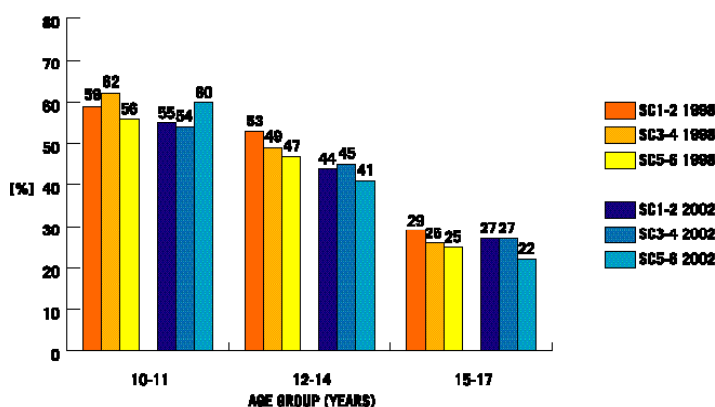
Children were asked about their participation in exercise outside of class time. They were asked the frequency with which they exercised so much that they get out of breath or sweat. Presented below are data illustrating the percentages reporting that they exercise in such a way four or more times a week (in keeping with the national targets) and those reporting that they exercise less than weekly. Overall, 48% of children report exercising four or more time per week while 12% exercise less than weekly. However, this masks some substantial gender differences. Although only 8% of boys and 14% of girls are exercising less than weekly, 59% of boys and 38% of girls are exercising four or more time per week. Although there are few global differences across social class, exercise participation does decrease with age. Exercising four or more times per week decreases from 59% of 10-11 year olds and 53% of 12-14 year olds to 35% of 15-17 year olds. This decrease is apparent among both genders but is particularly noticeable among girls (dropping from 55% of 10-11 year olds, through 44% of 12-14 year olds to 25% of 15-17 year olds).

Figure 48: Percentages of boys who report participating in vigorous exercise four or more times per week



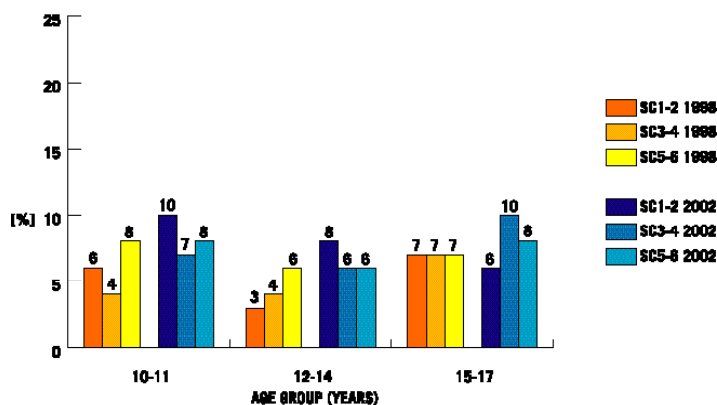
There is a slight fall compared to 1998 and no discernible class trend for boys.

Figure 49: Percentages of girls who report participating in vigorous exercise four or more times per week



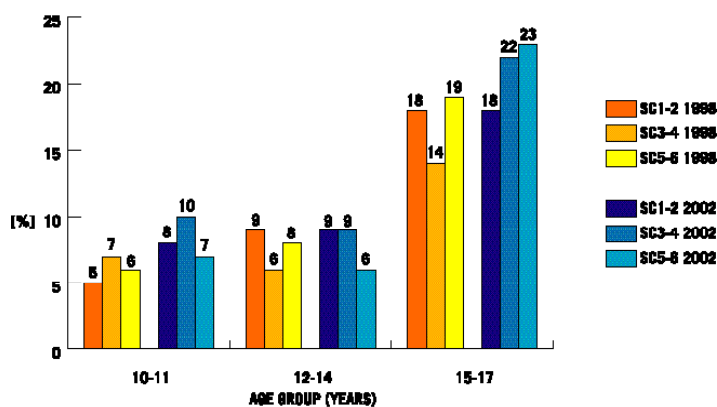
Activity rates for girls are lower than for boys and as in 1998 show a very sharp drop by the age of 15. There is a slight trend downwards overall and the inverse class trend is less distinct.

Figure 50: Percentages of boys who report participating in vigorous exercise less than weekly



These rates are relatively low generally and show no distinct trend compared with previously, though the tendency is upwards, especially in the younger age groups.

