



# Falkland Islands Health and Lifestyle Survey 2019

## Survey Report



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## **Preface**

A commitment was made to implement a public health strategy to support health promotion and disease prevention as part of the Islands Plan 2018 – 2022. As part of this process a permanent Public Health Unit was established following ExCo approval of a Public Health Strategy 2019 - 2021.

This strategy has four key areas of strategic focus to build a strong foundation for developing evidence-based population health improvements for the future:

- Data collection
- Capacity building
- Enabling healthier choices
- “Health in All Policies”

Population health surveys form a part of standardised data collection which can assist with evidence-based decision making, the development of policies and help identify population trends.

The Health and Lifestyle Survey 2019 forms an initial part of data collection. The survey is focused on lifestyle risk behaviours (LRBs) which can lead to diseases which are largely preventable. Understanding LRBs in the community, motivations for engaging in and barriers people encounter in trying to change will enable interventions to be developed which focus on community needs.

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## **1. Survey Overview**

### **Survey purpose**

The aim of the survey was to gather information which could provide an evidence base for the development of policies and prevention programmes around LRBs. LRB's such as smoking, poor dietary habits, inactivity and excess alcohol consumption are known to impact on health outcomes. As these behaviours have the potential to be modifiable and thereby improve population health outcomes it is important to gain an understanding of motivations for engagement and barriers to change.

The areas of interest for this survey were:

- General health
- Physical activity
- Dietary behaviours
- Smoking
- Alcohol consumption
- Sunbathing and sunburn

### **Survey methods**

This survey was conducted via post but was also available on request via email. The initial distribution was undertaken by cross-referencing the published electoral role (May 2018) with the telephone directory. To aim to reach work permit holders and their dependents larger companies were contacted to seek aid with distribution to employees.

### **Questionnaire design**

The questionnaire utilised was based on the validated Gibraltar Health and Lifestyle Survey, with some minor adaptations to suit local context. No identifying information was sought in the survey.

### **Target population**

The survey was aimed at all adults ( $\geq 18$  years), both permanent and temporary residents. The Census (2016) reported that there were 2,536 adults  $\geq 18$  years, 1,186 females and 1,350 males.

### **Distribution and response**

Postal distribution was undertaken in March 2019 and the survey remained open until 10<sup>th</sup> May 2019. The survey was promoted in local and social media, prior to and during the survey period with the intent of ensuring that as many people as possible were aware of the survey and knew how to gain access to the survey, should they wish to participate.

A response rate of 333 based on the Census (2016) population had been calculated to be able to generalise findings and make analysis statistically significant. A total of 603 surveys were returned of which five were excluded due to insufficient data for analysis ( $n=3$ ) and spoilt ( $n=2$ ), leaving an available sample of 598 for analysis, which is equivalent to 24% of the adult population  $\geq 18$  years.

### **Data processing and analysis**

The majority of the findings in this report are presented visually with easy to read graphs and charts, which provide an immediate graphical overview of the answers provided by respondents.

Within the report any reference to 'significance' refers to statistical significance. A statistically significant result is one where the result is unlikely to have occurred due to chance.

To allow for analysis some categories with small cell counts were combined. Where this has occurred, it is noted in the report.

Where possible, comparisons are made to other sources of published data from the Falkland Islands. Guidelines and recommendations are from international evidence-based standards.

As this was a cross-sectional survey, designed to give a snapshot of population health, no conclusions can be drawn around causality.

## 2. Profile of Respondents

### Profile of respondents comparable to the Census (2016)

An overview of the comparable demographics of the population in comparison to the Census (2016) can be seen in **Table 1**, and were considered to be in an acceptable range ( $\leq 9\%$  difference) to be representative.

**Table 1: Demographics of the survey respondents in comparison to the Census (2016)**

	FI Census 2016		Survey Sample	
	Number	%	Number	%
<b>Sex</b>				
Female	1186	47	331	55
Male	1350	53	266	44
Prefer not to say	0	0	1	0
Total	2536	100	598	100
<b>Age group (years)</b>				
18- 24	212	8	21	4
25 – 34	465	18	79	13
35 – 44	579	23	103	17
45 – 54	534	21	133	22
55 – 64	396	16	116	19
65 – 74	212	8	94	16
75 – 84	102	4	40	7
85+	36	1	11	2
Total	2536	100	597 <sup>a</sup>	100
<b>Place of residence</b>				
Stanley	2460	77	471	79
Camp (East or West mainland)	341	11	88	15
Outer Islands	40	1	14	2
MPC	359	11	25	4
Total	3200 <sup>b</sup>	100	598	100

<sup>a</sup> One survey respondent did not provide age group

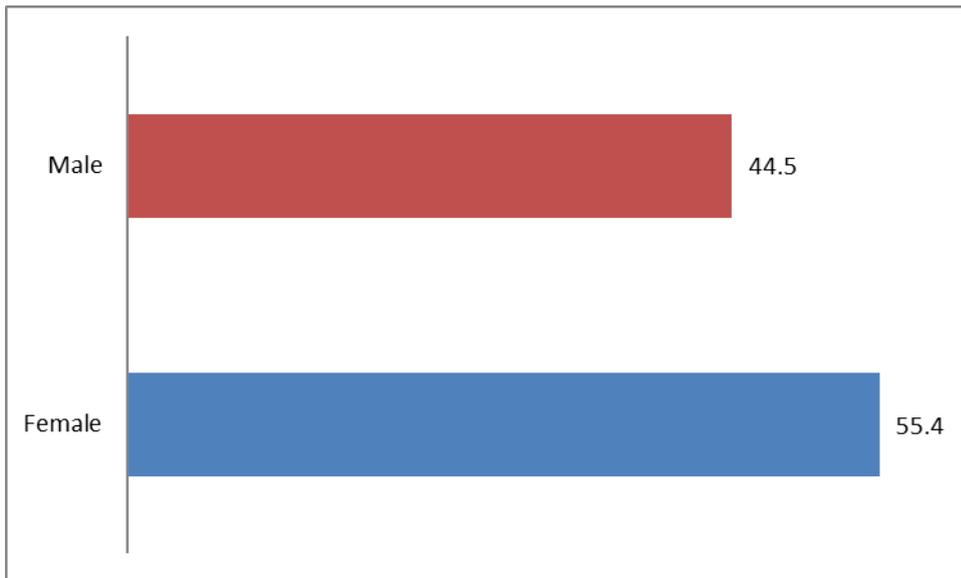
<sup>b</sup> Total population by location

## Respondents demographics

Figures 1 to 6 display the primary demographics reported by respondents.

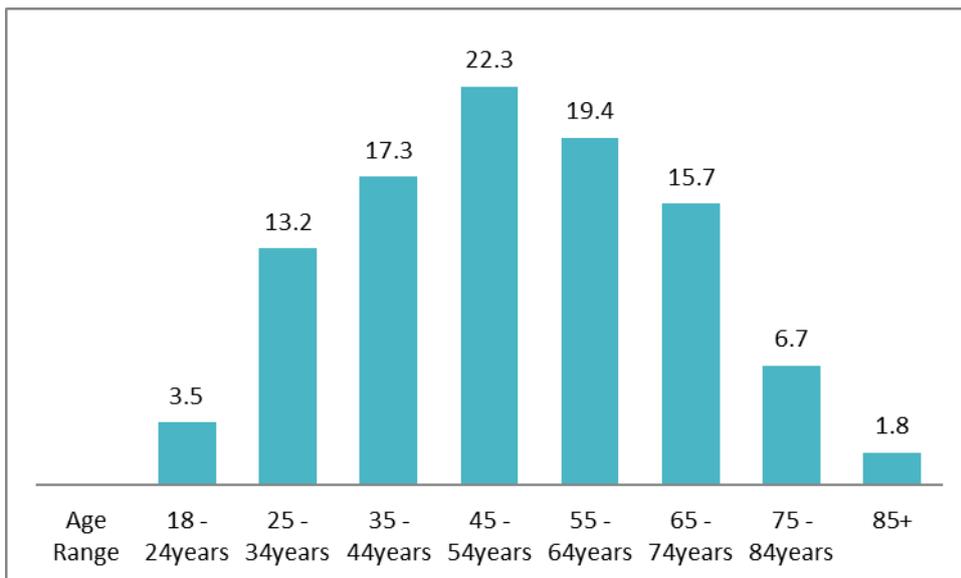
The sample had slightly more females (55.4%) compared to males (44.5%). One respondent (0.1%) preferred not to identify as either male or female. No significant differences were observed between gender and other demographic factors.

**Figure 1: Respondents by gender (%)**

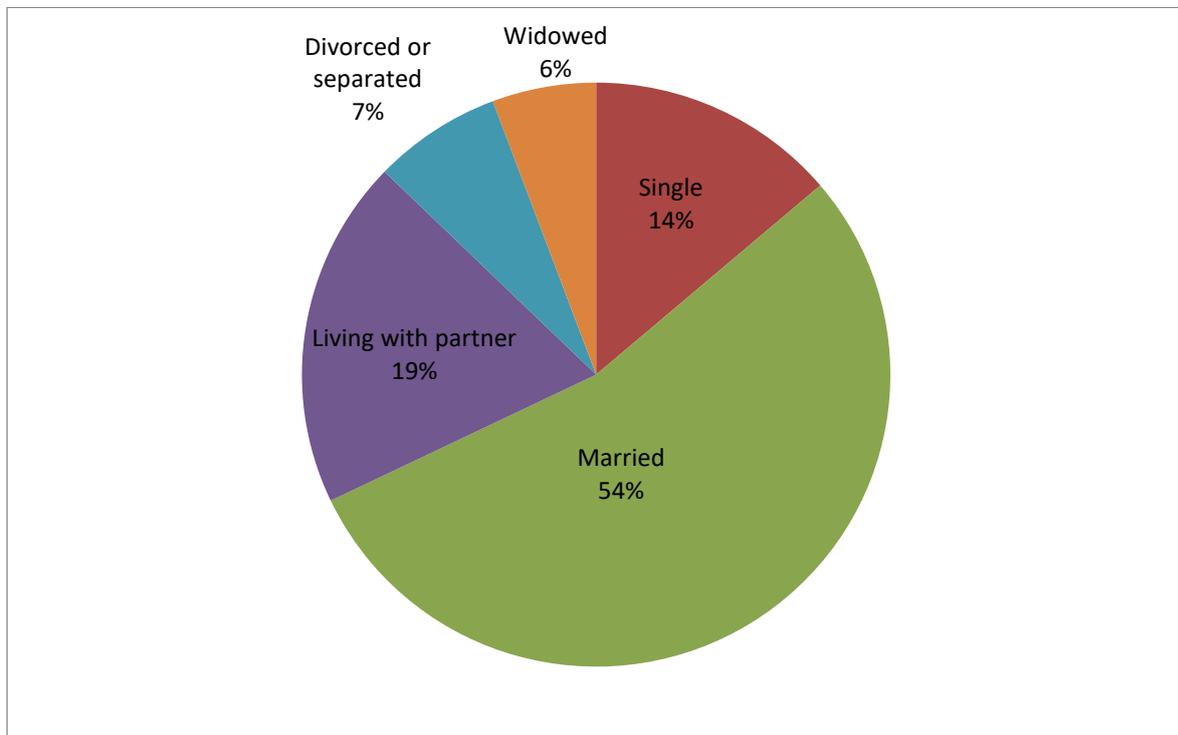


Base: All respondents 598 (preferred not to say excluded from graph as 0.1%)

