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Preface

It is hard to believe that seven years have passed since the first ever Health and Lifestyle Survey of Gibraltar’s adult population was conducted in 2008 and that it has been possible to do it all over again. Yet, this report is proof of that and presents the findings of the second Health and Lifestyle Survey of Gibraltar’s adult population, conducted during February 2015.

The Gibraltar Health & Lifestyle Survey of 2008 was a landmark event and repeating it is no less one. However, as pointed out in the first Report, population surveys are expensive exercises and it is reassuring that the Government has invested again in this important initiative to understand better the health of our people. Indeed, the Minister’s announcement of a second survey in the Budget Speech of 2014 came just a year after the first survey was published.

This Report builds upon the previous one. From the outset, the goal of the Survey was not just to capture another snapshot of the health of the local population, but to make comparisons wherever possible with the previous one and identify any trends over time. For this reason, the study methodology was kept as close to the first Survey as possible – the questionnaires were designed to be almost the same, the survey procedure was identical and the statistical interpretations were tuned with this purpose in mind.

The first Survey was ambitious in its scope and size, but this second one included more questions and more choices. All in all, over 24,000 separate pieces of data were captured and analysed. However, unlike the first Survey, which took over five years to process and report, this one has achieved the same in 18 months.

It is also intended that this Report should shadow that of the first survey as closely as possible to enable comparisons to be made. Hence, the Report is similarly organised into five parts: Part One explains how the Survey was done and validated; Part Two discovers the key findings across different lifestyle topics; Part Three explores the relationships between the topics for insights on whole lifestyles; Part Four compares Gibraltar’s position internationally, and finally Part Five brings together the substance of the Report. The Appendix carries a few notes on methodology and the Questionnaire itself.

This Report has been deliberately written for a wide audience, from scientists to casual readers. However, efforts have continuously been taken to ensure that scientific rigour is not sacrificed in the pursuit of an easy readable style.

It is hoped that this Report will not only be informative and educational in itself, but also enable informed decision making and purposive action to improve the health and lifestyle for all of Gibraltar’s people.

Dr Vijay Kumar
Director of Public Health
Gibraltar Health Authority

Foreword

Gibraltar’s second Health and Lifestyle Survey makes fascinating reading, especially for those of us with a particular interest in the health and well-being of our community. The information it contains gives an insight into how we live, but also challenges the very way in which we carry out our day-to-day activities. But it should also encourage us to improve, as a community and also as individuals, who daily make individual choices about what we do.

The most worrying, and quite surprising result of the Survey, is the fact that smoking prevalence has increased in Gibraltar, whereas in all other countries compared it has either stayed static or decreased. This is especially surprising as no one is today in any doubt at all as to the harmful effects of smoking. Fortunately, recent laws on smoking in enclosed spaces, and most recently in cars, do mean that those who don’t wish to smoke are much less exposed to the dangers of passive smoking, but the primary smoker is still a problem, and more importantly, still has a serious problem. This is one of the challenges that we need to overcome, and we must look at ways of discouraging smoking, especially among youngsters where the habit often starts.

Other challenges, again nothing new, include diet and exercise.

Ultimately we all make our individual choices, and the stresses of everyday life are not always conducive to our making the right ones. But this Survey provides us with the information, and challenges us all to do our best to improve our health and that of our families. For we are people and not statistics, and we must do all we can to live better, live longer, and be happier.

With very best wishes

Dr John Cortes
Minister for Health, the Environment, Energy and Climate Change
PART ONE

The Survey
1.1 Background

1.1.1 During March 2015, the Gibraltar Health Authority carried out its second Health and Lifestyle Survey of the local population. The first ever Health and Lifestyle Survey was conducted in 2008. Such surveys are sometimes conducted every year or two in large countries such as the UK, but for Gibraltar, a survey every five years is adequate.

1.1.2 The survey was designed, managed and analysed by the Public Health Department of the GHA, supported by fieldwork undertaken by Copywrite and data input provided by Micro Business Systems, both being locally-based commercial firms.

1.2 Report Contents

1.2.1 This Report presents the findings from the 2015 Survey and provides an insight into the health and lifestyle habits of the people of Gibraltar. The findings have been analysed and put into context, so that comparisons could be made in relation to the 2008 survey and other findings. Each chapter highlights the key points for easy reading.

1.2.2 Just as in the 2008 survey report, the findings here are also compared with countries close to Gibraltar, in terms of proximity and culture. International comparisons enhance the value of the Report, as Gibraltar can be viewed in context, in relation to its neighbours and peers.

1.2.3 It should be emphasised that this is a survey-based research project which closely follows 2008 procedures on a small sample of the population. This sample is used to estimate and predict the behaviour of the population as a whole. This means that there is room for error or ambiguity and therefore just as in 2008 these findings are only presented as a guide.

1.2.4 The volume of data generated by such surveys is vast and therefore quite deliberately, summaries have been added to each chapter and together with an end of Report summary to facilitate understanding and assimilation.

1.2.5 Finally, there are appendices with notes on the methodology applied, the Questionnaire employed and the References used.
2.1 Overview

2.1.1 The Gibraltar Health and Lifestyle Survey 2015 is the second survey of its kind conducted in Gibraltar, following on from the Health and Lifestyle Survey of 2008. The survey, like its predecessor, was aimed at understanding the perceived levels of health in the Gibraltar people and gathering data on lifestyle parameters. However, it had an additional purpose, to discover any time trends in the subjects studied.

2.1.2 The survey randomly selected 777 adult residents in Gibraltar via the Gibraltar Electoral Register, about 3% of the population. Trained surveyors were recruited to administer 20 minute face to face questionnaire to each respondent at their doorstep, but without any identity details being recorded.

2.1.3 The proportion of people who responded to the survey was more than 50% of the sample that was selected. Overall, females were over-represented in the sample (18% more than men), while the youngest age groups were under-represented.

2.2 Target Population

2.2.1 The target population is the term given to the population being studied, which in this case, is the adult population (persons of age 16 and over) of Gibraltar. The exact count of the population is unknown between censuses and therefore estimates were calculated.

2.2.2 The most recent actual count of the resident population is from the 2012 Census. As the survey was carried out in March 2015, it was desirable that figures were used as denominators should be more recent if possible. At the time of analysis, the Gibraltar Government Statistics Office had not published estimates for 2014 and therefore, figures from their publication “Abstract of Statistics 2013” were used to construct estimates. The numbers for each of the age and sex based sub-groups of the population were estimated by applying the proportional distributions of the 2012 Census to the estimated population for 2013.

2.2.3 Figure 2-1 shows the distribution of the total population figure for 2013. The total for The Target Population, that is, all adults aged 16+, was calculated to be 26,397.

Figure 2-1

<table>
<thead>
<tr>
<th>2013 Estimated Adult Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
</tr>
<tr>
<td>16-24</td>
</tr>
<tr>
<td>25-44</td>
</tr>
<tr>
<td>45-64</td>
</tr>
<tr>
<td>65+</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
2.2.4 To obtain a representative sample of this large population, the Electoral Register was used to pick out randomly the desired number of persons (777), just as in the previous Survey.

2.3 Data Collection and Response

2.3.1 The survey consisted of a 20 minute face-to-face questionnaire to be administered at the respondent’s home and each selected person was invited to take part in it. The entire field work was carried out by Copywrite, a Gibraltar-based commercial company, using six trained surveyors over a period of eight weeks. Of the adults selected, 414 returned survey forms, of which 406 were useful for the analysis. This represents a response rate of 52.3%, which is only marginally less than that of the previous survey, which had 55.8%. However, by a coincidence, the exact sample count (406) is identical to that of the previous survey. In fact, Copywrite submitted another eight survey returns, but these arrived too late for inclusion in the analysis.

2.3.2 In social surveys, responses of around 50% are considered very good as there are many reasons why some people do not respond. The reasons for the failure in this survey are summarised in the table below.

<table>
<thead>
<tr>
<th>Response Categories</th>
<th>No.</th>
<th>(%)</th>
<th>Exist</th>
<th>Present</th>
<th>Able</th>
<th>Willing</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Reply after four tries</td>
<td>210</td>
<td>27.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Passed Away</td>
<td>18</td>
<td>2.3%</td>
<td></td>
<td></td>
<td>No</td>
<td>(2.3%)</td>
</tr>
<tr>
<td>Doesn’t live there anymore</td>
<td>77</td>
<td>9.9%</td>
<td></td>
<td></td>
<td>(27%)</td>
<td></td>
</tr>
<tr>
<td>Abroad</td>
<td>15</td>
<td>1.9%</td>
<td></td>
<td></td>
<td>(11.8)</td>
<td></td>
</tr>
<tr>
<td>Prison</td>
<td>2</td>
<td>0.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unattempt due to time &amp; surveyor limitations</td>
<td>14</td>
<td>1.8%</td>
<td></td>
<td>Yes</td>
<td></td>
<td>(2.6%)</td>
</tr>
<tr>
<td>Change of use to office</td>
<td>3</td>
<td>0.4%</td>
<td></td>
<td></td>
<td>Yes</td>
<td>(4.1%)</td>
</tr>
<tr>
<td>Disabled</td>
<td>1</td>
<td>0.1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal</td>
<td>25</td>
<td>3.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unwell</td>
<td>5</td>
<td>0.6%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working late</td>
<td>2</td>
<td>0.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Successful</td>
<td>406</td>
<td>52.2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3.3 The largest category of failed responses were those households where there was no reply despite having tried four attempts at different times and dates to contact the person selected.

2.4 Data Entry, Processing, Validation and Analysis

2.4.1 As in the previous survey, the completed questionnaires were scanned by Micro Business System using optical mark recognition technology for Data Entry and entered into a spread sheet ready for analysis. Quality control checks were successfully undertaken, to match the scanned results against field responses as well as manually coded samples.
3.1 Purpose

3.1.1 Sample surveys are a means of collecting information from a subset of the population and use this information to make interpretations of the whole population, without having each individual completing the survey. Therefore it is very important that the sample reflects the true characteristics of the population as closely as possible.

3.1.2 Random sampling is one way of ensuring that the persons selected for the questionnaire are representative of the whole population. If all 100% of the persons selected had responded to the survey, then the data would be truly representative. The survey response was 52% meaning that 48% of those invited did not respond.

3.1.3 It is possible to make statistical adjustments to make up for the deficit. The key element is to ensure that whatever the sample, its structure is near identical to the target population, so that the respondents are truly representative of the whole population.

3.2 Population Structure

3.2.1 In reality there are certain subgroups within most populations who are less likely to respond to surveys than others. For example, younger people are often less responsive than older people and men are generally less responsive than women. A sample that closely matches the structure of its target population is more likely to yield trustworthy results.

3.2.2 For the Gibraltar Health and Lifestyle Survey 2015, the same structure as the 2008 Health and Lifestyle Survey was adopted so that the results would be comparable. The age and sex of respondents was used to estimate the representativeness of the sample. Figure 3-1 below compares the age/sex profile of the sample with that of the total population.

Figure 3-1

<table>
<thead>
<tr>
<th>Sex-Age</th>
<th>Gibraltar 2013 Population</th>
<th>Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults (%)</td>
<td>Respondents (%)</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-24</td>
<td>1,903 7%</td>
<td>13 3%</td>
</tr>
<tr>
<td>25-44</td>
<td>4,335 16%</td>
<td>36 9%</td>
</tr>
<tr>
<td>45-64</td>
<td>4,436 17%</td>
<td>61 15%</td>
</tr>
<tr>
<td>65+</td>
<td>2,397 9%</td>
<td>57 14%</td>
</tr>
<tr>
<td>All Males</td>
<td>13,070 50%</td>
<td>167 41%</td>
</tr>
<tr>
<td>Total</td>
<td>26,397 100%</td>
<td>406 100%</td>
</tr>
</tbody>
</table>

03 Data Validation
3.2.3 At a glance it is possible to see that the percentage columns for the sample population and the total population are roughly similar.

3.2.4 There are some important differences that need to be taken into account. In Gibraltar 50% of the total population is male, and 50% is female. The sample on the other hand, over-represents females and under-represents males (59% and 41% respectively).

3.3 Response Weighting

3.3.1 The differences in the age/sex distributions can become a problem when analysing the data because if the raw data is analysed exactly as it is, then it is clear that the responses given by certain groups will over-represent the true picture for the population, while others will under-represent it.

3.3.2 As in 2008, statistical “weights” were used with the data, enabling some responses to count for more than others and vice versa. This means, for example that the actual responses given by each female aged 45-64 will count slightly less and those given by each male 45-64 will count slightly more, restoring the balance in the overall response.

3.3.3 Weights calculated for the differences in age and sex structure between the population and the sample are shown in the table below. Most of the weights required to adjust each age/sex category are actually quite small (less than 2), suggesting good quality in the survey data.

<table>
<thead>
<tr>
<th>Weights</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>2.3</td>
<td>1.7</td>
</tr>
<tr>
<td>25-44</td>
<td>1.9</td>
<td>1.1</td>
</tr>
<tr>
<td>45-64</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>65+</td>
<td>0.6</td>
<td>0.7</td>
</tr>
</tbody>
</table>

3.3.4 Data has been weighted for the age and sex distribution of the population throughout all the analysis. The weighting process enables the results provided to be used as estimates for the whole population. The assumption made is that the population is accurately represented in the weighted sample and that the sampling procedures will have a small margin of error.

3.4 Testing

3.4.1 In order to make meaningful and accurate explanations on the analysis, significance testing was used at a 95% confidence interval. Such testing allows results to have statistical reliability.
4.1 Introduction

4.1.1 The survey gathered information about the respondent’s demographic data such as age, sex, marital status, housing type and employment status. This chapter analyses the population in respect of some of these socio-demographic parameters.

4.1.2 This data is also compared to the information published by the Government of Gibraltar Statistics Office for the whole population in the form of the 2013 Abstract of Statistics.

4.1.3 Slight discrepancies may be noticed in some totals presented due to rounding.

4.2 Age and Sex

4.2.1 Figure 4-1 below shows 2013 population estimates against the number of respondents for the survey. The survey sample has been weighted using the process described in the previous chapter to obtain altered counts and proportions to balance the data.

4.2.2 These weighted figures are set against the actual population to demonstrate that the proportions of persons in each age/sex category in the survey sample are the same i.e. the difference is 0%.

4.2.3 Figure 4-2 displays the proportion in each age group.

<table>
<thead>
<tr>
<th>Sex-Age</th>
<th>Gibraltar 2013 Population</th>
<th>Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adults (%)</td>
<td>Actual (Weighted)</td>
</tr>
<tr>
<td>Males</td>
<td></td>
<td>Males</td>
</tr>
<tr>
<td>16-24</td>
<td>1,903 7%</td>
<td>13 (29)</td>
</tr>
<tr>
<td>25-44</td>
<td>4,335 16%</td>
<td>36 (67)</td>
</tr>
<tr>
<td>45-64</td>
<td>4,436 17%</td>
<td>61 (68)</td>
</tr>
<tr>
<td>65+</td>
<td>2,397 9%</td>
<td>57 (37)</td>
</tr>
<tr>
<td>All Males</td>
<td>13,070 50%</td>
<td>167 (201)</td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td>Females</td>
</tr>
<tr>
<td>16-24</td>
<td>1,783 7%</td>
<td>16 (27)</td>
</tr>
<tr>
<td>25-44</td>
<td>4,364 17%</td>
<td>61 (67)</td>
</tr>
<tr>
<td>45-64</td>
<td>4,244 16%</td>
<td>95 (65)</td>
</tr>
<tr>
<td>65+</td>
<td>2,936 11%</td>
<td>67 (45)</td>
</tr>
<tr>
<td>All Females</td>
<td>13,327 50%</td>
<td>239 (205)</td>
</tr>
<tr>
<td>Total</td>
<td>26,397 100%</td>
<td>406</td>
</tr>
</tbody>
</table>
4.3 Marital Status

4.3.1 Figure 4-4 shows the breakdown of respondents by marital status and compares them to the whole population. The proportions taken from the 2012 Census are applied to the (estimated 2013) population figure to provide the number of persons in each marital status group.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Population</th>
<th>Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. adults</td>
<td>% of population</td>
</tr>
<tr>
<td>Married</td>
<td>14,476</td>
<td>55%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>30</td>
<td>0%</td>
</tr>
<tr>
<td>Single</td>
<td>7,533</td>
<td>29%</td>
</tr>
<tr>
<td>Divorced</td>
<td>2,576</td>
<td>10%</td>
</tr>
<tr>
<td>Widowed</td>
<td>1,812</td>
<td>7%</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>26,397</td>
<td>100%</td>
</tr>
</tbody>
</table>

4.3.2 There are slight differences in the way data is collected in the Census compared to the survey, for example, the 2012 Census did not collect information on unmarried people who were living together, whereas the survey did.

4.3.3 Despite that, there are only slight differences in each of the categories, and it is possible that even these could have been due to not categorising persons who cohabit.

4.3.4 The overall difference in 2015 is 0% whereas the marginal difference in 2008 was 4%. This shows that the Health and Lifestyle 2015 represents the population very well in respect of the data for marital status.

4.3.5 Figure 4-5 shows the proportion of survey respondents in each marital status visually, in the form of a pie chart.
4.3.6 When compared with the findings of the 2008 Survey, these figures seem to suggest that the proportion of married respondents has gone down while those who are cohabiting and divorced have increased.

4.4 **Employment Status**

4.4.1 The Census 2012 data differs too much from the survey data and therefore direct comparisons of the sample proportions to the population proportions cannot be made.

4.4.2 Figure 4-6 shows the proportion of survey respondents in each employment status.

4.4.3 These employment states have been categorised into “Economic Status” (i.e. Economically Inactive, Employed and Retired) so that the data is comparable to the Health and Lifestyle Survey 2008.

4.4.4 The Economic Status is categorised in Figure 4-7 and the proportion of survey respondents is shown on the chart.

4.4.5 Nearly two thirds (63%) of the respondents were employed at the time of the survey compared to 54% in 2008. Retired persons comprised of 27% and only 8% were economically inactive, in comparison to 25% and 17% respectively in 2008.

4.5 **Housing Type**

4.5.1 The data categorisation used for residence follows that of the Health and Lifestyle Survey 2008 and the 2012 Census. One piece of information collected was “co-ownership”, i.e. ownership equity shared with government. For analysis purposes, this group was added to the Own Home category to allow meaningful comparisons between the population and the sample proportions.

4.5.2 Figure 4-8 shows the breakdown estimates for each housing type by population compared to the survey sample.

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>Gibraltar 2013 Population</th>
<th>Survey Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own Home</td>
<td>13,042</td>
<td>218</td>
</tr>
<tr>
<td>Government housing</td>
<td>9,861</td>
<td>137</td>
</tr>
<tr>
<td>Private rental</td>
<td>3,418</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>77</td>
<td>13</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>26,397</td>
<td>406</td>
</tr>
</tbody>
</table>

4.5.3 In 2008, the proportion of people living in their own homes was 40%, but this rose to 49% in 2013 according to the Census and further rose to 54% in 2015. The total of people living in non-rented property i.e., those living in either government housing or their own home has been remarkably stable at 91% (2008), 86% (2013) and 88% (2015). This suggests that the increase in own homes has come almost entirely from people who have moved away from government housing.

4.5.4 The proportion of people who are living in privately rented accommodation and other properties has remained stable at around 9% between the two surveys.

4.5.5 Figure 4-9 shows the proportion of respondents who live in each housing type.
4.6 Summary

4.6.1 A combination of random sampling, good response rate and respondent weighting, show that the sample data closely resembles the total population.

4.6.2 Respondents analysed by age and sex match exactly with the population when an appropriate weighting is applied to adjust for sampling variation.

4.6.3 There are some differences in the data. The survey sample differs from the resident population in marital status. The survey sample slightly under-represents married persons.

4.7 Conclusion

4.7.1 The sample taken from the survey has demonstrated to be highly representative of the total population of Gibraltar and therefore its findings may be confidently used to describe the Health and Lifestyle of the people of Gibraltar in 2015.
PART TWO
General Findings
5.1 Introduction

5.1.1 This section covers the general health of the population. It is based on the response to four questions. The questions are very similar to those used in 2008 and this was done deliberately to enable comparisons and trend assessments to be made.

5.1.2 The four questions in the survey asked the respondents:

- to describe their general health in the form of five choices: very good, good, fair, bad and very bad. Respondents were left to interpret their health in whichever way they wanted.
- if they had any long-standing illnesses, disabilities or infirmities. Respondents were given seven different choices and they were also able to specify their illness or disability or infirmity if it was not on the list.
- which clinics they had attended within the last 3 years. This could give an insight into how cautious people are about their health.
- about their weight, whether they thought they were about the right weight, overweight or underweight. Respondents’ height and weight measurements were also taken, allowing the BMI to be calculated and making it possible to compare perceived body weight against actual weight.

5.2 Self-Reported General Health

5.2.1 Figure 5-1 below shows the proportions of all respondents that selected each of the five response categories.

5.2.2 A total of 77% of respondents described their health as good or very good and 16% described it as fair. This means that very slightly more respondents described their health as very good or good in comparison to 2008 (74%) and fewer respondents chose to describe it as fair compared to 2008 (19%). A very small proportion of respondents (5%) described their health as bad or very bad. This was very similar to 2008 (6%). This shows a remarkably stable trend. It can be confidently stated that more than three quarters of Gibraltar adults feel good about their health.

5.2.3 The same figures are analysed by gender in Figure 5-2.
5.2.11 Those aged 65+ differ slightly when rating their general health. Fewer respondents (57%) said their health was good or very good and 10% said their health was bad or very bad in comparison to none in the 16-24 category, 2% in 25-44 and 7% in those aged 45-64.

5.2.12 Figure 5-4 shows how the respondents in each marital status group rate their health.

5.2.13 The most striking finding is that 15% of widowed persons rate their health as bad or very bad, which is more than any other group. This group also had fewer persons declaring their health to be Good or Very Good. This could be largely due to the fact that many persons who are widowed are also older, i.e. being over 65.

