

The Regional Results from SLÁN & HBSC



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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. The main aims of the surveys were to:

- Produce reliable baseline data for a nationally representative cross-section of the Irish population which will inform the Department of Health and Children's future policy and programme planning.

- Establish 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.

The first report, The National Health and Lifestyle Surveys February 1999, presented a sociodemographic breakdown of results at a national level across the key areas identified in the Health Strategy: General health, smoking, alcohol, food and nutrition, exercise and accidents. This report presents the findings for the same topics at a regional level with some demographic analyses. It must be noted that the aim of the survey was to establish patterns in health and lifestyle at a national level. The significance therefore of findings at the regional level is somewhat reduced due to the smaller sample sizes.

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

summary

A summary of the main findings from SLÁN and HBSC is listed below. Very few regional differences existed in the adult data with the exception of the Eastern Board. Age and General Medical Services (GMS) status were found to influence the level of risk behaviour in this Board more so than others. The Eastern Health Board also contributed most of the regional differences in the children's data.

General Health

- The levels of self perceived excellent/very good general health are similar in all health boards with very little variation between males and females. The requirements cited for bettering health are the same in all boards except in the East where less pollution was ranked in the top four. In all boards GP and media were named as the main sources of health information with only the East choosing Media as number one.
- The levels of perceived health and happiness among the children are similar across health boards with no consistent variations. Girls aged over eleven are less likely to report being very healthy than boys of the same age in almost all health boards, but there are no such differences for reported happiness.

Smoking

- There are few regional differences in smoking status. However rates are higher in the East amongst the 35-54 year age group and medical card holders. In each board males smoked more cigarettes than females with similar numbers being smoked by each group.
- Smoking experimentation and current smoking rates are not consistently different between boys and girls, although where differences do emerge, boys are more likely to be involved. Boys from the Eastern Health Board are most likely to have experimented with smoking. However, the modal number of cigarettes smoked by those who report that they are current smokers is constant across all health boards at one cigarette per week.

Alcohol

- Regularity, frequency and quantity of alcohol consumption should no significant regional variation except in the Eastern Board. There is more regular alcohol consumption in the Eastern Health Board in all age groups. In all boards males consume more regularly than females as do non-GMS status respondents. There are slight regional variations in percentages of regular consumers. The highest rate of consumption among GMS respondents is in the East and lowest in the Midlands and among non medical card holders rates are again highest in the East and lowest in the North West. The lowest level of abstension in all age groups is in the East but in all boards GMS respondents are more likely to abstain. Although respondents in all ages in the Eastern board drink alcohol on a more regular basis they consumed less of it in a typical drinking occasion compared to other boards.

- The pattern of alcohol use among the children is complex. Gender differences emerge on all alcohol related variables although they are not all found in every board. Each significant gender difference illustrates that boys are more likely to experiment with alcohol, to drink regularly and to have experienced drunkness. Inter health board differences are most consistent among the Eastern Health Board, where both boys and girls report more use of alcohol than those in the rest of the country.

Nutrition and diet

- Levels of obesity are similar in all health boards except the Midlands where significantly more females reported being obese. However there is no regional variation in numbers on a weight reducing diet. Similar percentages of respondents in each board are consuming the recommended number of servings for each shelf in the food pyramid. Slight variations are observed across the various sociodemographic strata for the bottom two shelves but show no significant systematic pattern.

- Children are more likely to report eating fruit rather than vegetables. Girls are more likely to eat more fruit than boys, but the same pattern does not emerge for vegetables. In every health board, girls are more likely to report being on a weight reducing diet and that they should be on a diet. Although a few inter-board differences emerge, they illustrate no consistent pattern. No differences emerge between health boards in relation to dieting behaviour.

Excerise

- There are no regional variations in the levels of participation in strenuous and moderate exercise. In all boards higher percentages of non-GMS respondents partake in these types of exercise. More people in the East and fewer in the Midlands, particularly the men, take part in mild exercise. Eastern health board respondents are the most active overall in all age groups. In all boards medical card holders are more likely to not do any exercise in a week whereas fewer non-GMS respondents in the East do no exercise compared to other non-GMS across the boards.

- In almost all health board areas, girls are less likely to be exercising more than four times per week than boys and many more girls than boys report that they exercise less than weekly. There are no consistent patterns between health boards.

summary

Accidents

- Accidents are more likely to have occurred in the Eastern board particularly amongst the younger and older age groups. The three most frequent locations of injury and treatment are the same across the boards. There is no significant regional variation in the percentage of people drinking and driving. In all boards more males than females and non-GMS respondents report this behaviour. Respondents of all age groups in the Eastern board are more likely to always wear a seatbelt when in the front of a car.
- The rates of children wearing seatbelts and cycle helmets are low across the country. However, girls are more likely than boys to report always wearing a seatbelt but not a helmet. Children from the Eastern Health Board region are more likely to report consistently using a seatbelt. Across the country boys are more likely to report having had an injury or accident and are more likely to report that it occurred at a sports facility or field. Few inter-board differences emerged in relation to accidents.

methodology

SLÁN

A representative cross-section of the Irish adult population was surveyed in 1998. A national sample was estimated which could show differences according to social class status in key variables, smoking, exercise and percentage caloric intake from fat with national precision levels of 3.4% (i.e. percentage difference between estimated measure and 95% confidence limits). 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.

Ninety percent of the total sample was surveyed by post and the remaining 10% invited to attend a clinical examination. Results from this subsample will be reported separately. A national postal sample of 12,722 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. Following a reminder letter, fieldworkers from Research and Evaluation Services (RES) Ltd. called to the doors of non-responders. 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. Data entry was carried out by RES Ltd.

The North Eastern Health Board requested an augmented sample in that area in order to have precision estimates comparable with the average national sample. An extra sample of 1,076 was generated and sent postal questionnaires.

HBSC

The HBSC is a World Health Organisation (European) collaborative study. It runs on an academic 4-year cycle and in 1997/8, 29 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 requires 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 of the 8 Health Boards. 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

methodology

(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, information sheets for teachers and classroom based feedback forms. All returns were facilitated through the provision of FREEPOST envelopes. Consent forms for parents were provided for those who requested them. 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, and in some regions from Health Board staff. Data entry was conducted according to the International HBSC protocol by Research and Evaluation Services, Ltd.

Table 1: Summary of Methodologies

	SLÁN	HBSC
Population	Adults aged 18+	School going children aged 9-17
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 8 Health Boards
Survey Instrument	Self-completion questionnaire	Self-completion questionnaire
Delivery/ Reminders	Postal, letter 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	6, 539 adults	187 schools / 8, 497 pupils
Data Quality	Data were entered and validated according to preset protocol	Data were entered according to the HBSC international protocol

SLÁN

Excluding those not eligible (that is deceased or confirmed to have gone away at the follow-up stage), the total valid sample for the postal component was 10,515. A national response of 6,539 (62.2%) was obtained with regional response rates as follows:

Table 2: Regional response to SLÁN

Health Board	Valid Sample	Response (n)	Response (%)
Eastern	3651	1994	54.6
North Eastern (core)	743	505	68.0
North Eastern (extra)	820	543	66.2
Southern	1451	852	58.7
Western	918	605	65.9
South Eastern	1032	677	65.6
Mid Western	834	552	66.2
Midland	523	354	67.7
North Western	543	389	71.6
Unidentifiable		68	

Table 3: Age, gender and social group profile of SLÁN respondents

Health Board	Male %	Female %	18-34yrs%	35-54yrs%	55+yrs%	GMS%	Total n
Eastern	46.8	53.2	41.2	36.2	22.6	22.1	1994
North Eastern	45.1	54.9	41.1	34.0	24.9	35.3	1048
Southern	48.4	51.6	32.8	40.4	26.8	29.9	852
Western	47.1	52.9	31.3	40.8	27.9	30.6	605
South Eastern	47.1	52.9	34.3	36.4	29.3	27.0	677
Mid Western	46.6	53.4	34.5	37.8	27.6	34.4	552
Midland	45.0	55.0	34.3	40.5	25.5	36.9	354
North Western	43.9	56.1	36.4	33.8	29.8	37.8	389
NATIONAL	46.7	53.3	37.				

HBSC

A total of 258 schools were initially contacted (166 primary and 92 post-primary) across the 8 Health Boards. Table 4 below presents the response rates from both types of schools across Health Boards. The final three columns present the total number of completed questionnaires from each Health Board region, and the percentage of the total sample that it represents. Finally table 4 presents the percentages of young people aged 10-14 in each Health Board area recorded during the 1996 census. Clearly the data are representative of the population distribution for these age groups across regions, with only slight variations from the 1996 census.

Table 4: Regional response to the HBSC survey

Health Board	Primary Schools		Post-Primary Schools	
	Response (n)	Response (%)	Response (n)	Response (%)
Eastern	30	86	19	68
North Eastern	14	74	6	100
Southern	16	53	5	62
Western	16	59	8	62
South Eastern	11	69	5	83
Mid Western	13	72	9	82
Midland	10	77	11	79
North Western	6	67	8	80
Total	116	70	71	77

Within primary schools, a form was completed for each class indicating how many pupils were absent during data collection (6%) or whose parents or selves refused to participate (2%). Therefore, questionnaires were returned from 92% of pupils in selected primary schools. In post primary schools, the rate of refusal was nil, but absenteeism was higher (14%). Therefore questionnaires were returned from 86% of selected post-primary school pupils. The final sample size is n = 8497. Table 5 below presents the gender, age and social group profile of children according to Health Board.

Table 5: Age, Gender and Social Group Profile of HBSC Respondents

Health Board	% Boys	Mean Age (sd)		% Blue collar	N
		GIRLS	BOYS		
Eastern	60%	13.22 (1.79)	13.69 (1.76)	49%	2, 255
South Eastern	29%	14.05 (1.62)	13.64 (1.79)	52%	988
Southern	52%	13.27 (1.79)	14.40 (1.64)	43%	1, 399
Mid Western	36%	14.15 (1.80)	13.10 (1.81)	56%	712
Western	44%	14.17 (1.72)	13.54 (1.77)	50%	892
North Western	59%	13.84 (2.29)	13.88 (1.88)	57%	519
North Eastern	40%	14.12 (1.78)	13.98 (1.63)	56%	958
Midland	53%	13.37 (1.82)	14.10 (1.71)	61%	716
Total	49%	13.73	13.86 (1.77)	52%	8, 497

SLÁN

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%.

The data are presented Nationally and by Health Board. Significant differences between a Health Board versus all other Health Boards are indicated by ## (1% level). Where differences emerged between Health Boards analyses were performed to check for sociodemographic influences and are reported in the text. Gender differences within Health Boards are indicated by ** (1% level). The augmented North Eastern health board sample excluding the excess county Louth respondents has been reported on.

HBSC

Three sets of analyses have been conducted on the HBSC data from each Health Board. First the percentages of pupils in each board who report engaging in a series of health related behaviours are presented in a summary table below. Second, gender differences within the individual boards have been calculated and statistically significant differences ($p<0.01$) between boys and girls are noted in the text on each target area. Third, data from the individual Health Boards have been compared with that from the rest of the country. These analyses have been conducted for each gender separately. Where statistically significant differences ($p<0.01$) between boards were identified these are noted in the text. Note that the achievement of statistical significance is largely a function of sample size. Therefore it is more appropriate to examine the extent of the difference between groups rather than relying exclusively on statistical significance. In addition, when differences do emerge, the age differences rather than the geographical differences between boards should be considered first as explanatory factors. A number of the variables reported on in this report attained moderate phi co-efficients with age group. Where this is the case, and in order to avoid confounding by age, both gender and inter Health Board differences were cross tabulated with age group, and individual chi square tests were calculated for each cell. The remaining statistically significant differences are mentioned in the text.