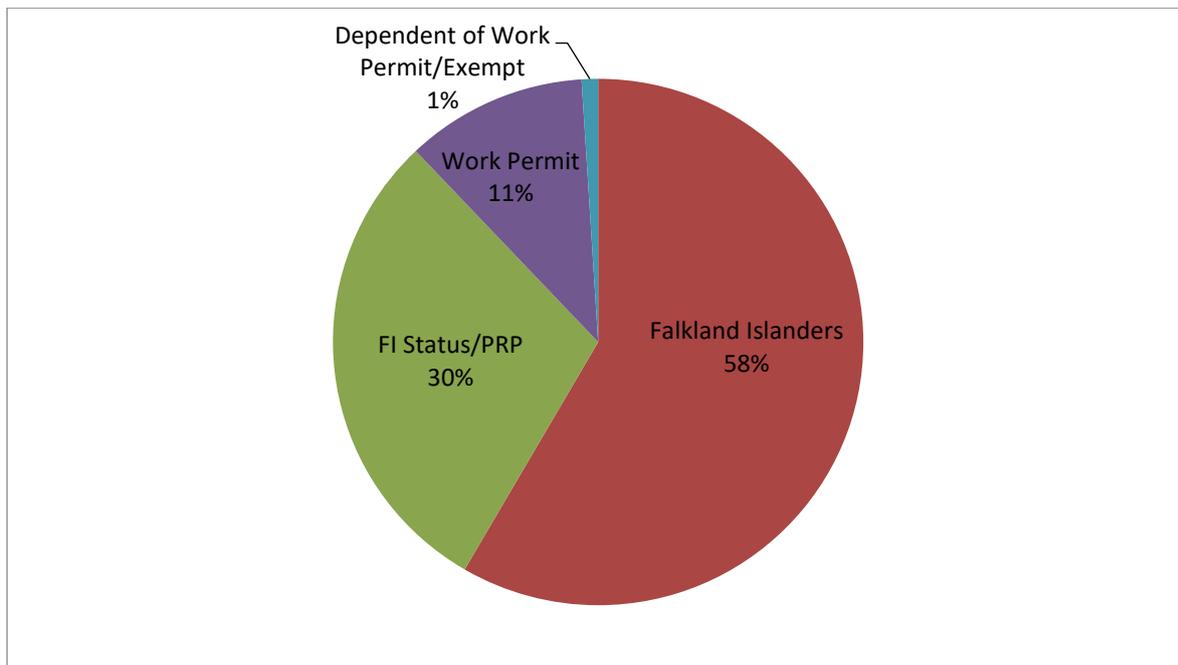
**Figure 2: Respondents by age range (%)**



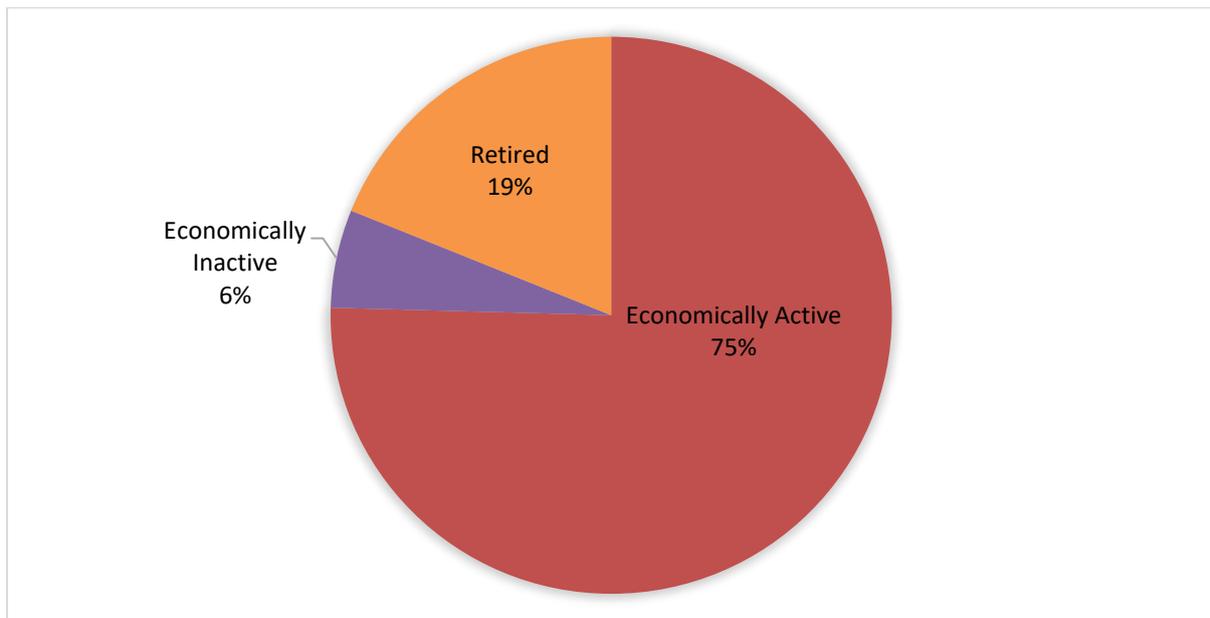
**Figure 3: Respondents by marital status**



**Figure 4: Respondents by immigration status**



**Figure 5: Respondents by employment status**

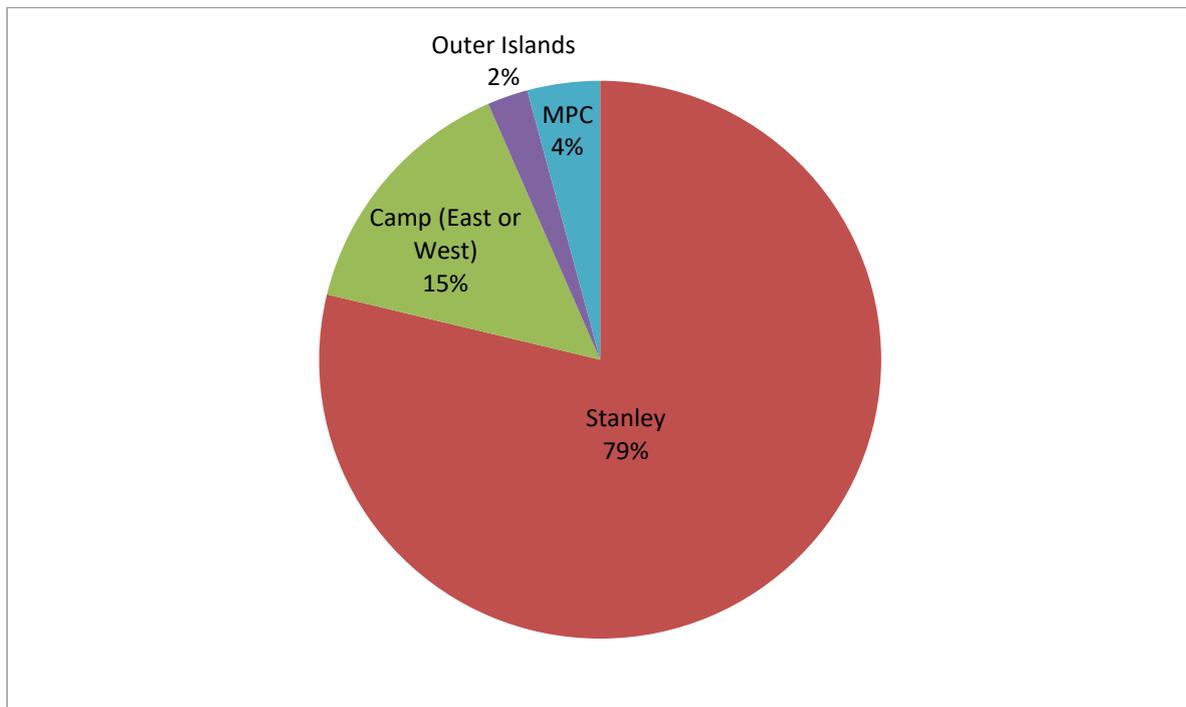


Note: Categories combined for analysis due to small cell counts

**Table 2: Employment status from survey**

Combined category label	Included	%
Economically active	Employed full time	52.4%
	Employed part time	9.2%
	Self employed	13.9%
Economically inactive	In training/apprenticeship	0.3%
	In full time education	0.5%
	Unemployed (seeking)	0.2%
	Unemployed (illness/injury)	1%
	Unemployed (carer family/home)	3%
	Voluntary	0.7%
Retired	Retired	18.8%

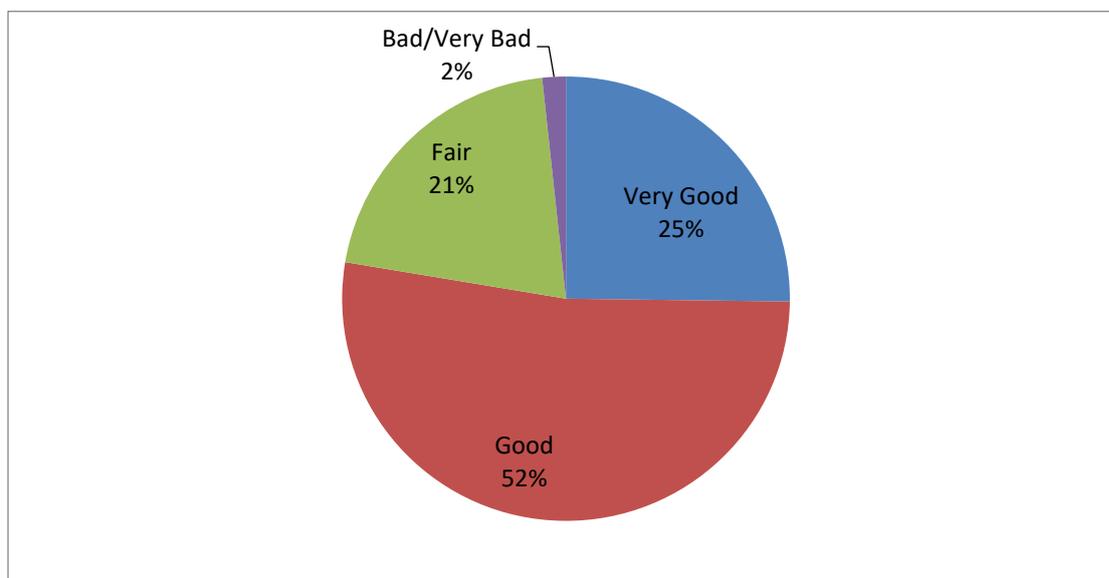
**Figure 6: Respondents by usual place of residence**



### 3. General Health

Self-evaluation of general health is associated with actual health status. Assessment of self-rated health as a single survey question as asked in this survey, has been developed by the World Health Organisation and has been validated as a tool to predict mortality.

**Figure 7: Respondents self-rated health**



Due to small cell counts self-rated health categories were combined into two for further analysis; good (very good & good) and poor (fair, bad & very bad). There was no significant difference between self-rated health and gender or place of residence. Those that were economically active were significantly more likely to have rated their health as good.

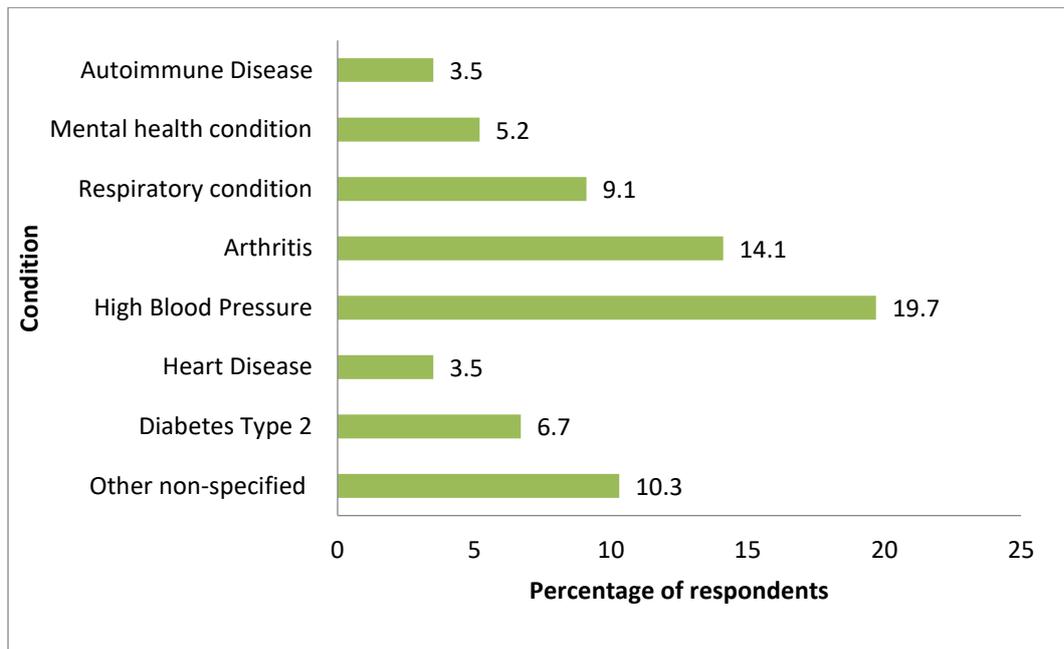
Of the respondents, 47.1% indicated that they had a long-term health condition, disability or infirmity. People were asked to select from a list of common conditions. The response provided by ailment type are set out in **Figure 8**.