5.2.14 In 2008 persons cohabiting did not rate their health as well as the married persons, but in 2015, their responses are very similar. However, none of the cohabiting respondents rated their health as bad or very bad, unlike 6% of married persons. Single persons were the most likely to rate their health as very good, reflecting the fact that most of these were young people.

5.2.15 Overall, self-reported health shows a downward gradient among the various marital status groups in the order: Single, Cohabiting, Married, Divorced and Widowed.

5.2.16 Figure 5-5 shows how the respondents in each economic status rate their health.

5.2.17 The proportion of respondents who are likely to say their health is Very Good or Good decreases gradually with age, from 86% of 16-24 year olds to 57% of those aged 65+. This is comparable to the results in 2008 where 83% of respondents aged 16-24 rated their health as very good and 51% in those aged 65+. Respondents under the age of 45 seem to rate their health better than those in 2008.

5.2.18 None of those aged 16-24 rated their health bad or very bad.

5.2.19 The proportion of the respondents who rated their health as Bad or Very Bad increases with age, from 2% in those aged 25-44 to 10% in those over 65.

5.2.20 Figure 5-3 shows that around 80% of all the respondents up to the age of 64 say their health is good or very good. This was the case in 2008.
5.2.17 Just as in 2008, retired persons were less likely to rate their health as Very Good or Good, when compared with the employed or the economically inactive. Age is likely to be as significant a factor as household income in accounting for these results.

5.2.18 As in 2008, there was no significant difference in self reported health between the employed and economically inactive groups, which is somewhat at odds with findings from larger countries. This perhaps reflects Gibraltar’s unique society.

5.2.19 There is a higher percentage of persons who rate their health as bad in the economically inactive category when compared to the employed. This may represent the subgroup who are economically inactive due to illnesses or disabilities.

5.2.20 Figure 5-6 shows the respondents’ self-reported general health by their type of housing.

5.2.21 Those living in their own home are more likely to rate their health as very good in comparison to government housing and private rentals.

5.2.22 A rating of Very Good or Good is equally likely (about 80%) to be given by persons living in own accommodation or private rental, but slightly less (about 74%) by those in government housing. Respondents from all three housing types reported similar rates for a fair level of general health. Thus, it does not appear that type of housing has a marked influence on self-reported health.

5.2.23 Persons living in government housing are more likely to rate their health as bad (7%), as against those in government housing (4%) and private rental accommodation (0%).

5.3 Long Standing Illnesses/Disabilities/Infirmities

5.3.1 The 2008 survey had an open-ended question asking respondents what they thought made them ill, but this proved not only difficult to analyse and interpret but also did not deliver insights to a level of precision that would be meaningful. This question was therefore dropped.

5.3.2 This Survey introduced two new questions, the first of which aimed to obtain a general insight into the prevalence of common health problems. It asked respondents if they had any long term illnesses/disabilities/infirmities. It gave each respondent 8 options: Diabetes, Autoimmune, Mental Health, Respiratory Condition, Heart Disease, Hypertension, Arthritis and Other so that they could select an appropriate option and/or specify one of their own.

5.3.3 Figure 5-7 shows all respondents results on any illnesses/disabilities/infirmities.

5.3.4 The top four illnesses mentioned by respondents were Hypertension (12.5%), Arthritis (10.0%), Diabetes (9.5%) and Respiratory conditions (8.1%). Other illnesses mentioned by respondents were high cholesterol, thyroid and joint problems.

5.3.5 Over half of the respondents didn’t answer this question, this could be largely due to the fact they didn’t have any illness, disability or infirmity.

5.3.6 Clearly there are limitations in using a social survey for medical measurements, but it does give an insight into where further research might be warranted. For example, the UK prevalence of hypertension is around 30% and the finding in this survey needs to be explored further to see if it represents an over/under estimate prevalence in Gibraltar or is merely a data aberration.

5.4 Clinics Attended

5.4.1 The second new question integrated into the questionnaire this year asked respondents what preventive care clinics they had visited over the past three years. The options listed were clinics for Blood Pressure check, Dental check, Eye check and Well Woman Clinics.

5.4.2 Once again, the purpose of this question was to obtain a general insight into the usage of preventative health care services.

5.4.3 Figure 5-8 shows all respondents attendance to these clinics.

5.4.4 Dental check was the most popular reason among all respondents for visiting a clinic, followed by blood pressure check and eye check. The relatively low proportions of women attending Well Woman clinics was somewhat surprising.

5.4.5 Figures 5-9 and 5-10 show the results split by sex.
5.6 Key Findings

5.6.1 More than three quarters (77%) of all respondents rated their health as good or very good in the survey, and just 5% reported their health as bad or very bad. These figures seem a slight improvement over the results of the 2008 survey (which had 74% and 6% respectively), but they are not statistically significant.

5.6.2 While men and women, for the most part, gave similar responses, there was a minor difference between men and women in how they view their own health in that males were more likely to rate their health as Very Good, whereas women were more likely to rate it as Good.

5.6.3 The proportion of respondents who are likely to say their health is Very Good or Good decreases gradually with age. Of those aged over 65 years, only 57% reported their health as good or very good in comparison to around 80% of people in other age groups. Respondents under the age of 45 seem to rate their health better than those in 2008.

5.6.4 Among the various marital status groups, self reported health shows a downward gradient in the order: Single, Cohabiting, Married, Divorced and Widowed. Widowed persons are more likely to rate their health as bad or very bad, possibly related to the fact that they could also be older.

5.6.5 Retired persons are less likely to report their health as very good in comparison to those who are employed or economically inactive. They mostly rate their health as fair.

5.6.6 Those who are employed are significantly less likely to report their health as bad compared to other groups. Like in 2008, there was no significant difference in self reported health between the employed and economically inactive groups, perhaps reflecting Gibraltar’s unique society.

5.6.7 Those living in their own home are more likely to rate their health as very good in comparison to government housing and private rentals. It does not appear that type of housing has a marked influence on self-reported health.

5.6.8 Summarising the findings on self-reported general health, it appears that respondents who are younger, who are single, who are employed or who live in their own home are most likely to rate their health as very good or good.

5.6.9 In contrast, respondents who are over 65, who are widowed, who are retired or who are living in government housing are most likely to report their health as bad or very bad.

5.6.10 Hypertension is the most common illness reported by those respondents who have an illness, disability or infirmity.

5.6.11 Arthritis and Diabetes were the second most common illness reported.

5.6.12 Two-thirds of all respondents undertake Dental check-ups but only half of the women attend Well Woman clinics.

5.6.13 Women appear to visit more clinics than men.

5.6.14 Looking at perceptions of body weight, as in previous surveys, half of the respondents said they were about the right weight for their height.
6.1 Introduction

6.1.1 In 2008, the World Health Organisation (WHO) estimated that 1.5 billion adults aged 20 and over (35% of the world’s adult population) were Overweight. In 2014, these were revised to more than 1.9 billion adults aged 18 years and older (38% of the world’s adult population). Of greater concern is the proportion of these that are Obese. In 2014, the WHO estimated that 10% of the world’s adult population was obese, but in 2014, this too has risen to 13%.

6.1.2 In 2014, more than half (53%) of the adult population in the European Union (EU) reported being overweight or obese, and obesity currently affects one in six adults (16.7%). In England in 2013, the equivalent figures were 62% overweight and 25% obese. The 2011-2013 Health Survey for England showed that 66.2% of men and 57.6% of women are overweight or obese. Estimates indicate that by 2034, 70 per cent of adults in the UK are expected to be overweight or obese.

6.1.3 Obesity is associated with numerous health issues, including heart disease, type2 diabetes, musculoskeletal disorders, cancers, depression and anxiety.

6.1.4 The meanings of the terms Overweight and Obese are shown in the Table below and further explored in this section.

6.1.5 Being overweight or obese increases a person’s risk of suffering several illnesses, including hypertension, cardiovascular disease, diabetes, arthritis, mental illness and some cancers. For example, the English Survey found that obese adults had about twice the prevalence of hypertension compared with adults who were in the normal range. In the long term, reduced life expectancy is likely and this is estimated by UK government studies to be by an average of around 11 years.

6.1.6 Severely obese individuals are three times more likely to require social care than those with a normal weight. This results in increased risk of hospitalization and associated health and social care costs. In addition to personal burden, obesity has a direct impact on national health costs. In the UK, obesity is estimated to cost the NHS £4.2 billion a year. This is approximately 10% of the total healthcare expenditure in the UK. This figure is expected to reach £9.7 billion by 2050.

6.1.7 The Health and Lifestyle Survey collected height and weight data from respondents so that each person’s Body Mass Index (BMI) could be calculated. This chapter examines the results.

6.2 Body Mass Index (BMI)

6.2.1 The Body Mass Index (BMI) is a simple but very useful tool that measures a person’s body weight in relation to his or her height, so tall or short persons can be adjusted for appropriately, giving some independent value to the measured weight. A detailed explanation of how BMI is calculated is given in the Appendix.

6.2.2 The BMI has an additional value, in that it can also be used as a proxy for measuring a person’s body fat and consequently, for classifying people into categories of weight imbalance that correlate to health and disease. This allows underweight, overweight and obese people to be identified. The BMI scores that define these categories are detailed in Figure 6-1 below.
6.2.3 In the survey, height and weight measurements of respondents were recorded. However, a small number of respondents were unable or unwilling to state one or both of these measurements. To compensate for this, responses were weighted to allow for the non-response and the consequent under-representativeness of the survey. The weighting used in this section is slightly different to that used elsewhere in the survey – this is to account for the slightly large amount of non-response.

6.2.4 As in the last survey, there may be specific reasons why some people were unable or unwilling to give their height or weight measurements and it is possible that these are the respondents at either end of the scale (i.e. underweight or obese). Therefore, there may be a small amount of non-response bias inherent in this chapter and those who are underweight or obese could be truly under-represented in the data.

6.2.5 Individual BMIs were calculated for those whose height and weight measurements were available. Figure 6-2 shows the proportion of respondents in each BMI category.

6.2.6 Figure 6-2 shows that 59% of respondents are classed as overweight or obese, of whom 24% are classed as obese and 35% overweight. These are very similar to 2008 figures.

6.2.7 Just 41% are considered to have a normal weight. There were no respondents who were underweight.

6.2.8 Figure 6-3 shows the difference in BMI categories by sex.

6.2.9 There is quite a difference between men and women. Nearly two-thirds (63%) of men are overweight or obese, while just over half of women (55%) are. This is not a significant difference.

6.2.10 There is a small difference in the sexes among those who are obese, with 23% of men compared with 25% of women, but this difference is not significant.

6.2.11 The percentage of obese women has increased from the last survey, from 20% in 2008 to 25% this year. Again, while a trend can be imagined from this, the figures themselves are not statistically significant.

6.2.12 Figure 6-4 shows the proportion of overweight and obese people in the sample by age group and sex separately.
6.2.13 As in the 2008 Survey, the tendency to be overweight or obese is the lowest among the youngest age group (16-24) for both men and women. However, men seem to become overweight or obese at a younger age than women.

6.2.14 Among men, the increase from the younger age groups to the eldest is hugely significant; nearly a third of men (31%) aged 16-24 are overweight or obese compared to at least 70% in those aged over 45.

6.2.15 This means that 3 out of every 4 men are overweight or obese.

6.2.16 In the last survey no men were obese in the youngest age group compared to 8% this year. This is a huge significance.

6.2.17 Among women, the difference isn’t as great until the age 65 where over 3 quarters of women are overweight or obese.

6.2.18 With the exception of the eldest age group, both the proportion of overweight women and the proportion of obese women increases with age.

6.2.19 In the youngest age group (16-24), 21% of women are overweight or obese. This proportion more than doubles to 46% in those aged 25-44 and increases significantly to 64% of women aged 45-64 and 78% of the eldest women, 65 and over.

6.2.20 Prior to the age of 65, women are much less likely to be overweight or obese than men.

6.2.21 In terms of obesity, nearly half of women (49%) aged 65 and over are obese, whilst just under a quarter of men (24%) are obese. This difference is hugely significant.

6.2.22 Average BMI is similar between men and women. Women have a BMI of 27 kg/m2 while men have a BMI of 28 kg/m2. The differences between the age/sex groups are shown in Figure 6-5.

6.2.23 As in Figure 6-4 there is a clear trend among women of BMI increasing with age, while for men BMI increase up until the age of 64 then decreases for those 65 and over. The results for men differ slightly to those in 2008. Men over 25 years of age stayed at a high “stable” BMI level.

6.2.24 To further demonstrate the relationship between BMI and age, Figure 6-6 plots the average BMI for each age.

6.2.25 Figure 6-6 shows a very strong pattern of BMI increasing with age until the late 70s. The black line shows an upward slope from left to right, demonstrating that as age increases, BMI increases too.

6.3 Obesity and Marital Status

6.3.1 For comparison purposes as in the previous report, the marital status groups have been combined as follows:

- Married and Cohabiting
- Single
- Other – Divorced or Separated, Widowed and Unknown

6.3.2 Figure 6-7 shows the difference in BMI category by each marital state.

6.3.3 As in 2008, single people are the least likely to be overweight (19%) or obese (16%). The proportion of overweight single persons has decreased from the last survey (from 29% in 2008) whereas that of persons with obesity has risen (from 9% in 2008). There is no statistical significance to these observations.

6.3.4 Nearly two thirds (65%) of single people have a normal weight compared to only around a third of those who are married/cohabiting and those divorced/widowed.

6.3.5 Single people have an average BMI of 25, compared to the other groups who have an average of 28. These results are similar to those in 2008.

6.3.6 Overall, single people demonstrate a significantly lower BMI distribution to the other marital states.
6.6 Key Findings

6.6.1 Around 60% of respondents were overweight or obese. This means that 3 out of every 5 Gibraltarians are overweight or obese. This was the same finding in the 2008 survey.

6.6.2 In total, 24% of the sample is obese, compared to 21% in 2008.

6.6.3 There is a difference in obesity levels by gender. About 63% of men are overweight or obese compared to 55% of women, however it is not statistically significant.

6.6.4 Men start to become overweight or obese at a younger age than women. This was also the case in 2008.

6.6.5 Over three-quarters of men are overweight from the age of 45.

6.6.6 In the last survey no men aged below 24 years were obese, whilst in 2015, about 8% of young men below 24 years are obese. This is a hugely significant difference.

6.6.7 In the ages of 65 and above, more than double the women are obese compared to the men (49% vs 24%). This is a huge increase from the previous survey where only 28% of women aged 65+ were obese.

6.6.8 The youngest women are the least likely to be overweight or obese.

6.6.9 There is a very strong pattern that shows BMI increases with age until the late 70s.

6.6.10 Single people are significantly less likely to be overweight or obese than any other marital state.

6.6.11 The economically inactive are the least likely to be obese.

6.6.12 People living in private rental accommodation and those living in their own home are least likely to be overweight or obese.
Diet

7.1 Introduction

7.1.1 The Global Strategy on Diet, Physical Activity and Health published by World Health Organisation (WHO) still holds good as do its key recommendations related to diet. These are:
- Limit energy intake from total fats
- Increase consumption of fruits and vegetables
- Limit the intake of free sugars
- Limit salt consumption

7.1.2 According to the WHO, a healthy diet helps protect against malnutrition in all its forms, as well as non-communicable diseases (NCDs), including diabetes, heart disease, stroke and cancer. Healthy dietary practices have long-term health benefits and are instrumental in reducing the risk of becoming overweight or obese and developing NCDs later in life.

7.1.3 The questionnaires used in the 2015 survey were largely modelled on those used in 2008. The replies given by respondents to questions on eating habits are summarised and presented in this chapter.

7.2 Fruit and Vegetables (5-a-day)

7.2.1 The WHO estimates that insufficient intake of fruit and vegetables causes around 14% of gastrointestinal cancer deaths, about 11% of ischaemic heart disease deaths and about 9% of stroke deaths globally. It recommends a minimum of 400g of fruit and vegetables per day (excluding potatoes and other starchy tubers) for the prevention of chronic diseases and nutritional deficiencies. The UK Department of Health simplifies this message into “Five Portions of Fruit and Vegetables a Day”.

7.2.2 The Health and Lifestyle Survey asked respondents how many portions of fruit and vegetable they normally eat in a day.

7.2.3 The most popular number of portions of fruit and vegetables eaten is five; it was found that 22% of respondents eat their five a day. This is an improvement over the last survey in which the most popular number of portions was two, which might suggest that the public is more aware of the importance of healthy eating.

7.2.4 Figure 7-1 shows the portions of fruit and vegetables eaten by respondents in 2015 compared to 2008.
7.2.5 Figure 7-1 shows that apart from eating 5+ portions of fruit and vegetables each day, all other portions in 2015 were lower than in 2008, however there is no statistical significance in the decrease. The increase from 22% in 2008 for 5+ portions to 31% in 2015 is statistically significant.

7.2.6 On average, respondents eat 3.59 portions of fruit and vegetables a day.

7.2.7 Women are slightly better at eating their fruit and vegetables, shown in Figure 7-2.

7.2.8 Just over a quarter of men say they consume the recommended daily amount of fruit and vegetables (5 or more portions a day), while over a third (35%) of women do so. However, the difference is not significant.

7.2.9 The majority of men (33%) eat just 1-2 portions of fruit and vegetables a day, whilst the majority of women (35%) eat 3-4 portions a day.

7.2.10 On average, men eat 3.3 portions a day whilst women eat 3.8 portions a day. These results were similar to those in 2008.

7.2.11 Figure 7-3 shows respondents who eat less than 5 a day split by age and sex.

7.2.12 About half of all the age groups are not eating the recommended 5 or more portions a day. However, this compares favourably with the 2008 survey, in which three quarters of all age groups were not eating the recommended quantities. Males between the ages of 25 and 44 are most likely to be eating less than 5 portions of fruit and vegetables a day.

7.2.13 Figure 7-4 shows the average portions eaten every day by age and sex.

7.2.14 Females on average, eat more fruit and vegetables on a daily basis than men.

7.2.15 Younger females are more likely to have more portions than older females, ranging from 4.3 to 3.4 in those aged 65 and over, although the difference is not significant.

7.2.16 Men, on the other hand, are stable throughout the age groups, with the exception of 25-44 year olds who, on average, have fewer portions a day.

7.2.17 The average diet of fruits and vegetables in the youngest age group has increased in both sexes from 2008. Men aged 16-24 were eating just 2 portions in the 2008 survey but this group in 2015 reports eating 3.6 portions a day. Similarly, women in this age group have also increased from 3.2 portions to 4.3 portions.

7.2.18 Figure 7-5 shows the number of portions of fruit and vegetables consumed by each BMI category.

7.2.19 There are no major differences between the BMI categories.

7.2.20 People with normal BMI are more likely to consume 5 portions of fruit and vegetable a day, although the difference is not significant.

7.2.21 On average those in the normal and overweight BMI categories eat 3.3 portions a day, those in the obese category eat 3.1 portions a day. Again, this is not statistically significant.
7.3 Bread

7.3.1 Respondents were asked how many times a week they eat wholemeal and white bread. Most of them made multiple choices and therefore not comparable to 2008 results as they only ticked one option.

7.3.2 In the survey, 55% of respondents said they eat wholemeal bread 2 or more times a week and 48% eat white bread two or more times each week.

7.3.3 Of those who have bread, 56% of women and 54% of men have wholemeal bread two or more times a week, whereas men are more likely to have white bread compared to women (50% vs 45% respectively). There is no statistical significance in the difference.

7.3.4 Figure 7-6 shows the regular consumption of bread (two or more times a week) for each age/sex category.

7.3.5 Women in the youngest and eldest age groups are more likely to have wholemeal bread than white bread, whereas, from the age of 25-64 the percentages for both breads look very similar.

7.3.6 Men are also more likely to have wholemeal bread than white bread with the exception of the youngest age group where there is a major difference.

7.3.7 69% of males in the youngest age group (16-24) have white bread compared to only 31% who have wholemeal bread.

7.3.8 Nearly a third (32%) of respondents said they eat wholemeal bread 5 or more times a week, compared to 28% who say they eat white bread 5 or more times a week. This is not significant.

7.3.9 Figure 7-7 shows regular bread consumption (2+ a week) by BMI category.

7.3.10 Wholemeal bread is more likely to be consumed by each BMI category, but the difference is greatest in the obese group where 65% of the group eat wholemeal bread regularly compared to 44% who eat white bread regularly. This is a significant difference. It is not possible to analyse the consumption of all bread because of the way the responses were given.

7.3.11 Figure 7-8 shows bread consumption (5+ a week) by BMI category.

7.3.12 Respondents in the obese and overweight groups are much more likely to have wholemeal bread five or more times a week than white bread.

7.3.13 However, respondents in the normal BMI group are slightly more likely to have white bread than wholemeal bread.

7.4 Breakfast Cereal

7.4.1 The survey asked whether respondents had breakfast cereal and if so which ones.

7.4.2 62% of respondents said they eat one or more types of breakfast cereal.

7.4.3 For the purpose of analysis, cereals have been grouped into 3 categories:
- Wholegrain/High Fibre refers to the cereals with good nutritional content such as porridge oats, muesli, Weetabix, all bran etc.
- Plain refers to the others which are generally neutral in terms of their nutritional content.
- Sugared/Flavoured refers to those cereals with a high content of sugars, salts or additives that are very poor in nutrition, such as Sugar Puffs, Coco Pops, Crunchy Nut, Cornflakes etc.

7.4.4 Figure 7-9 shows the consumption of breakfast cereals for all respondents and by sex. Respondents were able to select more than one cereal so the totals do not add up to 100%.
7.4.5 Nearly half of respondents say they have wholegrain or high fibre cereals, while 17% say they have plain cereals and 5% have sugary cereals. This is a significant improvement over the 2008 figures, in which 36% had wholegrain or high fibre cereals, while 10% had sugary cereals.

7.4.6 Men are more likely to have sugary cereals than women (6% vs. 3%). Women are more likely to eat wholegrain or high fibre cereal (50%) compared to men (45%), whereas men are more likely to have plain cereals (18%) compared to women (15%). However, these are not statistically significant.