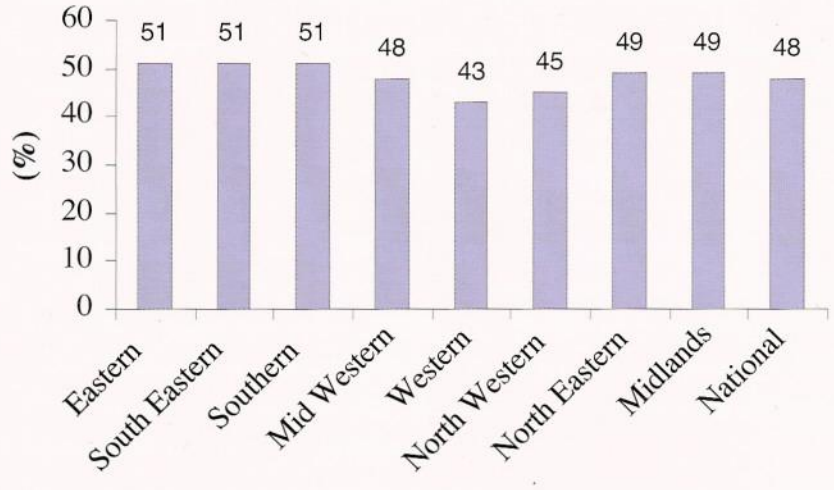
Table 6: Summary for all target behaviours by Health Board

Variable	EHB	SEHB	SHB	MWHB	WHB	NWHB	NEHB	MHB	All
% Very Healthy	30	24	30	28	26	23	24	30	28
% Very Happy	45	40	42	42	39	39	43	43	42
% Have ever smoked	50	49	49	44	49	45	52	48	49
% Currently smoke	22	22	20	19	22	15	24	19	21
% Have ever drunk alcohol	88	86	82	82	80	83	85	81	84
% Drink alcohol monthly	41	35	31	31	32	33	37	33	35
% Have ever been drunk	35	28	24	23	25	32	30	27	29
% Drunk 10+ times	8	4	5	4	4	6	5	3	6
% Exercise 4+ times per week	56	51	55	54	51	52	46	58	54
% Exercise less than weekly	9	9	7	10	9	10	11	7	9
% Eat fruit more than daily	37	37	38	35	34	24	34	37	36
% Eat vegetables more than daily	20	21	20	17	18	14	19	21	19
% Eat high fat/sugar foods 3+ a day	54	51	52	49	47	56	50	58	52
% On a weight reducing diet	8	11	7	10	8	6	8	8	8
% Feel that they should be on a diet	22	28	24	26	26	26	25	25	25
% Always wear a seatbelt	49	42	40	38	35	27	40	36	40
% Always wear a cycle helmet	10	6	9	6	5	8	7	5	8
% Had an injury in the last year	53	42	51	42	44	46	48	49	49
N	2, 255	988	1, 399	712	892	519	958	716	8, 497

SHAPING A HEALTHIER FUTURE: MAIN RESULTS

Overall 48% of respondents thought their general health was excellent or very good. The Western Health Board had a lower percentage of respondents perceiving excellent/very good health.

Figure 1: Perceived excellent/very good general health



There were a number of requirements indicated by respondents as being necessary for bettering their health. The top four ranked requirements were the same for all boards except in the East which ranked Less Pollution as number four (Table 7).

Table 7: Top five requirements for better health (percentages in brackets)

Health Board	1	2	3	4	5
Eastern	Less Stress (49)	More Willpower (41)	Change in Weight (32)	Less Polution (24)	More Money (23)
South Eastern	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
Southern	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
Mid-Western	Less Stress (44)	More Willpower (36)	Change in Weight (29)	More Money (25)	Better information about how to stay healthy
Western	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
North Western	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
North Eastern	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
Midland	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor
NATIONAL	Less Stress (42)	More Willpower (36)	Change in Weight (31)	More Money (21)	Regular Checks from Family Doctor

As seen in Table 8 below the majority of respondents obtained their health information from either their GP or media. Ranking patterns were again very similar in all boards though Media had a slight edge in the Eastern Board whereas the GP was the main source of health information everywhere else.

Table 8: Top five sources of health information (percentages in brackets)

Health Board	1	2	3	4	5
Eastern	Media (57)	GP (52)	Family/Friends (43)	Workplace (17)	Other HP (12)
South Eastern	GP (59)	Media (49)	Family/Friends (35)	Workplace (14)	HPU /DoH (10)
Southern	GP (56)	Media (54)	Family/Friends (40)	Workplace (13)	Other (12)
Mid Western	GP (62)	Media (52)	Family/Friends (35)	Workplace (11)	Other (10)
Western	GP (59)	Media (47)	Family/Friends (32)	Workplace (13)	Other (13)
North Western	GP (58)	Media (41)	Family/Friends (33)	HP/HB (13)	Workplace (12)
North Eastern	GP (57)	Media (47)	Family/Friends (35)	Workplace (12)	HP/HB (10)
Midland	GP (58)	Media (44)	Family/Friends (37)	Workplace (16)	HP/HB (11)
NATIONAL	GP (56)	Media (51)	Family/Friends (38)	Workplace (14)	HP/HB (11)

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

Children were asked two questions under the area of general health, first how healthy they think they are and second, how they feel about their lives at present. The figures below represent the rounded percentages within each group responding that they are very healthy to the first question and very happy to the second. The consistent finding across all eight Health Boards that boys perceive themselves as healthier than girls is of interest. The phi association between being very healthy and age group is 0.16 and that with social class is 0.01. The respective associations with very healthy are 0.20 (age group) and 0.04 (social class). Therefore, comparisons between the Health Boards and between boys and girls within each Health Board were broken down by age group. Almost all differences between Health Boards for both girls and boys disappear once age is considered. The only remaining significant difference is for 12-14 year old girls within the NWHB, 10% of whom report that they are very healthy, this contrasts with the 23% of 12-14 year old girls in the rest of the country who report that they are very healthy.

Significant gender differences within Health Boards are not found among the younger pupils (age 9-11). However, girls from 12-14 and 15-17 are less likely to report that they are very healthy than boys of a similar age within the EHB (12-14 yr old girls 22%; 12-14 year old boys 34%: 15-17 year old girls 13%; 15-17 year old boys 28%), SEHB (12-14 yr old girls 22%; 12-14 year old boys 34%: 15-17 year old girls 12%; 15-17 year old boys 35%), SHB (12-14 yr old girls 24%; 12-14 year old boys 35%: 15-17 year old girls 10%; 15-17 year old boys 28%), MWHB (12-14 yr old girls 23%; 12-14 year old boys 39%: 15-17 year old girls 8%; 15-17 year old boys 26%), WHB (12-14 yr old girls 23%; 12-14 year old boys 37%: 15-17 year old girls 9%; 15-17 year old boys 25%) and the MHB (12-14 yr old girls 25%; 12-14 year old boys 33%: 15-17 year old girls 16% ; 15-17 year old boys 28%). In the NWHB this difference holds only for 12-14 year olds (girls 10%; boys 28%) and in the NEHB it holds only for 15-17 year olds (girls 7%; boys 23%). The only reported gender difference in being very happy is within MWHB 12-14 year olds, where boys are more likely to report being very happy (55%) than girls (39%).

Figure 2: Percentages of respondents who report that they are very healthy

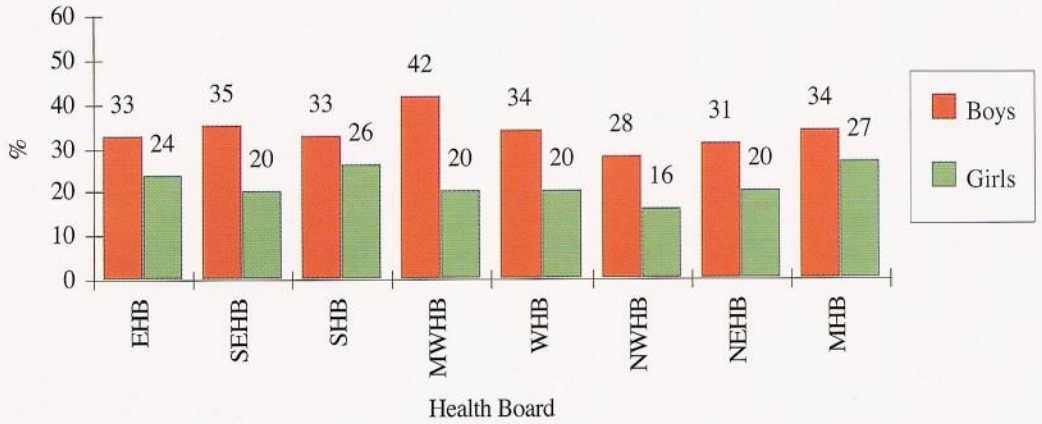
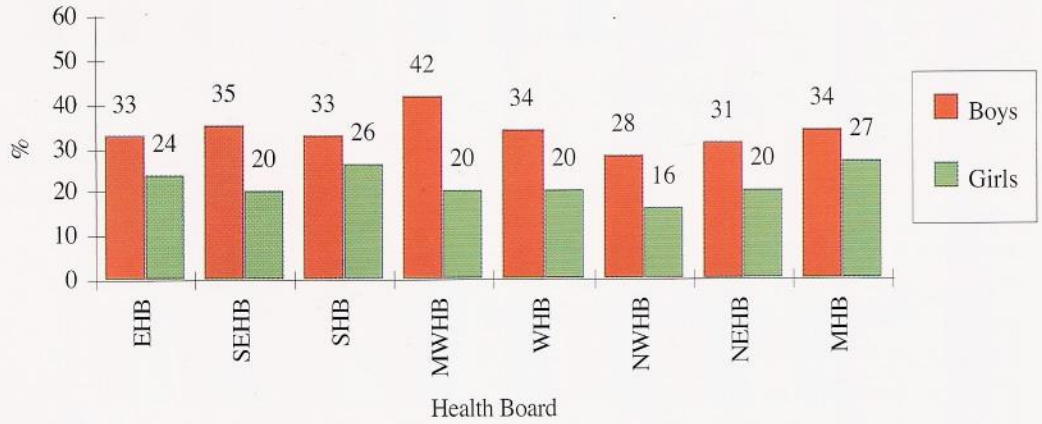


Figure 3: Percentages of respondents who report that they are very happy



Overall 31% of respondents reported being regular (1,728) or occasional (257) cigarette smokers. In addition, a further 133 people were regular or occasional cigar/pipe smokers. Smoking rates were highest in the East with significantly more 35-54 year olds smoking compared to their counterparts in other Boards (P<0.01). Rates were lowest in the non-GMS respondents. However, significantly different rates of smoking were observed across the boards amongst those with medical cards. The highest rates were observed in the East (44%) and Mid-West (39%) and lowest in the West (26%) and North-West (28%).

Figure 4: Regular/Occasional Cigarette Smokers

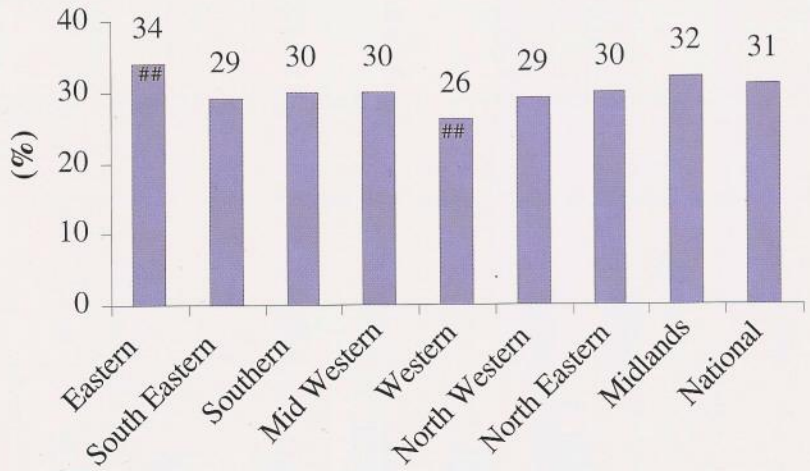


Figure 5: Regular/Occasional Cigarette Smokers by Gender

The number of cigarettes smoked per day by males in the East and South East were significantly higher compared to females. In general there was a trend for more cigarettes to be smoked by men.

Table 9: Mean number of cigarettes smoked per day by gender (standard deviation in brackets)

HEALTH BOARD	MALE	FEMALE	OVERALL	VALID N
Eastern	17.4 (11.0) **	14.9 (8.6)	16.1 (9.9)	641
South Eastern	19.7 (10.5) **	14.0 (7.4)	16.7 (9.4)	181
Southern	16.4 (10.8)	14.6 (8.1)	15.6 (9.6)	229
Mid Western	16.9 (10.5)	15.3 (7.8)	16.3 (9.6)	153
Western	16.2 (10.2)	13.5 (7.7)	14.8 (8.9)	136
North Western	20.3 (14)	15.4 (8.3)	17.0 (10.5)	104
North Eastern	16.7 (9.4)	13.6 (9.3)	15.0 (9.4)	151
Midland	17.3 (12)	14.7 (10.7)	16.1 (11.4)	104
NATIONAL	17.4 (10.8)	14.7 (8.4)	16.0 (9.7)	1866

smoking

Children were asked if they had ever smoked at least one cigarette, cigar or pipe and how often they smoked at present. The figures below represent the rounded percentages in each group who report having ever smoked and who report that they smoke at the moment. The median number of cigarettes smoked per week in each Health Board area is 1.

Smoking is one behaviour that is strongly related to age and both experimentation and current smoking increases with age (phi co-efficients for ever smoking and age groups = 0.33 and for current smoking and age groups = 0.27). It is interesting to note that associations between these smoking variables and social class are minimal, both with phi = 0.02.

Few global gender differences emerge in smoking, except within the SHB and the MWHB, and in both cases age differences between the girls and the boys contribute to these significances. Once these groups are broken down by age group, almost all of these significant differences disappear. One difference remains. Among younger (age 9-11) pupils in the SHB, the boys are more likely to have ever tried tobacco (33%) than the girls (14%). In addition, in the SEHB, younger boys are more likely both to have ever tried tobacco (boys 35%; girls 11%), and to report that they currently smoke (boys 19%; girls 4%).