As might be expected in an aging population arthritis was one of the most frequent conditions self-reported.

High blood pressure was reported by the highest number of respondents, with no significant differences observed between genders, place of residence or immigration status. An earlier study by King & Bleaney (1984)\* had found that high blood pressure prevalence was low in males but not females which they attributed in part to active lifestyles at the time.

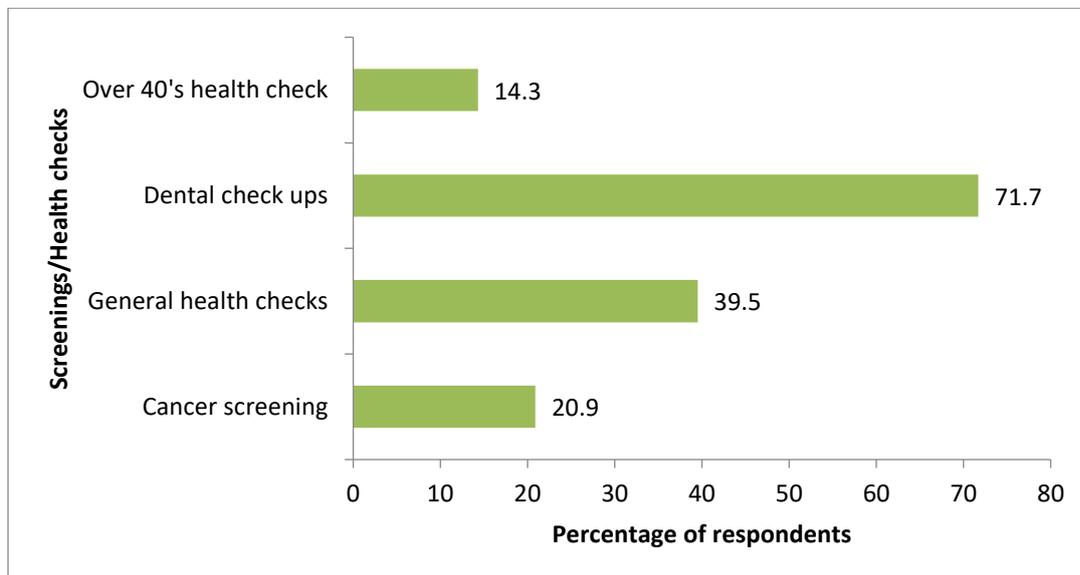
\*King, H.O.M. & Bleaney, A.A. (1984). *The low prevalence of hypertension in the Falkland Islands men*. Journal of the Royal College of General Practitioners. 34, 95 - 96

**Figure 8: Long standing condition, disability or infirmity**



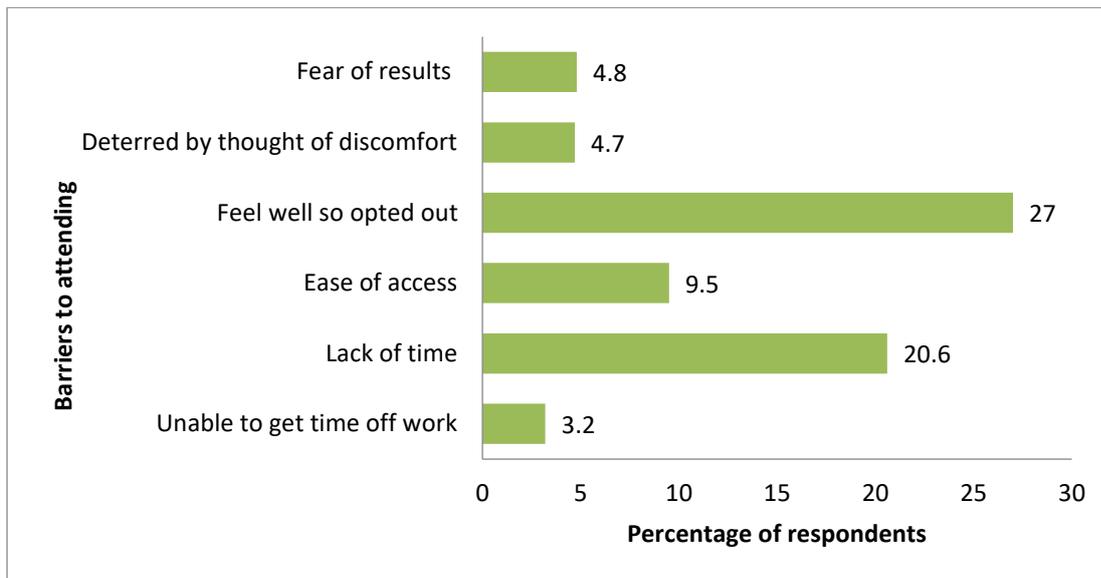
People were asked if they had attended any health screening in the previous 12 months, 87.4% of the respondents indicated that they had attended. A breakdown of the reported attendance at clinics/screenings is outlined in **Figure 9**.

**Figure 9: Reported attendance of screening and health checks**



An additional 9.8% indicated they did not attend any of the screening or health checks listed however 84% stated that they had attended if invited to do so. If people had opted not to attend when invited they were asked to nominate from a list of barriers to attendance as seen in **Figure 10**. Note that respondents could nominate more than one barrier.

**Figure 10: Barriers to attending health screening or clinics when invited**



Other reported reasons for non-attendance locally included attending check-ups while overseas or for work medicals, appointment times unsuitable or not available, forgot to attend, declined due to pregnancy, not motivated to attend.

#### 4. Physical Activity

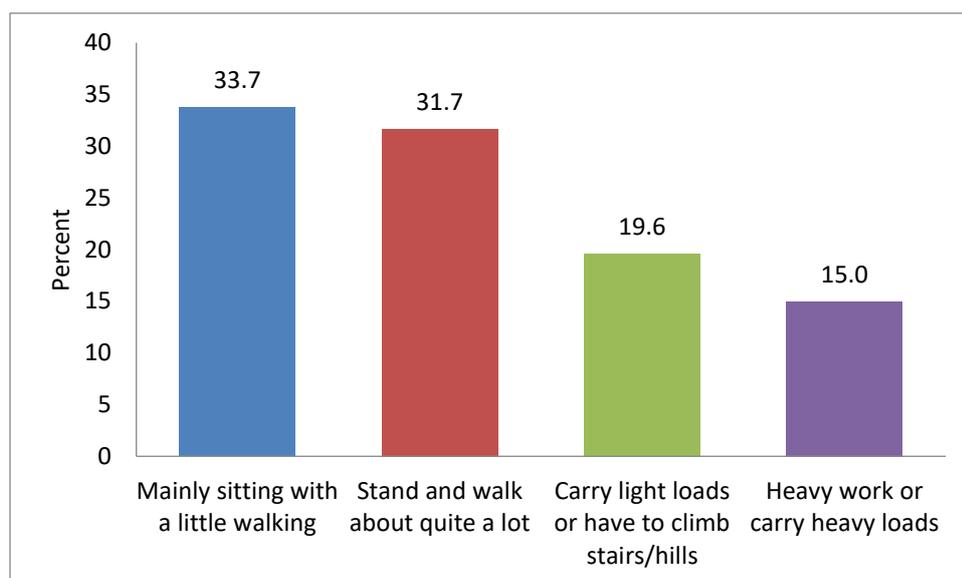
There is currently no standardised consensus of defining sedentary behaviour or gold standard for assessment with self-report measures often utilised. However, as a general rule most studies define sedentary behaviour as time spent in low energy tasks or specific behaviours (sitting or reclining) classified as low energy expenditure ( $\leq 1.5$  METs). 1 MET = 1kcal/kg/hour. Some examples of common sedentary behaviours for reference can be seen in **Table 3**.

**Table 3: Common sedentary behaviours performed sitting or reclining requiring  $\leq 1.5$  METs**

Home	Work/School	Transportation	Leisure
TV viewing	Computer work	Driving or riding in a vehicle	Playing an instrument
Talking on the phone	Sitting		Arts and crafts
Listening to music	Writing		Knitting/sewing
Eating	Talking on the phone		Meditating
Bathing	Sitting in class/office		Playing cards or board games
Reading	Typing		Viewing a sporting event
	Reading		Attending a religious service

Table adapted from American Heart Association (2016)

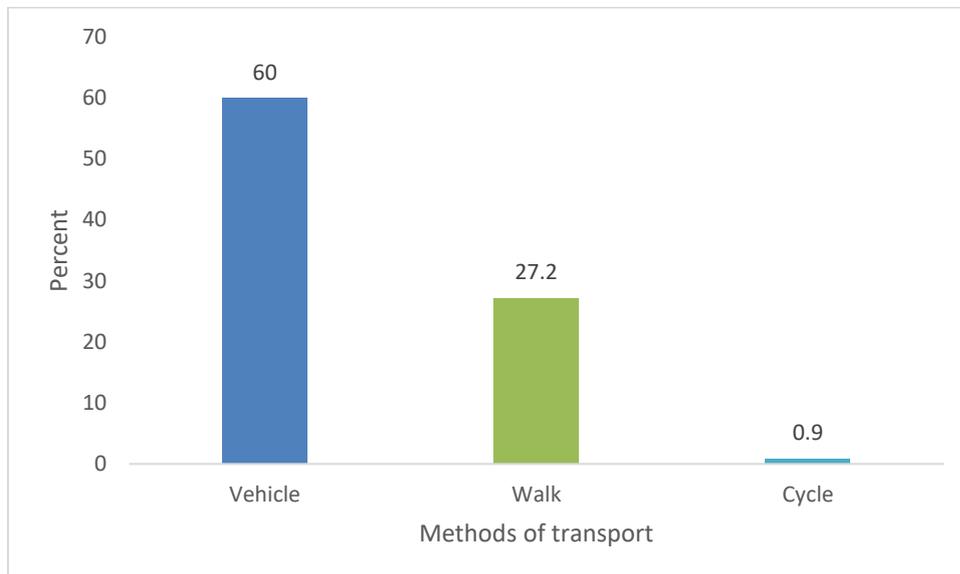
**Figure 11: Activity levels reported during normal daily routine**



Males were significantly more likely to undertake heavy work and females to report daily routines which included standing and walking. Place of residence was also significant with Camp (combined categories; East, West, Outer Islands and MPC) residents more likely to undertake heavy work. Work permit holders were significantly more like to spend their daily routine mainly sitting in comparison to Falkland Islanders or those who held FI status or PRP. Working age individuals (18 – 64 years) were significantly more likely to be more sedentary in daily routine.

Respondents were asked about methods of travel to work, 16.6% were unable to answer this question as they did not work and a further 2.7% lived on site therefore the analysis was undertaken on those that did work, see **Figure 12**.

**Figure 12: Methods of transport to get to work place**



Males were significantly more likely to use a vehicle to get to their place of work than females.

The UK Chief Medical Officers' guidelines on physical activity recommends that adults engage weekly in either 75 minutes of vigorous activity (heart rate and breathing increased but may have difficulty carrying on a conversation) or 150 minutes of moderate activity (heart rate and breathing increased but able to talk comfortably) or a combination of both to improve cardiovascular fitness. The guidelines also recommend participation in strength and balance movements on 2 days per week and to sit less. Examples of activities can be seen in **Table 4**.