7.4.7 Figure 7-10 shows the consumption of breakfast cereals by age.

7.4.8 The proportion of persons consuming breakfast cereals seems to be decreasing with age with only a slight increase in those aged 65 and over. There is a significant difference between the age groups, excluding the difference between 45-64 year olds and 65+.

7.4.9 Figure 7-11 shows the same information by age group.

7.4.10 The unhealthy sugary cereals are much more likely to be eaten by the youngest age group. 25% of those aged 16-24 eat these cereals compared to less than 5% of any other age group. This is a highly significant difference.

7.4.11 This age difference may relate to the way such products are marketed; in general these sugary cereals are aimed at children and young people.

7.4.12 Wholegrain cereals are the most popular among all the different age groups. Plain cereals are most popular with the youngest and eldest age group. These results were similar to those in 2008.

7.5 Spread used on Bread and Oil used for Frying

7.5.1 Respondents were asked which spreads they use on their bread and which oil they used for frying. However, due to the nature of how these questions were answered, there were only a few conclusions that could be made.

7.5.2 Respondents were much more likely to use butter or butter type spreads on their bread compared to the other listed options.

7.5.3 Younger respondents were more likely to use butter/butter type spread compared to the older ones in the survey.

7.6 Fish and Meat

7.6.1 Respondents were asked about their consumption of fish and meat each week, with fish (particularly oily fish), chicken and turkey to be considered healthy and beef, pork or lamb less so.

7.6.2 Over a third of respondents eat oily fish on a regular basis (i.e. 2 or more times a week) and 56% eat other fish regularly.

7.6.3 Of the respondents in the survey, 84% eat chicken or turkey regularly.

7.6.4 Of the respondents, 65% eat beef, pork or lamb regularly. These results are very similar to 2008.

7.6.5 Figure 7-12 shows the regular consumption of fish and meat among men and women. Regular consumption is defined as 2 or more times a week.

7.6.6 Figure 7-12 shows there is very little difference in the eating habits between men and women when it comes to fish and meat.

7.6.7 Figure 7-13 shows the same information for each age group.
7.6.8 Consumption of oily fish is nearly the same at all ages, whereas that of other fish increases with age.

7.6.9 Regular consumption of most meats (chicken, beef, pork or lamb) appears to decrease with age. Bacon is consumed significantly only by the youngest age group and appears to recede in popularity thereafter.

7.6.10 Figure 7-14 shows the same information for each BMI category.

7.6.11 Respondents who are overweight have the highest percentage of fish and meat consumption, followed by respondents with normal BMI and then respondents who are obese.

7.6.12 Of those who are overweight, 40% eat oily fish at least twice a week compared to 36% who are obese and 34% who have normal BMI. There is no statistical difference.

7.7 Sweets, Chocolate, Crisps, Fried Food and Sugary Drinks

7.7.1 Respondents were asked about their consumption of some of the less healthy foods.

7.7.2 Figure 7-15 shows the extent to which these food groups are consumed by men and women in Gibraltar. Again, “regularly” is defined as 2 or more times a week.

7.7.3 Figure 7-15 shows that men are more likely than women to consume each type of unhealthy food on a regular basis. In particular, there are marginal differences in the consumption of fried foods and crisps; 40% of men eat crisps regularly compared to 31% of women and 28% of men have fried foods at least twice a week compared to 18% of women. The figures for sweets and crisps are very similar to those of the 2008 survey; meanwhile the regular consumption of fizzy drinks has apparently increased, while that of fried foods has decreased.

7.7.4 Figure 7-16 looks at the excessive consumption of unhealthy food types i.e. 5 or more times a week.

7.7.5 With each food type, men are more likely to consume unhealthy items compared to women at an excessive level, although the differences are not large enough to be significant. However, this is with the exception of crisps, where men are much more likely to eat crisps at an excessive level compared to women, this difference being statistically significant.

7.7.6 A quarter of men and over a fifth of women have sweets and chocolates at least 5 times a week.

7.7.7 Squash or fizzy drinks were consumed by 19% of both men and women 5 or more times a week.

7.7.8 When compared to the results of the 2008 survey, the excessive consumption of fizzy drinks has definitely increased, while that of fried foods appear to have decreased.

7.7.9 Figure 7-17 shows the same information split up by age group.

7.7.10 Of those aged 16-24, 29% have crisps 5 or more times a week. This is a significant difference to all the other age groups.

7.7.11 The youngest age group (16-24) are more likely to have sweets, chocolates, fried foods and crisps at an excessive level compared to the other age groups.

7.7.12 There is no significant pattern to show that age is a factor when consuming unhealthy food types.

7.7.13 Figure 7-18 shows excessive consumption of unhealthy food types by BMI category. BMI is an interesting factor to consider when looking at unhealthy foods and drinks that people consume.
7.10.4 Those aged under 45 are most likely to have made dietary changes in the last year, with over 59% saying they have tried compared to those aged 45 and over. These percentages are higher than in the last survey suggesting more people have tried to change their eating habits.

7.10.5 Of those who tried to change their diet, 46% were 65 years or over compared to only 15% in 2008. This is a significant difference.

7.10.6 Figure 7-20 shows the differences in BMI groups regarding the proportion of people that have made changes to their diet.

7.10.7 There is no large significance between the different BMI categories in trying to change their eating habits.

7.10.8 Respondents with normal BMI were most likely to make any dietary changes, followed by respondents who were obese and the overweight. However, the differences are insignificant.

7.10.9 Amongst those who did make dietary changes, their main reasons were examined and categorised according to the previous survey, as follows:
- Appearance (e.g. for a better body)
- Health Reasons (to eat more healthily)
- Medical Reasons (doctor’s advice)
- Other

7.10.10 Figure 7-21 (A and B) shows the results.
7.10.11 Figure 7.21 shows that health reasons are the most popular reason to make dietary changes regardless of age and sex, followed by appearance and medical reasons.

7.10.12 The slight exception is the group who are 65 years and over, where medical reasons are more common.

7.10.13 Generally, the proportion of respondents citing medical reasons increases with age, whereas appearance is most popular in the younger age groups.

7.10.14 Figure 7.22 shows the responses categorised by BMI group.

7.10.15 Among obese people, almost a third (28%) give medical reasons (advice from a doctor) as their main reason for changing their diet, compared to 22% of overweight people and just 5% of normal weight people. The majority of respondents in all categories chose their health as their main reason for change.

7.10.16 Only about 20% of all respondents chose appearance as the main reason, which contrasts with almost 40% of respondents who gave this reply in the 2008 survey. This is a significant difference.

7.10.17 Normal weight people are more likely to give health reasons than obese and overweight people.

7.10.18 Respondents were asked what would help them change their diet. The following options were given to them to choose and they could also add their own reasons:

- More time to cook
- Information about healthy eating
- Advice from a health professional
- Cooking skills
- Better self-motivation
- Availability of healthcare choices in food outlets
- Other (own reason)

7.10.19 Over a third of respondents said that better self-motivation would help them change their diet.

7.10.20 Of those who responded, 24% said that advice from a health professional would help, and 18% said that more time to cook would help them change their diet.

7.10.21 Of the respondents in the survey, 14% said that more information on healthy eating would help them change their diet.

7.10.22 There was little difference between the sexes in response to the question, with the exception of “more time to cook” where women were more likely to choose this response in comparison to men.

7.10.23 Better self-motivation was the most common reason given by all the age groups for wanting to change their diet, with the exception of the eldest age group (65+) where more respondents cited advice from a health professional as the reason.

7.10.24 Each respondent was asked to rate their diet scale from 1 to 10 (1 being unhealthy and 10 being very healthy). This is obviously a very subjective measure and there are limits to what can be read from the replies.

7.10.25 Figure 7.23 shows the proportion of respondents selecting each number on the scale.

7.10.26 The largest number of respondents selected 7 on the scale, exactly as in 2008.

7.10.27 Just over 80% of respondents selected between 5 and 8 on the scale, exactly as in 2008.

7.10.28 Just 3% selected the bottom categories (1, 2, 3 or 4), whereas 11% chose these categories in 2008. The top two categories (9 and 10) were chosen by 11% while only 7% did so in 2008.

7.10.29 Overall, respondents seemed to be very satisfied with their diets just as in 2008. The average rating given by all respondents was 6.9, which is very slightly higher than in 2008 (6.4).

7.10.30 The average rating given by females was slightly higher than for men (6.95 vs 6.87) respectively, which is not significant. Figure 7.24 shows the differences in the sexes when rating their diet.
7.10.31 There is very little difference between the ratings of men and women. Both men and women are more likely to rate their diets as 7.

7.10.32 Figure 7-25 shows the differences by age group.

![Figure 7-25](image)

7.10.33 The youngest age groups have a higher average diet rate than the older age groups.

7.10.34 Figure 7-26 shows these results by BMI category.

![Figure 7-26](image)

7.10.35 Rating 7 is also the most popular choice for each BMI group.

7.10.36 Overall, the average rating given to their diets by persons in the normal BMI group is 7.3, while the overweight group is 6.7 and the obese group is 6.6.

7.11 The Diet Test

7.11.1 In order to create a general measure of the quality of the respondents’ diet, the results from a selection of questions already covered in this section were combined.

7.11.2 Respondents were then scored on their answers to these questions, the higher the score, the better the diet. The appendix explains in detail which questions were used and how the test scores were calculated.

7.11.3 Due to some differences from the previous survey, the scores were categorised into the following:
- Poor diet – test score between 0-6
- Average diet – test score between 7-13
- Good diet – test score between 14-20

7.11.4 Overall, for all survey respondents, the average diet test score was 9.8. This figure can be used as a benchmark for all other demographic and health categories in the remainder of this section.

7.11.5 Figure 7-27 shows the proportion of respondents in each of the three diet groups.

![Figure 7-27](image)

7.11.6 Based on the Diet Test, the majority of respondents in the survey have an average diet. This proportion is almost the same as reported in the 2008 survey.

7.11.7 Of the respondents in the survey, 17% have a good diet. This is a deterioration from the 2008 survey in which 23% had a good diet.

7.11.8 Of the respondents in the survey, 19% have a poor diet. This is also a deterioration from the 2008 survey in which 12% had a bad diet.

7.11.9 The average test score for men was 9.6 while for women it was 10.0, which suggests that women in the survey had healthier diets than the men. In comparison, the average test scores in 2008 were 13.0 for men and 13.7 for women.

7.11.10 Figure 7-28 shows the proportion of men and women in each of the Diet Groups.

![Figure 7-28](image)

7.11.11 Men are more likely to have a poor diet than women (22% vs 16%), although this is not statistically significant.

7.11.12 The average Diet Scores analysed by age and sex are shown in Figure 7-29 below.
7.11.13 There is no clear pattern as to whether or not diet scores improve with age.

7.11.14 Youngest males (16-24) have the lowest average, suggesting they have the worse diet compared to the other age groups.

7.11.15 Females aged from 25-44 have the highest average of 10.6.

7.11.16 Combining the ages together shows very little difference in the age groups, with the exception of 25-44 year olds who have the highest average at 10.2.

7.11.17 Figure 7-30 shows the average test scores achieved by persons in each of the three BMI categories.

7.11.18 Overweight respondents had a better average diet than those with a normal weight and those who are obese.

7.11.19 As mentioned earlier, the Diet Test scores were grouped into “Diet Groups” for analysis. Figure 7-31 shows the proportion of respondents in each diet group by BMI category.

7.11.20 As with the average Diet Test Score, there is a greater proportion of persons with a good diet in the overweight category than in the normal or obese.

7.11.21 Those who are obese have a poorer diet than those in other groups.

7.12 Diet and Marital Status

7.12.1 The relationship between diet and marital status was examined using some of the key diet indicators that were detailed earlier in this chapter and Figure 7-32 shows these comparisons.

7.12.2 For most of the indicators, the married/cohabiting respondents have healthier diets than the single or divorced/widowed.

7.12.3 For example, 35% of the married/cohabiting group are eating their 5 a day, compared to 34% of the divorced/widowed group and 22% of the single group, the significant difference lies between married/cohabiting and divorced/widowed with the single group. There is also a significant improvement in the married/cohabiting eating their 5 a day from 2008 to 2015.

7.12.4 The unhealthy snacks are most likely eaten by the single people.

7.12.5 Figure 7-33 analyses the marital states this time by the Diet Group.
7.12.6 About 18% of respondents who are married/cohabiting have a good diet compared to 17% of those who are single and 11% of those who are divorced/widowed.

7.12.7 Divorced/widowed respondents are most likely to have poor diets compared to the other marital states.

7.12.8 On average, those married/cohabiting had the highest score 10.2, single respondents had an average of 9.5 and divorced/widowed 8.9.

7.12.9 Single people are more likely to have tried to change their diet (62%) compared to married/cohabiting (60%) and divorced/widowed (43%).

7.13 Diet and Housing Type

7.13.1 Affluence can be related to diet, with research indicating that those with lower levels of affluence are likely to have poorer diets.

7.13.2 In the absence of data on household income to indicate affluence in Gibraltar, Housing type can be used as a kind of proxy measure of affluence.

7.13.3 Figure 7-34 shows the key indicators for each of the different housing types.

7.13.4 People living in Government houses are less likely to eat their 5 a day than those living in their own home or private rental.

7.13.5 Those living in Government housing are more likely to eat unhealthy foods at an excessive level (5 or more times a week).

7.13.6 Figure 7-35 shows housing type categorised by diet group.

7.13.7 Figure 7-35 shows that 19% of those living in their own home have a good diet compared to 13% of those living in Government housing. (Due to the small numbers in private rental accommodations statistics are insignificant)

7.13.8 Those living in their own home are also less likely to have a poor diet compared to those living in Government housing and private rentals. The difference between those living in their own home and those in Government housing is significant.

7.13.9 Overall, those living in their own home have an average diet score of 10.2, while those in private rentals have a score of 9.9 and those in government housing 9.0. The number of respondents who live in private rental accommodation is too small to show significant differences but the difference between the diets of those in Government housing and those in their own home is significant.

7.13.10 Overall, based on the key indicators analysed in the survey and the diet test results, these results suggest that those living in their own home in Gibraltar are likely to have a better diet than those in Government housing.
7.14 Key Findings

7.14.1 Less than a quarter of respondents eat 5 or more portions of fruit and vegetable each day.

7.14.2 On average, respondents eat 3.59 portions of fruit and vegetables each day.

7.14.3 Youngest respondents have improved their fruit and vegetable intake from the last survey.

7.14.4 Men are more likely than women to eat white bread regularly.

7.14.5 Of those in the 16-24 age group, 69% of young men eat white bread regularly.

7.14.6 Young people were more likely to eat unhealthy sugary breakfast cereals than any other age group.

7.14.7 Consumption of fish increases slightly with age, whereas consumption of meat decreases slightly with age.

7.14.8 Men are more likely than women to eat unhealthy foods such as sweets, chocolates and crisps.

7.14.9 Nearly a quarter of respondents eat crisps at an excessive level.

7.14.10 Young people (16-24) are the most likely to eat unhealthy food types at an excessive level.

7.14.11 Olive oil and butter/butter type spreads are the most common products people use for frying food and bread spread.

7.14.12 Women are more likely than men to have tried to change their eating habits in the past year.

7.14.13 Respondents over the age of 65 had significantly tried to change their diet in comparison to the last survey.

7.14.14 Generally, health reasons are the most popular reason for respondents to have made dietary changes.

7.14.15 Appearance is most popular in the younger age groups, whereas medical reasons are the most common in those aged 65 and over.

7.14.16 Obese people are more likely to change their diet due to medical reasons than overweight or normal BMI people.

7.14.17 Over a third of respondents said that better self-motivation would help them change their diet.

7.14.18 Respondents on average rated their diet as 6.9 (1=very bad and 10=very good).

7.14.19 The youngest age group (16-24) rated their diet better than any of the other age groups.

7.14.20 Of the respondents in the survey, 17% have a good diet according to the diet test score, whilst 19% have a poor diet.

7.14.21 Women are more likely to have a better diet than men.
8.1 Background

8.1.1 The World Health Organisation states: “The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing around 6 million people a year. More than 5 million of those deaths are the result of direct tobacco use while more than 600,000 are the result of non-smokers being exposed to second-hand smoke.”

8.1.2 Smoking is a contributing factor in many of the main causes of death and chronic disease in developed countries. Cancer, respiratory and heart diseases are all linked to the effects of tobacco. Smoking is one of the biggest causes of death and ill health in the UK and every year around 100,000 people in the UK die from smoking, with many more living with debilitating smoking-related illnesses. In 2013, adult smoking rates by country were 20% in England; 23% in Scotland; 21% in Wales and 24% in N. Ireland.

8.1.3 A report by ‘action on smoking and health’ (ASH), in 2015, showed that about 10 million adults (22% of adult men and 17% of adult women) smoke cigarettes in Great Britain; equating to about a sixth of the total UK population. Further research shows that in the UK, two-thirds of smokers start before age 18 and smoking prevalence is highest in the 25-34 age group (25%) and lowest amongst those aged 60 and over (11%). The cost of smoking to the National Health Service in England is estimated to be £2 billion a year.

8.1.4 There are strict policy guidelines and legislation restricting the purchase and use of tobacco in many countries today. The ban on smoking in public places became effective in the UK in 2007; Spain followed in 2011 with the Gibraltar Smoke-Free Environment Act 2012 coming into effect in October 2012.

8.1.5 The impact of the smoke ban law in England carried out by Prof. Linda Bauld from the University of Stirling and the UK Centre for Tobacco Control Studies showed benefits for health and changes in attitudes and behaviour.

8.1.6 A study of bar-workers showed their respiratory health had greatly improved after the reduction in exposure to secondhand smoke; whilst another study looking at children’s exposure to secondhand smoking in England, between 1996 and 2007, found that their exposure levels had declined by nearly 70%.

8.1.7 A study by the UK Department of Health examining emergency admissions between July 2002 and September 2008 in England found a 2.4% reduction in admissions for heart attacks.

8.1.8 In October 2015, the new law banning smoking in cars with children came into effect in the UK. In Gibraltar, this law took effect from Thursday, 31st March 2016.

8.1.9 According to the 2008 Health and Lifestyle Survey in Gibraltar 29% of the survey respondents were smokers; and smoking rates were significantly higher than England and Wales.

8.1.10 The figures in this section need to be read with caution because of the way the data was collected. Unfortunately, a number of respondents skipped this section and therefore had to be considered non-respondents. This leads to a smaller sample and may affect the interpretation of the data (for example, the percentage of smokers).
8.2 Smoking Prevalence

8.2.1 In the survey, 35% of respondents said they currently smoke, either regularly or occasionally compared to 29% in 2008. Although there is an apparent increase from 2015, this is not statistically significant.

8.2.2 Men are more likely to smoke than women, just as in 2008. Of those who smoke, 40% of men are smokers compared to 29% of women. This is marginally significant.

8.2.3 Figure 8-1 shows the gender differences for each age category.

8.2.4 Smoking prevalence varies between men and women. For women, smoking prevalence decreases as age increases.

8.2.5 Among men, over a third in the youngest age group are smokers and this increases to nearly half in those aged 25-64. This might imply that more men take up smoking after 25, but is more likely to be a statistical fallacy of the data collection process mentioned earlier.

8.2.6 The smoking prevalence among men decreases to 16% in those aged 65 and over.

8.2.7 For women, smoking is most prevalent in the youngest group 16-24, although there is very little difference between the age groups until the age of 64, with around a third of women continuing to remain smokers.

8.2.8 Women who are 65 and over have the lowest prevalence with 14% being smokers. This percentage has risen from the previous survey (7%), a significant difference. It may reflect a generational effect, with women being born in the 1930s and 1940s coming into this age group.

8.3 Regular Smokers

8.3.1 Regular smokers are those who smoke at least one cigarette (or roll-up) a day. This is the equivalent to daily smokers in the previous survey.

8.3.2 Among those who do smoke, 92% are regular smokers.

8.3.3 Of the women who smoke, 90% of women are regular smokers.

8.3.4 Of the men who smoke, 94% of men are regular smokers.

8.3.5 Figure 8-2 shows the distribution of regular smokers by age group.

8.3.6 The vast majority of smokers in each age group smoke regularly.

8.4 Cigarette Consumption

8.4.1 On average, respondents who smoke each smoke 15 cigarettes a day. Males smoke 17 cigarettes on average whereas females smoke 12, which is a statistically significant difference.

8.4.2 Figure 8-3 shows the average cigarette consumption by age.

8.4.3 Figure 8-3 shows that the average cigarette consumption is similar in each age group, with smokers in the 45-64 age group having the highest consumption. The average consumption in the youngest age groups has risen since the last survey where the average consumption in 16-24 year olds was 8 and 25-44 year olds was 10. It has dropped in the two eldest age groups in 2015 from the previous survey where 45-64 years old average consumption was 22 and in the 65+ was 21.

8.4.4 Cigarette consumption levels can be analysed further by categorising smokers on how many cigarettes they smoke:

- Heavy Smokers = 20 or more cigarettes a day
- Moderate Smokers = 10-19 cigarettes a day
- Light Smokers = less than 10 cigarettes a day

8.4.5 Figure 8-4 shows the percentage of male and female smokers in each of these consumption categories.
8.5.2 Nearly two thirds of ex-smokers started smoking under the age of 17 compared to 26% from the age of 18 and over.

8.5.3 On average, ex-smokers started their habit at 17 years of age.

8.5.4 Women started at an age of 16 on average whereas men were slightly older at 18.

8.5.5 There is very little difference between the average age people started smoking, see Figure 8-7.

8.6 Parental Influence

8.6.1 The survey asked if either one or both of the respondent’s parents smoked when they were children. Of those who are current smokers, 80% said that one or both parents smoked. This percentage slightly increased from 2008 (78%) but this increase is not statistically significant.

8.6.2 Of those current smokers, 77% said their father smoked, 45% said their mother smoked, 42% said both parents smoked and 20% said neither parent smoked.