In relation to inter-board differences, which emerge in four cases, the differences between the SHB, the WHB, the NEHB and the NWHB and the other boards disappear once age is taken into account. Fewer young (age 9-11) girls in the MWHB have ever tried cigarettes (6%) than those in other all other health boards together (18%). Younger boys in the EHB (23%) and the MHB (28%) are more likely to report having tried tobacco in comparison to younger boys in the rest of the country (15% and 16% respectively), while those in the MWHB are less likely to have tried tobacco (6% v's 18%). Boys aged 12-14 in the EHB are more likely to report having tried tobacco (55%) and to currently smoke (23%) than other 12-14 year old boys in the country (47% and 17%, respectively). Finally, 15-17 year old girls in the SEHB are less likely to report both ever having tried tobacco (58%) or to currently smoke (30%) than others in the country (72% and 39%).

Figure 6: Percentages of respondents who report ever smoking

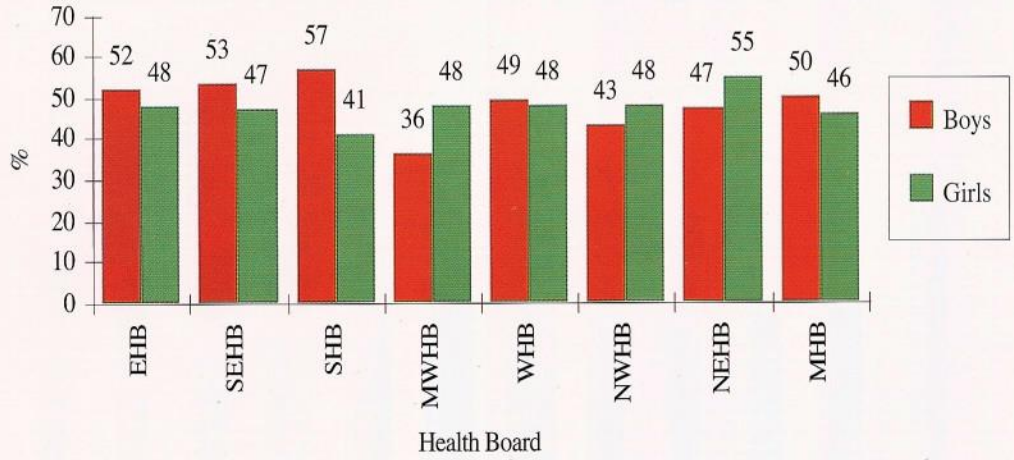
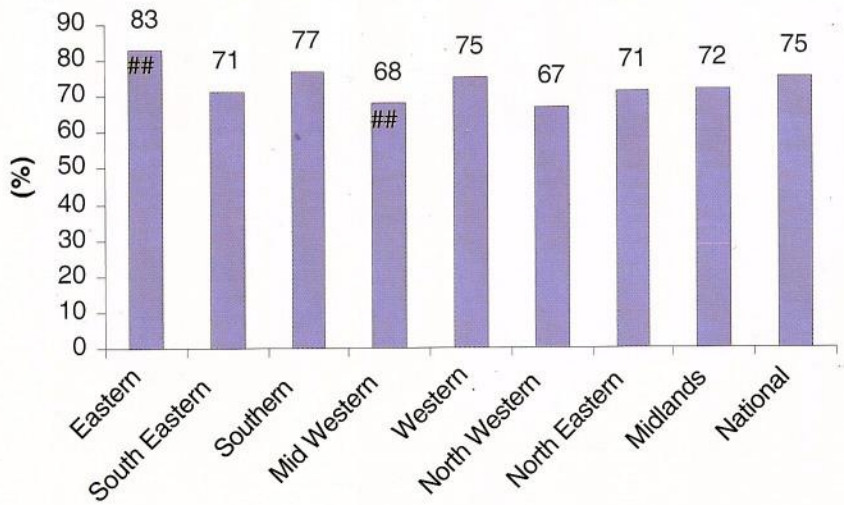


Figure 7: Percentages of respondents who report that they currently smoke

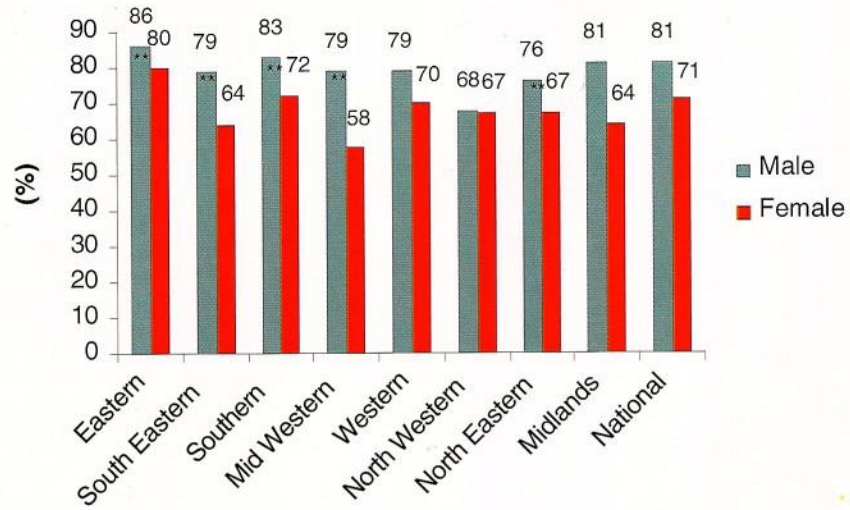
Overall three-quarters of respondents had consumed alcohol in the month before completing the questionnaire. The highest rates of regular consumption were observed in the East followed by the Southern Board and the lowest in the North Western Health Board.

Figure 8: Regular alcohol consumers



Higher percentages of males than females consumed alcohol regularly and this trend was observed in each health board.

Figure 9: Regular alcohol consumers by Gender



Age influenced the varying rates of regular consumption between health boards. Significantly higher rates were observed in each age group of the Eastern Board whereas lower rates were evident in two of the three age groups in the North East, Mid West and North Western Health Boards (Table 10).

Table 10: Regular alcohol consumers by age group

Health Board	18-34 yrs	34-55 yrs	55+ yrs	Overall
	%	%	%	%
Eastern	90.8 **	85.7 ##	63.4 ll	82.8
North Eastern	81.5 **	75.6	49.0	71.0
Southern	90.6	76.6	61.5	77.0
Western	88.8	76.1	57.0	74.7
South Eastern	84.5	75.1	50.2	70.9
Mid Western	83.1	71.2 ##	42.2 ll	67.6
Midland	84.5	76.7	44.2	71.6
North Western	77.8 **	77.2	40.4 ll	66.7
NATIONAL	86.8	78.7	53.5	75

** P < 0.01, 18-34 years age group, ## P < 0.01, 35-54 years age group, ll P < 0.01, 55+ years age group

Significant differences emerged in regularity of consumption between the boards when stratified for GMS status. In all boards medical card holders were less likely to consume alcohol regularly compared to non-card holders. There were slight regional variations amongst GMS respondents with the highest percentages of regular consumers in the Eastern board and the lowest in the Midlands (51%). Similar variations were observed in non-GMS respondents with highest rates in the Eastern board and lowest in the North-West (75%).

Abstension

The lowest rates of non-drinkers were observed in the Eastern Health Board and highest in the North West and Mid-Western Boards. Again age distribution had an effect on the varying rate of abstension. In each age group the rate was significantly lower in the East compared to the other Boards. Significantly more middle aged people in the Mid Western and more younger people in the North Western Board did not drink alcohol. In all boards medical card holders were more likely to abstain than non-card holders.

Table 11: Non-drinkers by gender

Health Board	Male	Female	Overall	Valid n
	%	%	%	
Eastern	6.1	9.0	7.6 ##	1943
North Eastern	13	17	15.5	582
Southern	7.3	16.4	12.1	799
Western	12.0	17.0	14.7	577
South Eastern	10.8	18.9	15.0	645
Mid Western	8.4	26.3	18.5 ##	525
Midland	10.7	21.0	16.1	335
North Western	16.1	21.5	19.4 ##	372
NATIONAL	9.5	15.8	13.0	6269

Frequency of consumption

Most respondents (62%) usually drank alcohol on one or two occasions in a typical week. However 11% had an alcoholic drink 5+ days of the week. Overall, females drank significantly less frequently in the week than men and this was significantly so in the East. Overall there were more frequent drinkers in the Eastern Health Board. Significantly higher percentages of middle and older aged people in the East drank alcohol on five or more days of the week.

Figure 10: Consumption of alcohol five days or more in a typical week

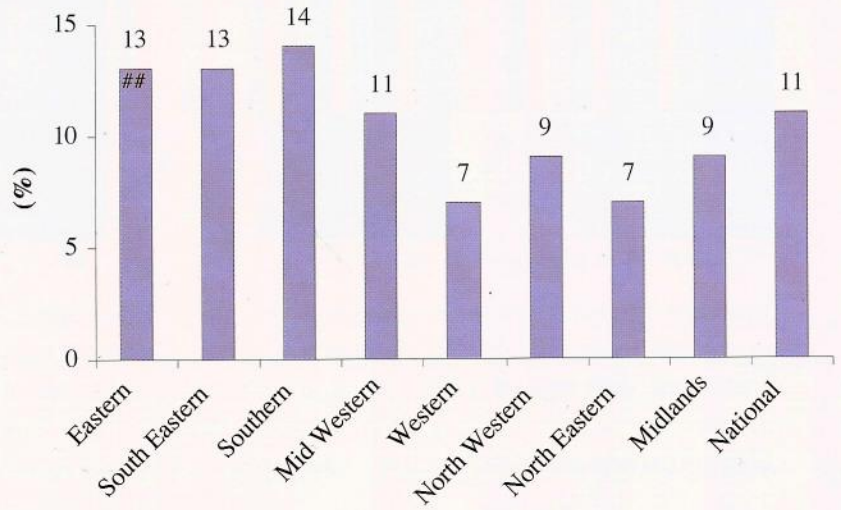
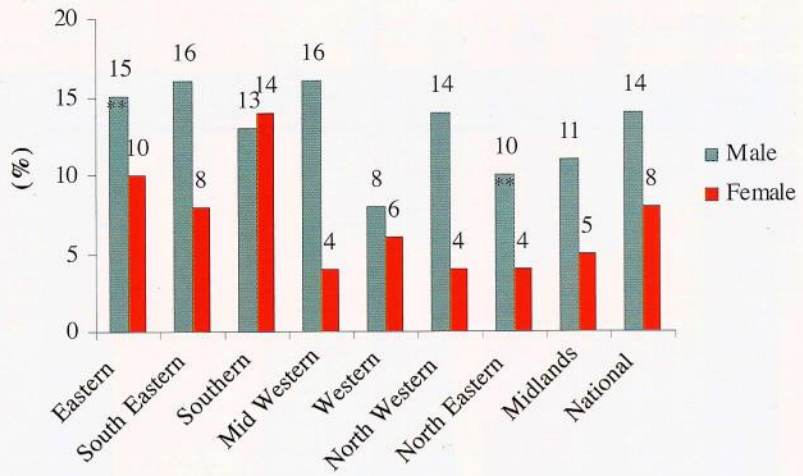


Figure 11: Gender Distribution of alcohol consumption five days or more in a typical week



Quantity of alcohol consumed on typical drinking occasion

All men drank more on average than females when last out. Slightly less was consumed in the East across each of the age groups compared to the other boards. The opposite was observed in the North Eastern Health Board.

Table 12: Mean number of drinks consumed on typical drinking occasion (standard deviation in brackets)

Health Board	Male	Female	Overall	Valid n
Eastern	6.5 (5.0) **	4.3 (3.2)	5.4 (4.3)	1252
North Eastern	7.1 (6.6) **	4.8 (3.0)	6.0 (5.2)	302
Southern	6.7 (5.9) **	4.1 (3.5)	5.6 (5.2)	459
Western	6.5 (4.7) **	4.6 (3.8)	5.6 (4.4)	317
South Eastern	6.2 (4.6) **	4.7 (4.1)	5.5 (4.4)	340
Mid Western	6.8 (6.3)	5.2 (4.9)	6.1 (5.8)	263
Midland	7.6 (6.6) **	4.5 (2.8)	6.4 (5.6)	170
North Western	6.6 (5.4) **	4.2 (2.2)	5.4 (4.3)	158
NATIONAL	6.7 (5.4)	4.5 (3.5)	5.7 (4.8)	3513

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

Overall, 27% of males and 21% of females consumed more than the recommended weekly limits for alcohol (Table 13). There were no significant regional differences in rates of heavy drinking.

Table 13: Percentage consuming more than recommended limits by gender

Health Board	Male %	Female %	Overall %	Valid n
Eastern	28.5	20.3	24.6	1236
North Eastern	31.1	24.3	27.8	295
Southern	28.3	20.0	24.8	448
Western	23.0	20.8	22.0	309
South Eastern	26.8	24.1	25.7	331
Mid Western	25.5	23.6	24.7	251
Midland	26.8	17.2	23.0	161
North Western	23.1	19.4	21.3	150
NATIONAL	27	21	24.7	3430

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

Children were asked if they had ever tasted an alcoholic drink, how often they drink anything alcoholic (such as beer, wine, spirits, cider or alcopops) and how often (if ever) they had ever had so much alcohol that they were really drunk. The figures presented below are for those who report ever having had a drink, for those who report drinking alcohol every month or more frequently, those who have ever been drunk and those that have been drunk more than ten times. These are all variables on which age-related differences would be expected, given that phi co-efficients with age are 0.23 for ever drinking, 0.30 for monthly drinking, 0.36 for ever having been drunk and less impressively 0.11 for having been drunk more than 10 times. The associations with social class are lower, with none exceeding 0.04.