Figure 51: Percentages of girls who report participating in vigorous exercise less than weekly



Unlike the boys, inactivity rates in girls are much higher and rise very sharply by the age of 15. The class pattern is not consistent, but inactivity may be inversely related to social class in the younger age groups and positively related in the older age group.

accidents





Health Promotion Strategy Target

Strategic Aim: to contribute to a reduction in the percentage of the population affected by fatal and non-fatal injuries. Objectives include: to work in partnership to promote safety and injury prevention (especially amongst children and older people) with a particular focus on fall prevention, accidents in the home and on the road and farm.

No data on fatal injuries were collected but the pattern of non-fatal but limiting injuries in Ireland was recorded. Seventeen percent (18% in 1998) of respondents indicated having had an injury in the past two years which interfered with their daily activities and of these 89% (85% in 1998)* were accidental.
 * 91% (85% in 1998) men, * 88% (85% in 1998) women.

Males were more likely to have suffered such an injury with 21% (23% in 1998) compared to 14% (14% in 1998) females. There also appeared to be an inverse age relationship with 20% of the 18-34 year olds having a serious injury compared to 12% of the older 55+ age group. Thirty one percent (35% in 1998) of the injuries were at home or in the garden, 20% (19% in 1998) at work and 19% (16% in 1998) during sport.

Table 22: Site of injury by gender

	MALES		FEMALES	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
At home/garden	23	21	45	41
At work	26	28	12	11
During sport	25	31	7	8

Table 23: Site of Injury by gender and age

	Home/Garden		Work		Sport		Car/Bike		On foot		Other	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
MALES												
18-34 years	10	8	24	26	41	50	14	10	5	3	5	3
35-54 years	18	25	37	34	23	24	11	10	5	4	6	4
55+ years	48	40	11	25	3	7	13	5	16	13	9	9
FEMALES												
18-34 years	30	29	18	14	12	12	20	21	6	14	15	10
35-54 years	43	46	11	14	9	10	14	9	11	12	12	10
55+ years	50	53	4	3	1	-	5	10	24	22	16	12

Forty percent (38% in 1998) of respondents received treatment of their injuries in the accident and emergency service in hospitals. Twenty nine percent (32% in 1998) used the GP service and 10% (25% in 1998) treated the injury themselves.

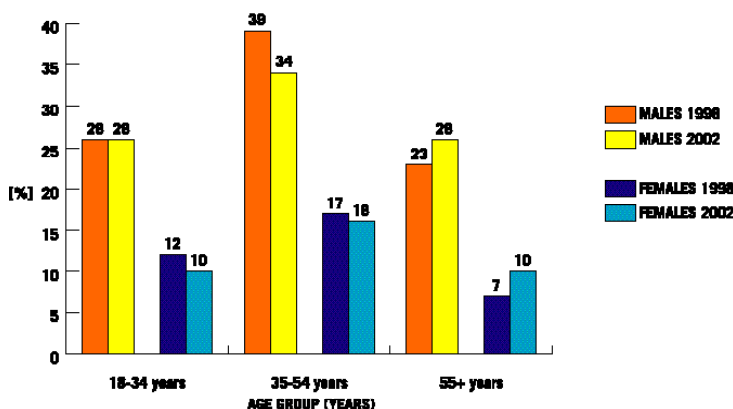
Table 24: Treatment of injury by gender

	MALES		FEMALES	
	SLÁN 1998	SLÁN 2002	SLÁN 1998	SLÁN 2002
Accident & Emergency	40	41	35	39
GP Service	31	26	33	31
Self treated	21	11	29	10

Eighty four percent (68% in 1998)* of respondents reported always using seatbelts when riding in the front seat of a car. *79% (61% in 1998) men, *90% (74% in 1998) women

A major concern around road safety is drinking and driving. Of those respondents who normally drank and who normally drove a car, 19% (20% in 1998) indicated that they had driven soon after consuming 2 or more alcoholic drinks. A significantly higher percentage of males to females reported doing this (27% (28% in 1998) to 11% (12% in 1998) respectively) and as seen in Figure 52 below, predominantly the middle, 35-54 year age group.