These recommendations are made as there are known benefits to health and wellbeing which includes:

- A reduction of disease risk for developing Type II diabetes, cardiovascular disease and cancers (Colon and Breast)
- Joint and back pain is reduced
- Falls risk is reduced
- Mental health is improved
- Risk of dementia is reduced
- Sleep patterns are improved
- Aids management of stress
- Helps maintain a healthy weight
- Improves overall quality of life

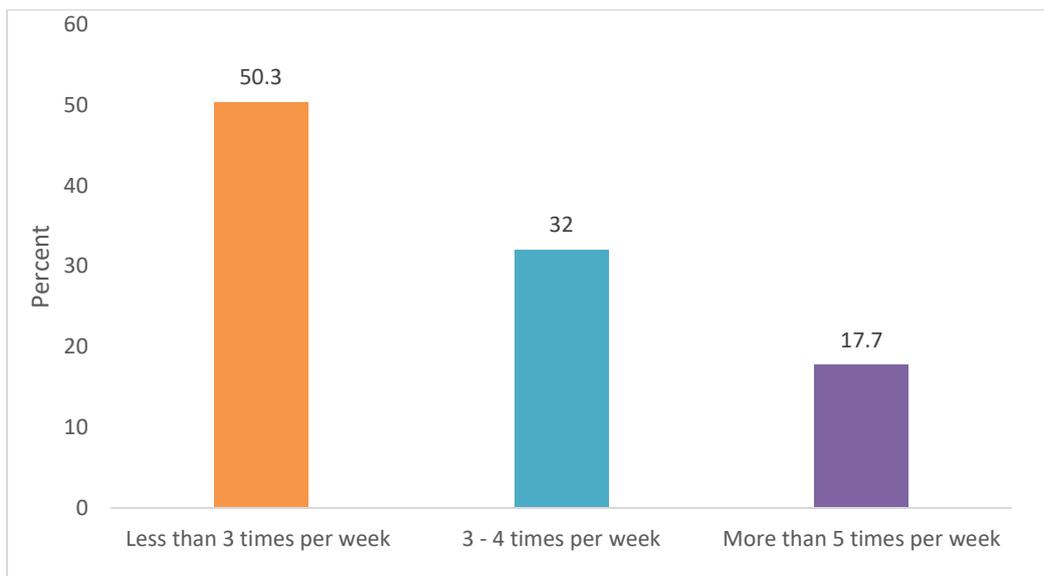
**Table 4: Examples of activities**

Moderate Activities	Vigorous Activities	Strength Activities	Balance Activities
Walking (4mph)	Running (6mph)	Weight lifting	Dance
Cycling (10 – 12mph)	Stair climbing	Carrying groceries	Tai Chi
Gardening	Circuit training	Yoga	Bowls
Dancing	Football	Pilates	Yoga
Aqua-aerobics	Mountain hiking	Lifting and carrying	Pilates
Doubles tennis	Swimming laps		Stability board

Note: These examples are a guide whether or not something feels like a moderate or vigorous activity will depend upon individual fitness levels and abilities.

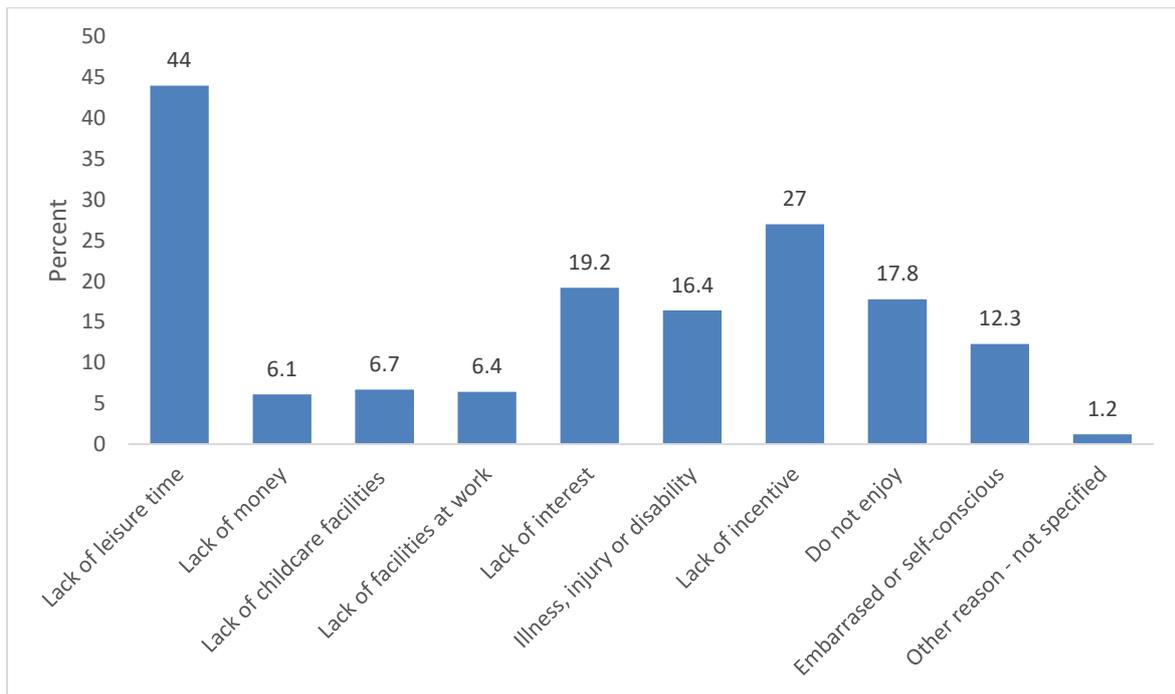
Half of the respondents (50.3%) (see **Figure 13**) reported participating in physical activity on less than 3 occasions per week. While there was no gender difference a significant impact was seen on self-rated health with those participating less than 3 time per week associated with poor health. Camp (combined categories; East, West, Outer Islands and MPC) residents were significantly more likely to report more activity than Stanley residents. Age had no significant impact on physical activity reported.

**Figure 13: Time spent in physical activity of 20 minutes or more per week**



Respondents were asked to nominate reasons which are barriers to being more physically active both in their daily routine and for planned activity. The results can be seen in **Figure 14**. The most common response was lack of time (44%). Note that respondents could select more than one reason.

**Figure 14: Barriers to being more physically active**



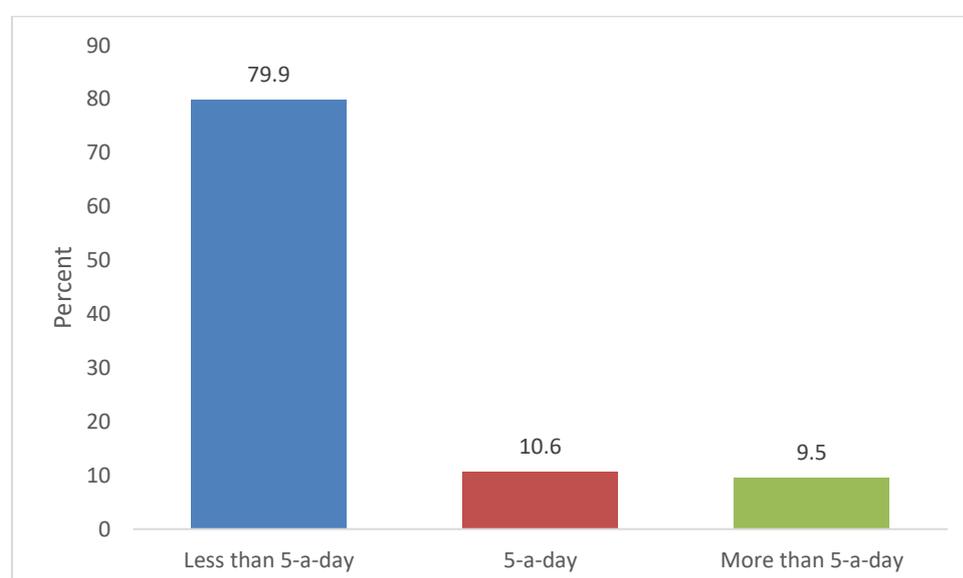
As already noted causality cannot be concluded from a cross-sectional survey however it is not unreasonable to assume that long working hours and multiple jobs as reported in the Census (2016) impacts on the amount of leisure time available.

## 5. Dietary Behaviours

The World Health Organisation recommends eating 400g of fruit and vegetables a day (5 x 80g portions) to lower risk of developing chronic disease such as cardiovascular disease, stroke and cancers. Fruit and vegetables are excellent sources of health boosting vitamins, minerals and fibre to aid good digestive health.

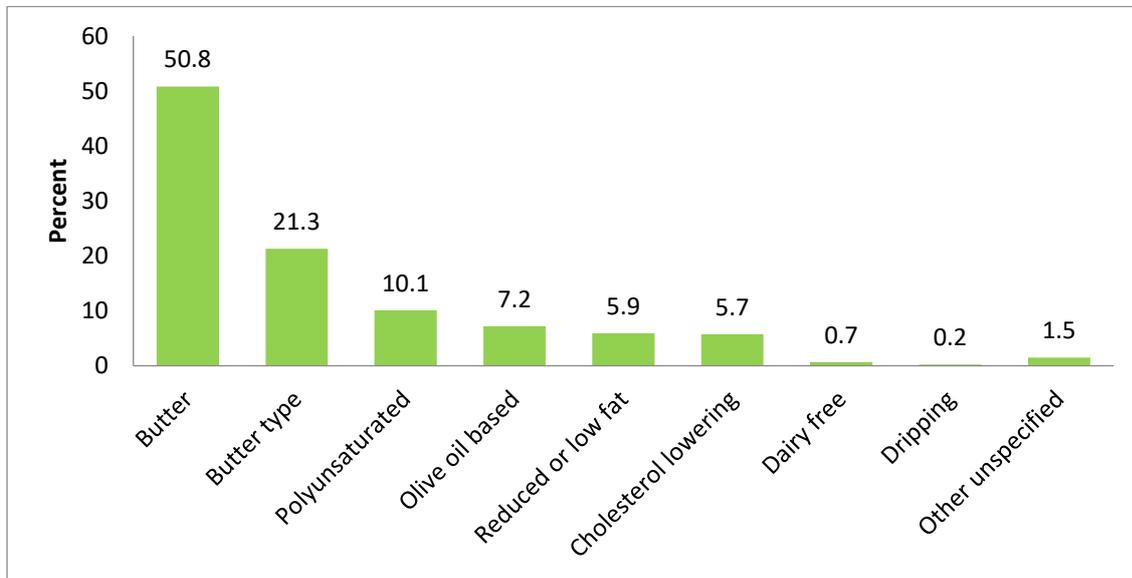
Respondents were asked how many portions of fruit and vegetables they normally eat in a day, the responses ranged from 0 to 10 with a mean of  $3.15 \pm 1.721$ . The vast majority 79.9% of the respondents did not meet the recommended 5-a-day guideline (**Figure 15**), 20.1% of the respondents met or exceed the guideline amount. No demographic factors (marital status, immigration status, age, place of residence, economic status) was significant in the amount of fruit and vegetables consumed.