Once age differences across health boards are controlled for, a number of gender differences remain. Younger boys (age 9-11) are more likely than girls to have tried alcohol in the NWHB (boys 83%; girls 56%), the SHB (boys 82%, girls 59%) and the MWHB (boys 84%; girls 60%). They are also more likely than girls to report that they drink monthly in both the EHB (boys 33%; girls 18%) and the SHB (boys 24%; girls 16%). Younger boys are also more likely to report that they have ever been drunk in three Health Boards regions, the EHB (boys 17%; girls 7%), the SHB (boys 12%; girls 3%) and the MHB (boys 32%; girls 14%). All gender differences in the 12-14 year old age group also suggest that boys are more involved with alcohol than girls. In the MHB they are more likely to have ever tried alcohol (boys 88%; girls 72%), while they are more likely to report drinking monthly in the EHB (boys 39% ; girls 32%), the MWHB(boys 36%; girls 20%), the WHB (boys 31%; girls 18%) and the MHB (boys 31%, girls 16%). Boys age 12-14 in the WHB are more likely than girls to report ever having been drunk (boys 20%; girls 12%), while boys of this age in the EHB are more likely to report both having ever been drunk (boys 20%; girls 12%) and having been drunk ten or more times (boys 7%; girls 3%). For older (15-17 year old) pupils, boys in both the SEHB and the SHB are more likely to report drinking monthly (SEHB boys 67%; SEHB girls 46%: SHB boys 54%; SHB girls 39%). Finally boys are more likely to report having been drunk ten or more times in the SEHB (boys 17%; girls 4%), the SHB (boys 15%; girls 4%) and the MHB (boys 22%; girls 9%).

Age differences also influence comparisons between boards. Once these are considered, the major differences remaining are located among EHB respondents who report more involvement with alcohol than other areas of the country. Young (9-11 years) EHB boys report more monthly drinking (33% v's 22%), while 12-14 year old EHB boys are more likely to report ever having had an alcoholic drink (92% v's 84%), drinking monthly (39% v's 29%), ever having been drunk (36% v's 23%) and having been drunk ten or more times (7% v's 2%) than boys of the same age in the rest of the country. In addition 15-17 year old EHB boys are more likely to report having ever been drunk (68% v's 52%) and having been drunk ten times or more (23% v's 16%) than those in the rest of the country. EHB girls are also more likely to have alcohol involvement than those in other boards. Young EHB girls are more likely to have ever tried alcohol (71% v's 59%) and those aged 12-14 are more likely to have ever tried alcohol (90% v's 80%), to drink monthly (32% v's 22%) and have ever been drunk (23% v's 16%). Older (age 15-17) EHB girls are more likely to drink monthly (65% v's 51%), have ever been drunk (60% v's 47%) and have been drunk ten or more times (15% v's 7%) than those in the rest of the country.

In the MHB, 9-11 year old boys are more likely to report ever having been drunk (32%) than those in other areas of the country (14%), while girls aged 15-17 from the NWHB are also more likely to report ever having been drunk (66% v's 48%). All other significant differences indicated that children from other Health Board regions are less likely to be involved in alcohol. It should be considered that these findings are to be expected in conjunction with the higher rates in the EHB, given that the EHB sample comprise a substantial proportion of

the rest of the country when these individual comparisons are being conducted. In comparison to other girls aged 15-17 in the country, those from the SEHB are less likely to report that they drink monthly (46% v's 55%) and that they have been drunk ten or more times (4% v's 9%). Boys in the SHB aged 12-14 are less likely to report both drinking monthly (24% v's 36%) and having been drunk (21% v's 29%) while those aged 15-17 are also less likely to report having been drunk (50% v's 59%). Young (age 9-11) WHB boys report lower levels of involvement than the rest of the country. They are both less likely to have ever had an alcoholic drink (65% v's 79%) and less likely to drink monthly (12% v's 28%). Girls aged 12-14 from the WHB are also less likely to report ever having had an alcoholic drink (76% v's 83%)than other girls in the country. In addition, 12-14 year old MHB girls are less likely to have ever tried alcohol than others (72% v's 83%), and 15-17 year old MHB boys are less likely to have been drunk ten times or more (9% v's 19%).

Figure 12: Percentages of respondents who report ever having had an alcoholic drink

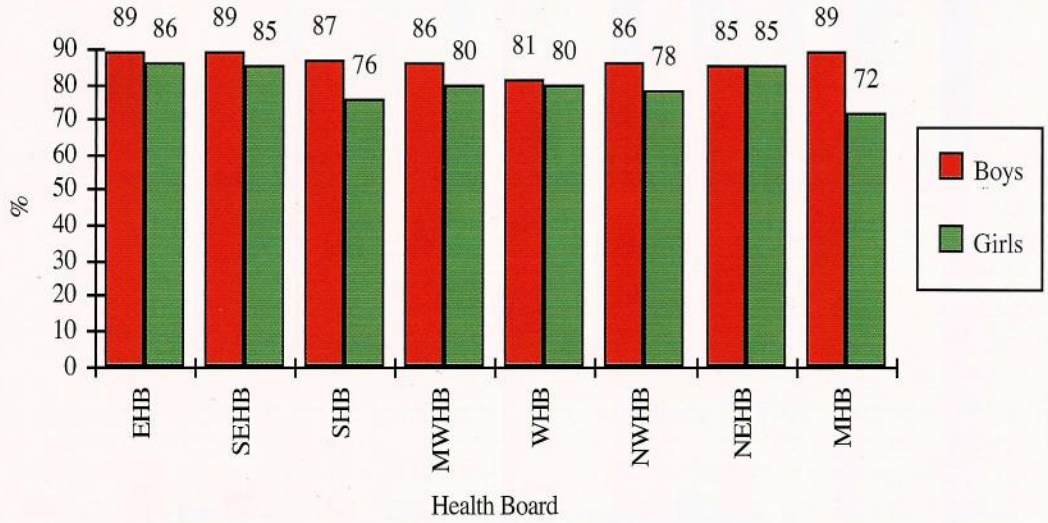


Figure 13: Percentages of respondents who report drinking alcohol at least monthly

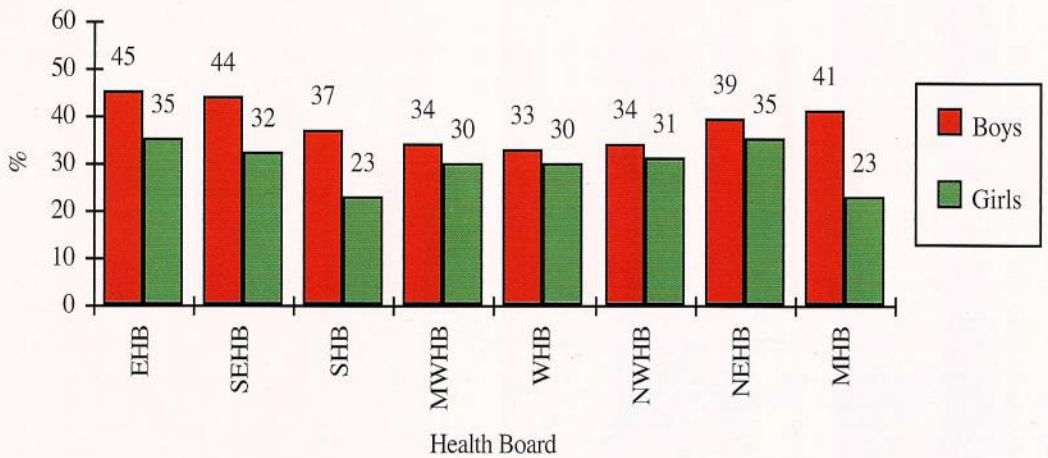


Figure 14: Percentages of respondents who report having been really drunk

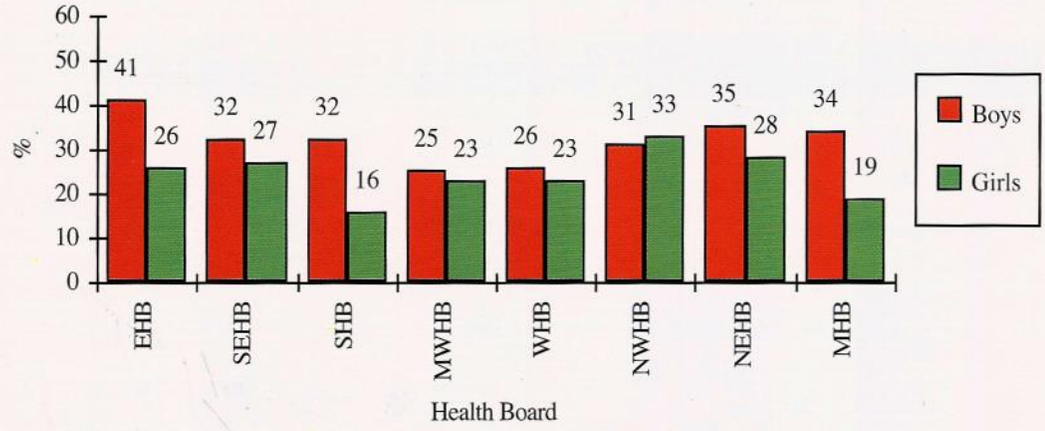
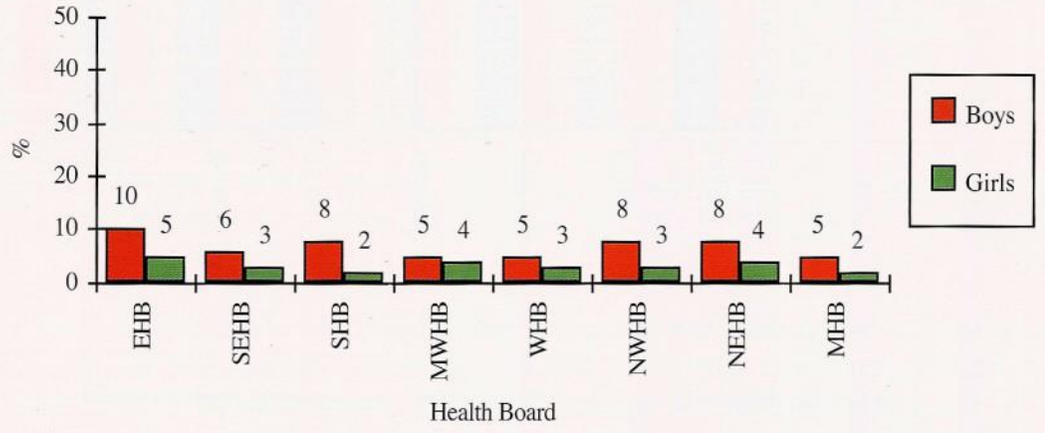
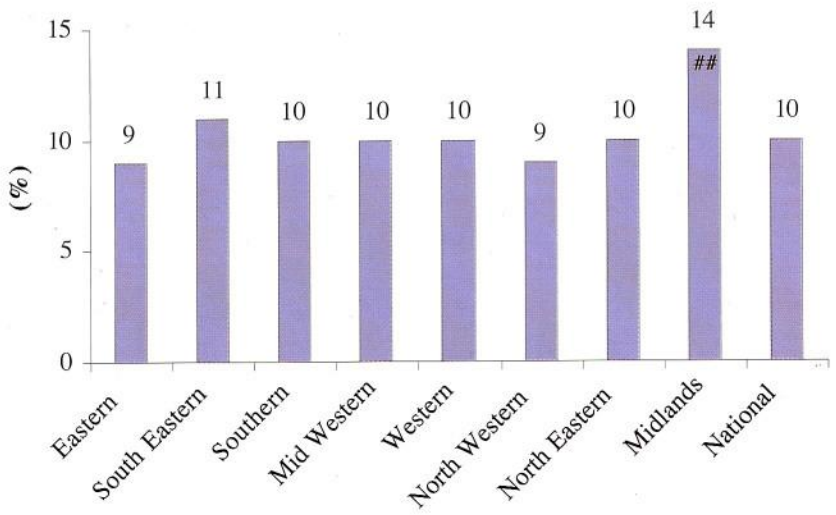


Figure 15: Percentages of respondents who report having been really drunk ten or more times



Using self-reported height and weight, the body mass index was calculated and used as a measure of normal weight, overweight or obesity. A significantly higher percentage of respondents in the Midlands Health Board were obese compared to other Boards. Higher percentages of those with medical cards reported being obese but there were no significant regional differences.