Figure 52: Percentage of those regular drinkers who report driving a car after drinking two or more alcoholic drinks



This shows relatively little change from previously with younger drivers appearing to be more conscientious and women less likely to drive than men. Children were asked about their use seatbelts and cycle helmets. The data presented below for seatbelt use exclude those who do not travel by car or report that there is no seatbelt where they sit in the car. It should be noted that the percentage of those reporting that there is no seatbelt where they sit is low (0.4%). Overall, 62% of children report that they always wear a seatbelt, but this masks some substantial gender differences as 57% of boys and 65% of girls report always wearing a seatbelt when traveling by car.

Figure 53: Percentages of boys who report always wearing a seatbelt

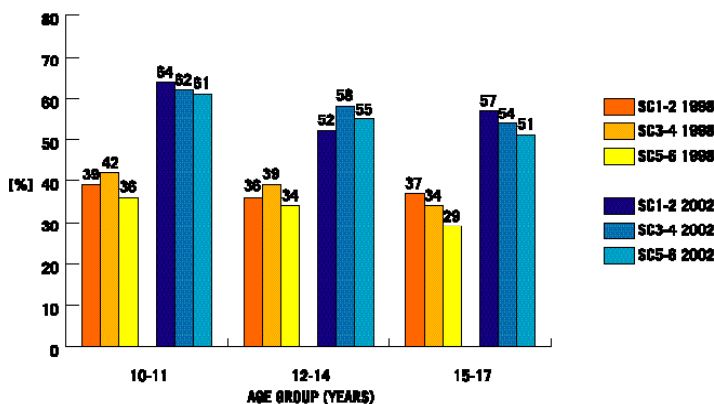
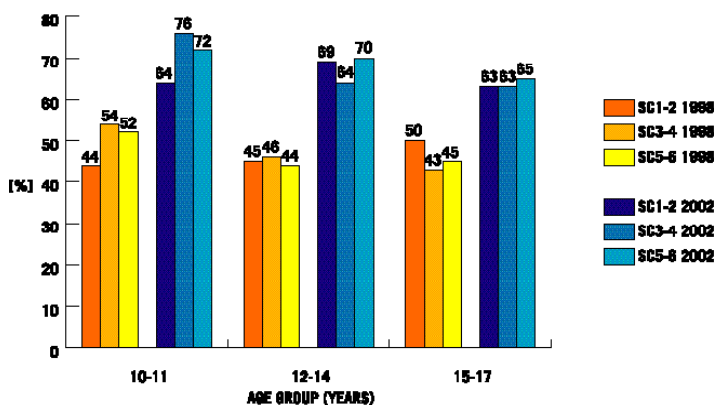


Figure 54: Percentages of girls who report always wearing a seatbelt



The rates for cycle helmet use have been calculated by excluding those who report that they do not ride bicycles. Overall, 8% of children report that they always wear a helmet and no gender or social class differences emerge. There are, however, substantial age differences. The rates decrease from 14% at ages 10-11, through 8% at ages 12-14 to 5% at ages 15-17. Interestingly, this mirrors the increase in those reporting that they do not ride bicycles which were 10% (10% for both boys and girls), 18% (10% for boys and 25% for girls) and 37% (22% for boys and 47% for girls) for the three age groups respectively.

Figure 55: Percentages of boys who report always wearing a cycle helmet (having removed those who report they do not ride bicycles)

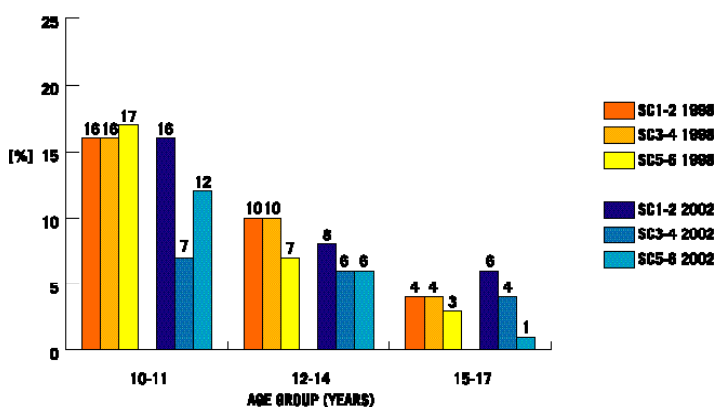
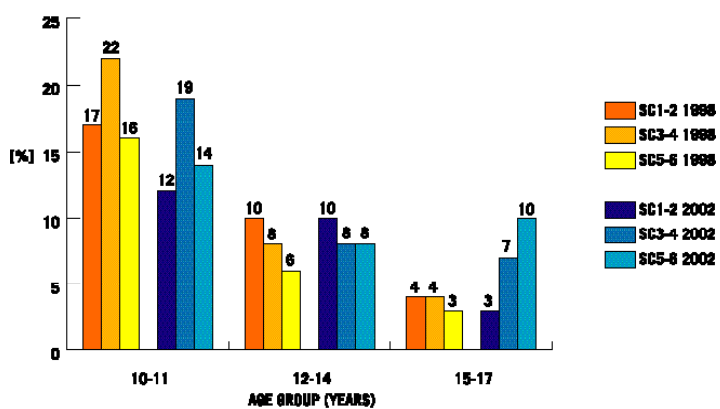