8.6.3 This data shows that over three quarters of smokers come from a background where at least one parent smoked.
8.7 Advice

8.7.1 Nearly half of smokers say they have been advised by a doctor, nurse or other health professional to stop smoking because of their health.

8.7.2 Figure 8-8 compares the proportion of smokers who have been advised to quit against those who have not, by age.

8.8 Quitting

8.8.1 Smokers were asked to choose from a list of factors what would help them stop smoking. The results are shown in Figure 8-9.

8.8.2 As in the 2008 survey, better self-motivation was the most popular response, with nearly half of respondents choosing this. The next most popular was advice from a GP. The Stop Smoking clinic was selected by 23% as against only 12% of smokers in 2008. This suggests that there is greater awareness of the potential of this service, which has been available in the GHA from 2013.

8.9 Smoking and Marital Status

8.9.1 Figure 8-10 shows current smokers by marital status. Due to some small numbers, the categories divorced and widowed have to be read with caution.

8.9.2 Those that are divorced have the highest smoking prevalence, followed by single persons and then married/cohabiting persons and finally widowed. This is in some contrast to 2008 when single persons had the highest prevalence (39%), but there is no statistical significance to the difference in percentages.

8.9.3 The difference between married/cohabiting and single is statistically not significant.

8.9.4 Single persons are slightly most likely to be regular smokers (those who smoke at least one cigarette a day) with 96%, compared to 94% of those who are divorced or widowed and 90% in the married or cohabiting category. These differences are not significant.

8.9.5 In 2008, it was found that although single people were most likely to smoke, married/cohabiting persons smoked significantly more cigarettes. In 2015, single people were also more likely to smoke (with the exception of the combined group; Divorced/Separated and Widowed), however, the average cigarette consumption for marital status is very similar.

8.10 Smoking and Housing Type

8.10.1 Figure 8-11 shows smoking prevalence by housing type.

8.10.2 It is seen that those living in their own home are least likely to smoke, followed by those in Government housing and then those in private rental, although the figures for private rental are too small to be significant.

8.10.3 Around 90% of persons in each housing type are regular smokers.

8.10.4 There is very little difference in the average number of cigarettes consumed by persons living in different housing types, with each type consuming between 11 and 15 cigarettes regularly.
8.11 Smoking and Economic Status

8.11.1 Figure 8-12 shows smoking prevalence by economic status.

8.11.2 Of those who smoke, 19% of smokers are retired persons, 36% are employed and 38% are economically inactive. The higher percentage in the economically inactive category is due to small numbers and therefore not significant. But it is seen that the retired are the least likely to smoke.

8.11.3 Although retired persons are less likely to smoke, 96% of them smoke regularly compared to 92% who are employed and 84% economically inactive.

8.11.4 The average number of cigarettes consumed is similar in each economic status with the employed consuming 11 cigarettes on average, and the other categories 15.

8.12 Key Findings

8.12.1 In the survey, 35% of survey respondents are current smokers. The percentage was lower in 2008 (29%), however there is no significant difference.

8.12.2 Men are more likely to smoke than women. This is marginally significant.

8.12.3 Men in the ages from 25-64 are more likely to smoke than other age groups.

8.12.4 Older women (65+) are less likely to smoke than those aged under 65. However there is a significant difference to the last survey in 2008.

8.12.5 Females in the youngest age group are more likely to smoke than other females, although there is no statistical significance.

8.12.6 On average, respondent smokers consume 15 cigarettes regularly.

8.12.7 On average, men smoke more cigarettes than women (17 vs 12). This is a significant difference.

8.12.8 Current smokers are mostly moderate smokers.

8.12.9 Women are more likely to be moderate smokers compared to men, who are more likely to be heavy smokers.

8.12.10 Over three quarters of smokers had at least one parent who smoked.

8.12.11 Older smokers (45+) are significantly more likely to be advised to stop smoking than those aged under 45.

8.12.12 The majority of smokers believe that better self-motivation is the key to helping them quit.

8.12.13 Divorced/Widowed persons are more likely to smoke than any other marital status.

8.12.14 Despite divorced/widowed persons having higher smoking prevalence, single people are more likely to be regular smokers.

8.12.15 Those living in private rentals are more likely to smoke (42%) than those living in Government housing (36%) or their own home (27%), although there is no significant difference.

8.12.16 Retired persons are least likely to smoke (11%) compared to those employed (36%) and those economically inactive (38%).

8.12.17 A greater percentage of retired persons smoke regularly (96%) compared to persons in any other economic status.
9.1 Background

9.1.1 The excessive consumption of alcohol can have an impact on the incidence of diseases and other health conditions in individuals and is of growing concern to health professionals and governments worldwide.

9.1.2 According to the World Health Organisation (WHO) ‘Global status report on alcohol and health 2014’, about 3.3 million deaths (5.9% of all global deaths), were attributable to alcohol consumption in 2012. The European Union (EU) has the highest alcohol consumption in the world.

9.1.3 Irresponsible or excessive drinking can result in an increase in emergency hospital admissions, anti-social behaviour and crime; all with their associated costs and consequences.

9.1.4 According to the 2011 General Lifestyle Survey for Great Britain (England, Wales and Scotland):

- More than 9 million people in England drink more than the recommended daily limits.
- In 2012 there were 8,367 alcohol-related deaths in the UK and in 2012-2013, 1,008,850 hospital admissions related to alcohol consumption.
- The number of people between 60 and 74 years of age admitted to hospitals in England with mental and behavioural disorders associated with alcohol use has risen by over 150% in the past ten years, and the figure for 15-59 year olds has increased by 94%.
- Alcohol misuse costs the NHS £3.3bn per year and around £21bn per year in healthcare, crime and lost productivity costs.
- Older people tend to drink more frequently than younger people who are more likely to drink more heavily.

9.1.5 The 2008 Health and Lifestyle Survey in Gibraltar showed that the majority of Gibraltarian adults either abstain from alcohol completely or drink very occasionally, unlike in the UK where drinking alcohol regularly is an established culture.

9.1.6 The figures in this section need to be read with caution because of the way the data was collected. A few respondents skipped this section and therefore were considered non-respondents, which creates difficulties in interpreting the data.

9.2 Non-Drinkers

9.2.1 Overall, 71% of respondents drink alcohol at least occasionally (once a month).

9.2.2 This leaves 24% of respondents who say they never drink alcohol at all, and the remaining 5% did not give a response. This is somewhat less than the 32% reported in the 2008 survey, although the figures may not be strictly comparable for the reason cited above.

9.2.3 Figure 9-1 below shows the proportion of men and women in the survey by frequency of alcohol consumption.
9.3 Frequency of Alcohol Consumption

9.3.1 Figure 9-3 shows the proportion of those who do drink by frequency of alcohol consumption.

9.3.2 Just under half of respondents drink occasionally, meaning at least once a month (44%), while over a fifth (24%) of respondents drink at least twice a week.

9.3.3 Figure 9-4 shows the frequency of alcohol consumption by sex, of those who drink.

9.3.4 Over half of women and over a third of men say they only drink occasionally (meaning once a month). These figures are statistically significant.

9.3.5 Of those who do drink, 26% of women and 30% of men say they drink 2-4 times a month. There is no significant difference.

9.3.6 Of those who do drink, 11% of women and 18% of men drink 2-3 times a week. This difference is marginal.

9.3.7 Of those who drink alcohol, 8% of women and 10% of men drink 4 or more times a week. There is no statistical difference between the sexes.
9.3.8 Using the same technique as in the last survey, the alcohol consumption was categorised to enable the
data to be more meaningfully analysed.
- Occasionally or 2-4 times a month – OCCASIONAL DRINKERS
- 2-3 times a week – REGULAR DRINKERS
- 4 or more times a week – PERSISTENT DRINKERS

9.3.9 Figure 9-5 shows the frequency of alcohol consumption in an average week among those who do drink,
using the categories mentioned above.

9.4.1 Respondents who do drink alcohol were asked how many units they would normally drink in an average
week.

9.4.2 Overall, drinkers in the survey consume an average of 5.6 units of alcohol in a standard week. Men drink
7.1 units on average whilst women drink 3.7 units on average. This is a significant dif
9.4.3 Figure 9-7 shows the average units of alcohol consumed by the different age groups.

9.3.10 Among all drinkers (73%) are occasional drinkers, 15% are regular drinkers and 9% are persistent
drinkers, drinking 4 or more times a week.

9.3.11 Among men, the proportion of regular and persistent drinkers is higher than women; 10% are heavy
drinkers and 19% are regular drinkers.

9.3.12 Among women, 11% are regular drinkers and 8% are persistent drinkers.

9.3.13 Figure 9-6 shows the differences in frequency of alcohol consumption for each age group.

9.3.14 The proportion of persistent drinkers increases steadily with age, from 4% in the youngest age group to
20% in those aged 65 and over. This was the same in 2008.

9.3.15 The numbers for each individual age group are too small to assess their significance, but breaking up the
data into wider age groups i.e. under 45 and over 45 it is seen that only 5% of those aged under 45 are
persistent drinkers, whereas 13% of those aged over 45 are persistent drinkers.

9.4.4 Those aged 65 and over drink the most on an average week, whereas the youngest age group drink the
least.

9.4.5 Figure 9-8 shows the mean units of alcohol consumed by age and sex. Due to small numbers, the age
groups have been combined.

9.4.6 Figure 9-8 above shows that men consume significantly more than women drinkers in the comparable
groups.

9.4.7 Younger people are drinking more units a week, with the exception of the occasional drinkers where there
is no age difference.

9.4.8 A pattern emerges in which young people are less likely to be persistent drinkers (4 or more times a week)
but if they are, they are likely to consume more units of alcohol than the older age group (Figure 9-8).
### Heavy Drinking

**9.5.1** The UK Sensible Drinking guidelines recommend no more than 2-3 units of alcohol per day for women and no more than 3-4 units for men. These recommendations are used throughout the rest of the analysis.

**9.5.2** Respondents were categorised according to how much they drink in an average week.
- **Light Drinkers** – men who drink up to 10 units per week or women who drink up to 7 units per week.
- **Moderate Drinkers** – men who drink between 10 and 21 units per week and women who drink between 7 and 14 units per week.
- **Heavy Drinkers** – men who drink more than 21 units per week or women who drink more than 14 units per week.

**9.5.3** Using this it was found that 5% of survey respondents are heavy drinkers.

**9.5.4** The majority, 85% are light drinkers and 10% are moderate drinkers.

**9.5.5** Figure 9-9 shows these categories by sex.

**9.5.6** The majority of drinkers are light drinkers. Men are more likely to be moderate or heavy drinkers compared to women, although statistically there is no significant difference.

**9.5.7** Figure 9-10 shows the results by age group.

**9.5.8** The largest proportion of heavy drinkers is in the 25-44 age group (8%). In this survey, the smallest proportion is in the 45-64 year olds in contrast to 2008 survey where 45-64 year olds had the highest percentage of heavy drinkers, however, there is no significant difference.

**9.5.9** Figure 9-11 shows the average number of units being consumed each week by the respondents who are classified as heavy drinkers.

**9.5.10** Overall, 7% of men and 3% of women are classified as heavy drinkers.

**9.5.11** This would be the equivalent of an estimated over 1,300 persons in Gibraltar who are drinking on average 33 units a week.

### Binge Drinking

**9.6.1** Respondents were asked whether they had six or more standard drinks on one occasion, to gauge the extent of binge drinking in Gibraltar. Binge drinking is defined in this survey as six or more standard drinks on one occasion for reasons of consistency with the 2008 survey. Some other surveys define binge drinking as six standard drinks for women and eight standard drinks for men on one occasion.

**9.6.2** Figure 9-12 presents the overall results by sex.

**9.6.3** Overall, 17% of respondents admit to binge drinking at least once a month. This percentage has dropped from 2008 (32%), this is significant.

**9.6.4** Of those who do binge drink, 10% admit to binge drinking at least once a week.

**9.6.5** Among those who drink, 23% of men and 9% of women binge drink at least once a month. This is a significant difference. Figures in 2008 were much higher than in this survey, 42% and 18% respectively.

**9.6.6** Figure 9-13 shows the results by age.
9.6.7 27% of the youngest age group (16-24) admit to binge drinking at least once a month compared to 15% in those aged 25-44 and 16% in those aged 45-64. The proportion of older persons (65+) who binge drink at least once a month was 12% in contrast to the 2008 survey in which it was only 3%. These figures however, are not statistically significant.

9.6.8 As age increases, binge drinking decreases, although in the middle years the prevalence of binge drinking is fairly constant.

9.6.9 A fifth of the youngest age group say they binge drink at least once a week compared to just 7% in those aged over 25.

9.7 **Awareness of the Health Risks related to Alcohol Consumption**

9.7.1 Only 5% of both men and women feel that their current level of alcohol is harmful to their health.

9.7.2 Even among those who admit to binge drinking, only 16% of women and 8% of men believe that their current drinking level is harmful to their health.

9.8 **Drinking Behaviour and Socio-Economic Indicators**

9.8.1 In this section, the Alcohol Consumption Categories in section 9.3.8 are applied to socio-economic data to analyze any patterns that might help identify specific groups within the sample, who are more prone or at risk to unhealthy drinking.

9.8.2 Some indicators, such as marital status, have been combined due to the small numbers in some of the categories so that there is more confidence in conclusions.

9.9 **Alcohol and Marital Status**

9.9.1 Figure 9-14 shows the proportion of non-drinkers in each marital status.

9.9.2 Widowed and divorced respondents are more likely to be non-drinkers than those in another marital status. People living with their partner (cohabiting) are less likely to be non-drinkers. Married and single persons show similar levels of abstinence from alcohol.

9.9.3 Figure 9-15 shows the frequency of alcohol consumption by marital status.

9.9.4 In each of the marital status, the majority of respondents only drink occasionally. The group with the highest percentage of persistent drinkers (10%) are the married/cohabiting. These results differ from the previous survey where the divorced/widowed persons were more likely to be persistent drinkers compared to the other groups.

9.9.5 Divorced and widowed persons are less likely than the other two groups to be persistent drinkers.

9.9.6 Single persons are more likely to be occasional drinkers than any of the other categories. The results in section 9-6 to 9-10 also show that the younger age groups were less likely to drink often.

9.9.7 Over 80% of each marital status was found to be made up of light drinkers, consuming less than 10 units a week for men, and less than 7 units for women.

9.9.8 Married or cohabiting respondents were found to be heavier drinkers than the other groups (7%) compared to those who are single (2%).

9.9.9 On average, married or cohabiting people consume 6.2 units a week, whereas single respondents consume 5.1 units a week and divorced and widowed consume 3.2 units per week.
9.10 Alcohol and Economic Status

9.10.1 Figure 9-16 shows the proportion of each economic group who are non-drinkers.

9.10.2 The respondents who are retired or economically inactive are those who are likely to be non-drinkers, with over a third in each category saying they never drink alcohol. These findings are similar to those of the 2008 survey.

9.10.3 The employed are much more likely to drink.

9.10.4 Figure 9-17 shows the frequency of alcohol consumption by economic status.

9.10.5 Retired people are the most likely to be persistent drinkers, consuming alcohol on four or more days each week.

9.10.6 Only 8% of the economically inactive are persistent drinkers.

9.10.7 Figure 9-18 shows the proportion of light, moderate and heavy drinkers by economic status.

9.10.8 Of those who were economically active, 8%, at the time of the survey, were heavy drinkers. This group includes those who are unemployed as well as those who are students and home carers. Retired persons are the least likely to be heavy drinkers.

9.10.9 None of the economically inactive respondents were moderate drinkers, they were either light or heavy drinkers.

9.10.10 The average number of alcohol units consumed by each category was as follows: Economically inactive 4.8 units a week, Employed 5.8 units a week and Retired 5.3 units a week. Overall there is very little difference between the groups.

9.11 Alcohol and Housing Type

9.11.1 Figure 9-19 shows the proportion of non-drinkers in each housing type.

9.11.2 Close to half of those living in privately rented accommodation are non-drinkers, compared to a third of those living in government housing and 16% of those living in their own home.

9.11.3 In the analysis by housing below, private rental accommodation has been excluded as a category due to small numbers, making it statistically insignificant. Figure 9-20 shows the frequency of alcohol consumption by the two remaining categories.

9.11.4 Respondents living in government housing are more likely to be persistent drinkers as 13% of them drink alcohol four or more times a week compared to 5% of those living in their own home.

9.11.5 Those who own their own home are more likely to be regular drinkers, drinking 2-3 times a week, compared to those living in government housing.
9.12.1 The proportion of non-drinkers in the survey is 24%. This figure has decreased from 2008, 32% and the difference is significant.

9.12.2 Of those who never drink alcohol, 31% are women compared to 17% of men. The figures corresponding to this in 2008 were 44% of women and 19% of men. These are significant differences.

9.12.3 The proportion of non-drinkers increases steadily with age.

9.12.4 Of those who drink alcohol, 71% drink alcohol at least occasionally.

9.12.5 Men are more likely to drink more often than women.

9.12.6 As in 2008, those aged over 45 are significantly more likely to be persistent drinkers than those aged under 45.

9.12.7 Men drink significantly more units of alcohol in an average week than women (7.1 vs 3.7). These are slightly lower than those in 2008 (7.7 vs 3.8).

9.12.8 Men are more likely to be moderate/heavy drinkers compared to women.

9.12.9 Of those who drink alcohol, 17% of respondents admit to binge drinking at least once a month. This has decreased significantly from the previous survey where 32% of respondents binged drink at least once a month.

9.12.10 Of those who binge drink, 10% admit to binge drinking a least once a week. This was very similar in 2008.

9.12.11 Men are significantly more likely to binge drink than women; 23% of men binge drink at least once a month compared to 9% of women. These figures have also improved from the last survey (44% vs 18%) which is significant.

9.12.12 Those in the youngest age group (16-24) are significantly more likely to binge drink than the older groups.

9.12.13 Of those in the youngest age group, 20% admit to binge drinking at least once a week. This has also improved from the previous survey in 2008, where 31% said they binge drink at least once a week.

9.12.14 Married/cohabiting people are most likely to be persistent drinkers followed by single respondents.

9.12.15 On average, married/cohabiting respondents drink more units of alcohol each week. In 2008, single respondents were heavier drinkers.

9.12.16 Economically inactive and retired persons are most likely to be non-drinkers, parallel to 2008.

9.12.17 Those living in their own home are significantly more likely to drink at least twice a week compared to those in Government housing.

9.12.18 Those in Government housing appear to be more persistent drinkers, drinking more than 4 times a week.
10 Physical Activity

10.1 Background

10.1.1 According to the World Health Organisation (WHO), insufficient physical activity is 1 of the 10 leading risk factors for death worldwide and a key risk factor for non-communicable diseases (NCDs) such as cardiovascular diseases, cancer and diabetes.

10.1.2 Research shows that worldwide, people are less physically active and in the WHO European Region, one third of adults and two thirds of adolescents are insufficiently active.

10.1.3 The health benefits of having a physically active lifestyle are well acknowledged by the World Health Organisation (WHO) that advocates regular and adequate levels of physical activity in adults to:
• reduce the risk of hypertension, coronary heart disease, stroke, diabetes, breast and colon cancer, depression and the risk of falls;
• improve bone and functional health; and
• maintain energy balance and weight control.

10.1.4 The WHO emphasizes that current levels of physical inactivity are partly due to:
• insufficient participation in physical activity during leisure time
• increase in sedentary behaviour during occupational and domestic activities
• increase in the use of “passive” modes of transport
• increased urbanization which has led to several environmental factors which may discourage participation in physical activity such as violence, high-density traffic, low air quality, pollution; and a lack of parks, sidewalks and sports/recreation facilities.

10.1.5 The UK analysis of the Global Burden of Diseases, Injuries and Risk Factors Study found physical inactivity and low physical activity to be the fourth most important risk factor in the UK. Physical inactivity has a significant financial burden in the UK. In 2009/10, the direct financial cost of physical inactivity to the NHS was estimated to be greater than £900 million.

10.1.6 According to a European Commission report on physical activity levels published in March 2014, 16% of Ireland had the highest reported prevalence of regular exercise with UK at 10% of adults reporting to exercise or play sport regularly, higher than the EU average of 8%.

10.1.7 According to the Health Survey for England in 2012:
• 10% of adults play sport regularly,
• 44% of adults never do any moderate physical activity,
• 68% of adults walk for extended periods on four or more days per week,
• 13% of adults are sedentary for longer than 8.5 hours a day.

10.1.8 Studies published in England in 2015 indicated that women were slightly more likely than men to want to do more physical activity (69% and 66% respectively). 44% of men and 45% of women agreeing that they could get enough physical activity in their daily life without specific activities such as jogging or going to the gym.

10.1.9 Work commitments, not having enough leisure time, lack of motivation and caring for children or older people were some of the factors cited as barriers to doing more physical activity; whilst factors that might encourage more activity included the participant’s own ill health or advice from a doctor or nurse.
10.2.6 Women are significantly more likely to walk to work than men. More than half of women compared to over a third of men walk to work.

10.2.7 This shows that women are more likely than men to be getting exercise from their daily journey to work.

10.2.8 Over a third of men use their moped to get to work compared to 17% of women and this is a significant difference. In the case of the car, 23% of women use their car compared to 20% of men.

10.2.9 Figure 10-3 shows the breakdown by age group.

10.2.10 Of all the age groups, 45-64 year olds are more likely to walk to work. The number of people walking to work has increased from the last survey, although there is no statistical significance. The highest percentage of people walking to work in the last survey was from the youngest age group, which in contrast is the lowest percentage this year.

10.2.11 Using the moped to travel to work has become more popular in the youngest age groups (16-44) and this could be due to the lack of parking facilities in Gibraltar.

10.2.12 Use of the car is the highest in the older age group (45-64). This was also the case in 2008.

10.2.13 The questionnaire also asked respondents about their daily routine (informal exercise) i.e. whether they spent their day sitting at a desk, standing, carrying or heavy lifting.