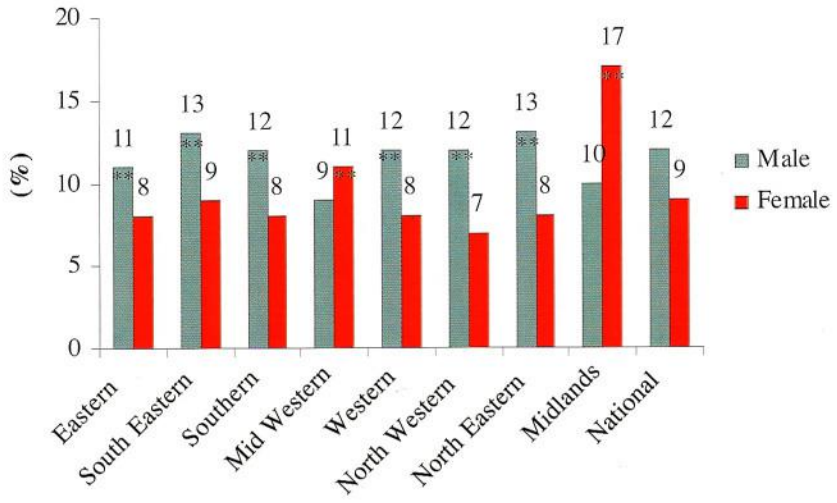
Figure 16: Obesity Distribution



BMI ranges Normal: <25, Overweight: 25-29.99, Obese: ≥30

Significantly more females reported normal height to weight ratios compared to males. There were more obese men than women in all boards except the Midlands and Mid-West.

Figure 17: Gender Distribution of Obesity



Thirteen percent of respondents reported being on a weight reducing diet. There were no significant regional differences. As might be expected significantly higher percentages of females than males, in all Boards, were on such a diet.

Table 14: Percentage of respondents on weight reducing diets by gender

Health Board	Male %	Female %	Overall %	Valid n
Eastern	5.3 **	19.2	12.7	1832
North Eastern	6.1 **	18.5	13.3	542
Southern	4.5 **	17.9	11.6	753
Western	4.9 **	17.9	12.0	543
South Eastern	6.4 **	21.4	14.2	650
Mid Western	8.2 **	16.2	12.3	479
Midland	6.5 **	21.8	15.4	318
North Western	4.8 **	18.1	12.2	343
NATIONAL	5.7 **	18.6	13	5887

Irish healthy eating guidelines encourage people to eat a variety of foods based around the food pyramid.

CEREALS, BREADS AND POTATOES

More people in the West and North West were reaching the target of six plus servings of cereals, breads or potatoes per day. Significantly more men than women in the South Eastern Board consumed the recommended amounts.

Analyses across age groups found that significantly more older people in the North East, more middle-aged in the Western and both the younger and older people in the North Western Board consumed six plus servings of cereals, breads and potatoes. Significantly fewer people in the younger and middle aged groups in the Eastern Board consumed the recommended number of servings compared to other Boards. Consumption was significantly higher amongst the non-GMS respondents in the North Western Board (53%) and lower in the East (35%).

Figure 18: Percentage consuming the recommended 6+ servings per day of cereals, breads and potatoes

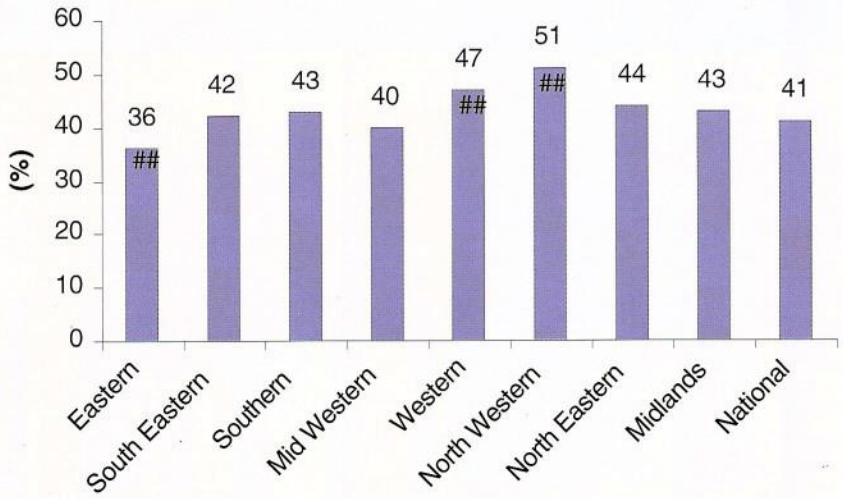
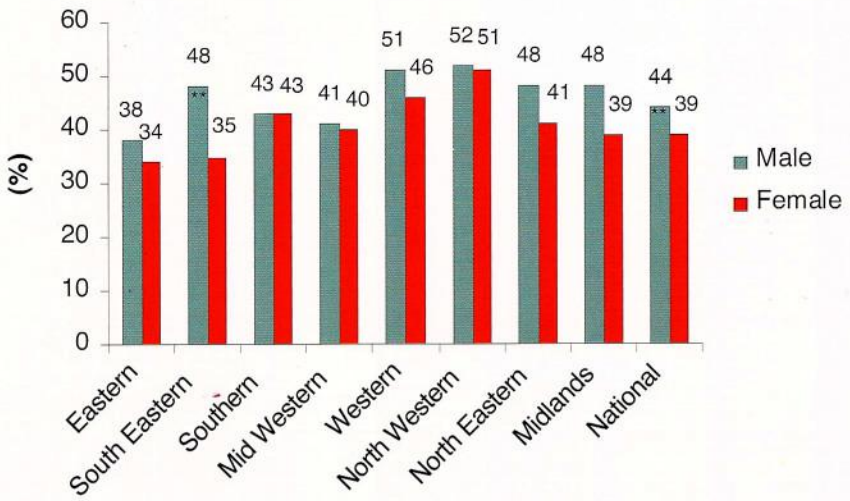


Figure 19: Gender Distribution of those consuming the recommended 6+ servings per day of cereals, breads and potatoes



FRUIT AND VEGETABLES

Less men than women reached the target intake of fruit and vegetables in all Health Boards. Overall the Southern Health Board had a higher percentage of people consuming four or more fruit and vegetable servings per day (Figure 20). This was predominantly amongst the over 55s age group. In all boards a higher percentage of non-GMS respondents consumed the recommended number of servings.

Figure 20: Percentage consuming the recommended 4+ servings per day of fruit and vegetables, including fruit juice and vegetable soups

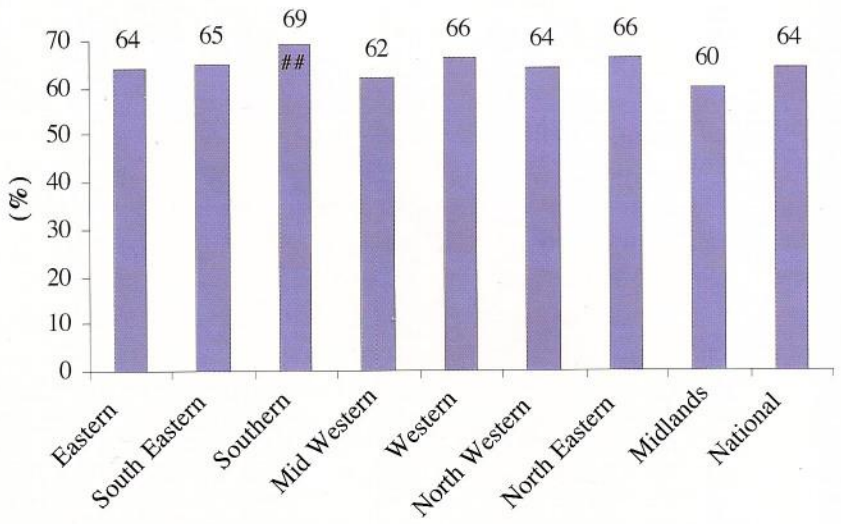
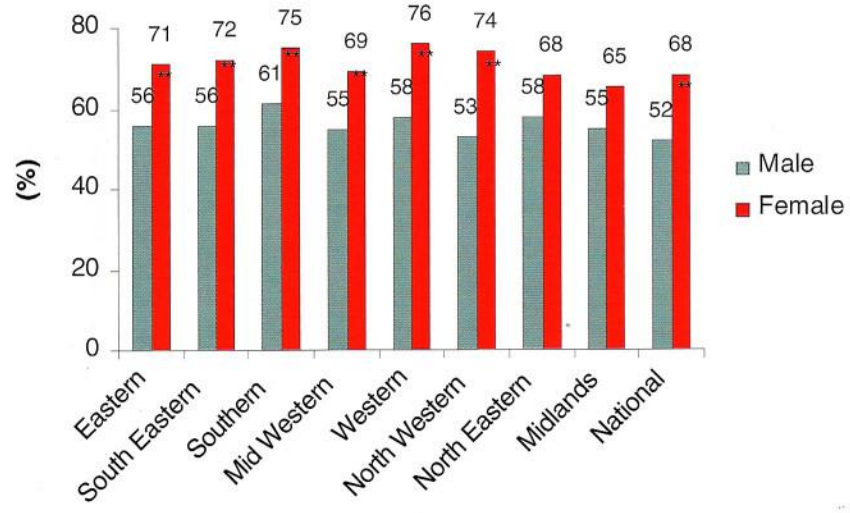


Figure 21: Gender Distribution of those consuming the recommended 4+ servings per day of fruit and vegetables, including fruit juice and vegetable soups



MEAT, FISH AND POULTRY GROUP

As with the fruit and vegetable guideline, fewer men than women in each Board reported consuming within the maximum recommended servings of meat, fish and poultry. In the Eastern Board significantly more people reached the target especially in the 18-54 years age range. There were no GMS variations across the boards.

Figure 22: Percentage consuming the recommended up to two servings per day

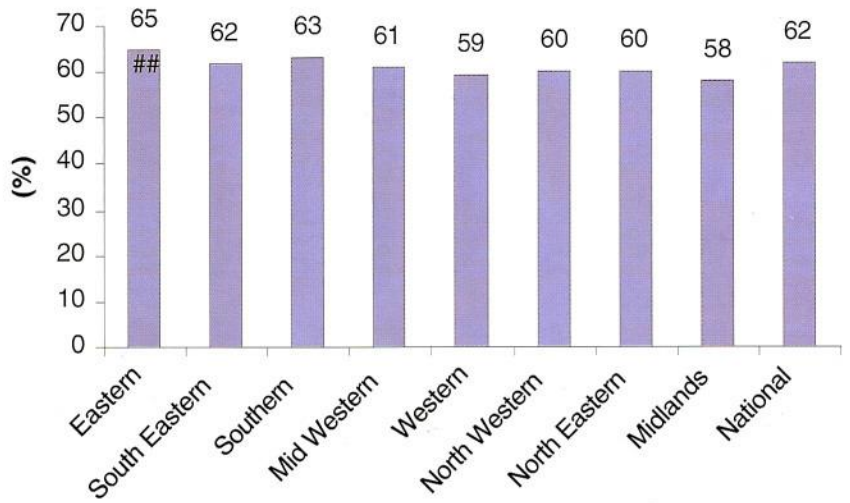
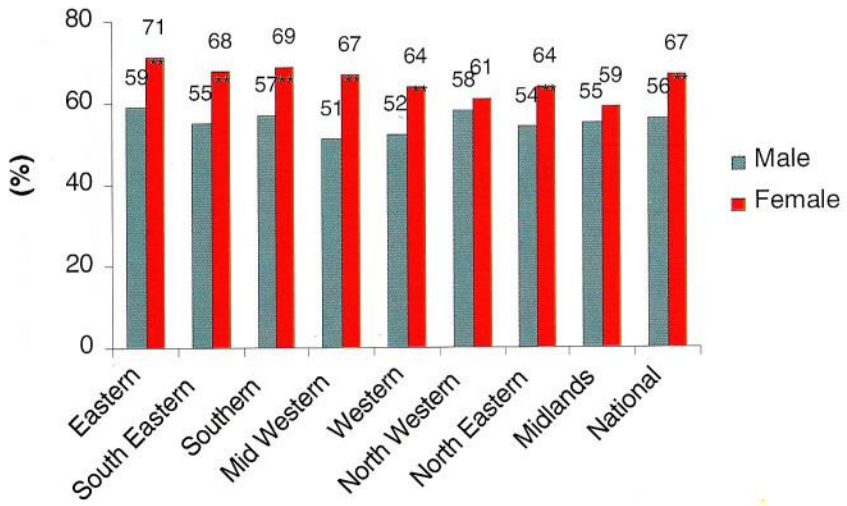


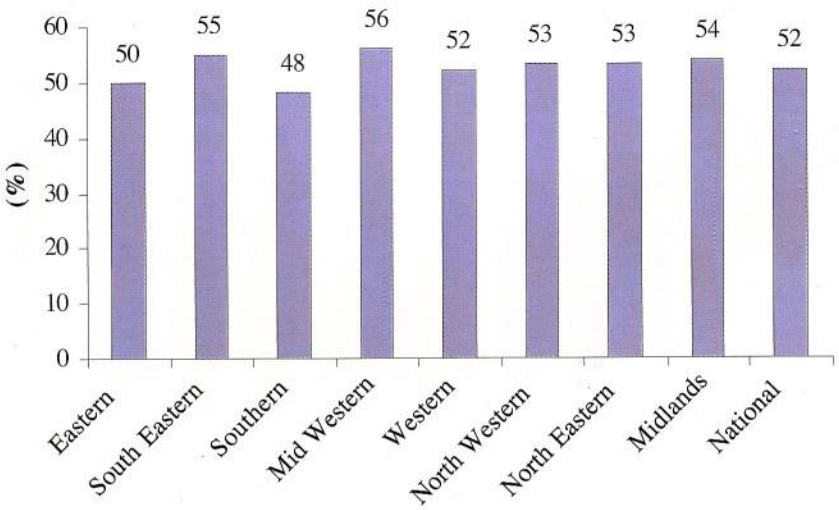
Figure 23: Gender Distribution of those consuming the recommended up to two servings of meat, fish and poultry per day



DAIRY FOODS

There was not much variation across the health boards or between gender in terms of those consuming up to three servings of dairy produce per day.