Figure 56: Percentages of girls who report always wearing a cycle helmet (having removed those who report they do not ride bicycles)



appendix

SLÁN

	Males SLÁN 1998	Males SLÁN 2002	Females SLÁN 1998	Females SLÁN 2002
Self-reported health (excellent & very good)	48.2	53.8	49.1	56.5
Daily activity/work limited by long term illness	12.9	13.4	13.6	12.1
Health would be better if I had less stress	41.0	34.5	46.6	38.7
Greatest source of health information (GP)	51.9	56.1	58.2	61.4
Greatest factor preventing people from improving their general health (Financial problems)	39.4	36.3	45.8	45.4
Health state today:				
Have no problems with mobility (walking about)	89.7	88.3	88.0	88.7
Have no problems with self care (washing and dressing one's self)	97.1	96.8	96.8	96.7
Have no problems with usual activities (e.g. work, study, housework, family or leisure activities)	86.9	87.0	85.4	85.4
Have no pain/discomfort	72.4	71.5	68.9	70.3
Am not anxious/depressed	75.1	77.7	68.9	74.3
Self-rated health state (median)	80.5	82.6	82.3	80.3
Good or very good quality of life	83.4	84.3	84.5	87.4
Satisfied or very satisfied with health	70.6	70.9	72.9	74.5
Attended an alternative/complementary therapist	16.1	21.3	22.8	29.8
Attended for aches pains and muscle problems (of those who attended alternative/complementary therapist)	60.6	65.9	56.9	57.5
Have all 32 natural teeth	26.0	28.9	24.3	26.2
Use recommended pea sized amount of toothpaste	11.0	20.3	17.1	26.1
Normal or low blood pressure	54.5	57.3	67.4	73.3
Had blood pressure checked up to one year ago	57.0	66.6	75.3	83.1
Normal or low cholesterol	25.2	31.8	24.2	32.4
Had cholesterol checked up to one year ago	23.9	30.0	20.6	33.1
Had general health check up in the last 3 years	61.5	64.4	70.0	69.4
Attended doctor's surgery for most recent check (of those who had general check in the last 3 years)	71.1	68.3	81.2	79.4
Attend doctor's surgery for regular checks (e.g. once every three months) or treatment	28	24.4	39.2	34.2
Been told by a doctor that you have or have had any of the following:				
Angina	3.6	3.9	2.7	2.2
Heart attack (coronary thrombosis, myocardial infarction)	2.4	2.4	1.1	1.4
High blood pressure	9.5	11.6	13.1	13.3
Stroke	1.0	1.3	0.9	0.7
Diabetes	2.3	2.9	1.8	2.0
High cholesterol	5.9	8.8	5.3	7.3
Anxiety	4.8	5.8	8.2	8.8
Depression	5.1	7.6	9.4	10.7
Other diagnosis	8.0	4.1	10.3	6.8
Regularly taking any prescribed pills or medication	25.7	27.5	37.7	43.4
Have any difficulty reading the instructions (if regularly taking any prescribed pills or medication)	6.6	5.0	5.7	4.3
If sexually active, always used contraception/protection	35.6	26.3	31.2	42.9

Most frequently used methods of contraception:

Contraceptive pill	8.2	11.9	25.5	30.0
Condom	47.8	59.7	40.0	35.7
Withdrawal	7.6	9.1	7.2	6.0
Currently pregnant	-	-	2.8	2.8
Ever been on the contraceptive pill	-	-	48.2	54.8
Mean number of years on contraceptive pill	-	-	4.8	5.4
Breastfed last child	-	-	26.3	27.0
Breast fed for 4-6 months	-	-	22.8	24.8
Mean age at which child stopped any breastfeeding	-	-	5.3	5.1