10.2.14 Figure 10-4 shows the responses about their daily routine. This question could be answered by all respondents.

10.2.15 The majority of respondents are most likely to sit or stand during their daily routine, with 15% saying they carry light loads or have to climb hills or stairs and 7% saying they do heavy work.
10.2.16 Women are significantly more likely to stand than men but men tend to do more carrying and heavy lifting than women.

10.2.17 Figure 10-5 shows this data by age group.

10.2.18 Generally, the people who are sitting or standing during their daily routine appears to increase with age, from over a third in the youngest age group to just over a half in those aged 65+ in the sitting category, and 20% to 39% in the standing category although this holds no statistical significance.

10.2.19 The proportion of respondents carrying or lifting heavy loads decreases with age, as might be expected.

10.3 Organised Sport or Physical Activity (Formal Exercise)

10.3.1 Respondents were asked to indicate how many hours a week they do exercise that makes them “out of breath and sweaty for 20 minutes.”

10.3.2 Over half of respondents (53%) said that they exercise intensively for at least 3 hours a week. This proportion has significantly decreased from the last survey where 68% of respondents said they exercised intensely for at least 3 hours a week. The proportion of females (60%) is higher than that of males (45%) and this difference is also significant.

10.3.3 Figure 10-6 shows hours of intensive exercise each week.

10.3.4 The proportion of respondents who exercise intensely decreases with age.

10.3.5 Three quarters (75%) of those aged 16-24 exercise intensively for at least 3 hours a week. This is a significant improvement from 2008 where just over half (54%) of this age group did so.

10.3.6 Of those aged 65 and over, 15% do 3-4 hours of intensive exercise each week. This has risen from the last survey (5%). Only 6% of those aged over 65 do more than 5 hours a week but this is an improvement since none of the responders in 2008 did this. These are both significant differences.

10.3.7 The proportion who exercise intensely for more than 5 hours a week also decreases significantly with age.

10.4 Reasons for Not Exercising

10.4.1 Respondents who exercise for less than 3 hours a week were asked the reasons that prevent them from doing so. They were each able to give a maximum of three reasons and no time period was specified. Those who exercise intensively for 3 hours or more were not asked to answer this question. Figure 10-7 shows the results.

10.4.2 Lack of leisure time was the most popular reason preventing exercise (40%) even more so than in the 2008 survey (22%) in which also it was the leading reason. Women in particular gave this reason (43%) compared to men (36%), although the difference is not statistically significant.

10.4.3 The next most popular reasons were illness, injury or disability and lack of incentive. Both were slightly more popular reasons for men.

10.4.4 The “Other” category included reasons such as self-consciousness, lack of child facilities, lack of transport and money. These figures were very low to compare by themselves so were therefore combined into this category.

10.4.5 Figure 10-8 shows the same information by age group.
10.4.6 Lack of leisure time was the most popular reason given by those aged 16-24 and 25-44. Lack of incentive was the most popular reason given by those aged 45-64 and illness, injury or disability was most popular among 65+.

10.4.7 These results were very similar to those in 2008.

10.5 Overall Levels of Activity

10.5.1 By combining the results for both informal and formal exercise, it is possible to gauge the overall levels of activity among respondents. The categories were as follows:
- Low – Less than 3 hours of intense exercise per week and an inactive daily routine (mainly sitting)
- Moderate – 3-4 hours of intense exercise per week and mainly sitting during the daily routine or less than 3 hours of intense exercise per week and an active daily routine (walking/carrying/lifting)
- High – 5 or more hours of intense exercise per week or 3-4 hours of intense exercise per week and an active daily routine (walking/carrying/lifting)

10.5.2 Figure 10-9 shows how respondents fall into the three different activity levels.

10.5.3 Overall, most respondents have a moderate to high activity level.

10.5.4 The majority of females have a moderate activity level (43%) compared to men who have 28% moderate activity level. This is a significant difference between the sexes.

10.5.5 Men are significantly more likely to have high activity levels than women (39% vs 24%).

10.5.6 Figure 10-10 shows this information by age group.

10.5.7 There is a clear pattern that the proportion of people with low levels of activity increases with age, from 16% in 16-24 year olds to nearly half (45%) of those aged 65 and over.

10.5.8 The chart also shows that the proportion of people in the high activity group decreases steadily with age.

10.6 Physical Activity and Marital Status

10.6.1 Figure 10-11 shows the activity levels by marital status.

10.6.2 Single persons are significantly more likely to have high activity levels (50%), than persons who are married or cohabiting (27%) or any other marital status group (21%). These differences can be to a large extent due to the age groups as seen in figure 10-10.

10.6.3 Married or cohabiting persons are more likely to have moderate activity levels compared to any other marital status.

10.7 Physical Activity and Economic Status

10.7.1 Figure 10-12 shows the difference in activity levels by economic status.

10.7.2 Moderate levels of activity are very similar in the different economic categories.

10.7.3 Retired persons are much more likely to have low activity levels compared to any other economic status.

10.7.4 Employed persons are more likely to have high activity levels to those who are economically inactive, although there is no statistical significance due to the small numbers in the economically inactive group.
10.7.5 The employed are more likely to have low levels of activity compared to the economically inactive but this is partly driven by age since the inactive group will have young people in full time education.

10.8 Physical Activity and Housing Type

10.8.1 Figure 10-13 shows the differences in activity levels between the two main housing types.

<table>
<thead>
<tr>
<th>Housing Type</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>No Response</th>
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</thead>
<tbody>
<tr>
<td>Government</td>
<td>23%</td>
<td>19%</td>
<td>20%</td>
<td>5%</td>
</tr>
<tr>
<td>Own Home</td>
<td>41%</td>
<td>9%</td>
<td>11%</td>
<td>5%</td>
</tr>
</tbody>
</table>

10.8.2 People in Government housing are more likely to have moderate levels of activity compared to those living in their own home. This is marginally significant.

10.8.3 Those living in their own home have a higher percentage of people with high and low activity levels, although there is no statistical significance in the difference in housing type.

10.9 Key Findings

10.9.1 Among those who work, women are much more likely than men to walk to work, getting some regular exercise in their daily routine.

10.9.2 People in the older age groups are more likely to walk to work than those in the younger age groups, in contrast to the conclusions in 2008. However this holds no statistical significance.

10.9.3 Women are significantly more likely to stand and walk around during their daily routine (45%) than men (just 23%).

10.9.4 Just over half of respondents say they exercise intensely for 3 hours a week. Females are significantly more likely to exercise at this level for 3 hours a week than men.

10.9.5 The proportion of people who exercise intensely decreases with age, although more people in the oldest age groups are exercising more hours a week compared to the last survey. This is significant.

10.9.6 Three quarters of those aged 16-24 say they exercise at this level for more than 3 hours a week and 30% say they exercise intensely for more than 5 hours a week.

10.9.7 Overall, 32% of respondents are categorised as having high levels of activity compared to 26% in 2008. However this is not statistically significant.

10.9.8 Men are significantly more likely to have higher levels of activity (39%) compared to women (24%).

10.9.9 There is also a clear pattern of the proportion of persons in the high activity group decreasing with age.

10.9.10 Single persons are significantly more likely to be in the high activity group (50%) than the married or cohabiting (27%).

10.9.11 A significantly lower proportion of retired people is found in the high activity group, and these people also form the highest proportion in the low activity group compared to any other economic status.

10.9.12 There is a higher proportion of people in Government housing with moderate activity levels compared to those living in their own home.
11 Sunbathing

11.1 Background

11.1.1 The Health and Lifestyle Survey 2015 uses the same questions for sunbathing as those used in 2008 to understand and estimate the potential health risks to which Gibraltar’s population is exposing themselves. This helps determine the population’s knowledge and self-prevention measures taken.

11.1.2 Gibraltar’s location at the entrance to the Mediterranean and warm sunny climate with an average of 10.5 hours of sunshine per day and an estimated 300 days of sunshine each year makes sunbathing a potential risk factor for cancer and a genuine public health issue.

11.1.3 Sun safety is an issue of concern as sun damage can occur due to exposure to ultraviolet (UV) radiation that penetrates deep into the skin and damages cells even when the sun does not feel hot.

11.1.4 According to Cancer Research UK, overexposure to ultraviolet (UV) radiation from the sun or sunbeds is the main cause of skin cancer. In the UK more than 80% of cases of melanoma, the most serious type of skin cancer, could be prevented through enjoying the sun safely and avoiding sunburn.

11.1.5 The 2008 Health and Lifestyle Survey found generational differences in knowledge about skin cancer preventative measures with young people being more aware of keeping babies out of the sun and taking adequate sun protection measures as opposed to older people who were more aware of using sunhats and wearing loose clothing.

11.2 Suntan

11.2.1 In the present survey, 25% of all the respondents said that a suntan was important to them. This figure has significantly dropped from 36% in the last survey. There has been a slight increase in the number of people who rated suntan as very important with 16% in 2015 compared to 13% in 2008, but this is not statistically significant.

11.2.2 As with 2008 results, there are significant differences between men and women, shown in Figure 11-1 below.
11.2.3 Having a suntan is significantly more important to women than men. Close to half of women said that a suntan was important to them compared to just a third of men. Both figures have slightly increased from the last survey, but this difference is not significant.

11.2.4 There are also differences between age groups, seen in Figure 11-2 below.

11.3 Sun Cream

11.3.1 Nearly a third of respondents (31%) say they do not normally use sun cream.

11.3.2 Of those who use sun cream, 60% use sun protection factor (SPF) 15 and above. This result has significantly improved since 2008 (45%).

11.3.3 Of those who use sun cream, 7% use a lower sun protection factor and the remaining 2% don't know the SPF they use.

11.3.4 There is a significant difference between men and women, shown in Figure 11-3 below.

11.3.5 Men are significantly much less likely to use any sun cream at all in comparison to women. Nearly 50% of men compared to just 15% of women do not use sun cream.

11.3.6 Women are significantly more likely to use high protection (SPF 15 or higher) sun creams, 77% compared to just 42% of men.

11.3.7 Figures for the use of sun cream have increased from the previous survey in 2008. In 2008, only 53% of women used SPF 15+ which was significantly less. On the other hand, there is no statistical difference in men's use of sun creams as the equivalent figure for men in the 2008 survey was only slightly less, at 36%.

11.3.8 Use of sun cream also varies by age group, shown in Figure 11-4.

11.4 Sunburn

11.4.1 Respondents were asked whether they had been sunburnt (causing redness and soreness) within the last twelve months and how many times they had experienced this.

11.4.2 Over a quarter of all the respondents experienced sunburn within the last twelve months. This result has slightly risen from 2008 where less than a quarter of respondents reported being sunburnt, but this holds no statistical significance.

11.4.3 Men and women had the same likelihood of having experienced sunburn within the last twelve months (29%).

11.4.4 The youngest age group was the most likely to have experienced sunburn in the last year, shown in Figure 11-5 below.
11.4.13 Of those who experienced sunburn in the last year, 37% of men said they do not normally use any sun cream at all, as against only 14% of women. The difference is significant.

11.4.14 Women are significantly more likely to use sun cream than men – 85% of women use sun cream compared to 58% of men. These results are very similar to those in 2008.

11.5 Awareness of Skin Cancer Prevention

11.5.1 Respondents were asked how important they think different factors are in preventing skin cancer. They had the option of choosing four responses:
• Very Important
• Fairly Important
• Not Important
• No Opinion

11.5.2 Figure 11-7 shows the proportion of respondents who think that each factor is either very important or fairly important in the prevention of skin cancer.

11.5.3 The majority of the respondents (89%) are aware that babies should be kept entirely out of the sun. This has slightly dropped from 2008 (93%) and the difference is significant.

11.5.4 Unlike 2008 results, this year both men and women had the same awareness when it came to keeping babies out of the sun. They both said it was very important, although women were more likely to say it was very important than just fairly.

11.5.5 The majority of the respondents were aware of using sun cream, avoiding the midday sun and staying in the shade as much as possible to prevent skin cancer.

11.5.6 Women were more likely than men to say the use of sun cream and avoiding the midday sun was very important.

11.5.7 The majority of respondents (83%) were aware of using wide brimmed hats in the sun, although only 58% said it was very important.
11.5.8 Only 66% of respondents thought that wearing loose fitting clothing in the sun was important. Just under a fifth said it was not important.

11.5.9 Of all the factors investigated, loose clothing was the least important chosen by the survey respondents, similarly in 2008.

11.5.10 Women were more aware of the importance of wearing loose fitting clothes in the sun than men.

11.5.11 Figure 11-8 shows the awareness of these factors by age group.

11.6.1 A quarter of respondents say that a suntan is important to them. This has dropped from 36% in 2008 and the difference is significant.

11.6.2 Having a suntan is significantly more important to women than men (48% vs 33%)

11.6.3 Nearly a third of respondents (31%) don’t normally use sun cream.

11.6.4 Of those who use sun cream, 60% of respondents use SPF 15+ compared to 45% in 2008. This is a significant difference.

11.6.5 Women are significantly more likely to use higher SPF compared to men.

11.6.6 Nearly half of the male respondents said they never use sun cream compared to only 15% of women.

11.6.7 The youngest (16-24) and eldest (65+) age groups are least likely to use sun cream and the eldest age group are least likely to use a high SPF, similarly in 2008.

11.6.8 The youngest age group (16-24) are most likely to experience sunburn.

11.6.9 The younger age groups were more aware of keeping babies out of the sun, using sun hats, avoiding the midday sun and keeping in the shade, whereas the older age groups were more aware of wearing loose fitting clothes and sun hats to prevent skin cancer.
PART THREE
Lifestyles
12 Lifestyle Trends

12.1 Introduction

12.1.1 This section analyses the relationship between the different factors in the previous chapters. This should enable some meaningful conclusions to be drawn regarding the health and lifestyles of the population of Gibraltar.

12.1.2 The findings in this section cannot be compared to that of the previous survey in 2008 since the way the data has been analysed is different and has been improved.

12.1.3 The following six chapters are organised around reviews of the relationships between different possible paired combinations of the different lifestyle factors. Such reviews show situations where certain risk factors appear to enhance one another and others where they operate independently. Such relationships have great impact on the overall lifestyle of the individuals concerned and the health outcomes of such lifestyles.

12.1.4 The following table shows the arrangement of the reviews, the numbers referring to the chapter in which the review is found:

<table>
<thead>
<tr>
<th></th>
<th>Obesity</th>
<th>Diet</th>
<th>Smoking</th>
<th>Alcohol</th>
<th>Physical Activity</th>
<th>Sunbathing</th>
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13 General Health

13.1 Introduction

13.1.1 The general self-reported health of the respondents was examined in Chapter 5. A large proportion of respondents (77%) thought that they were in good or very good health. This was a general pattern seen across all age groups, with the exception of those aged 65+ where a larger proportion (10%) thought that their health was bad or very bad and a further 31% thought their health was only “fair”.

13.1.2 The same Chapter also looked at individuals’ perception of body weight – respondents were asked to guess whether they thought they were the right weight for their height.

13.1.3 Finally, respondents were asked about their long standing illnesses, disabilities and infirmities and the clinics they attended the past three years, as described in 5.1.2. Due to the small numbers in these questions, there is no statistical significance and therefore excluded from this section.

13.2 General Health and Obesity

13.2.1 Figure 13-1 shows each BMI category and examines how each group rated their general health.

13.2.2 The obese group were less likely to rate their health as good or very good, with just 22% saying their health is very good compared to over 30% in the other BMI groups. However, the differences are not statistically significant.

13.2.3 The obese people are more likely to rate their health as fair, bad or very bad compared to those with normal weight and are overweight. There is a significant difference between the people with normal BMI and the obese people.

13.2.4 Around half of each group rated their health as good, suggesting some lack of knowledge among the overweight and obese groups.
13.2.5 This is further demonstrated below when comparing the perception of BMI with the actual measured BMI of each respondent.

13.2.6 In chapter 5, it was found that 54% of respondents thought that they were either underweight or about the right weight for their height. There were 37% of respondents who acknowledged that they were overweight and the remaining 8% were unsure.

13.2.7 Figure 13-2 shows the results from chapter 6, categorising each respondent into the appropriate group. The chart strikingly shows that 36% of overweight or obese persons believe that they are the right weight or even underweight. This is in fact slightly more than the figure (34%) found in 2008, indicating that consistently more than one third of people in Gibraltar do not have a clear idea about the risk status of their body weight.

13.2.8 According to the BMI classification, 41% of respondents have a normal weight. This suggests that 13% of respondents believe they are about the right weight for their height when in fact they are actually overweight or obese.

13.2.9 According to the BMI calculations about 60% of respondents are overweight or obese, yet only 37% knew they were overweight.

13.2.10 The two sets of data are compared in full in Figure 13-3.

13.2.11 Nearly half of the persons who are overweight think they are the right weight.

13.2.12 Figure 13-4 shows the summarised comparisons of respondents’ body weight misconceptions.

13.2.13 The chart strikingly shows that 36% of overweight or obese persons believe that they are the right weight or even underweight. This is in fact slightly more than the figure (34%) found in 2008, indicating that consistently more than one third of people in Gibraltar do not have a clear idea about the risk status of their body weight.

13.2.14 Only 55% of those who are overweight are aware that they are.

13.2.15 The proportion of people who were unaware of their weight differed between men and women. Figure 13-5 shows this data, where “overweight” refers to both overweight and obese people.

13.2.16 Women appear to be slightly more aware of their weight than men. Women who know they are overweight represent 59% of the population compared to 52% of men. However, this is not statistically significant.

13.3 General Health and Diet

13.3.1 Figure 13-6 shows the proportion of persons who eat their 5 portions of fruit and vegetables each day, according to how they rated their health.

13.3.2 Over half of those who rated their health as good were eating their 5 a day, while just 3% of those who rated their health as bad or very bad were eating their 5 a day. This is a significant difference.

13.3.3 Over a quarter of those who rated their health as very good were eating their 5 a day.

13.3.4 Figure 13-7 examines the diet groups by the way respondents rated their health. Those who rated their health as bad or very bad have been grouped together due to their small numbers.
13.4.5 Heavy smokers are less likely to rate their health as good or very good. Just two thirds (66%) of heavy smokers say their health is good or very good compared to at least 74% in each of the other groups. This holds no statistical significance.

13.4.6 Light smokers are more likely to rate their health as good compared to the other groups, with 60% doing so. None of the light or moderate smokers rated their health as very bad.

13.5 General Health and Alcohol

13.5.1 Figure 13-10 shows the self-reported general health for each of the three drinking categories (by frequency of drinking) as well as non-drinkers.

13.5.2 Non-drinkers are most likely to rate their health as only fair, bad or very bad, with 36% doing so, compared to 23% of persistent drinkers, 17% of regular drinkers and 15% of occasional drinkers. The difference is significant between the different types of drinkers (excluding persistent drinkers).

13.5.3 It is the occasional and regular drinkers who rate their health the best overall, with over 80% in both categories saying their health is good or very good.

13.5.4 Regular drinkers are more likely to say their health is very good, with over 50% doing so, whilst occasional drinkers are more likely to say their health is good.

13.5.5 Figure 13-11 shows the same information by amount of alcohol consumed.

13.5.6 Moderate drinkers are the ones most likely to say their health is very good. Over a third (38%) of moderate drinkers rate their health as very good compared to 15% of non-drinkers, 32% of light drinkers and 26% of heavy drinkers. This is significant (excluding the difference with light drinkers).
13.5.7 This may be lack of awareness that heavy consumption of alcohol is actually bad for their health or it could be that due to the small numbers it is not a true result.

13.6 General Health and Physical Activity

13.6.1 Figure 13-12 shows the self-reported general health of the respondents in each exercise category (low, moderate, high) which were categorised in chapter 10.

![General health by exercise level](image)

13.6.2 Of those who rated their health as good or very good, 90% had high exercise levels. This is significantly higher than either of the other two groups and also higher than any other groups seen in this section, by diet, BMI, smoking and drinking.

13.6.3 This suggests that the amount of physical activity that a person undertakes has a close association with how people perceive their general health.

13.7 General Health and Sunbathing

13.7.1 Figure 13-13 compares those who think a suntan is important with those who do not, to see if there are any differences in their self-reported general health.

![General health by importance of a suntan](image)

13.7.2 80% of those who say a suntan is important to them rate their general health as good or very good while 76% of those who don’t recognise the importance of a suntan rate their health as good or very good. However there is no statistical significance.
14 Obesity

14.1 Introduction

14.1.1 Obesity, being such an important measure of a person’s general health, is examined in this section with reference to some of the other lifestyle factors.

14.2 Obesity and Smoking

14.2.1 Data collected in the Health and Lifestyle Survey allows for analysis to see if there is a link between weight (measured by BMI) and smoking among survey respondents.

14.2.2 Figure 14-1 compares the proportion of smokers and non-smokers in each BMI category.

![Figure 14-1
Smokers vs non-smokers by BMI Category](image)

14.2.3 Figure 14-1 shows that there is no difference between the different BMI categories when it comes to smokers and non-smokers.

14.2.4 There is very little difference between the average BMI of smokers and non-smokers; non-smokers have an average of 26.8 whilst smokers have an average BMI of 26.4.

14.2.5 When considering smokers by their smoking habit (light, moderate or heavy) there are greater differences, with light smokers having the lowest average BMI and heavy smokers having the highest. Figure 14-2 shows the results.

![Figure 14-2
Average BMI by smoking habit](image)

<table>
<thead>
<tr>
<th>Category</th>
<th>Average BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy Smokers</td>
<td>27.49</td>
</tr>
<tr>
<td>Moderate Smokers</td>
<td>26.22</td>
</tr>
<tr>
<td>Light Smokers</td>
<td>25.24</td>
</tr>
<tr>
<td>All Smokers</td>
<td>26.43</td>
</tr>
<tr>
<td>Non Smokers</td>
<td>26.78</td>
</tr>
<tr>
<td>All Respondents</td>
<td>27.02</td>
</tr>
</tbody>
</table>
14.2.6 Figure 14-3 shows the proportion of smokers in each BMI group by the extent of a person’s smoking habit.