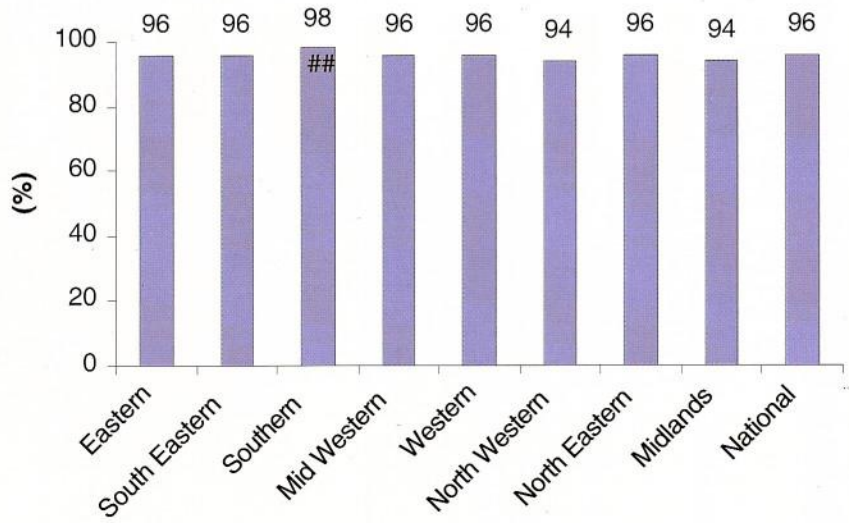
Figure 24: Percentage consuming the recommended up to three servings per day of dairy foods



TOP SHELF – HIGH FAT / HIGH SUGAR

Almost all respondents had at least 3 servings per day of these foods regardless of gender or location, with the Southern Health Board respondents having the highest reported intake.

Figure25: Percentage consuming three plus servings of high fat/sugar foods per day



Overall 12% of respondents ate fried foods 4+ times per week (Table 15). Males were much more likely to eat fried foods 4+ times per week in all Boards. In all boards non-GMS respondents consumed fried foods less frequently than GMS but there was no significant regional variation.

Table 15: Respondents consuming fried food more than 4 times per week by gender

Health Board	Male %	Female %	Overall %	Valid n
Eastern	17.0 **	6.6	11.6	1960
North Eastern	16.0 **	7.3	11.3	593
Southern	16.6 **	5.8	11.0	805
Western	15.1 **	6.3	10.4	586
South Eastern	19.3 **	5.6	12.2	650
Mid Western	16.1 **	11.1	13.3	528
Midland	21.0 **	6.4	12.8	343
North Western	23.0 **	10.1	16.1	373
NATIONAL	17.3 **	7.1	12	6327

High percentages of respondents continued to use butter with 59% reporting daily use. Those in the Mid-West and North Western boards were significantly more likely to use butter daily (Table 16). The older age group in the Mid-West and the younger group in the North West showed significant differences in their daily use. In all Boards higher percentages of males consumed butter daily. Higher percentages of medical card holders in each board reported using butter daily.

Table 15: Respondents consuming butter daily by gender

Health Board	Male	Female	Overall	Valid n
	%	%	%	
Eastern	59.7	53.7	56.6	1584
North Eastern	56.6	52.6	54.0	491
Southern	63.3	53.6	58.0	635
Western	63.1	58.4	61.0	456
South Eastern	67.6	58.1	62.7	525
Mid Western	69.0	62.6	65.7 ##	443
Midland	68.8	60.8	64.5	273
North Western	73.7	58.0	65.1 ##	295
NATIONAL	63.1	55.9 **	59	5091

Fifty-six percent reported using low fat, polyunsaturated spreads. This was predominantly among the older males and females. There were no regional differences in low-fat spread use (Table 17). Females were more likely to use the spreads especially in the Eastern, Western and Mid-Western Health Boards.

Table 15: Respondents consuming low fat spread daily by gender

Health Board	Male	Female	Overall	Valid n
	%	%	%	
Eastern	51.4	59.9 **	56.0	1497
North Eastern	52.9	58.0	55.2	471
Southern	58.2	58.8	58.7	588
Western	52.4	61.4 **	57.6	429
South Eastern	50.9	53.5	52.1	480
Mid Western	41.4	60.9 **	52.3	363
Midland	51.0	61.1	56.7	224
North Western	50.0	62.6	57.7	265
NATIONAL	51.8	59.1 **	56	4690

Children were asked how often they eat a number of foodstuffs and if they were on a diet to lose weight. The figures below represent the percentages in each group who report that they eat fruit more than once a day, that they eat vegetables (raw or cooked) more than once a day, that they eat high fat or high sugar foods (sweets, chocolate, cakes, pastries, crisps, or soft 'fizzy' drinks) at least three times per day, those who report being on a diet to lose weight and those who are not on a diet, but report that they need to lose some weight. The associations between these variables and age and social class are low, those with age ranging from 0.07 to 0.04 while those with social class range from 0.01 to 0.09.

A number of gender differences emerge within individual boards, girls are more likely than boys to report eating fruit more than daily in the EHB (44% v's 33%), the SHB (45% v's 30%), the WHB (38% v's 29%) and the NEHB (38% v's 28%). However, no gender differences emerge in relation to vegetables. Girls are also more likely to report being on a weight reducing diet and that they should be on such a diet in every Health Board area, the individual values can be seen in the figures below.

Girls in EHB (44%) and in the SHB (45%) are more likely to report eating fruit more than daily than those in the rest of the country (39%), while boys in the MHB are more likely to report eating vegetables more than daily (24%) than other boys (18%). Two differences emerge in relation to eating high fat and or sugar foods. Girls in the WHB are less likely (49%), while those in the MHB are more likely (58%) to report eating high fat and or sugar foods three or more times per week than girls in the rest of the country (49% and 47% respectively). No statistically significant differences emerge between Health Boards in relation to dieting behaviour.

Figure 26: Percentages of respondents who report eating fruit more than once a day

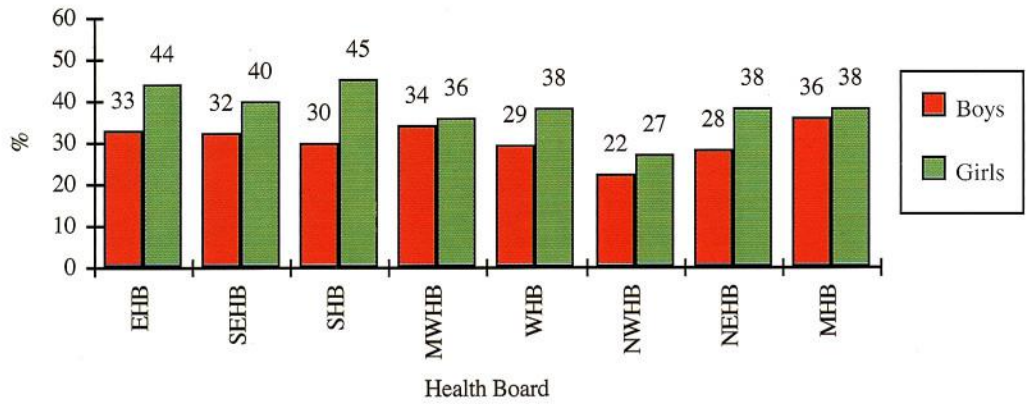


Figure 27: Percentage of respondents who report eating vegetables more than once a day

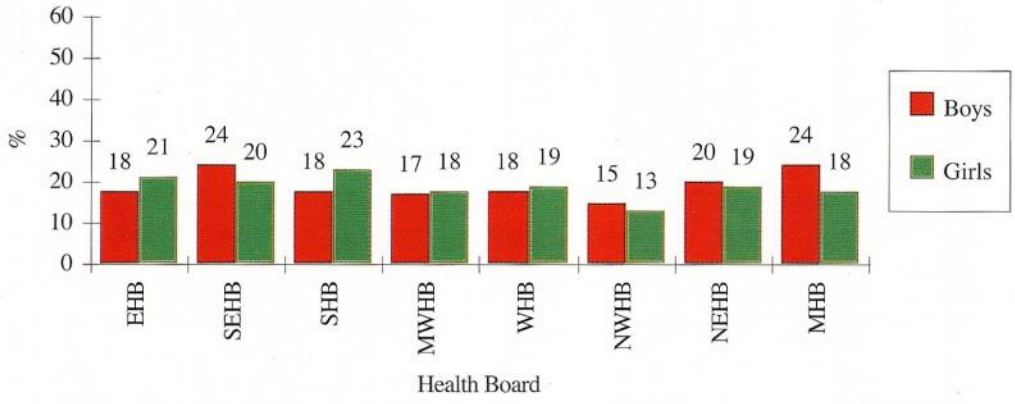


Figure 28: Percentage of respondents who report eating high fat and or sugar foods three or more times per day

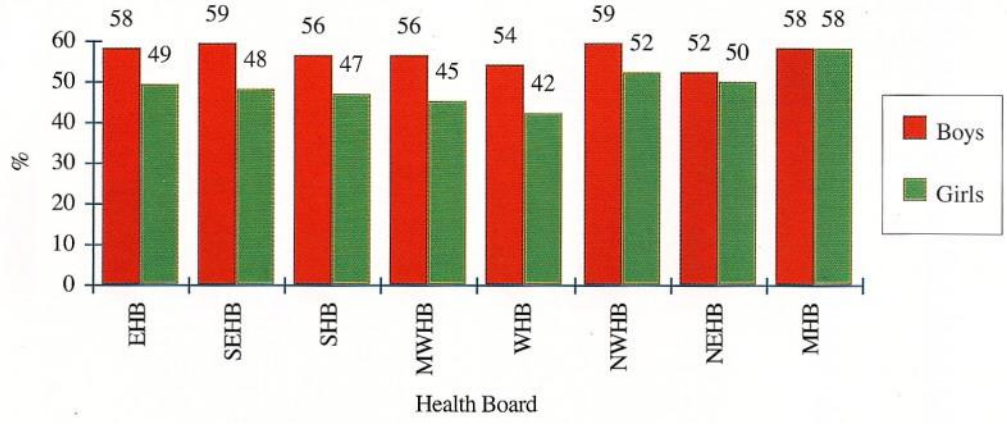


Figure 29: Percentage of respondents who report they are on a weight reducing diet

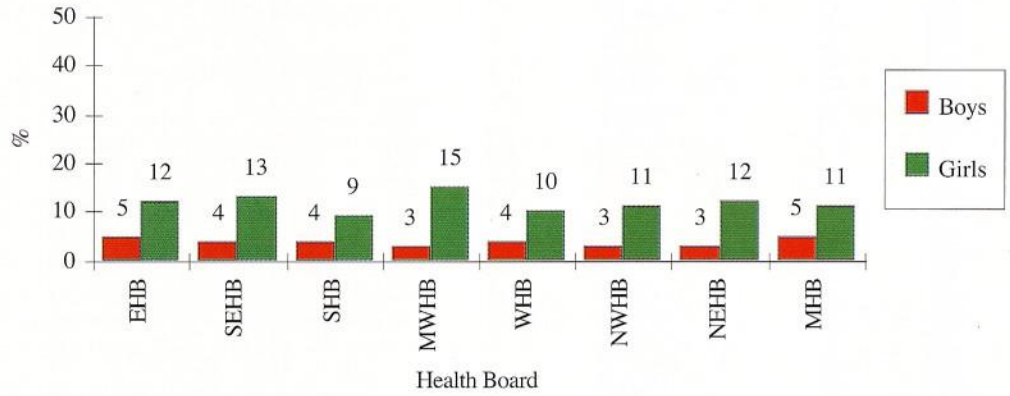
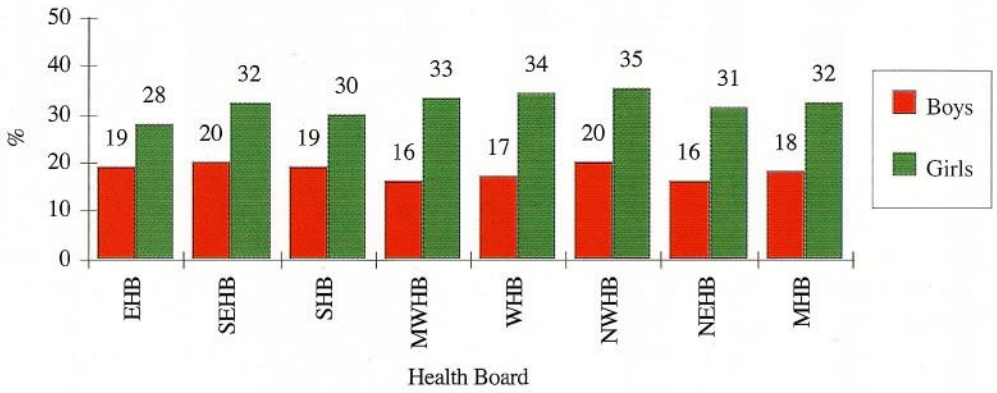


Figure 30: Percentages of respondents who report that they should be on a weight reducing diet



Overall, 42% of respondents engaged in some form of regular physical exercise. Twenty-four percent reported doing mild exercise four times per week for at least 20 minutes, 31% did moderate exercise three times per week and 9% did strenuous exercise three times per week.