**Figure 15: Fruit and vegetable daily intake compared to 5-a-day guidelines**



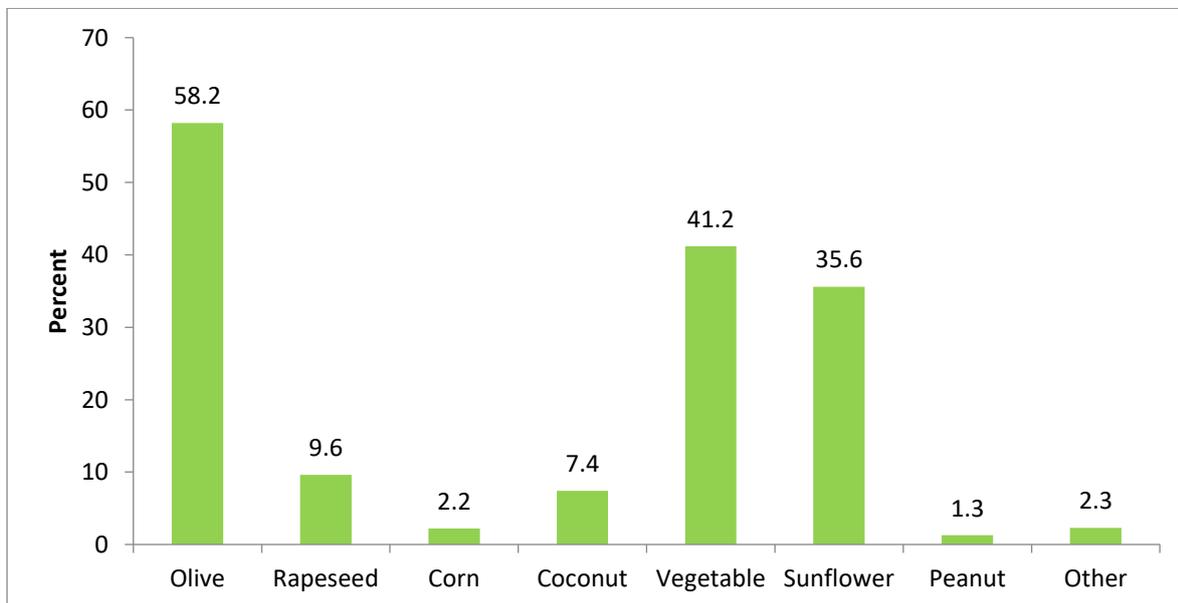
Respondents were also asked to compare the amount of fruit of vegetables they ate to the previous year, 72.2% reported eating the same amount, 12.5% indicating they had decreased their intake and the remaining 15.3% indicating an increase.

**Figure 16: Types of spread typically used**



Types of spread typically used were asked, while 11.3% of respondents reported not using any type of spread, butter (**Figure 16**) was the most frequently (50.8%) reported.

**Figure 17: Types of oil used for cooking or frying**



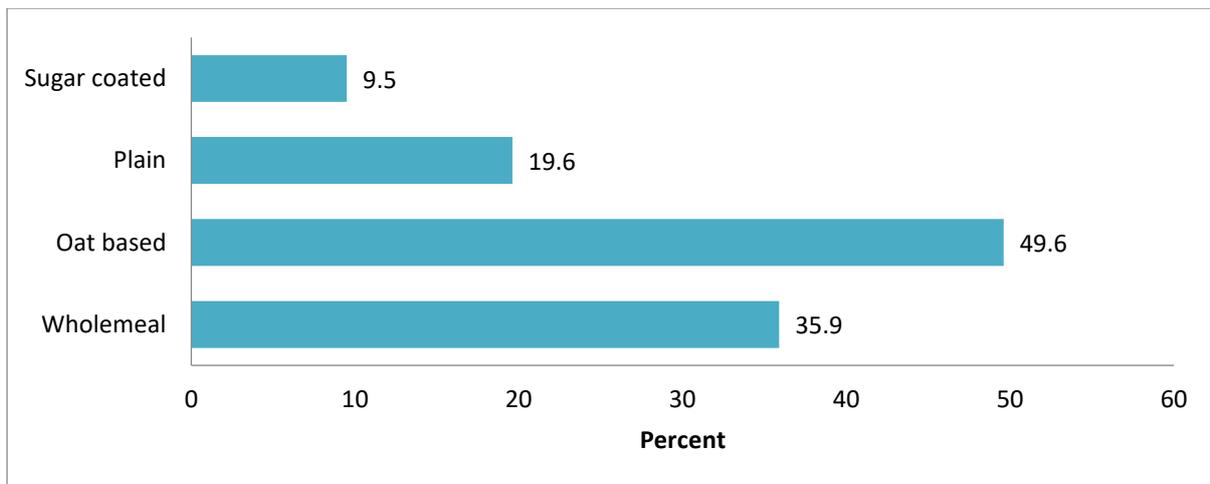
Respondents reported using olive oil (58.2%) most frequently. Other types included dripping or lard (1.2%), walnut (0.3%), rapeseed (0.3%) and unspecified types (0.5%).

The survey asked respondents about the number of meals and snacks they ate per day. The mean number of meals reported was 2.46 and snacks 1.70.

There was a question which asked respondents to rank their meals and snacks in order of the size of meals or snacks, however due to the nature of responses few conclusions can be drawn. The evening meal was indicated as the largest meal of the day by the majority of people who did answer (76%). Breakfast was reported as the lightest meal (49.1%) with 21.4% of respondents indicating they did not eat breakfast.

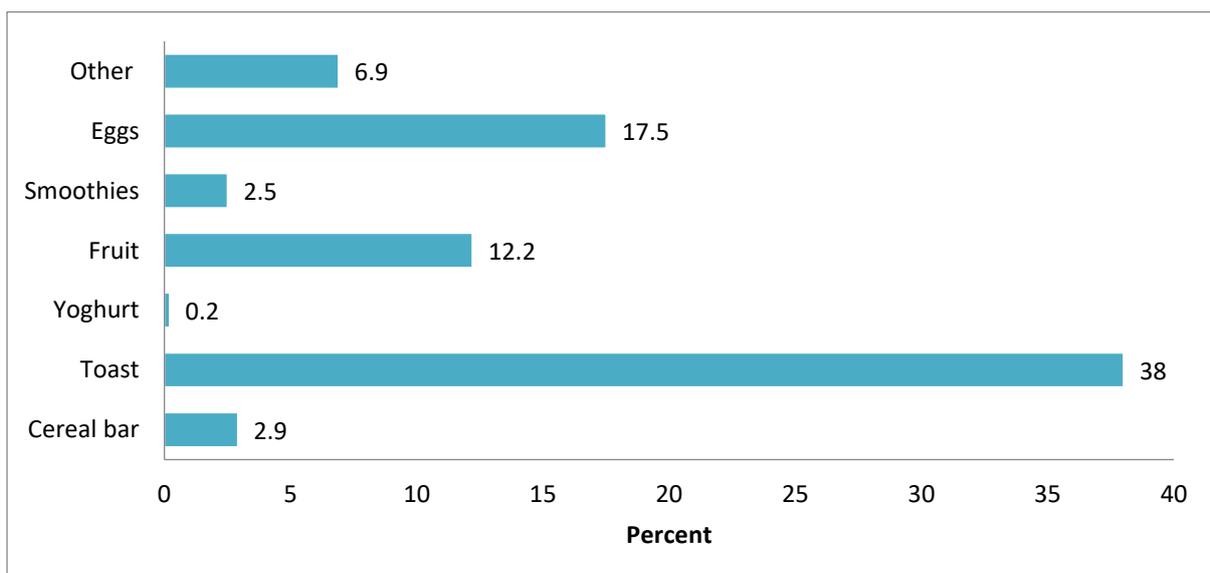
Cereals were consumed by 79.7% of the respondents, not just as a breakfast food. Oat based cereals (see **Figure 18**) were the most popular choice.

**Figure 18: Types of breakfast cereal eaten**



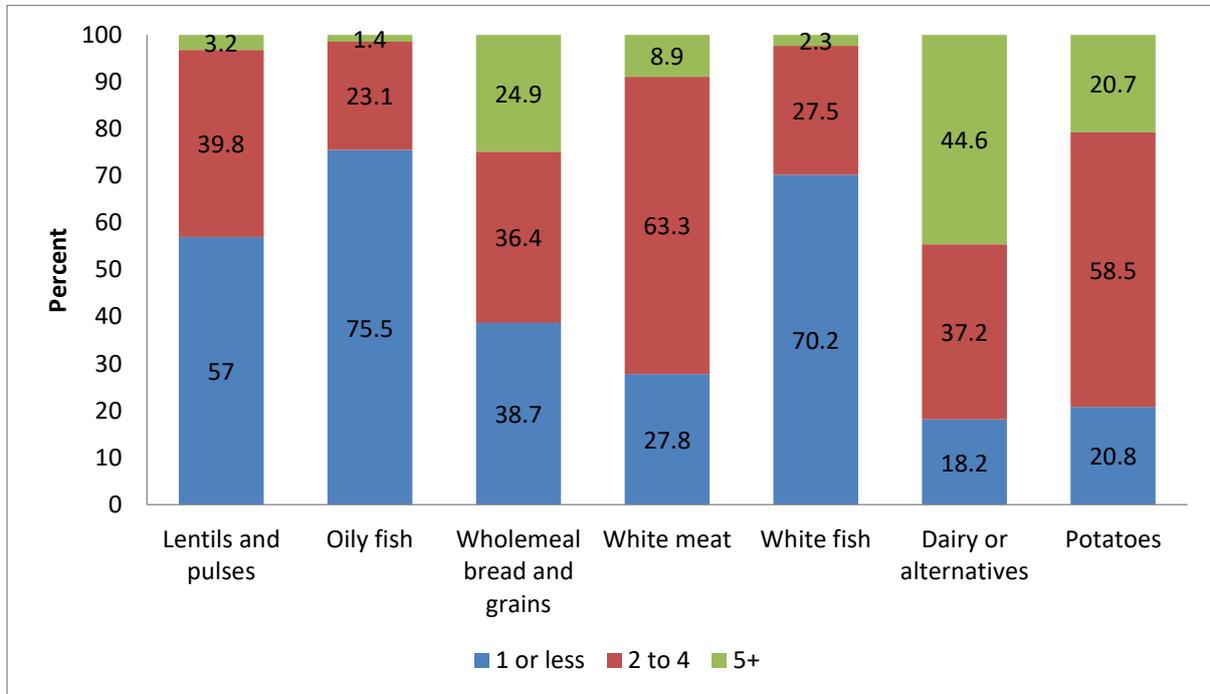
Of those eating breakfast, 56.35 indicated they included other items as breakfast choices (see **Figure 19**), toast, eggs and fruit being the most frequent choices.

**Figure 19: Other food items chosen for breakfast**

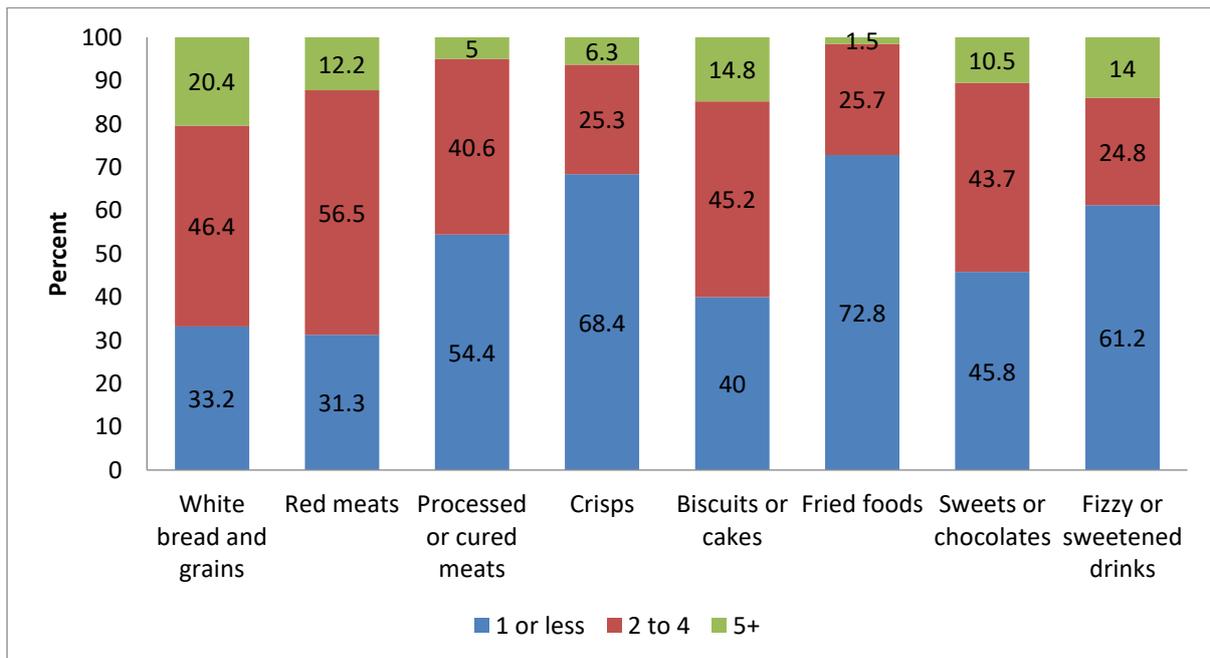


As an overview of dietary habits respondents were asked to nominate how often (1 or less, 2-4 times, 5 or more times) per week they ate particular food items. For the purposes of analysis these were categorised on the basis of healthier items (**Figure 20**) and less healthier items (**Figure 21**).