How many times per week on average engage in the following

Any kind of exercise for more than 20 minutes:				
Strenuous exercise 3 or more times weekly	14.1	15.2	5.9	6.6
Moderate exercise 3 or more times weekly	26.5	25.9	35.0	37.3
Mild exercise most days of the week	24.1	21.5	25.5	21.6
Do light housework most days				
Heavy household work most days	13.0	13.1	34.0	29.3
Use car as transport when going out shopping	67.9	72.3	71.4	76.4
Very physically active in job	26.5	28.7	20.7	19.6
Smoke cigarettes	32.1	28.3	30.7	25.8
Mean number of years been a smoker	21.6	22.3	20.5	21.1
Smoked cigarettes in the past	58.1	42.6	65.3	48.7

Spend part of day where other people are smoking...:

At home	25.7	21.1	30.7	22.5
In the workplace	35.5	29.0	24.2	16.6
On public transport	4.5	3.3	3.5	2.7
In a pub or club	52.7	47.3	34.7	31.6
Other places	16	12.9	15.3	14.0
I don't often spend time with smokers	29.1	32.8	39.6	44.0

Had a drink during the past week	71	71.9	55.6	59.6
On the average day drank alcohol, drank more than 6 drinks	34.7	41.4	11.6	16.2
In the last year, drank alcohol in a typical week	75.8	71.9	56.1	56.1
Mean number of days in a typical week that involved alcohol consumption	2.7	2.8	2.5	2.6
During the last 12 months, experienced problems as a result of someone else's drinking (2002 arguments with family and friends about drinking, 1998 family/marital difficulties)				
During the last 12 months driven a car soon after consuming 2 or more alcoholic drinks	5.4	3.9	8.4	7.2

On how many occasions (if any) have you:

Ever used marijuana (grass, pot) or cannabis (hash, hash oil) in lifetime	21.9	26.2	13.8	19.1
Ever used marijuana (grass, pot) or cannabis (hash, hash oil) during the last 12 months	11.0	12.1	6.2	6.7
Ever used marijuana (grass, pot) or cannabis (hash, hash oil) during the last 30 days	6.7	7.8	2.8	3.0

appendix

Used any of the following drugs in the last 12 months:

Tranquillisers or sedatives without a doctor's prescription	1.3	1.4	1.3	1.0
Amphetamine	3.6	2.4	1.3	0.6
LSD	1.9	1.6	0.8	0.8
Cocaine	1.8	3.0	0.6	1.9
Relevin	0.08	0.2	0.09	0.4
Heroin	0.5	0.4	0.3	0.5
Ecstasy	2.9	3.9	1.5	2.4
Drugs by injection with a needle	0.2	0.2	0.04	0.5
Solvents	0.5	0.7	0.3	0.6
Magic mushrooms	2.2	2.3	0.6	1.3

Had one or more injuries serious enough to interfere with daily activities in the last 2 years	22.9	20.7	14.2	13.9
Most recent injuries that were non-accidental	14.8	8.7	15.3	12.4
Where most recent injury happened:				
At home or in the house	12.1	13.1	34.7	31.6
At work	26.2	28.4	12.2	10.9
Injury resulted from fall (most frequent cause of injury)	32.7	36.6	43.7	53.0
Medical treatment needed due to injury	86.8	72.8	83.8	75.4
Always use seatbelts when driving or riding in the front seats of a car	60.6	78.5	73.7	89.5
Have a medical card	26.1	24.0	32.4	29.7
Have private health insurance that covers the cost of private medical treatment		51.7		57.2
Have the use of a car		73.6		71.4
Think could eat healthier	72.0	77.9	73.5	75.5
Read food labels	43.2	51.7	67.4	74.4
Most frequently looked at information on food labels – ingredients	43.2	68.2	67.4	63.5

Follow any of the following diets:

Vegetarian	2.1	2.9	4.5	3.3
Diabetic	2.3	2.6	1.9	2.1
Weight reducing	5.7	4.9	18.2	19.8
Vegan	0.2	0.1	0.3	0.1
Gluten free	0.7	1.0	1.0	1.8
Low cholesterol	6.8	9.1	9.1	8.7
Do not follow a special diet	83.2	69.7	68.8	58.9
Have taken any vitamins, minerals or other food supplements during the past year	38.2	42.6	54.9	59.7
Consume fried foods daily	5.5	5.6	1.8	1.5
Consume butter or hard margarine as a spread or for cooking food every or most days	62.9	53.7	56.2	43.2
Consume a low fat or polyunsaturated spread as a spread or in cooking every or most days	51.2	45.4	59.5	53.2
Consume vegetable oil every or most days	17.5	19.2	18.4	17.5
Consume lard or dripping in fried, roasted or baked foods every or most days	7.1	5.2	4.9	2.4
Consume full-fat milk	67.5	60.5	57.8	47.3
Drink up to one pint of milk daily	84.8	81.7	93.2	93.2
Cook vegetables boiled from cold water (excluding potatoes)	59.2	55.3	50.6	42.8
Have been advised to take folic acid supplements			22.8	32.3

HBSC

	Boys HBSC 1998	Boys HBSC 2002	Girls HBSC 1998	Girls HBSC 2002
Weekly pocket money €12.60 (£10.00)	41.4	38.5	36.8	43.5
Think they will go to college or university when finished school	50.2	54.0	70.8	74.1
Have ever smoked tobacco	50.8	39.8	47.5	42.3
Do not smoke	78.8	82.9	78.8	80.2
Present consumption of types of alcohol on a daily or weekly basis:				
Beer (Guinness, Lager)	12.3	8.9	3.8	3.2
Wine	4.0	2.1	2.2	2.2
Spirits / Liquor	5.8	5.5	3.8	6.8
Cider (Bulmers, etc.)	9.1	6.9	3.9	4.2
Alcopops (Woodies, Hooch, Bacardi Breezer)	5.4	4.2	3.1	8.1
Been really drunk 2 or more times	22.9	20.5	14.3	20.2
Taken any of the following drugs in life:				
Cannabis	16.2	14.2	8.6	11.7
Glue or solvents	6.0	7.7	3.7	4.9
Any other drug		6.7		4.7
Taken any of the following drugs in past 12 months:				
Cannabis	14.0	13.4	6.7	9.5
Glue or solvents		5.1		3.4
Any other drug		5.6		4.1
Consumption of following types of food once a day or more: (note categories altered since 1998)				
Fruits	68.5	29.1	76.9	36.3
Vegetables	67.6	36.5	75.7	43.4
Sweets (candy or chocolate)	77.3	47.9	75.3	53.5
Coke or any other soft drink that contains sugar	70.4	40.2	55.7	35.2
Low fat / semi-skimmed milk	27.1	13.8	27.2	17.3
Whole fat milk	66.9	49.2	60.3	42.2
Brown bread (whole wheat or rye bread in 1998)	42.7	21.3	41.4	18.4
Crisps	57.0	25.6	54.5	27.3
Cakes or pastries	26.8	8.1	21.2	6.7
Chips / fried potatoes	30.0	14.6	18.5	9.8
Hamburgers, hot dogs, sausages	19.8	10.3	9.7	4.8
On a diet or doing something to lose weight	4.2	6.7	11.7	18.5
Vegetarian		3.5		6.0
Always, often or sometimes go to bed hungry		18.6		13.7
Brush teeth more than once a day	46.7	50.6	67.8	69.0
Use pea sized (recommended) amount	12.7	22.1	15.9	25.3
Exercise in free time so much that you get out of breath or sweat four or more times per week	62.3	59.3	45.0	38.2
During the past 12 months, did not go on family holiday (in Ireland or abroad)	22.7	21.9	26.4	20.4
Do not have your own bedroom	38.5	30.0	36.9	28.3
Family does not own a car, van or truck	6.9	4.2	7.0	5.1
Feels very or quite happy about life at present	90.7	91.3	86.6	87.0