Significantly more respondents in the Eastern Board participated in mild exercise. This was mainly amongst the 35-54 year age group. Substantially fewer people in the Midlands engaged in mild exercise with almost a two-fold difference in the over 55 years. Higher percentages of GMS respondents participated in mild exercise in all boards. There was little variation across boards in each group except in the Midlands where significantly fewer non-GMS (16%) took this type of exercise and in the East with a high of 27%.

Figure 31: Percentage engaging in mild physical exercise for at least 20 minutes most days of the week

Figure 32: Percentage engaging in mild physical exercise for at least 20 minutes most days of the week by Gender

More women than men and non medical card holders regularly participated in moderate exercise in each Health Board.

Figure 33: Percentage engaging in moderate physical exercise for at least 20 minutes three days of the week

Figure 34: Percentage engaging in moderate physical exercise for at least 20 minutes three days of the week by gender

In all Boards except the Western, South Eastern and Midlands men were significantly more likely than females to take regular strenuous exercise. Participation in this type of exercise was almost twice as high in the non-GMS groups compared to the GMS in all boards.

Figure 35: Percentage engaging in strenuous physical exercise for at least 20 minutes three days of the week

Figure 36: Percentage engaging in strenuous physical exercise for at least 20 minutes three days of the week by gender

Sedentary rates were similar between males and females. The Eastern Health Board respondents were most active across all age groups. Significantly more people, aged 35 plus years, in the North East region did no exercise in the week. Higher percentages of GMS respondents reported doing no exercise at all in the week in all boards. Amongst the non-GMS respondents there was significant variation across the boards with the North Eastern Board reporting a high of 20%. The Eastern Board had the lowest percentage of non-exercisers (12%) in the non-GMS grouping.

Table 18: Percentage doing *no excercise* at all in the week by gender

Health Board	Male	Female	Overall	Valid n
	%	%	%	
Eastern	15.9	17.3	17.0 ##	1896
North Eastern	30.6	24.8	27.9	568
Southern	18.8	19.6	19.7	793
Western	21.8	17.4	20.6	572
South Eastern	24.4	20.8	22.8	640
Mid Western	24.8	21.2	23.3	520
Midland	27.3	21.4	24.0	337
North Western	28.1	20.2	24.1	373
NATIONAL	22.1	20.0	21.4	6196

Children were asked how often they usually exercise in their free time so much that they get out of breath or sweat. The figures below reflect those who report that they exercise in such a way four or more times per week and those who report that they do so less than weekly. Neither of these variables are associated in a meaningful way with social class (phi co-efficients 0.03 and 0.02 respectively), although associations with age are slightly higher (0.18 and 0.11 respectively).

Consistent gender differences can be identified, with boys in almost every health board area more likely to report exercising four or more times per week. Girls aged between 12-14 and 15-17 report less frequent exercise than boys in the EHB (45% v's 68% and 29% v's 50%), SEHB (66% v's 51% and 72% v's 28%), SHB (52% v's 64% and 28% v's 48%), MWHB (53% v's 72% and 29% v's 60%), WHB (48% v's 64% and 28% v's 61%) and the NEHB (44% v's 64% and 21% v's 50%). Younger girls, aged 9-11 years, in the NEHB also report less frequent exercise (46%) than boys of the same age (72%). There are also a number of differences in the percentages who exercise less than weekly. Older (15-17 years) girls in the EHB (16%), SEHB (16%) and the NEHB (24%) are all more likely to report exercising less than weekly when compared to boys of the same ages in the same regions (8%, 1% and 10% respectively). Girls aged 12-14 in the EHB are also more likely to report exercising less than weekly (11%) than similar boys (6%).

Once age group is taken into consideration, only three significant difference emerges between Health Boards. Young (9-11 years) girls in the SHB are more likely to report exercising more than four times per week (67%) than girls of the same age in the rest of the country (57%) and more older boys (115-17 years) in the SEHB report exercising at least four times per week (72%) than those in other areas (52%). Finally, 12-14 year old boys in the NWHB are more likely to report exercising less than weekly (11%) than 12-14 year old boys in the rest of the country (5%).

Figure 37: Percentages of respondents who report that they exercise four or more times per week

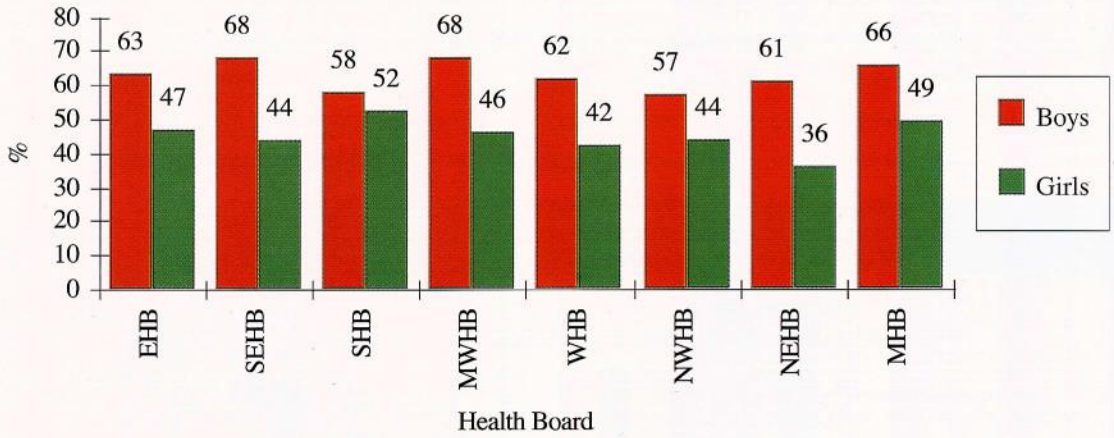
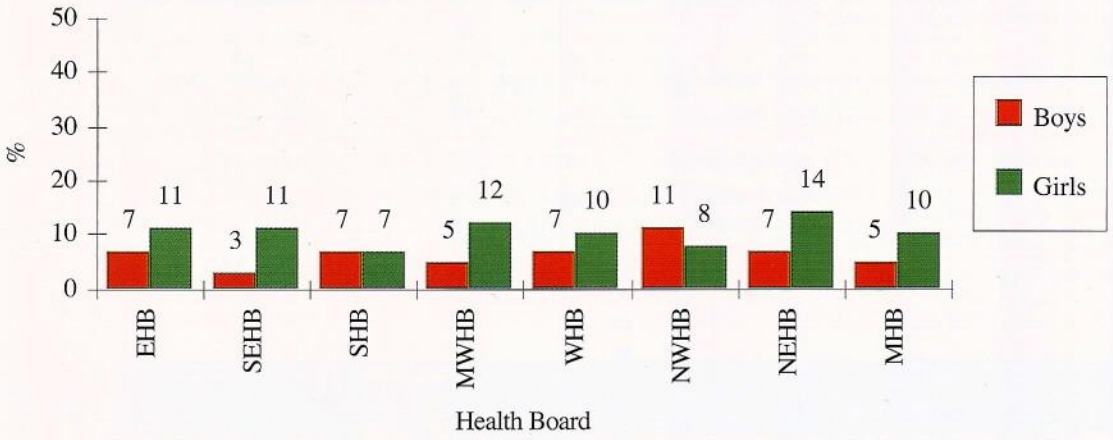


Figure 38: Percentages of respondents who report that they exercise less than weekly



No data on fatal injuries were collected but the pattern of non-fatal but limiting injuries in Ireland was recorded. Eighteen percent of respondents indicated having had an injury in the past two years which interfered with their daily activities and of these 87% were accidental.

Overall males were more likely to have suffered such an injury with 22% compared to 14% females. Those in the Eastern Board were significantly more likely to have had an accident and was mainly in the under 35 and over 55 year age groups. The respondents in the North Western Board were least likely to have had a serious injury especially in the younger age groups.

Figure 39: Occurrence of injury

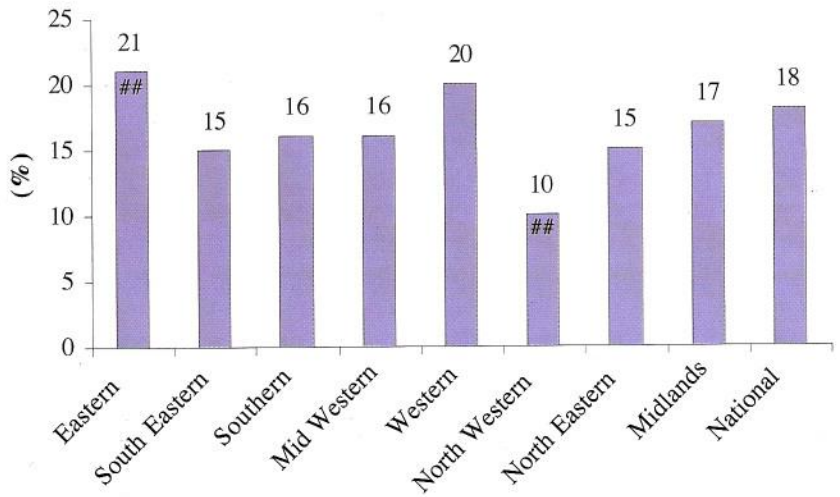
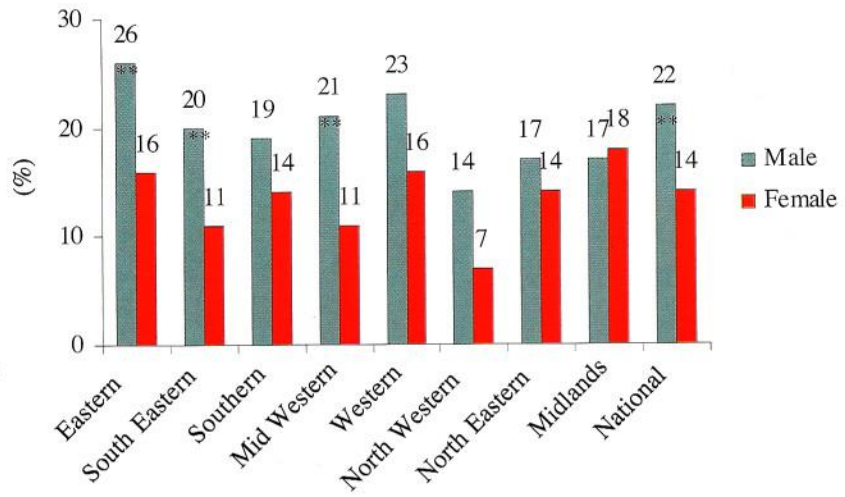


Figure 40: Occurrence of injury by gender



SITE OF INJURY

Eighteen percent of the injuries were at home/garden, 21% at work and 21% occurred during sport. These main three places were mirrored in all regions except the North East.

Table 19: Top three places of injury occurring (percentages in brackets)

Health Board	1	2	3
Eastern	Sport (23)	Home/garden (22)	Work (20)
North Eastern	Home/garden (26)	Car/bike (17)	Work (16)
Southern	Work (22)	Home/garden (17)	Sport (17)
Western	Home/garden (21)	Work (18)	Sport (17)
South Eastern	Work (23)	Sport (20)	Home/garden (17)
Mid Western	Home/garden (26)	Work (19)	Sport (18)
Midland	Home/garden (25)	Sport (20)	Work (14)
North Western	Work (28)	Home/garden (22)	Sport (14)
NATIONAL	Sport (21)	Work (21)	Home/garden (18)

TREATMENT OF INJURY

Overall the main treatment of injuries was carried out by the accident and emergency service in hospitals (47%). This was observed in each Health Board except the Western and Midlands (Table 20). Nationally 36% used the GP service and 15% treated the injury themselves.