14.2.7 Over 60% of heavy smokers are overweight or obese, compared to 54% of moderate smokers and 41% of light smokers. There is no significant difference.

14.2.8 Furthermore, 28% of heavy smokers are obese compared to 21% of moderate smokers and 8% of light smokers. There is a significant difference between heavy smokers and light smokers.

14.3 Obesity and Alcohol

14.3.1 There are known associations between high alcohol consumption and weight gain. This section analyses Gibraltar’s survey responses to see if these associations are found in the data.

14.3.2 Figure 14-4 shows drinkers and non-drinkers and the proportion of each group that fall into each BMI.

14.3.3 There are some differences in drinkers and non-drinkers according to their BMI. Drinkers are significantly more likely to have a normal weight compared to non-drinkers (44% vs 32%). There are more overweight drinkers than non-drinkers but the difference in the obese category is significant. Of those who are obese, 33% are non-drinkers compared to 18% of drinkers.

14.3.4 This is a difficult measure from which to draw conclusions; those who are obese may have existing medical conditions such as diabetes or heart problems that mean they are encouraged to avoid drinking alcohol, therefore distorting these figures.

14.3.5 Looking solely at those who do drink (71% of respondents), Figure 14-5 shows each BMI group by frequency of alcohol consumption.

14.3.6 Persons with normal BMI are less likely to drink regularly. In the normal weight category, 45% are occasional drinkers, 41% are regular drinkers and 39% of persistent drinkers.

14.3.7 In contrast, overweight persons are more likely to have greater frequency of alcohol consumption. There are 34% of occasional drinkers who are overweight, 39% of regular drinkers and 40% of persistent drinkers are overweight. These differences are non-significant.

14.3.8 Persistent drinkers are more likely to be obese than the other two groups, but due to the small numbers, this is not significant.

14.3.9 Occasional drinkers appear to be the healthiest in terms of BMI, with only 52% being overweight or obese, compared to 56% of regular drinkers and 61% of persistent drinkers. The differences are not statistically significant.

14.3.10 Figure 14-6 looks at the three groups categorised by the amount of alcohol consumed.
14.4 Obesity and Physical Activity

14.4.1 There are obvious links between obesity levels and exercise, with those who do not exercise enough being more “at risk” of being overweight or obese.

14.4.2 Using the exercise levels described in Chapter 10, the proportion in each BMI group can be compared, as shown in Figure 14-7.

Figure 14-7
Exercise level by BMI Category

14.4.3 There are interesting differences in the chart above. High exercise levels are significantly associated with lower obesity levels, with 29% of the low exercise group being obese, compared to just 13% of the high exercise group.

14.4.4 Conversely, the proportion of people with a normal BMI is associated with high exercise levels, with 32% of the low exercise group having a normal BMI, compared to over a third of the moderate exercise group and 50% of the high exercise group. There is a significant difference between low exercise and high exercise levels in relation to obesity.

14.4.5 Overall, 64% of the low exercise group are overweight or obese, 61% of the moderate exercise group are overweight or obese and 45% of the high exercise group are overweight or obese.

Figure 14-8

<table>
<thead>
<tr>
<th>Hours of exercise each week</th>
<th>BMI Category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;3</td>
</tr>
<tr>
<td>Normal</td>
<td>30%</td>
</tr>
<tr>
<td>Overweight</td>
<td>38%</td>
</tr>
<tr>
<td>Obese</td>
<td>28%</td>
</tr>
<tr>
<td>All Respondents</td>
<td>96%</td>
</tr>
</tbody>
</table>

14.4.6 Over a quarter of respondents who do less than the recommended exercise levels are obese, compared to 19% of those doing at least 3 hours of intense exercise each week. This is a significant difference.

14.4.7 A further 38% of those doing less than the recommended exercise level (3 hours a week) are overweight.

14.4.8 Those doing more than 5 hours a week are less likely to be overweight or obese, although there are still 41% of them who are overweight or obese.

14.4.9 On average, those doing less than 3 hours of intense exercise each week have a BMI of 28. Those doing 3-4 hours a week have an average BMI of 26. These are significantly different but both of these BMIs are within the overweight BMI category. Those who do 5 or more hours a week have an average BMI of 25, which again is different, which although borderline, still falls within the overweight category.

14.4.10 Figure 14-9 looks at this data the other way around, i.e. examining exercise level by BMI group.

Figure 14-9
Activity Levels by BMI Category

14.4.11 Figure 14-9 shows that 71% of obese respondents are doing less than 3 hours of intensive exercise each week, compared to 62% of those who are overweight and 44% of those who have a normal weight. There is a significant difference between those who are obese and those who have a normal BMI.

14.4.12 From a long term health perspective, it is interesting to look at the extent of exercise and the reasons for not exercising among the different BMI groups.

14.4.13 Figure 14-10 below looks at the reasons for not exercising according to each BMI group.

Figure 14-10
Factors preventing exercise by BMI Category

14.4.14 Lack of leisure time was the most common reason in all BMI categories.

14.4.15 Obese persons are most likely to say illness, injury or disability prevents them from exercising compared to the other groups, with 29% saying so.

14.4.16 Generally, the differences are small.

14.5 Obesity and Sunbathing

14.5.1 Figure 14-11 compares those persons identified in Chapter 11 who said suntan was either fairly or very important to them and those who said it was not important.
14.5.2 Those who said a suntan was very or fairly important to them were significantly more likely to have a normal BMI than those who don’t recognise the importance of a suntan (43% vs 37%).

14.5.3 Overall, those who say a suntan is not important to them are slightly more likely to be overweight or obese than those who do regard suntan as important.

14.6 Obesity and Diet

14.6.1 Figure 14-12 shows the BMI categories by diet group.

14.6.2 There are no significant differences between the different diet groups. 58% of people with a good diet are overweight or obese, 56% of people with an average diet are overweight or obese and 54% of people with poor diets are overweight or obese.
15 Diet

15.1 Introduction

15.1.1 This section analyses relationships between diet and the other lifestyle factors such as smoking, alcohol, exercise etc.

15.2 Diet and Smoking

15.2.1 Historically, research around the world has found a significant difference in the diets of smokers compared to non-smokers. Generally, smokers are thought to have poorer diets than non-smokers.

15.2.2 Figure 15-1 shows some key indicators, analysed in Chapter 7, categorised by smoking status.

Figure 15-1
Diet indicators - smokers vs non-smokers

15.2.3 There is a significant different between the diets of smokers and non-smokers. Smokers are much more likely to have squash, fizzy drinks, sweets, chocolates and crisps at an excessive level, and least likely to eat oily fish, wholegrain cereal and have their 5-a-day compared to non-smokers.

15.2.4 Figure 15-2 shows the proportion of smokers in each of the Diet Groups compared to non-smokers.

Figure 15-2
Diet group by smoking status

15.2.5 There is no difference in respondents who have an average diet.
15.3.6 Smokers are much more likely to have a poor diet than non-smokers; 28% compared to 7%. This is a significant difference. Conversely, smokers are much less likely to be in the good diet group, just 9% of smokers have a good diet compared to 27% of non-smokers. This is significant.

15.3.7 On average, smokers score 8.6 on the Diet Test compared to non-smokers whose average score is 11.3. This is a significant difference.

15.3 Diet and Alcohol

15.3.1 Figure 15-3 shows the different Diet Groups (as defined in Chapter 7) by respondents’ frequency of alcohol consumption.

15.3.2 Regular drinkers (those who drink 2-3 times a week) are more likely to have good diets than any other respondents, with 30% having a good diet compared to 20% of those who do not drink, 17% of occasional drinkers and 10% of persistent drinkers. The differences are not significant.

15.3.3 Non-drinkers have the highest proportion of respondents with average diets compared to the other groups.

15.3.4 Non-drinkers also have the lowest proportion of respondents with poor diets, with only 11% having a poor diet.

15.3.5 On average, regular drinkers have a Diet Test score of 10.8, non-drinkers have an average Diet Test score of 10.5, occasional drinkers 9.7 and persistent drinkers have an average of 9.5. There is a significant difference between the persistent drinkers and the regular drinkers.

15.3.6 Figure 15-4 shows the amount of alcohol consumed by respondents categorised by their Diet Test score.

15.3.7 Heavy drinkers have the highest proportion of respondents with good diets, followed closely by the non-drinkers. The differences are not significant.

15.3.8 It is the non-drinkers who are least likely to have a poor diet.

15.3.9 On the Diet Test, the non-drinkers scored an average of 10.5, light drinkers scored 9.9, moderate drinkers scored 9.0 and heavy drinkers scored an average of 10.8 on the diet test score. The difference between the moderate drinkers and the heavy drinkers is significant.

15.3.10 The light drinkers and the heavy drinkers are more likely than the moderate drinkers and non-drinkers to have tried to change their diet in the last year.

15.3.11 Non-drinkers and light drinkers are more aware of their correct BMI than the other two groups.

15.4 Diet and Exercise

15.4.1 Diet and exercise are inextricably linked in health terms. This section investigates the diet trends for each of the exercise levels identified in chapter 10.

15.4.2 Figure 15-5 shows the diet indicators for each of the three exercise levels.

15.4.3 The high level exercise group appear to be the healthiest diet group. They are most likely to have their 5-a-day, eat oily fish at least twice a week and least likely to eat sweets and chocolate and fizzy drinks.

15.4.4 These figures are also very close to those with moderate exercise. Moderate exercisers are more likely to have wholegrain cereal for breakfast, eat chicken or turkey at least twice a week and least likely to have crisps excessively.

15.4.5 None of the exercise groups is consistently better in all the indicators.

15.4.6 Figure 15-6 shows the Diet Group for each of the three exercise categories.
15.4.7 Figure 15.6 shows that there is little difference between the exercise groups in terms of their diet. The low exercise group have a smaller proportion of respondents with a good diet compared to the moderate and high level exercise groups.

15.4.8 On average, the moderate exercises had a higher Diet Test score, with 10.4. Those in the high exercise group had an average of 10.0, very little difference, and those in the low exercise group had an average of 9.6.

15.4.9 The moderate exercise group are more likely to be aware of their correct BMI: 65% of this category correctly identified their BMI group, compared to 62% of the low group and 59% of the high group. However, the differences are not statistically significant.

15.5 Diet and Sunbathing

15.5.1 Figure 15.7 shows the respondents who said suntan is important to them against those who said it’s not, split up by Diet Group.

15.5.2 Those who say a suntan is important to them are nearly twice as likely to have a poor diet (23%) as those who say suntan is not important to them (13%). This difference is significant.
16 Smoking

16.1 Introduction

16.1.1 Typically smokers are associated with less healthy lifestyles in other respects. In the sections below, smoking habit is examined against alcohol consumption, physical activity and sunbathing behaviour.

16.2 Smoking and Alcohol Consumption

16.2.1 On average, smokers drink 7.7 units a week, while non-smokers drink 5.4 units a week. This difference is significant.

16.2.2 Figure 16-1 compares the proportion of drinkers by smoking habit.

![Figure 16-1: Proportion of people who drink and don’t drink by smoking habit](image)

16.2.3 Non-smokers are more likely to drink alcohol compared to smokers. 70% of non-smokers say they drink alcohol compared to 64% of smokers. This difference is not statistically significant.

16.2.4 Figure 16-2 shows the amount of alcohol consumed by smokers and non-smokers.

![Figure 16-2: Amount of alcohol consumed by smoking habit](image)

16.2.5 Nearly 90% of non-smokers are either light drinkers or don’t drink at all compared to 75% of smokers. This is a significant difference.

16.2.6 Smokers are slightly more likely to be moderate drinkers than non-smokers (9% vs 7%). The difference is not significant.

16.2.7 Smokers are also slightly more likely to be heavier drinkers than non-smokers (6% vs 4%). This also has no statistical significance.
16.3 Smoking and Physical Activity

16.3.1 Figure 16-3 shows activity levels by smokers and non-smokers.

16.3.2 There is very little difference in exercise levels between smokers and non-smokers. Of those who exercise at a moderate or high level, 67% are non-smokers and 66% are smokers.

16.3.3 Figure 16-4 shows the exercise levels by smoking intensity.

16.3.4 Light smokers are more likely to have high exercise levels compared to the other categories; 37% of those who are light smokers are in the high exercise group, 33% are non-smokers, 27% are moderate smokers and 25% are heavy smokers. However, these are not significant differences.

16.3.5 Heavier smokers are more likely to be moderate exercisers.

16.4 Smoking and Sunbathing

16.4.1 Figure 16-5 shows the smoking habit of each of the sunbathing categories (that is, those who said suntan is very/fairly important as against to those who said that it was not important).

16.4.2 Non-smokers are more likely to say that suntan is not important to them compared to smokers.

16.4.3 In general, 43% of respondents who say they smoke say that a suntan is very or fairly important to them compared to 37% of non-smokers.

16.4.4 Heavier smokers are more likely to be moderate exercisers.
17 Alcohol

17.1 Introduction

17.1.1 Alcohol consumption has already been compared with most of the lifestyle factors earlier in this report. In this section alcohol consumption is compared with the remaining two lifestyle factors, physical activity and sunbathing, to see if there are any interesting relationships.

17.2 Alcohol and Physical Activity

17.2.1 Figure 17-1 shows the activity level of the respondents categorised by drinkers and non-drinkers.

Figure 17-1
Activity level by drinkers or non-drinkers

17.2.2 Over a third (36%) of drinkers are in the high level activity group compared to non-drinkers (23%). This is a significant difference.

17.2.3 Non-drinkers are more likely to be moderate exercisers than drinkers.

17.2.4 Figure 17-2 shows the activity level of the respondents according to the frequency of their alcohol consumption.

Figure 17-2
Activity levels by frequency of alcohol consumption

17.2.5 Non-drinkers are seemingly less likely to be active than the drinkers.

17.2.6 From all the groups, non-drinkers are the least likely to have a high level of activity, 23%, compared to the all drinkers category, there is a significant difference between non-drinkers and occasional drinkers.

17.2.7 Of all drinkers, occasional drinkers appear to be the most active, with 71% having either moderate or high level of activity. However, there is no statistical significant difference in the groups.
17.2.8 Figure 17-3 looks instead at the amount of alcohol consumed and compares the activity levels of each group of drinkers.

![Figure 17-3](image)

**Activity levels by amount of alcohol consumed**

17.2.9 It appears to be the light drinkers who have the highest levels of activity, 37%. Of those who are moderate drinkers, 30% have high levels of activity compared to 26% of heavy drinkers with high levels of activity.

17.2.10 Figure 17-4 shows the proportion of drinkers in each of the exercise levels.

![Figure 17-4](image)

**Proportion who drink alcohol by exercise level**

17.2.11 Respondents in the high exercise group are the most likely to drink alcohol. In fact, the proportion of alcoholic drinkers increases as exercise level increases.

17.2.12 Figure 17-5 shows the frequency of alcohol consumption in each exercise group.

![Figure 17-5](image)

**Frequency of alcohol consumption by exercise level**

17.2.13 The moderate exercisers are slightly more likely to be persistent drinkers, although the differences are not significant.

17.2.14 Respondents who have high levels of activity are usually occasional drinkers. This result tallies with comments made earlier.

17.2.15 Figure 17-6 shows the amount of alcohol consumed by each of the exercise groups.

![Figure 17-6](image)

**Amount of alcohol consumed by exercise level**

17.2.16 The high exercise group are likely to be light drinkers.

17.2.17 Overall, 16% of those with low activity levels are moderate or heavy drinkers, 8% with moderate activity levels are moderate or heavy drinkers and 9% of those with high levels of activity are moderate or heavy drinkers.

17.3 Alcohol and Sunbathing

17.3.1 Of those who say a suntan is important to them, 40% drink alcohol whereas 45% are non-drinkers. This holds no significant difference. There is no difference for respondents who say suntan is not important to them, with 50% being non-drinkers and 52% being drinkers.

17.3.2 Occasional drinkers are more likely to rate suntan as important to them compared to regular or persistent drinkers. Due to small numbers in the other groups, there is no statistical significance.
18 Physical Activity & Sunbathing

18.1 Introduction

18.1.1 The final comparison to be made is that of physical activity and sunbathing.

18.2 Physical Activity and Sunbathing

18.2.1 Figure 18-1 compares each exercise level and shows the proportion of respondents who think that a suntan is or is not important to them.

Figure 18-1
Proportion who think a suntan is important by exercise level

18.2.2 The proportion of respondents who say a suntan is important to them increases as exercise intensity increases, with 46% of those in the high level activity stating that suntan is important to them.

18.2.3 The proportion of respondents who say a suntan is not important to them is much higher in each of the different exercise levels, with the difference in the high level being much smaller than the other two groups.
19.1.1 Around 75% of those who are overweight or obese rated their health as good or very good suggesting the lack of knowledge about their BMI.

19.1.2 Around 55% of those who are actually overweight (by BMI calculations) are aware that they are. Over a third of all respondents think that they are about the right weight for their height and the rest are not sure.

19.1.3 Women appear to be more aware of being overweight than men, although the difference holds no statistical significance.

19.1.4 Those who rate their health as bad or very bad are most likely to have an average diet based on the Diet Test score.

19.1.5 Smokers are less likely than non-smokers to rate their health as good or very good suggesting some awareness that may or may not be related to their smoking habit.

19.1.6 Occasional drinkers rate their health better than any other drinking category or non-drinkers.

19.1.7 Respondents in the high activity group are significantly more likely to rate their health as good or very good than those who smoke, drink alcohol or are overweight or obese.

19.1.8 Smokers, in general, have a lower BMI average than non-smokers. This varies by smoking habit, with heavy smokers having the highest BMI average of all smokers and non-smokers. But there is no statistical significance.

19.1.9 Over 60% of heavy smokers are overweight or obese compared to 54% of moderate smokers and 41% of light smokers. This holds no statistical significance.

19.1.10 Contrary to expectations, non-drinkers are significantly more likely to be obese than drinkers. This could also be due to the fact that some people do not have alcohol due to medical reasons.

19.1.11 Heavy drinkers are much more likely to be overweight or obese compared to other drinkers, though the numbers are too small for any significance.

19.1.12 There is some evidence to suggest that BMI increases with increased frequency of alcohol consumption.

19.1.13 The proportion of obese persons decreases significantly as exercise levels increase.

19.1.14 Over a quarter of respondents who do less than the recommended exercise levels are obese compared to 19% of those doing at least 3 hours a week. This is significant.

19.1.15 Those doing 3-4 hours of exercise a week have a lower average BMI than those doing less than 3 hours a week, although both averages fall in the overweight category.
19.1.16 Those who are obese do significantly less exercise each week than those who are overweight and those who have a normal weight.

19.1.17 Those who say a suntan is important to them are more likely to have a normal BMI than those who say it is not important. They are also less likely to be overweight or obese.

19.1.18 Smokers are significantly more likely to have a poor diet compared to non-smokers.

19.1.19 Non-smokers have a much higher average in the Diet Test than smokers.

19.1.20 On the Diet Test score, regular drinkers had the highest average score, followed closely by non-drinkers.

19.1.21 Non-drinkers have the lowest proportion of respondents with poor diets compared to the other drinking categories.

19.1.22 Non-drinkers and light drinkers are more aware of their correct BMI than the other groups.

19.1.23 The high level exercise group appear to be the healthiest diet group. There is very little difference and consistency within the groups.

19.1.24 The moderate exercise group are more likely to be aware of their correct BMI than the low and high exercise groups.

19.1.25 Those who say a suntan is important to them are nearly double as likely to have a poor diet than those who don’t have an interest in suntan. This difference is significant.

19.1.26 Smokers drink on average 7.7 units a week compared to non-smokers who drink 5.4 units a week. This is significant.

19.1.27 There is no difference in exercise levels between smokers and non-smokers. Looking at the smoking consumption, light smokers are more likely to be in the high exercise level than any of the other smoking categories and non-smokers.

19.1.28 Non-smokers are more likely to say a suntan is not important to them.

19.1.29 Over a third of drinkers are in the high level exercise group compared to 23% of non-drinkers.

19.1.30 Alcohol consumption, whether in frequency or amount, seems to be associated with a higher level of physical activity.
PART FOUR
International Comparisons
20 Introduction

20.1 Objective

20.1.1 As in the previous survey report, this report too has initially concentrated on finding and interpreting relationships within the data collected to obtain a better understanding of the health and lifestyle habits of Gibraltar’s population.

20.1.2 Next, it is important to examine this data in context and the approach chosen here is the same as that in the earlier survey, which is to compare this survey’s findings with those of comparable ones carried out in other countries and states.

20.2 Materials

20.2.1 This chapter utilises survey data from different sources and Figure 20-1 summarises the main features of each survey used in this comparative analysis.

Figure 20-1

<table>
<thead>
<tr>
<th>Country/State</th>
<th>Survey Name</th>
<th>Data Collection Period</th>
<th>Survey Population</th>
<th>Data Collection Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gibraltar</td>
<td>GHA Survey of Health and Lifestyles 2015</td>
<td>2015</td>
<td>Adults aged 16+</td>
<td>Interview-led questionnaires</td>
</tr>
<tr>
<td>Scotland</td>
<td>Scottish Health Survey 2014</td>
<td>2014</td>
<td>Adults aged 16+</td>
<td>Interviews</td>
</tr>
<tr>
<td>England</td>
<td>Health Survey for England 2013</td>
<td>2013</td>
<td>Adults aged 16+</td>
<td>Interviews</td>
</tr>
<tr>
<td>Wales</td>
<td>Welsh Health Survey 2014</td>
<td>2014</td>
<td>Adults aged 16+</td>
<td>Self-completed questionnaire</td>
</tr>
<tr>
<td>Jersey</td>
<td>Jersey Annual Social Survey 2014 (2013 survey used where data was unavailable for 2014)</td>
<td>2013/2014</td>
<td>Adults aged 16+</td>
<td>Self-completed questionnaire</td>
</tr>
<tr>
<td>Guernsey &amp; Alderney</td>
<td>Guernsey and Alderney Healthy Lifestyle Survey 2013</td>
<td>2013</td>
<td>Adults aged 18+</td>
<td>Self-completed questionnaire</td>
</tr>
<tr>
<td>Malta</td>
<td>Lifestyle Survey 2007</td>
<td>2006-2007</td>
<td>Adults aged 18+</td>
<td>Self-completed questionnaire</td>
</tr>
<tr>
<td>Spain</td>
<td>Encuesta Nacional de Salud 2011/12</td>
<td>2011/2012</td>
<td>Adults aged 18+</td>
<td>Self-completed questionnaire</td>
</tr>
<tr>
<td>Isle of Man</td>
<td>Isle of Man Health and Lifestyle Survey 2009</td>
<td>2009</td>
<td>Adults aged 16+</td>
<td>Telephone questionnaire</td>
</tr>
</tbody>
</table>
20.2.2 The countries or states used have been specifically selected for comparison with Gibraltar based on one or more of the following criteria:
- Geographical proximity or similarity of climate (Spain, Malta)
- Similarity of culture and lifestyle (England, Wales, Scotland, Spain)
- Similarity of country size and access to healthcare (Jersey, Guernsey, Malta, Isle of Man).