**Figure 20: Consumption occasion per week of healthier food items**

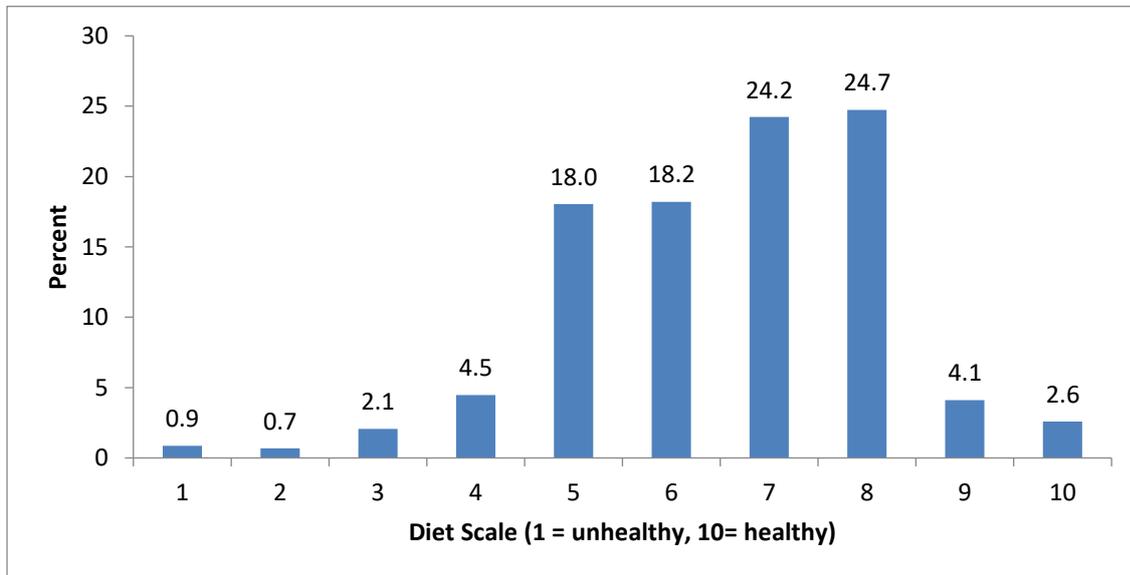


**Figure 21: Consumption occasions per week of unhealthier food items**



Respondents were asked to self-rate their own diet from a scale of 1 to 10 (1 being unhealthy and 10 being very healthy). This is a very subjective measure and there are limits to what can be read from the replies. An almost equal number self-rated on the scale as 7 (24.2%) and 8 (24.7%) (see **Figure 22**). With the majority (85.2%) rating between 5 – 8 on the scale.

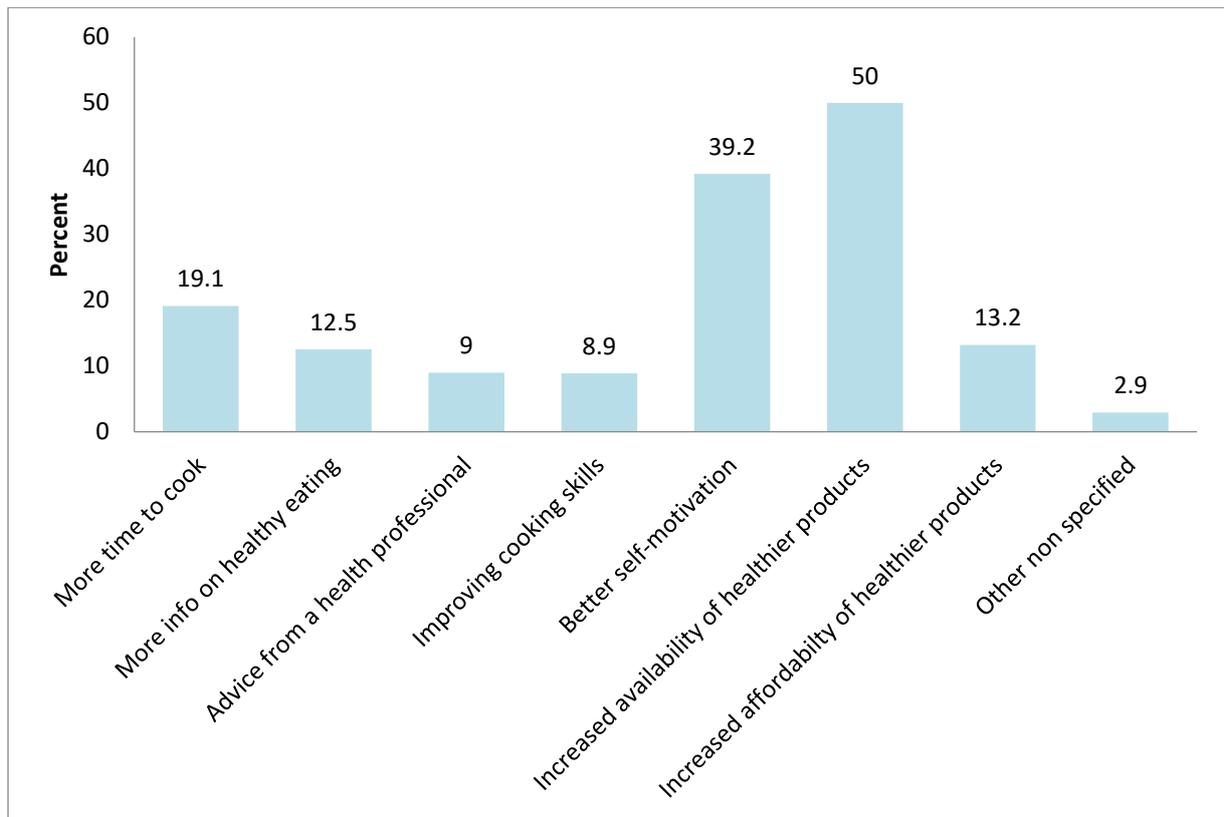
**Figure 22: Respondents self-rating of dietary intake**



Many of the respondents (69.6%) indicated that they had tried to improve or change their dietary pattern in the past year. With the most frequently cited reason being for health.

Respondents were asked what could help them to change their dietary intake. Note in the chart (**Figure 23**) respondents could select more than one reason. A small percentage, 1.5% indicated that they did not wish to change their current dietary intake.

**Figure 23: Reasons given that could aid dietary change**



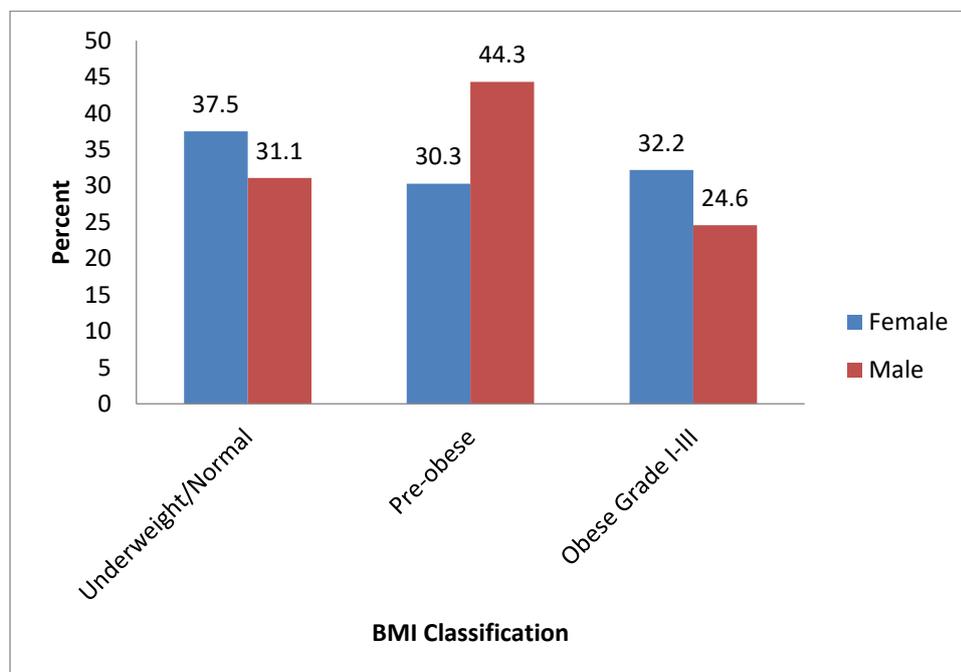
## 6. Overweight and Obesity

Obesity is associated with an increased risk for non-communicable disease development and as such is considered one of the greatest threats to public health.

The survey asked respondents to provide information about their height and weight. From this self-report data, a calculation was made of people's Body Mass Index (BMI), which is a standardised way of determining whether a person's weight is healthy or not. Once the BMI calculation is made a person's weight can be allocated to a specific group. In line with the World Health Organisations classification the groups are underweight (BMI below 18.5), healthy weight (BMI 18.5 – 24.9), overweight (BMI 25 – 29.9) and obese (BMI over 30).

Mean BMI from the sample was calculated to be  $27.8 \pm 5.66 \text{ kg/m}^2$ . To allow for analysis the people who reported being unsure (4.2%) of their weight status were excluded from the calculation in **Figure 24** and underweight (1%) combined with normal weight.

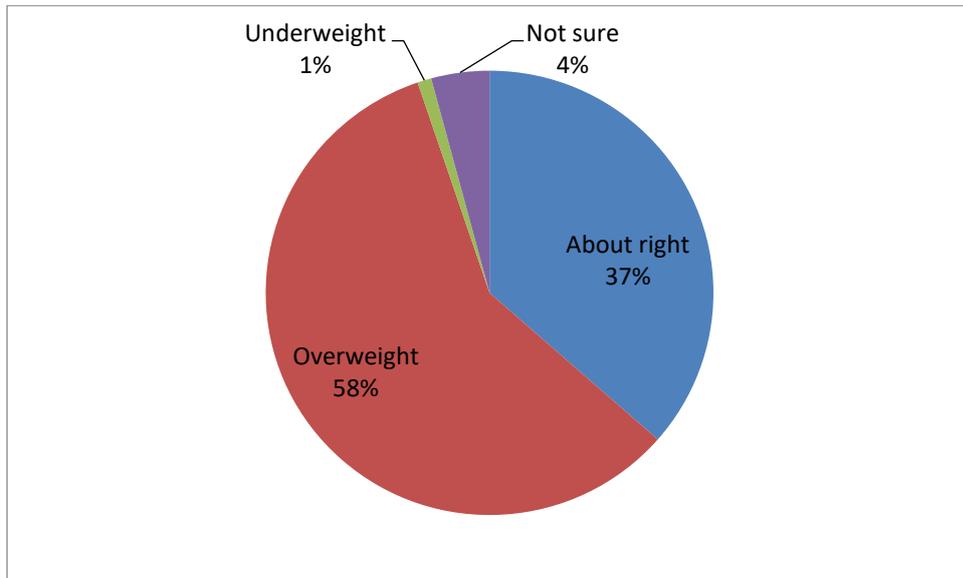
**Figure 24: Calculated BMI by gender from self-reported height and weight**



Calculated BMI (see **Figure 24**) indicates that 68.9% of males and 62.5% of females are above a healthy weight. Place of residence or immigration status had no impact on weight status.

Respondents were also asked for their perception of their weight status with the option of selecting either about right, overweight, underweight or not sure. The results can be seen in **Figure 25**. Further analysis indicated males were significantly more likely to underestimate being overweight (51.6% versus calculated BMI 69%) compared to females who overestimate being overweight (68.4% versus calculated 62.5%).