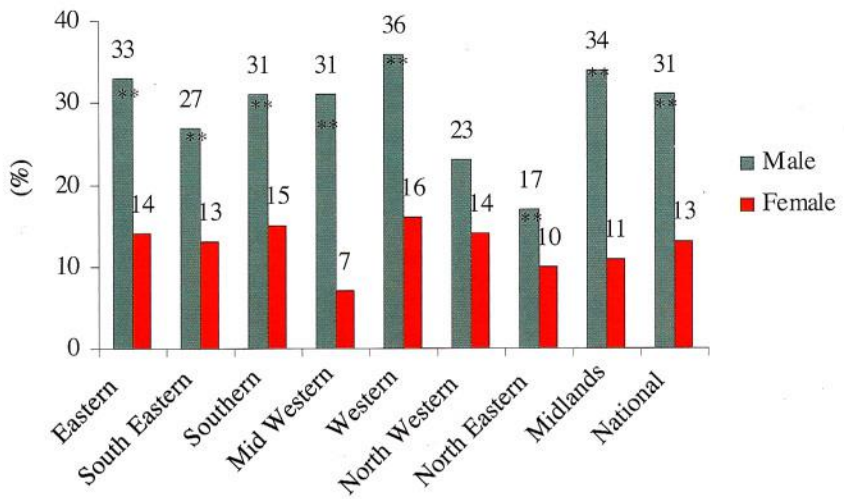
Table 20: Top three places of treatment (percentages in brackets)

Health Board	1	2	3
Eastern	A&E Hospital (40)	GP (28)	Myself (26)
North Eastern	A&E Hospital (31)	GP (31)	Myself (24)
Southern	A&E Hospital (50)	GP (38)	Other (17)
Western	GP (44)	A&E Hospital (33)	Myself (22)
South Eastern	A&E Hospital (36)	GP (34)	Myself (25)
Mid Western	A&E Hospital (37)	GP (34)	Myself (27)
Midland	Myself (33)	GP (33)	A&E Hospital (28)
North Western	A&E Hospital (38)	GP (31)	Myself (29)
NATIONAL	A&E Hospital (47)	GP (36)	Myself (15)

A major concern around road safety is drinking and driving. Of all respondents, those in the North Eastern Board were least likely to do this. Men in all Boards except the North West were significantly more likely to drink and drive than women. A higher percentage of non-GMS respondents reported this behaviour in all health boards but there was no regional variation.

Figure 41: Percentage drinking and driving after having consumed two or more alcoholic drinks

Figure 42: Percentage drinking and driving after having consumed two or more alcoholic drinks by gender



Significantly fewer men than women reported always wearing a seatbelt in the front of a car. Respondents of all ages in the Eastern Board were more likely to wear a belt whereas those in the Mid-West under the age of 35 years were least likely. Similar numbers of GMS and non-GMS respondents reported always wearing a seatbelt. Regional variations existed amongst the non-GMS respondents with those in the Eastern board (75%) more likely and those in the Mid-West were least likely (58%) to wear a belt.

Figure 43: Percentage respondents always using seatbelts in the front seat of a car

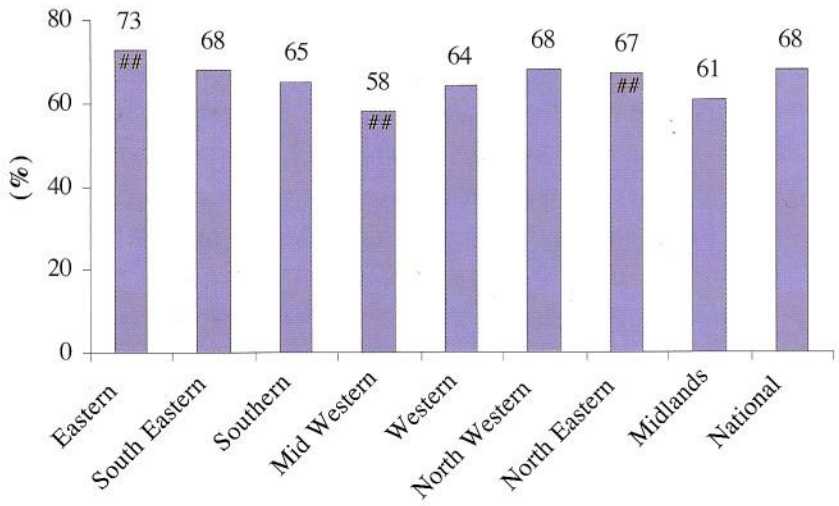
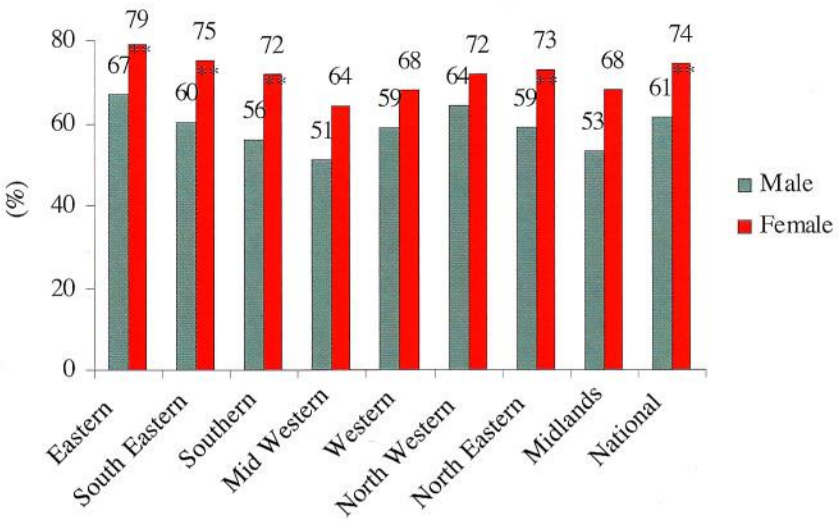


Figure 44: Percentage respondents always using seatbelts in the front seat of a car by gender



Children were also asked how often they use a seatbelt when in a car and how often they wear a helmet when riding a bicycle. The figures below represent the percentages in each group who report always using a seatbelt or always wearing a helmet. Note that this is not related to car ownership or access as the percentages are calculated out of those who say that they travel by car and bicycle respectively. These activities are not associated with social class (phi = 0.03 and 0.02 respectively), nor is seatbelt use associated with age (phi = 0.04). However, the association between cycle helmet use and age is moderate at 0.17. Therefore age group has been taken into account when interpreting differences in cycle helmet use.

These safety behaviours are uniformly low across the country. In every Health Board with the exception of the MWHB, girls are significantly more likely to report always using a seatbelt, but no gender differences in helmet use emerge. The individual values can be seen in the figures below. Health Board differences between groups suggest that EHB pupils are more likely to use seatbelts (EHB boys 44%; EHB girls 55%: Other boys 31%; Other girls 43%). In addition younger (9-11 years) EHB boys are more likely (20%) to use cycle helmets than other young boys (12%), while older EHB girls (15-17) are also more likely to report cycle helmet use (6%) than other 15-17 year old girls (2%).

Figure 45: Percentages of respondents who report that they always wear seatbelts

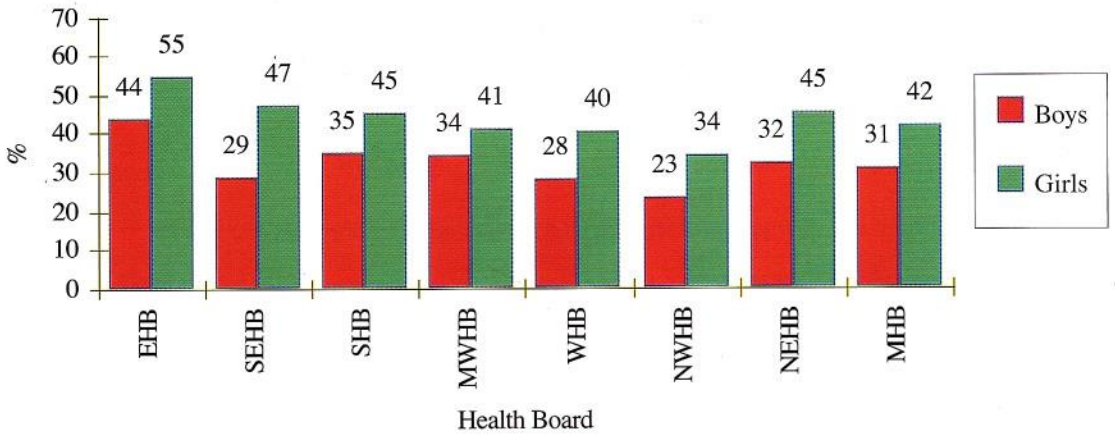
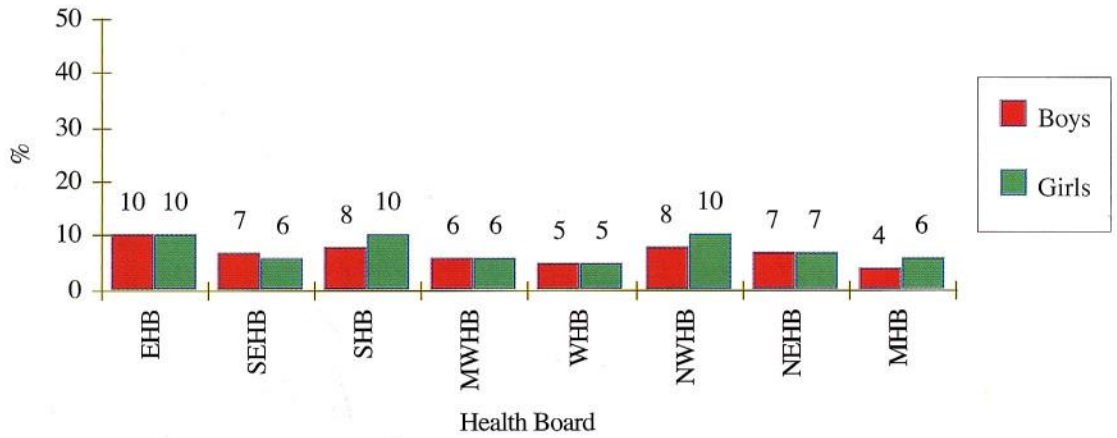


Figure 46: Percentages of respondents who report that they always wear cycle helmets



Finally, children were asked if they had an accident, and if so, what the location was for the most serious accident they had. The figures below represent the percentages reporting that they had an injury and those that reported that their injury occurred at a sports facility or field. Neither of these variables are associated with age or social class (phi co-efficients range from 0.01 to 0.08).

In all areas of the country, boys are significantly more likely than girls to report both having had an accident and to have had it at a sports facility or field. There are no significant inter Health Board differences in having had any injury at all. Girls in the EHB are less likely to report having received an injury at a sports facility than those in the rest of the country (5% v's 9%). Boys in the SHB are more likely (28% v's 19%), and those in the WHB less likely (15% v's 22%) to report that they received an injury at sports facility or field.

Figure 47: Percentages of respondents who report that they have had an injury in the last year

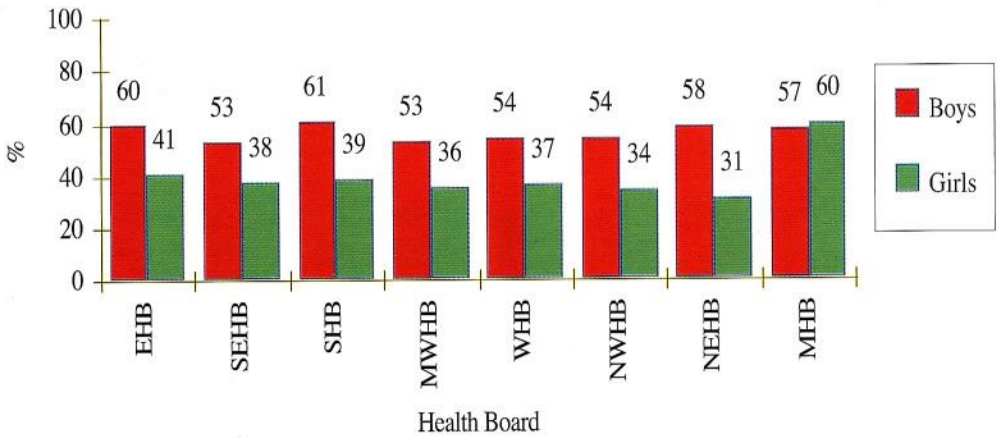
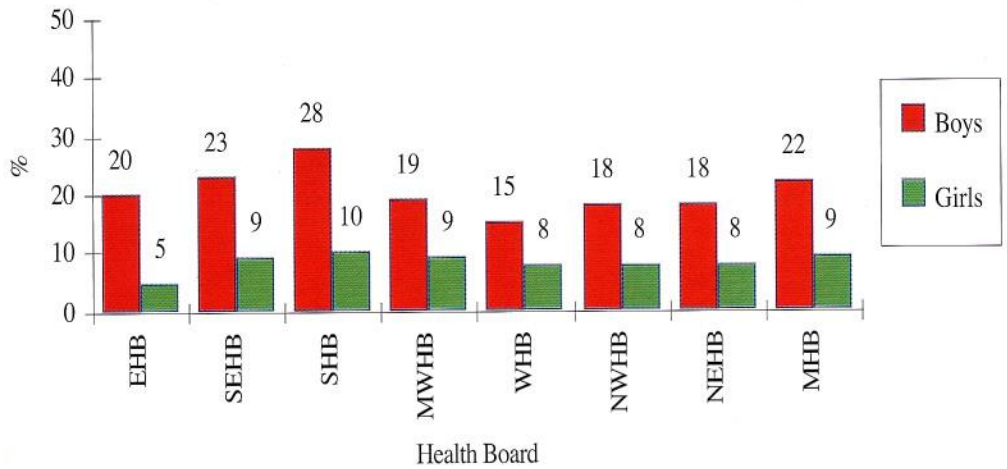


Figure 48: Percentages of respondents who report that they have had an injury in a sports facility In the last year



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