20.2.3 Each survey is slightly different, as there are differences in the data collection procedures, the ages of the respondents and the time periods used.

20.2.4 None of the sources can be regarded as entirely perfect comparisons for Gibraltar’s data, but together they do provide a very useful insight by allowing the general patterns to be compared.

20.3 Approach

20.3.1 The standardisation for this analysis has been done by age and sex only. There are bound to be other demographic reasons that have an influence, but this is likely to be less significant.

20.3.2 The Gibraltar census population, split by age and sex, was used as the standard population.

20.3.3 Most countries had data available by age and sex and therefore were fully standardised. Some reports did not present the data broken down by age and sex and it was not possible to standardise the comparator data in some sections. Reference is made to these wherever they arise.

20.3.4 There were no data available for comparisons for physical activity and therefore this section was excluded in international comparisons.
21 Obesity Comparisons

21.1 General Comparisons

21.1.1 Obesity is associated with an increased risk of numerous serious health conditions, creating a considerable and growing burden on the healthcare resources in developed countries all around the world. The general consensus around the world is that levels of obesity are rising sharply and Gibraltar is by no means an exception to this trend.

21.1.2 In this chapter, the data has been standardised by age and sex for most countries and provide a useful view of Gibraltar’s relative position against other countries. Data for Jersey was not standardised due to absence of age or sex breakdown. Data for Malta was semi-standardised as it was only available broken down by age.

21.1.3 Surveys use different age groups in their population definitions. Countries such as Guernsey, Malta and Spain have surveyed persons who are over the age of 18, whereas Scotland, England, Wales and Gibraltar use persons 16 and over.

21.1.4 All countries use self-reported measurements, i.e. weights and heights, to calculate BMI, with the exception of Scotland and England who measured each respondent. Respondents who are not actually measured may tend to under-represent their weight and therefore data from such surveys might artificially show a smaller percentage of obese persons.

21.1.5 Figure 21-1 shows the data from the OECD Statistics Report for 2015. The data has not been standardised but they provide a useful view of Gibraltar’s position in the international obesity league.
21.1.6 Figure 21-1 shows a wide range in obesity levels between different countries.

21.1.7 The United States and New Zealand have some of the highest levels of obesity for both men and women, while Japan and Korea have very small proportion of obese persons for both men and women. The UK also features high on the charts.

21.1.8 For men, Gibraltar’s obesity level sits roughly between England and Spain, just as it did in 2008. However, while that was also the case for women in 2008, Gibraltar women now have higher obesity levels than both England and Spain.

21.1.9 For both men and women, Gibraltar’s obesity levels are higher than in Guernsey or Jersey, just as it was in 2008.

21.1.10 Figure 21-2 widens the comparison, including both Obese and Overweight persons, for eight countries studied.

21.1.11 Gibraltar has lower levels of excess weight than Scotland, England and Malta, but has higher levels than Jersey, Guernsey, Isle of Man, Wales and Spain. Gibraltar figures are very close to those of Wales and Spain. (Data on gender for Malta was not available)

21.1.12 Gibraltar women have higher levels of excess weight than any of the other countries, with the exception of Scotland. Its figures are very close to those of England and Wales.

21.1.13 Gibraltar men have lower levels of excess weight than Scotland and England. Its levels are similar to Wales, but higher than Guernsey and Spain.

21.1.14 Analysis by age group is an important aspect, as this would help point to potential problems in the future.

21.1.15 Figure 21-3 shows the percentage of obese persons by age and country.

*The asterisks show the countries being analysed throughout chapters 21 to 25 in comparison to Gibraltar.
21.1.16 Gibraltar has the highest prevalence of obesity in older adults (over the age of 65) compared to all other countries. Gibraltar residents over the age of 65 are more likely to be obese than any of the other countries studied (with the exception of Scotland in those aged 45-64).

21.1.17 Gibraltar has lower prevalence of obesity in the younger age groups. This suggests that obesity increases with age, which can also be seen in countries such as England, Spain and Malta.

21.1.18 Figure 21-4 shows a breakdown of obesity for men by age and country. Figure 21-4 shows the percentage of men who are obese.

21.1.19 Gibraltar men aged 45-64 are more likely to be obese than men in any of the other countries. This could be a possible fallacy due to the small sample size.

21.1.20 All countries follow a similar pattern in men, where the prevalence of obesity increases up until the age of 64 and then decreases thereafter.

21.1.21 Spain and Guernsey have very similar obesity prevalence for men, having the lowest compared to all other countries studied.

21.1.22 Figure 21-5 shows the proportions of obese women by age and country.

21.1.23 Gibraltar women over the age of 65 are significantly more likely than any of the other countries to be obese.

21.1.24 As with Scotland, England and Spain, Gibraltar also has a pattern where, as age increases obesity increases.

21.1.25 Gibraltar women have lower obesity prevalence in their younger years compared to other countries.

21.1.26 There is a higher proportion of obese women in the 16-24 age group compared to men, especially for Scotland and Guernsey.
22.1.1 There are questions on the Gibraltar survey that can be compared with one or more surveys to gain an understanding of the Gibraltarian diet, in a wider international context.

22.1.2 However, the comparison surveys researched for this report use a wide variety of methods to understand their nation’s dietary habits. Each of them differs from the methods used in Gibraltar, making them difficult to compare.

22.1.3 All the survey data for other countries in this section were standardised for age and sex, except for Guernsey and Isle of Man which were partly standardised as data on either age or sex was not available. Jersey data was not available for standardisation at all and therefore these are crude results.

22.2 Five-a-day

22.2.1 Figure 22.1 shows the proportion of persons who consume at least their recommended five portions of fruit and vegetables a day.

Gibraltar does well in comparison to the countries studied. The proportion of responders having the recommended Five-a-day is average in comparison to the other countries.

22.2.3 Figure 22.2 shows the proportion of persons who consume at least their recommended five portions of fruit and vegetables each day by sex.
22.2.4 Gibraltar men do well compared to men in other countries, with over a quarter of men consuming the recommended Five-a-day. In this respect, Gibraltar men do better than men from Guernsey and Scotland. However, this proportion is significantly lower than men from the Isle of Man, and slightly lower than Welsh men.

22.2.5 Gibraltar women are slightly better than men in comparison to other women in other countries. They are significantly lower than women from the Isle of Man but are higher than any of the other countries studied, with Welsh women closely behind.

22.2.6 The Isle of Man stands out as being particularly good with nearly half of both men and women eating their recommended Five-a-day.

22.2.7 Generally, Gibraltar compares most closely with Wales in terms of fruit and vegetable consumption.

22.2.8 Figure 22-3 shows the proportion of the population eating their Five-a-day by age.

22.2.9 In general, Gibraltar is doing well compared to the other countries. Gibraltar has the highest percentage of persons aged 16-24, who eat their recommended Five-a-day.

22.2.10 Gibraltar has higher proportions than England, Scotland and Guernsey at all ages, while Guernsey falls significantly lower than the other countries.

22.2.11 Gibraltar (4.0) has the highest average of fruit and vegetable consumption in those aged 16-24 compared to England (3.0) and Scotland (2.8).
23 Smoking Comparisons

23.1 Smoking Prevalence

23.1.1 In Gibraltar 35% of the population said they currently smoke. This is an increase from the last survey in 2008, however, this difference is not statistically significant. It is possible that some of the figures could be due to the way the questionnaire was answered, as a few individuals skipped the smoking section and therefore were treated like non-respondents.

23.1.2 Figure 23-1 shows smoking prevalence among different countries.

23.1.3 Gibraltar has the highest smoking prevalence compared to all the other countries studied. These high figures seen in Gibraltar could be an artefact for the reason mentioned above.

23.1.4 Spain and Malta also have high smoking rates.

23.1.5 Guernsey has the lowest smoking prevalence compared to the other countries.

23.1.6 Figure 23-2 shows smoking prevalence by gender. This data is not available for Jersey.
23.1.7 Gibraltar men have the highest smoking prevalence compared to men and women of all the other countries studied.

23.1.8 Gibraltar men are much more likely to smoke than English men, a difference of 16%. There is also a 12% greater likelihood of smoking in Gibraltar women compared to English women. Both these differences are significant.

23.1.9 Figure 23-3 shows smoking prevalence by age group for the selected countries.

23.1.10 Gibraltar has the highest smoking prevalence for all the age groups compared to the other countries.

23.1.11 All countries studied, with the exception of Guernsey follow a similar pattern where smoking prevalence peaks at 25-44 year olds and then decreases.

23.1.12 On average, Maltese men smoke 17 cigarettes a day, whereas Jersey men and Gibraltar men smoke 15, Scottish men smoke 13.5 and English men smoke 10.6.

23.1.13 On average, Maltese women smoke 11.7 cigarettes daily, Jersey women smoke 11, Gibraltar women smoke 10.5 and English women smoke 10. Scottish women smoke the most, with 13 cigarettes on average.

23.2 Quitting

23.2.1 Respondents were asked what factors could help them to stop smoking. Better self-motivation was the most common factor chosen by smokers in Gibraltar (45%), whilst 73% of smokers in Guernsey selected will power as the main response.

23.2.2 The second most popular reason given by both countries was advice from a doctor or health professional with 31% of Gibraltar smokers choosing this and 26% from Guernsey.

23.3 Health

23.3.1 In Guernsey, smokers rated their health lower than those who did not smoke and these results were very similar to those in Gibraltar.

23.3.2 Based on self-reported height and weight, in Guernsey there was a smaller proportion of current smokers who were classed as obese, whereas in Gibraltar there was no difference between smokers and non-smokers with reference to obesity.
24 Alcohol

24.1 Overview

24.1.1 Alcohol is a psychoactive substance with dependence-producing properties.

24.1.2 According to the World Health Organisation (WHO), the harmful use of alcohol ranks among the top five risk factors for disease, disability and death throughout the world and in 2012, about 5.9% of all global deaths were attributable to alcohol consumption.

24.1.3 Studies indicate that drinking alcohol is associated with a risk of developing health problems such as alcohol dependence, liver cirrhosis, cancers and injuries.

24.1.4 In addition to the health consequences, alcohol contributes to a wide range of social and criminal justice costs, placing a considerable burden on economy.

24.1.5 According to the European Status Report on Alcohol and Health 2010, published by the World Health Organisation (WHO), globally, the highest rates of morbidity and mortality due to alcohol occur within the WHO European region.

24.1.6 Many respondents skipped this section of the questionnaire and therefore they were considered non-respondents. This may reduce statistical reliability and some of the figures may have to be read with caution.

24.2 Non-Drinkers

24.2.1 In Gibraltar, nearly a fifth (17%) of men and nearly a third (31%) of women say they do not drink any alcohol. This is nearly a quarter (24%) of the overall population.

24.2.2 Figure 24-1 shows data for non-drinkers from some of the countries studied. Data from Guernsey and The Isle of Man were not available for standardisation and therefore unstandardised comparisons are used.

24.2.3 All countries follow the same pattern where there are more female non-drinkers than males.
24.2.4 Around a quarter of Gibraltar adults do not drink any alcohol, which is closest to England with (18%). Spain has the highest abstinence in comparison to all the other countries studied. Malta has the highest abstinence but all the data from Malta is derived from an older survey dated 2006/2007.

24.2.5 England, Scotland and Wales closely resemble each other with lower levels of abstinence with around 14-18% of the overall population.

24.2.6 Guernsey has the smallest proportion of non-drinkers, out of the countries analysed.

24.2.7 Figure 24-2 shows the proportion of non-drinkers by age group for the countries analysed.

24.2.8 Gibraltar, Malta and Guernsey follow very similar patterns in the proportion of non-drinkers, where the proportion of non-drinkers increases with age.

24.2.9 The proportion of non-drinkers in the eldest age group is significantly higher in all countries, with the exception of England.

24.2.10 Spain has the highest proportion of young people who are non-drinkers (33%) followed by England (23%). Gibraltar has the lowest (with the exception that Guernsey has none) proportion of young adults who are non-drinkers (11%).

24.2.11 Guernsey has the lowest level of abstention in all of the age groups.

24.3 Frequency of Alcohol Consumption

24.3.1 As the data becomes more detailed, its comparability decreases. This is largely because different surveys ask slightly different versions of questions, in a way that is most appropriate to their population.

24.3.2 The alcohol questions used in Gibraltar’s Health and Lifestyle Survey closely follow those used in the Guernsey and Jersey surveys. Comparable data for the other countries is not available and therefore not examined in this section.

24.3.3 Jersey’s data was not standardised and Guernsey’s data was semi-standardised due to the nature of the data.

24.3.4 It should also be pointed out that the data for Gibraltar and Guernsey differ slightly. In Gibraltar all adults aged 16 and above were surveyed, while in Guernsey only those within the age range 18-74 were surveyed, with slight variances caused by the youngest and the oldest populations not being represented. Jersey data does not differ from that of Gibraltar in this respect.

24.3.5 Figure 24-3 compares the frequency of alcohol consumption in Gibraltar with that of Guernsey and Jersey.

24.3.6 Gibraltar stands out as being considerably different from both Guernsey and Jersey in the frequency of alcohol consumption. Both Guernsey and Jersey have more than double the number of persistent drinkers compared to Gibraltar. They are also much more likely to be regular drinkers. These differences are significant.

24.3.7 In Gibraltar, 77% of the population either do not drink at all or are occasional drinkers. This figure contrasts significantly with the same figures for Guernsey (46%) and Jersey (53%).

24.3.8 Figure 24-4 compares the frequency of alcohol by sex for both men and women in Gibraltar and Guernsey. Data was not available by sex for the Jersey population.
24.4.2 These comparisons should be made with caution as some of the units have been calculated differently, but the general patterns can be compared.

24.4.3 Each survey reported on whether or not respondents were drinking within the recommended limits of 21 units a week for men and 14 units a week for women, though the English survey questioned respondents on their drinking in the last week.

24.4.4 In Scotland, 26% of men and 21% of women had drunk above the limit.

24.4.5 In England, 27% of men and 20% of women had drunk above the limit.

24.4.6 In Wales, 53% of men and 42% of women had drunk above the limit.

24.4.7 The figures for Gibraltar are much lower with 7% of Gibraltar men and 3% of Gibraltar women having drunk above the limit.

24.4.8 The survey found that Gibraltar men aged 25-44 were most likely to drink over the limit (14%) which is still considerably lower than the same group of men in Wales (54%), England (24%) and Scotland (20%).

24.5 Binge Drinking

24.5.1 Gibraltar’s data relating to binge drinking is not directly comparable to any of the selected countries, due to a difference in the definition used. In Gibraltar, respondents were asked how often they drank 6 or more standard drinks on one occasion. The surveys for England, Scotland, Jersey, Isle of Man, Wales and Guernsey define a binge drinker as a man who drinks more than 8 units on any one day in the previous week and a woman who drank more than 6 units on any one day of the previous week.

24.5.2 The surveys for Malta and Spain do not collect data on binge drinking.

24.5.3 While the data cannot be compared directly, differences or similarities in the patterns and trends can be observed.

24.5.4 In Scotland, England, Wales, Guernsey and Isle of Man, men were more likely to be categorised as binge drinkers than women, matching what is seen in Gibraltar.

24.5.5 Binge drinking in these countries was also the highest in the youngest age group (16-24) and decreased as age increased, also seen in Gibraltar.
25 Sunbathing Comparisons

25.1 Overview

25.1.1 With the exception of Guernsey, the comparison surveys used do not cover this topic at all. Perhaps understandably, sun exposure is a subject of lesser interest in the northern latitudes where year-round sunshine is not an issue. Jersey does collect similar information but the data was not comparable to Gibraltar data.

25.1.2 The Guernsey survey asks questions about sunbathing and sunburn. In fact some of the questions used in the Gibraltar survey were borrowed from the Guernsey survey.

25.1.3 It should be cautioned that the Guernsey survey takes data from adults aged 18-74 whereas Gibraltar’s survey takes data from adults aged 16 and over. The data therefore is not an exact match but it gives an idea of how Gibraltar compares to Guernsey.

25.2 Sun cream

25.2.1 In Gibraltar, nearly a third of respondents said they do not usually use sun cream. In Guernsey, this figure was 27%.

25.2.2 As in Gibraltar, it is Guernsey’s men who are much less likely to use sun cream than the women. A third of Guernsey men do not usually use sun cream compared to 22% of Guernsey’s women. In Gibraltar, 49% of men do not usually use sun cream compared to 15% of men. There is a difference in both sexes.

25.2.3 The use of sun protection factor (SPF) 15+ sun creams is similar in both countries, with 63% of respondents in Guernsey using SPF 15+ compared to 60% of Gibraltarians.

25.2.4 Of those who use sun cream, 55% of Guernsey’s men use SPF 15+ compared to 42% of Gibraltar’s men.

25.2.5 Of those who use sun cream, 70% of Guernsey’s women use SPF 15+ compared to 77% of Gibraltarian women.

25.3 Sunburn

25.3.1 Respondents in both surveys were asked how many times in the previous 12 months had they suffered from sunburn. In Guernsey, 40% said they had been sunburnt at least once in the last 12 months, compared to only 28% in Gibraltar. This difference is significant.

25.3.2 In Gibraltar, there was almost no difference between men and women in this respect: 28% of men and 29% of women had been sunburnt at least once in the last year.

25.3.3 In Guernsey, however, there was a greater difference between the sexes; 43% of men and 36% of women had been sunburnt at least once in the last year.
25.4 Awareness of Skin Cancer Prevention

25.4.1 Respondents in both surveys were asked if they knew the importance of each of the main factors that help to prevent skin cancer (some factors differed in the surveys). Figure 25-1 shows the results in those factors that were comparable.

![Figure 25-1](image)

25.4.2 There is very little difference between both countries in their awareness of the factors that can prevent skin cancer. Gibraltar respondents are more aware of the importance of sun cream than those from Guernsey.

25.4.3 Guernsey respondents are slightly more aware of avoiding the midday sun than those from Gibraltar.

25.4.4 Generally, Gibraltar people exhibit a good understanding of the key factors that help to prevent skin cancer.
26 Key Findings

26.1.1 Gibraltar has higher obesity levels than Spain but lower than the UK, this was the same as in 2008.

26.1.2 Gibraltar women have higher obesity levels than any of the other countries studied with the exception of Scotland.

26.1.3 Gibraltar has the highest prevalence of obesity in adults aged 65 and over compared to the other countries but has one of the lower prevalence in the younger age groups.

26.1.4 Gibraltar men aged 45-64 are more likely to be obese than men of the same age in the other countries studied.

26.1.5 Both men and women in Gibraltar are only significantly worse than the Isle of Man at eating their 5-a-day.

26.1.6 Compared to the other countries studied (with the exception of the Isle of Man) Gibraltar people are quite good at eating their 5-a-day. This was not the case in 2008 where Gibraltar was worse than England, Jersey and Wales.

26.1.7 Gibraltar’s smoking prevalence is the highest of all the countries studied, followed by Spain and Malta. In 2008, Gibraltar’s smoking prevalence was lower than Spain’s.

26.1.8 Gibraltar men and Maltese men have 17 cigarettes a day on average, whereas Jersey men have 15, Scottish men have 13.5 and English men have 10.6.

26.1.9 On average, Scottish women have 13 cigarettes a day, Gibraltar and Maltese women have 12, Jersey women have 11 and English women have 10.

26.1.10 Gibraltar people are significantly less likely to be regular or persistent drinkers compared with Jersey and Guernsey.

26.1.11 Both Guernsey and Jersey have much higher rates of heavy drinkers, though this could be related to a difference in the data collection methods.

26.1.12 In Scotland, England, Wales, Guernsey and Isle of Man, men were more likely to be categorised as binge drinkers than women, matching what is seen in Gibraltar.

26.1.13 Binge drinking in these countries was also the highest in the youngest age group and decreased as age increased, which is also seen in Gibraltar.

26.1.14 Gibraltar has similar figures to Guernsey when it comes to the use of sun cream. Nearly a third of Gibraltar people use sun cream compared to 27% in Guernsey. In 2008, Guernsey had a lower percentage of people using sun cream whereas Gibraltar’s percentage is stable.

26.1.15 As in Gibraltar, it is Guernsey’s men who are much less likely to use sun cream than their women. This was the same case as in 2008.

26.1.16 Gibraltar people were much less likely to get sunburnt during the last year compared to the population of Guernsey, with only 28% suffering sunburn compared to 40% in Guernsey. In 2008 survey the figures were very similar.

26.1.17 There is very little difference between the awareness of skin cancer prevention in both countries, with Gibraltar being more aware of the use of sun cream and Guernsey more aware of avoiding the midday sun.
PART FIVE
Summary
The Sample

A combination of random sampling, good response rate and respondent weighting show that the data closely resembles the total population of Gibraltar.

General Health

Of those respondents who rated their health, 77% rated their health as good or very good and only 5% rated it as bad or very bad.

Men were more likely to rate their health as good or very good in comparison to women.