**Figure 25 Survey respondents weight perception**

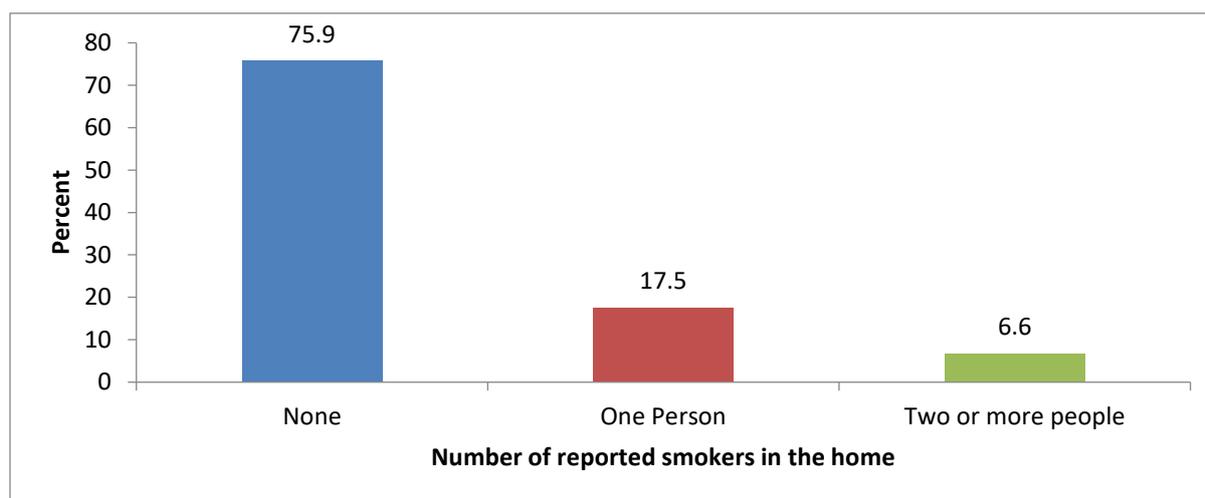


## 7. Smoking

The World Health Organisation (2019) state that tobacco use remains the leading cause of preventable illness and death worldwide.

The vast majority (75.9%) of respondents reported (see **Figure 26**) living in a smoke free home.

**Figure 26: Reported smokers in the home**



Of the respondents 76.5% classified themselves as non-smokers (38.4%) or ex-smokers (38.1%) and 23.4% as smokers, regular (17.5%) or occasional (5.9%). Of those smoking, the mean cigarettes smoked daily was  $9.63 \pm 6.573$ .

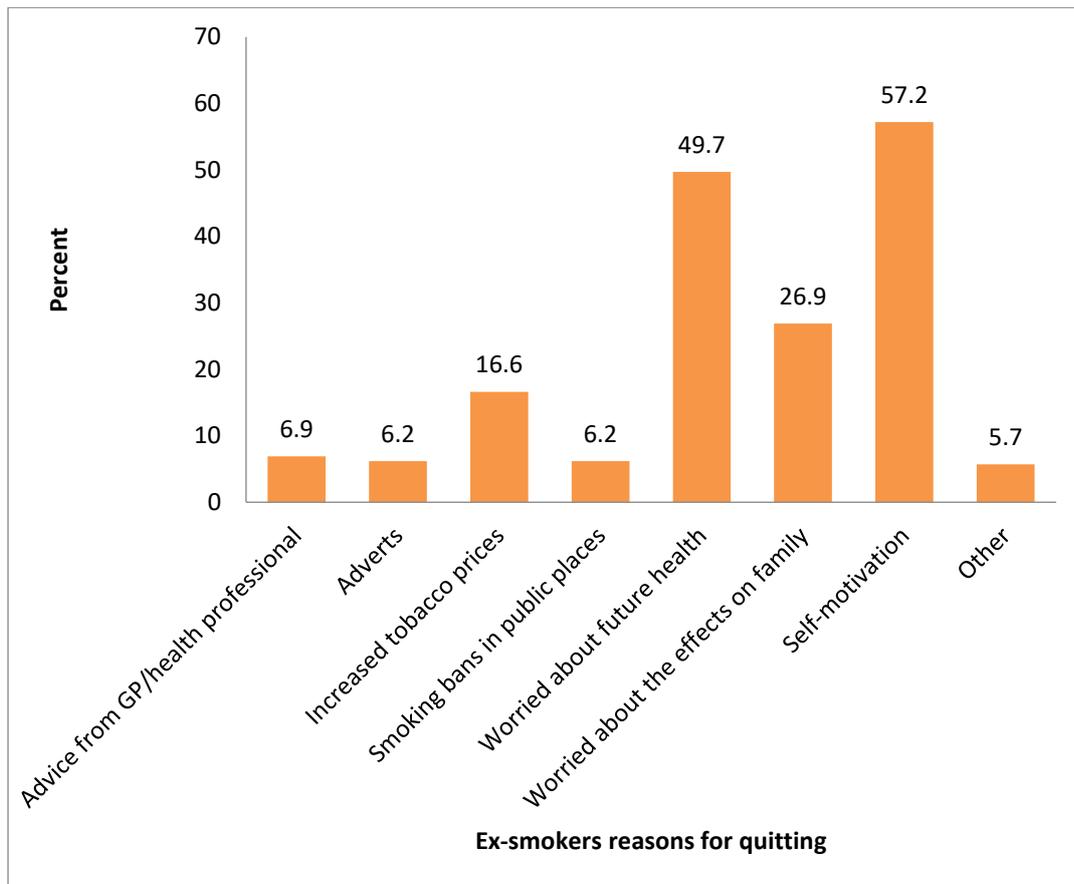
While place of residence or immigration status had no impact on smoking status, the distribution between smokers and non-smokers was less apparent in single people; however married, divorced or separated individuals had a significant tendency to be non-smokers.

A direct comparison can not be made with the Census (2016) data as the methodologies are not the same however the findings in this study indicate smoking rates are higher (+5.4%) than reported in the last census. As with the findings of the Census (2016) retired people were more likely to be non-smokers, and the highest percentage (42.6%) of smokers, which was significant was found in younger age groups (18- 34 years). The gender trend although not significant was consistent with the Census findings with more males (25.7%) than females (21.8%) being smokers.

Ex-smokers were asked at what age they started smoking (mean = 16 years) and their reasons for quitting. Note respondents could select one or more reasons from the list seen in **Figure 27**.

The survey also asked if either or both of the respondent's parents smoked when they were children. Of those who are current smokers, 55.6% indicated their mother was a smoker and 69.2% their father a smoker.

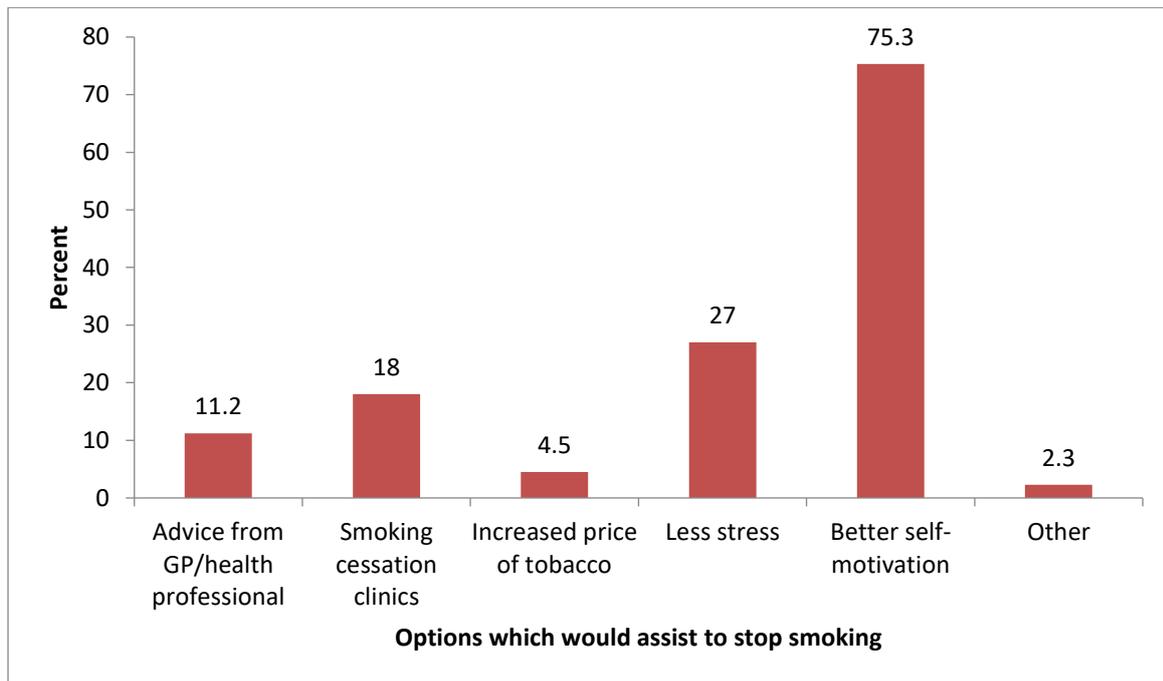
**Figure 27: Ex-smokers reasons for quitting**



Of those who were ex-smokers, 65.5% had quit more than 10 years ago. Of the reasons provided for quitting (see **Figure 27**), self-motivation (57.2%) was the biggest influence with future effects on health, self (49.7%) and family (26.9%) important influences. Of the other reasons stated planning for or being pregnant was most frequently cited (1%).

Respondents who are current smokers were asked if they had been advised to quit by a health care professional, 64.4% said yes and 35.6% no. They were also asked what could aid them to quit, respondents could select more than one option. (see **Figure 28**). Within the other category (**Figure 28**), 0.7% indicated that had no desire to quit presently and 0.8% didn't specify what would aid them to quit. The remainder indicated support from family (0.2%), a change in present health (0.3%), complementary therapies (0.2%) or new hobbies (0.2%) would aid them to quit.

**Figure 28: What would help smokers to quit**



## 8. Alcohol Consumption

Excess alcohol consumption is identified as a causal factor in the development of many health conditions, including high blood pressure, depression and some cancers. In addition, alcohol increases the risk of road accidents, violence and other accidental injuries.

The UK Chief Medical Officers guidelines about alcohol intake for adults (excluding during or planning a pregnancy, where the advice is to avoid alcohol to minimise risk) can be seen in **Table 5**.

**Table 5: UK Chief Medical Officer’s guidance on alcohol consumption for adults**

Level	Units per Week	Male/Female
Low Risk	Less than 14	Males & Females
Increased Risk	Over 14 and up to 50	Males
Increased Risk	Over 14 and up to 35	Females
High Risk	More than 50	Males
High Risk	More than 35	Females

See below for some common examples of what 1 unit of alcohol looks like in measures.

### What does **1 unit of alcohol** look like?

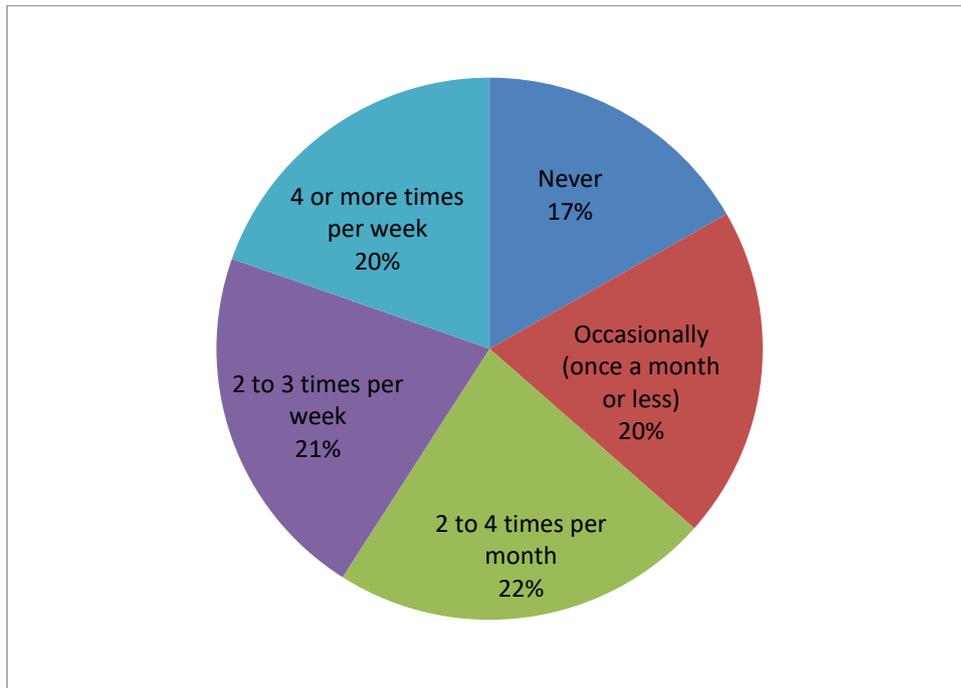


**drinkaware**

Graphic courtesy of Drinkaware <https://www.drinkaware.co.uk/>

Reported frequency of occasions for consumption of alcohol by the respondents can be seen in **Figure 29**.