appendix

In the last 6 months had the following either daily, weekly or more than weekly:				
Headache	21.2	19.7	30.6	32.5
Stomach-ache	12.1	9.6	16.7	17.4
Back ache	16.3	15.6	14.4	14.0
Feeling low	18.7	21.5	26.1	29.5
Irritability or bad temper	47.5	44.3	46.5	44.2
Feeling nervous	29.2	30.2	34.5	32.9
Difficulties in getting to sleep	29.3	25.3	31.7	29.6
Feeling dizzy	16.7	13.9	16.6	15.9
Believe body to be of above average weight (picture based)	20.9	23.6	31.3	31.8
Think body is a bit too fat or much too fat	21.4	21.2	42.4	39.0
Think you are quite or very good looking	34.8	36.5	25.4	25.4
Gave up something for Lent this year	34.6	40.3	44.3	41.4
During the past 12 months, was injured and had to be treated by a doctor / nurse	48.3	56.6	32.1	37.6
During the past 12 months, in a physical fight	60.0	54.9	29.6	24.5
How often been bullied at school in the past couple of months	29.5	27.6	19.9	22.4
How often taken part in bullying another student(s) at school in the past couple of months?	34.4	30.0	14.1	15.3
Always use seatbelt when sitting in car	36.1	56.7	46.7	65.3
Always wear helmet when riding bicycle	8.4	5.9	9.1	6.3
Think family is quite or very well off	51.1	55.9	42.5	45.8
Generally speaking, always feel safe in area where you live		57.9		50.2
Very easy or easy to talk to the following persons about things that really bother you				
Father	51.8	60.8	40.1	45.5
Mother	69.7	72.9	76	76.4
Elder brother	34.5	35.4	22.2	24.5
Elder sister	32.5	35.8	40.9	38.7
Best friend		78.5		88.5
Like school a bit or a lot at present	64.6	62.0	79.5	71.4
Excellent or very good health (very healthy or quite healthy in 1998)	93.5	87.4	89.5	84.2
Live with mother	97.5	96.7	98.3	97.5
Live with father	92.7	88.1	91.9	88.2
Usually spend four or more days time with friends right after school	38.7	47.1	28.4	36.9
Usually spend four or more evenings per week out with friends	43.8	44.0	31.8	34.7
In your opinion, teacher thinks your school performance compared to your classmates is very good or good	61.7	58.3	71.3	62.8
Feel some or a lot of pressure by schoolwork that has to be done	68.7	66.9	66.7	63.0

project team

Centre for Health Promotion Studies, National University of Ireland, Galway

Prof. Cecily Kelleher	Surveys Scientific Director
Dr. Saoirse Nic Gabhainn	Principal Investigator HBSC (Republic of Ireland)
Ms. Sharon Friel	Co-ordinator of SLÁN
Ms. Jane Sixsmith	Co-ordinator of SLÁN Examination Study
Ms. Helen Corrigan	Researcher HBSC/SLÁN
Ms. Pauline Clerkin	Researcher HBSC/SLÁN (until May 2001)
Ms. Geraldine Nolan	Consultant Nutritionist, National Nutrition Surveillance Centre
Ms. Orla Walsh	Researcher, National Nutrition Surveillance Centre
Ms. Mary Cooke	Administrative Director, Centre for Health Promotion Studies
Ms. Marie Galvin	Database co-ordinator, HBSC
Ms. Fiona Lawless	Database co-ordinator, SLÁN
Ms. Maura Owen	Database
Ms. Martha Higgins	Project Secretarial Support
Ms. Christina Costello	Project Secretarial Support

National Steering Committee

Mr. Chris Fitzgerald (Chair)	Principal Officer, Department of Health and Children
Dr. Mary Codd	Department of Health and Children
Prof. Leslie Daly	Department of Public Health Medicine and Epidemiology, National University of Ireland, Dublin
Dr. Clodha Foley-Nolan	Southern Health Board
Dr. Brian Gaffney	Health Promotion Agency, Northern Ireland
Prof. Ian Graham	Department of Epidemiology and Preventive Medicine, Royal College of Surgeons in Ireland
Ms. Jacky Jones	Western Health Board
Prof. Cecily Kelleher	Director, Centre for Health Promotion Studies, National University of Ireland, Galway to 31 December 02, now Professor of Public Health Medicine and Epidemiology, University College Dublin
Ms. Deirdre Mahony	Administrative Officer, Health Promotion Unit, Department of Health and Children
Ms. Katrina Ronis	Health Promotion Advisor, Department of Health and Children to November 2002
Dr. Emer Shelley	Department of Health and Children (to April, 2002)

Ethical Approval for the surveys was obtained from Faculty of Public Health Medicine, Royal College of Physicians of Ireland