**Figure 29: Respondents reported frequency of alcohol consumption occasions**

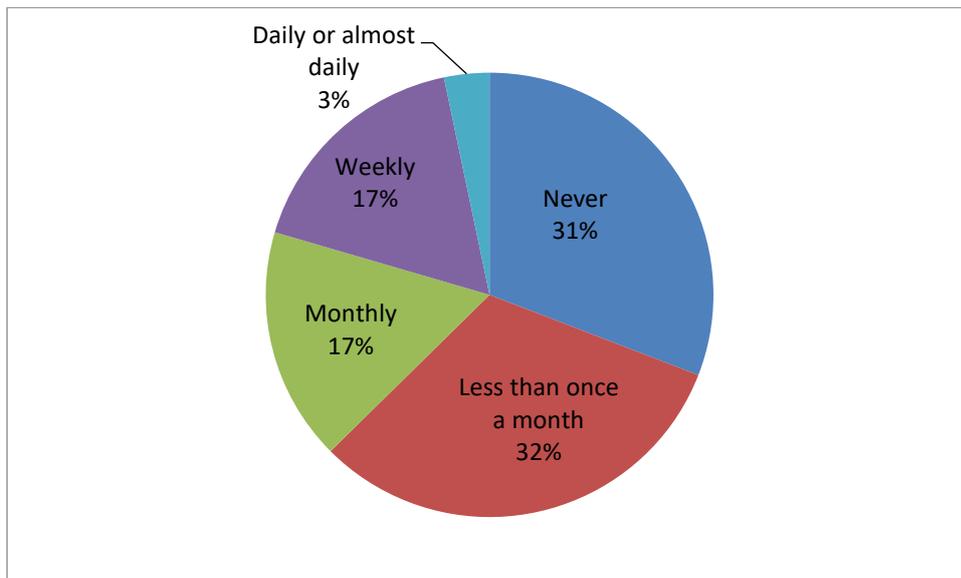


Of those that reported drinking alcohol, mean weekly intake was 11.1 units, although some people reported far higher levels of intake. A total of 24.6% reported exceeding the recommended safe intake levels, 18% of females and 32.2% of males, which was significant. This finding is also higher than found in the Census 2016 (8% females and 20% males). Other demographic factors (age, immigration status, place of residency, marital status and economic status) were not found to have a significant impact in this study.

The NHS defines binge drinking as “drinking lots of alcohol in a short space of time or drinking to get drunk”. Individual tolerances for alcohol will vary, however increased risk of harm from a single drinking session has been suggested to be above consumption of 5-7 units.

Respondents who reported consuming alcohol were asked how often they drank six or more units of alcohol on a single occasion, a measure of binge drinking. (see **Figure 30**). Males were significantly more likely to engage with binge drinking and more frequently, on a weekly or daily basis, compared to females.

**Figure 30: Respondents self-reported excessive alcohol consumption**



Respondents were asked if they perceived their current level of alcohol intake to be harmful to their health. A large proportion of survey respondent opted not to answer the question but of the 358 who did, 70.1% said no, 13.7% yes and 13.7% were unsure. Males had a significant tendency to be less aware of the harmful effects of excessive alcohol consumption.

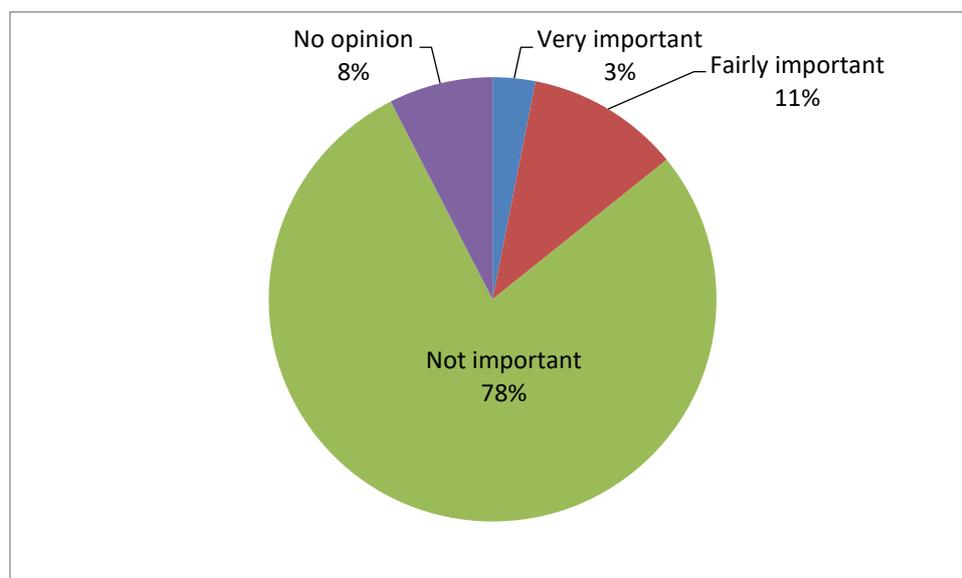
## 9. Sunbathing and Sunburn

Cancer Research UK advise that too much ultraviolet (UV) radiation from the sun or sunbeds is the main cause of skin cancer. Skin cancer is the commonest cancer in many countries worldwide, including the Falkland Islands. Simple precautions can ensure that you can enjoy the sun safely, reducing skin cancer risk and have sufficient exposure to ensure adequate production of vitamin D. Which can be achieved by short bouts of exposure while making sure not to burn.

Vitamin D is essential to help build and maintain strong bones and teeth. It is unusual compared to other vitamins, as our main source is via exposure to sunlight rather than dietary sources. However, it was recognised by SACN (Scientific Advisory Committee on Nutrition) in 2016 that dietary guidelines should also be revised to include dietary intake for everyone. The new guideline is 8.5 -10µg/daily for infants 0 – 1 years and 10µg/daily for everyone else from food or supplements.

Respondents were asked how important a suntan was to them, overall 78.3% indicated a suntan was not personally important to them, with 14.2% indicating it was very or fairly important to them (see **Figure 31**).

**Figure 31: Importance of a suntan**



Usage of sunbeds currently or in the past was only indicated by 2% of respondents.

Factors that are advised by Cancer Research UK to minimise risk for skin cancer are:

Being aware:

- Get to know how your skin reacts to sun – if you have fairer skin you can see the damage, skin turning pink or red. If you have darker skin it might feel irritated, tender or itchy.

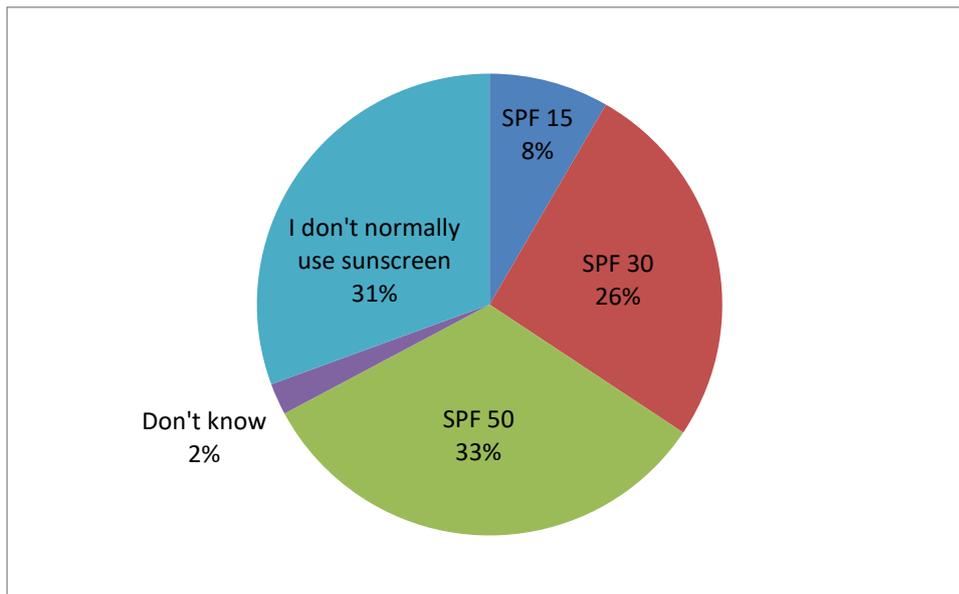
- Keep a check of the UV index, the higher the index the greater the risk. If the UV index is 3 or higher, take precautions to protect your skin.

Enjoying the sun safely:

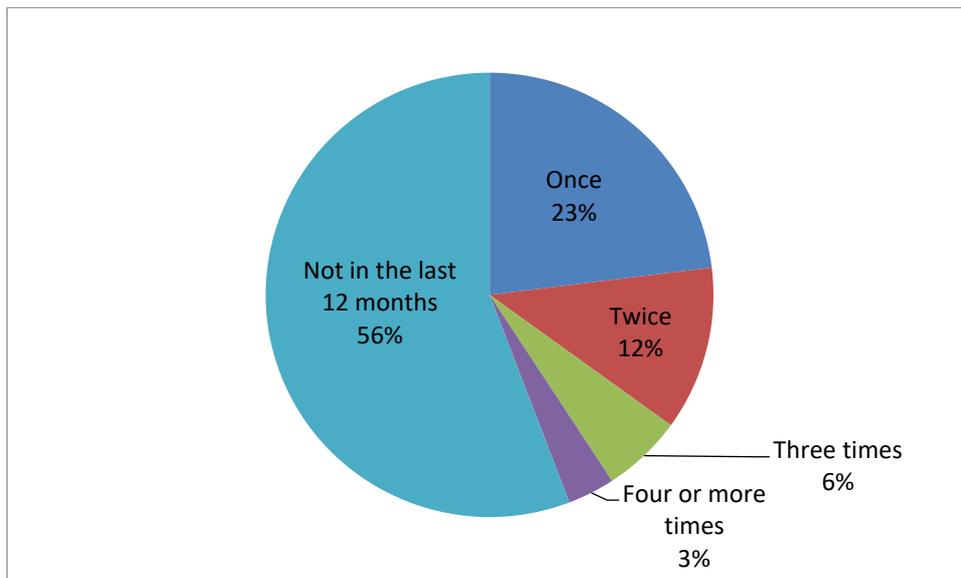
- Wear a hat to shade your face and long sleeves to protect your arms.
- Wear sunglasses to protect your eyes. Wraparound styles work best.
- For any areas where you can't cover your skin ensure you use a sunscreen of SPF15 or higher with 4 or 5 stars. Put plenty on and reapply regularly.
- If possible stay out of the mid-day sun, if not possible ensure use of sunscreen and cover up as much as possible
- Ensure babies are protected from sunburn at all times, babies under 6 months should be kept out of direct sunlight.

Respondents were asked if they used a sunscreen and what factor if so (**Figure 32**), and if they had been sunburnt during the past 12 months (**Figure 33**). Almost a third (31%) of respondents reported not using a sunscreen. 44% of the respondents had experienced sunburn on one or more occasions in the previous 12 months.

**Figure 32: The use of sunscreen**



**Figure 33: Number of occasions of sunburn in the last 12 months**



To gain an understanding of respondents' awareness of skin cancer prevention, questions were asked about how important they believed certain known preventative actions to be, with four options for response (very important, fairly important, not important, no opinion). Some respondents chose not to answer all or some of the questions therefore limited conclusions can be drawn. The responses from those that did answer can be seen in **Figure 34**.

**Figure 34: Awareness of action to prevent skin cancer**