Health Board Liaison Contacts

Dr. Fenton Howell	Specialist Public Health Medicine, Dept of Public Health, Railway St, Navan, Co Meath.
Dr. Alan Smith	Specialist Public Health Medicine, Dept of Public Health, Railway St, Navan, Co Meath.
Dr. Nazih Eldin	Regional Health Promotion Officer, Dept. Health Promotion, Railway Road, Navan, Co. Meath
Ms. Marian Kiernan	Co-ordinator CVD, Farrell Street, Kells, Co. Meath
Dr. Deirdre Mulholland	Specialist Public Health Medicine, Dept. Public Health, Dr. Steeven's Hospital, Dublin 8
Ms. Maria Lordan-Dunphy	Director of Health Promotion, 3rd Floor 191-197 Parkhouse, North Circular Road, Dublin 7
Ms. Jo O'Rourke	Workplace HPO, 3rd Floor, Park house, NCR, Dublin 7
Mrs. Pauline Bryan	Director of Primary Care, South Western Area Health Board, Oak House, Millennium Park, Naas, Co. Kildare
Ms. Siobhan Fitzpatrick	Co-ordinator for Cardiovascular Strategy, South Western Area Health Board, Oak House, Millennium Park, Naas, Co. Kildare
Ms. Martina Queally	Director of Health Promotion, Health Promotion Unit, City Gate, 15 St. Augustine St., Dublin 8
Ms. Sharon Foley	Health Promotion Manager, Southern Cross Business Park, Bray, Co. Wicklow
Ms. Sharon Barnes	Administrator, Southern Cross Business Park, Bray, Co. Wicklow
Ms. Joan Ita Murphy	Health Promotion Officer, Health Promotion Department, Bray, Co. Wicklow
Ms. Mairead Fennessy	Senior Researcher, Dept. Public Health, Top Floor, St. Conice's Hospital, Kilkenny

project team

Dr. Clíodhna Foley-Nolan	Specialist Public Health Medicine, Dept. Public Health, Sansfield House, Sansfield Road, Wilton, Cork
Ms. Karen O'Mullane	Senior Health Promotion Officer, Dept. Health Promotion, Eye, Ear and Throat Hospital, Western Road, Cork
Dr. Catherine Murphy	Senior Area Medical Officer, Floor 2 Abbey Court House, Georges Quay
Ms. Mary Byrne	Director of Public Health Nursing, Hospital Grounds Skibereen, Co. Cork
Mr. Frank Haughton	Dept. Public Health, Parkview House, Limerick
Ms. Jacky Jones	Regional Health Promotion Manager, The Annex, 1st Floor, West City Centre, Seamus Quirke Road, Galway
Ms. Fiona O'Donovan	Research Officer, The Annex, 1st Floor, West City Centre, Seamus Quirke Road, Galway
Dr. Diarmuid O'Donovan	Specialist Public Health Medicine, Dept. Public Health, Merlin Park, Galway
Dr. Mary O'Rourke	CVD Project Manager, Dept. Public Health, Merlin Park, Galway
Ms. Michelle Share	Dept. Health Promotion, Ballyshannon
Dr. Pranni Rattigan	CVD, 3rd Floor Bridgewater House, Sligo
Ms. Anna Kelly	Director of Public Health Nursing, Community Care, Ballybofey, Co. Donegal
Ms. Carmel Brennan	Project Manager Cardiovascular Health Strategy, Midland Health Board Offices, William St., Tullamore, Co. Offaly
Mr. Matthew McCann	Regional Health Promotion Manager, Midland Health Board, The Mall, William St, Tullamore, Co. Offaly
Ms. June Boulger	Snr. Health Promotion Officer, 3rd Floor the Mall, William Street, Tullamore, Co. Offaly
Ms. Mary Hegarty	Lead Qualitative Researcher - Public Health, Midland Health Board Over Old ESB, William St, Tullamore, Co. Offaly

External Reviewer

Dr. Hanno Ulmer	Institute for Biostatistics and Documentation, University of Innsbruck, Austria
-----------------	---

Specific SLÁN Acknowledgements

Field Nurse Researchers

Dr Helen Grimes and staff, Department of Clinical Biochemistry, University College Hospital, Galway
All personnel involved in the administration of SLÁN

Specific HBSC Acknowledgements

International Co-ordinator, Dr Candace Currie, University of Edinburgh
International Databank Manager, Dr Oddrun Samdal, University of Bergen
The Department of Education and Science
The Management Authorities, Principals and Teachers in all schools who participated
The Parents and Children who consented and participated
All respondents to the questionnaire

Data Entry:

Research and Evaluation Services Ltd., Belfast



The National Health & Lifestyle Surveys

Results of National Health and Lifestyle Surveys
SLÁN [Survey of Lifestyle, Attitudes and Nutrition]
and
HBSC [Health Behaviour in School-Aged Children]