Hypertension was the most common illness of respondents who could answer the question.

Dental check-ups were the most popular for all respondents.

Obesity

Of those whose BMI was calculated, 60% of respondents are overweight or obese. This means that 3 out of every 5 Gibraltar people are overweight or obese.

Of the BMI categories, 24% of respondents are obese.

There is a difference between men and women; 63% of men are overweight or obese compared to 55% of women.

Men start to become overweight at a younger age than women.

Over three quarters of men are overweight from the age of 45.

In the last survey no men aged 16-24 were obese. This year 8% were obese. This is significant.

Diet

Under a quarter of respondents eat 5 or more portions of fruit and vegetable each day.

Men are more likely than women to eat unhealthy foods such as sweets, chocolates and crisps.

The youngest age group (16-24) rated their diet better than any other age group even though they are the most likely to eat unhealthy food types at an excessive level.
27.4.4 Using the diet test as a measure, women in the survey are more likely to have a better diet than men.

27.4.5 The youngest men (16-24) had a worse diet than any of the other age/sex categories.

27.4.6 Respondents who are married/cohabiting are more likely to have a better diet than those who are single, divorced or widowed.

27.4.7 Those living in their own home have a better diet than those living in Government housing.

27.5 **Smoking**

27.5.1 The findings show that 35% of survey respondents are current smokers.

27.5.2 Men aged 25-44 are more likely to smoke than other age groups and females.

27.5.3 Younger females are more likely to smoke than older females.

27.5.4 Over three quarters of smokers had at least one parent who smoked.

27.5.5 Older smokers are significantly more likely to be advised to quit smoking.

27.5.6 Current smokers are mostly moderate smokers consuming 10-19 cigarettes a day.

27.5.7 The majority of smokers believe that better self-motivation is the key to helping them quit.

27.6 **Alcohol**

27.6.1 24% of respondents are non-drinkers.

27.6.2 The results indicate that 19% of men and 31% of women say they never drink alcohol, a significant difference.

27.6.3 The proportion of non-drinkers increases steadily with age.

27.6.4 Those aged 45 and over are significantly more likely to be persistent drinkers than those aged under 45.

27.6.5 Men drink significantly more units of alcohol per week than women (7.1 vs 3.7).

27.6.6 Of those who binge drink, 17% admitted to binge drinking at least once a week.

27.6.7 Those in the youngest age group (16-24) are significantly more likely to binge drink than any other age group.

27.6.8 Married/cohabiting are more likely to be persistent drinkers followed by single respondents.

27.7 **Physical Activity**

27.7.1 The proportion of people who exercise intensely decreases with age.

27.7.2 Three quarters of those aged 16-24 say they exercise intensely for more than 3 hours a week.

27.7.3 Nearly a third of respondents are categorised as having high levels of activity.

27.7.4 Men are significantly more likely to have higher levels of activity compared to women.

27.7.5 Single persons are significantly more likely to be in the high activity group than any other of the marital status.

27.8 **Sunbathing**

27.8.1 A quarter of respondents say that a suntan is important to them.

27.8.2 Women are significantly more likely to acknowledge the importance of a suntan than men (48% vs 33%).

27.8.3 Nearly a third of respondents do not usually use sun cream.

27.8.4 Of those who use sun cream, 60% of respondents use SPF 15 or above. This result has significantly improved since the last survey in 2008 (45%).

27.9 **Lifestyle Trends**

27.9.1 Around 70% of those who are overweight or obese rated their health as good or very good suggesting the lack of knowledge about their BMI.

27.9.2 Over 50% of those who are actually overweight (by BMI calculations) are aware that they are. Over a third of respondents think they are about the right weight for their height.

27.9.3 Smokers are less likely to rate their health as good or very good suggesting some awareness that may or may not be related to their smoking habit.

27.9.4 In general, smokers have a lower BMI average than non-smokers.

27.9.5 Contrary to expectations, non-drinkers are more likely to be obese than drinkers, this could be due to the fact that some people will not have alcohol due to medical reasons.

27.9.6 Of those that do drink, there is some evidence to suggest that BMI increases with increased frequency of alcohol consumption.

27.9.7 Heavy drinkers are much more likely than any other drinking category to be overweight or obese, although the numbers are too small to be statistically significant.
27.9.8 Over a quarter of respondents who do less than the recommended exercise are obese.

27.9.9 Those exercising for 3-4 hours a week have a lower BMI average, although they are still classed as overweight.

27.9.10 Those exercising for 5 or more hours a week have a significant lower BMI average, although it is still in the borderline normal/overweight category.

27.9.11 Non-smokers score a much higher average in the diet test than smokers.

27.9.12 Regular drinkers (those who drink 2-3 times a week) are more likely to have a good diet compared to any of the other drinking categories, with 30% of regular drinkers having a good diet.

27.9.13 The moderate exercise group are more likely to be aware of their correct BMI.

27.9.14 Smokers drink, on average, 2.3 units of alcohol more each week than non-smokers.

27.10 International Comparisons on Diet and Weight

27.10.1 Gibraltar has higher obesity levels than Spain but lower than England and Scotland.

27.10.2 Gibraltar women have higher obesity levels than any of the other countries studied with the exception of Scotland.

27.10.3 Gibraltar has the highest prevalence of obesity in adults from the age of 45 (with the exception of Scotland in those aged 45).

27.10.4 Gibraltar has lower prevalence of obesity in the younger years which suggests that obesity increases with age, which can also be seen in countries such as England, Spain and Malta.

27.10.5 Gibraltar people are doing relatively well eating their 5-a-day compared to the other countries studied. They are better than England, Scotland and Guernsey at eating their 5-a-day.

27.11 International Comparisons on Smoking

27.11.1 Gibraltar has the highest smoking prevalence compared to all of the other countries studied. However, this could be due to how this section of the questionnaire was answered.

27.11.2 Gibraltar men are much more likely to smoke than English men, with a 16% difference. There is also a 12% difference from Gibraltar women smoking to English women.

27.11.3 All countries studied (with the exception of Guernsey) follow a similar pattern where smoking prevalence peaks at the age of 25-44 and then decreases.

27.11.4 On average, Maltese men smoke 17 cigarettes a day, compared to Jersey and Gibraltar men 15, Scottish men 13.5 and English men 10.6.

27.11.5 On average, Maltese women smoke 11.7 cigarettes a day, compared to 11 for Jersey women, 10.5 for Gibraltar women and 10 for English women. Scottish women have the highest average consumption with 13 daily.

27.12 International Comparisons on Drinking

27.12.1 Gibraltar people are much less likely to be regular or persistent drinkers in comparison to Jersey and Guernsey.

27.12.2 Data for England, Scotland, Wales, Guernsey and Isle of Man show similar patterns of binge drinking to those seen in Gibraltar, with men being more likely to be binge drinkers and highest in the youngest age group and steadily decreasing.

27.13 International Comparisons on Sun Safety

27.13.1 Nearly a third of Gibraltar people use sun cream compared to 27% of respondents in Guernsey.

27.13.2 Gibraltar people are significantly less likely to have been sun burnt in the last year compared to those in Guernsey.
In a Nutshell

28.1.1 This is the second Health and Lifestyle Survey of the adult population of Gibraltar and once again has revealed interesting findings about the health and lifestyle of the people of Gibraltar. As well as finding some encouraging points, it also highlights areas for concern.

28.1.2 Following up on the findings of the Health and Lifestyle Survey 2008, has provided opportunities to make comparisons which help not only to identify trends in changes taking place over the seven years that have elapsed, but also to reinforce those findings that have remained constant.

28.1.3 In the main, the results of the survey are very similar to those in 2008:
- The levels of Obesity remain high.
- Smoking levels are high and smoking prevalence has actually increased from 2008.
- The survey demonstrated a generally low level of alcohol consumption in the population among all ages and in comparison to the countries studied.
- Gibraltar people have a good awareness of the risk factors related to skin cancer and have a generally healthy attitude towards risky sunbathing behaviour.

Key Points for Concern

28.2.1 Smoking in Gibraltar is higher than that of any of the comparable countries that were chosen for study. What is even more of concern is the high prevalence among the younger ages (although smoking prevalence is high at all ages).

28.2.2 The survey found that smokers have poor diets and are unlikely to have as good diets as non-smokers. Smokers were also themselves less likely to rate their health as good or very good which suggests some awareness, which may or may not be related to their smoking habit. All this points to a potential excess of present and future disease burden in this sub-population.

28.2.3 In Gibraltar, 3 out of every 5 adults are overweight or obese. Of those who had their BMI calculated, 60% of respondents were overweight or obese. This is a serious concern for the population of Gibraltar. It brings significant health risks and likelihood of disease to these people and consequently increases the future burden of healthcare.

28.2.4 In the 2008 survey, no young men aged 16-24 were found to be obese whereas this Survey found 8% of this age group to be obese. Men also become overweight or obese at a younger age than women, exposing the gender gap. There are also high levels of obesity from the age of 25 onwards. Gibraltar has the highest prevalence of obesity in adults over the age of 45 amongst all the countries studied, except Scotland.

28.2.5 A worrying aspect is that over a third of overweight or obese people thought they were actually the right weight for their height, indicating ignorance or denial of their problem.

28.2.6 Physical activity is something that seems to have divided perceptions in Gibraltar. There are those who exercise intensely for at least 3 hours a week and those who do not exercise at all. The majority of those exercising for more than 3 hours a week are people in the younger age groups, as in 2008. For those in the older age categories also, exercising has become more popular now than in 2008.
28.2.7 Alcohol consumption is similarly two-sided. Over half of Gibraltarian adults either abstain from alcohol completely or drink only very occasionally. In this respect, Gibraltar has a similar pattern to Spain but very different to that of the UK or Guernsey.

28.2.8 However, among those who do drink, older drinkers seem to be significantly more likely to be persistent drinkers than those under 45 years of age.

28.2.9 Gibraltar people seem to be sensible with awareness of skin cancer and sun safety, especially in comparison with surveys from other countries. However, there are significant proportions of people who admit to not using sun cream, who have got sun burnt and for whom a suntan is very important.

28.3 **Key Areas for Action**

28.3.1 This is the second Health and Lifestyle Survey conducted in Gibraltar. The main aims of this survey were to gain a better understanding of the levels of perceived health of the population in Gibraltar. The findings are very similar to those in 2008 and therefore some key concerns are also repeated in this section.

28.3.2 Just as in the 2008 survey, Gibraltar has a very high prevalence for smoking and if anything, appears to be slightly worse. This is a major health concern in Gibraltar. It is now well-known that the list of harms to the human body from tobacco consumption is long and practically endless. The wide supply of cheap tobacco in Gibraltar makes prevention extremely difficult. Since the last survey, the “No Smoking Clinic” has been set up and a small number of smokers have certainly made good use of it by quitting, but reducing the burden of smoking requires much more decisive action at a national level.

28.3.3 Obesity is a big problem in Gibraltar. The Public Health Department has launched several campaigns to promote healthy eating, such as its “Couch Potato” campaign among adults and the “Change-4-Life” campaign aimed at children. However, at a more fundamental level, the reform of Gibraltar’s School Tuck Shops which sell a wide range of unhealthy snacks from within school premises is urgently needed alongside campaigns for healthier lunches for children, in the drive to reduce childhood obesity and the consequent health burdens in the years to come.

28.3.4 Physical activity is another lifestyle choice. The survey shows that there are some people who take regular exercise while others take none at all. It is now increasingly being recognised that regular physical activity protects against heart disease, stroke, type 2 diabetes, depression, certain types of cancer, arthritis and falls. In addition, it has a range of lifestyle benefits such as improved mood, better social engagement and good sleep rhythms. The challenge for Gibraltar is to put in place strategies that engage those not doing any exercise to incorporate it into their daily routines.

28.3.5 Although Gibraltar does not seem to have the problems with alcohol as opposed to other countries, it is a matter of concern that 17% admitted to binge drinking at least once a week and that persons in the youngest age group (16-24) are significantly more likely to binge drink than any other age group. In addition, men in particular drink a lot more than women. Hence, although, Gibraltar’s problems due to alcohol consumption may be of lower magnitude, it has pockets of concern that need to be addressed.

28.3.6 Generally, sun awareness is good in Gibraltar. However, notwithstanding that, a third of the population still does not usually use sun creams while in the sun. It is important to address this group through the annual sun safety educational campaigns.
PART SIX
Appendices
BMI Measurement Bias

The exceptions to this were the height and weight questions. In total, 4.6% of respondents did not provide one or both of these measures, meaning that their BMI could not be calculated. In order to compensate for this loss, the data was re-weighted as described in chapter 3, based on statistical assumption that the missing numbers were probably similar to the ones available on the survey data. These alternative weights were used for all the analysis on relating to BMI.

While this provides some degree of confidence to the analysis, it cannot entirely correct the issue. It is quite likely that respondents not willing or able to give their height or weight measurements did not have unusual characteristics (for example, a very obese person may choose not to reveal weight), which negates the statistical assumption. This is therefore a source of statistical bias.

However, as the extent of this bias cannot be estimated, known or proven, the data collected has been analysed and presented as accurately as possible and the interpretations should be read as subject to this caveat.

Body Mass Index

Respondents self-reported their height and weight for the survey. During the analysis stage, these measurements were cleaned so that all measurements were in the same metric form i.e. metres and kilograms.

The following formula was applied to calculate each respondent’s BMI:

\[
\text{BMI} = \frac{\text{weight (kg)}}{\text{(Height)(m)}}^2
\]

From this each respondent was given an accurate figure for their BMI ranging from 18.52 to 44.79.

In addition, respondents were then categorised according to which of the following BMI groups they fell into:

<table>
<thead>
<tr>
<th>Category</th>
<th>BMI Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>Less than or equal to 18.49</td>
</tr>
<tr>
<td>Normal Weight</td>
<td>18.50 – 24.99</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.00 – 29.99</td>
</tr>
<tr>
<td>Obese</td>
<td>Greater than or equal to 30.00</td>
</tr>
</tbody>
</table>
3. **The Diet Test**

The following questions, taken from the diet section of the health and lifestyle survey, were used to calculate test scores in the diet test:

- How many portions of fruit and vegetable do you normally eat each day?
- Which type of spread do you usually use on your bread?
- Which sort of fat or oil do you usually use for cooking or frying food?
- What type of cereal do you eat most often?
- How often do you eat oily fish?
- How often do you eat chicken or turkey?
- How often do you eat crisps?
- How often do you eat sweets and chocolates?
- How often do you eat sweetened squash or fizzy drinks?
- How often do you eat fried foods?

The responses to these questions were given a score between 0 and 2. A zero indicates the worst (unhealthiest) response to the question, while 2 represents the healthiest response.

The score for each question was added together to reach a total for all 10 questions; this total was the respondent’s diet test score.

The diet test score was then used to categorise respondents into one of the following three diet groups:

- Poor diet – test score between 0-6
- Average diet – test score between 7-13
- Good diet – test score between 14-20

4. **Measuring Alcohol Consumption**

Question 31 of the survey asked respondents how much alcohol they drink in an average week. They were shown pictures to help them to determine what glass or bottle sizes constitute a unit for different kinds of alcoholic drinks.

The results for this question are subject to more error than any other on the survey. For many respondents there may be no such thing as a normal week – for example those who drink infrequently (just on special occasions), or those who drink differently from week to week, for example more at the beginning of the month after pay day and less at the end of the month.

There will also be people who have difficulty in accurately recalling how much they drink, perhaps more so for those who drink a lot.

Additionally, the presence of an interviewer may lead to under-represent the amount they really drink due to perceived social pressure.

5. **Units of Alcohol**

As mentioned, respondents were shown pictures of typical alcoholic drinks to help them understand what constitutes a unit of alcohol.

As a guide, the following guidelines were used to calculate total units consumed:

- Low alcohol beer – 0.5 units
- Normal beer – 2.5 units
- Strong beer – 4 units
- Small glass of wine – 1.5 units
- Fortified wine – 1 unit
- Spirit measure – 1 unit
- Alcopops – 2 units
APPENDIX II
The Questionnaire

Lifestyle Survey
GIBRALTAR

Please read the instructions for answering each question carefully. Please check you have answered all the questions we have asked you to answer.

GENERAL HEALTH

1. How would you describe your general health? (Please tick one box only)
   - Very good
   - Good
   - Fair
   - Bad
   - Very bad

2. Do you have any long standing illness, disability or infirmity? (Please tick all that apply)
   - Diabetes
   - Heart Disease
   - Hypertension
   - Arthritis
   - Other, please specify below

3. In the past 3 years, have you attended any of the following?
   - Well Woman Clinic (Cervical cancer screening, Breast mammography)
   - Blood Pressure checked in last 12 months
   - Dental checkup in last 12 months
   - Eye check

EXERCISE

4. Which of the following best describes the amount of exercise you get during your daily routine? (Please tick one only)
   - Mainly sitting with little walking about e.g. office worker
   - Stand and walk about quite a lot but don't carry or lift often e.g. housewife, messenger
   - Carry light loads or have to climb hills or stairs e.g. postman, packer
   - Heavy work or carry heavy loads e.g. builder

5. How do you normally get to your place of work? (Please tick only one)
   - Walk
   - Moped
   - Cycle
   - Car
   - Bus
   - Other
   - Don't Work

6. How many hours a week do you exercise to make you out of breath and sweaty for 20 minutes?
   - Less than 3 (go to question 7)
   - 3 - 4 (skip question 7)
   - More than 5 (skip Q7)

7. If you feel that your present work and recreational exercise is not enough to keep healthy, which of the following prevent you from taking more exercise? Please tick no more than 3 boxes.
   - Fitness, injury or disability
   - Lack of incentive
   - Not interested or do not enjoy
   - Embarrassed or self-conscious about body shape
   - Other reasons:
     - Please specify:

THE FOOD YOU EAT

8. Based on the following information, how many portions of fruit and vegetables do you normally eat each day? (NOTE: This does not include potatoes)
   - One portion of fruit and vegetables is... (examples of portions – please see pictogram)
     - Portion size irrespective of quantity is only counted as 1 portion
     - Portions per day

9. Compared to last year, would you say that the amount of fruit and vegetables you are eating is...
   - More
   - Less
   - About the same

10. Which type of spread(s) do you usually use on your bread?
   - Marmalade
   - Jam
   - Margarine
   - Butter
   - Reduced fat or low fat spread (Gold, Vitelite Light Flour Light)
   - Cholesterol lowering spread e.g. Benecol, Proactive
   - Other (please write in the box)

11. What type of oil do you use for cooking or frying food?
   - Peanut oil
   - Olive oil
   - Rapeseed oil
   - Soya oil
   - Sunflower oil
   - Vegetable oil
   - Other: (please specify)
12. What type of breakfast cereal do you eat most often? (at any time of the day) *(tick as many)*
- Wholemeal or bran cereal e.g. All Bran, Weetabix
- Sugar coated / flavoured (Sugar Puffs, Coco pops)
- Special K
- Out based cereal or porridge (Muesli, Readybreak, Quaker Oats)
- Plain cereals e.g. Cornflakes, Rice Krispies
- Other: ____________________________
- Do not eat breakfast cereals (go to Q14)

13. If you do not have cereal for breakfast, what do you have?
- Cereal Bar
- Fruit
- Toast
- Smoothies
- Yoghurt
- Eggs
- Other: ____________________________

14. What is your main meal of the day? *(please rank)*
- Breakfast
- Lunch
- Supper

15. How often do you eat the following? (Please tick one box for each food type)

<table>
<thead>
<tr>
<th>Meals / Times per Week</th>
<th>5 or more</th>
<th>2 to 4</th>
<th>1 or less</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baked beans/bread/pizzas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>City fish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wholemeal bread</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continental breakfast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken or turkey</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meals / Times per Week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White bread</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cresps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweets and chocolate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweetened squash, Fizzy drinks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bacon breakfast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beef, pork or lamb</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fried foods</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Have you tried to improve what you eat over the course of the past year?
- Yes
- No (Please go to Q18)

17. What was the reason for changing? (Please tick one box only)
- Mainly for appearance (e.g. for a better body)
- Mainly to save money
- Mainly for medical reasons (e.g. on doctors advice)
- Other: ____________________________
- Other (please write in the space provided)

18. On a scale of 1-10, where 1 is very unhealthy and 10 is very healthy, how would you rate your current diet? (Please tick one box only)

<table>
<thead>
<tr>
<th>Very Unhealthy</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very Healthy</th>
</tr>
</thead>
</table>

19. If you wanted to change your diet, what could help you to change? (Please tick all that apply)
- More time to cook
- Information about healthy eating
- Advice from a health professional
- Cooking Skills
- Better self motivation
- Availability of healthy choices in food outlets
- Other: ____________________________

20. Do you think you are...?
- About the right weight for your height
- Underweight
- Overweight
- Not sure

21. How many people living with you at home now, including yourself, smoke? (Please tick one box only)
- None (Please go to Q30)
- One person
- Two or more people

22. Did your parents smoke regularly when you were a child? (Tick if yes)
- Father
- Mother

23. Do you smoke? (Please tick one box only)
- Yes, regularly, at least one cigarette (or rollup) a day
- Yes, I only smoke occasionally
- No, I am an ex-smoker Please go to Q27
- No, I don't smoke at all Please go to Q30

24. How many cigarettes or grams of loose tobacco do you smoke each day?

<table>
<thead>
<tr>
<th>Cigarettes</th>
<th>OR</th>
<th>Grams</th>
</tr>
</thead>
</table>

25. Has a doctor, nurse or other health professional ever advised you to stop smoking because of your health?
- Yes
- No

26. If you wanted to stop smoking, what things or people could help you? (Please tick all that apply)
- Advice from a GP / health professional
- Less stress
- Stop Smoking clinic
- Better self motivation
- Increased prices of tobacco
- Other: ____________________________

27. Ex-Smokers: At what age did you start smoking regularly (at least one cigarette a day)? (Please write in the box)

<table>
<thead>
<tr>
<th>Years</th>
</tr>
</thead>
</table>

28. How long ago did you stop smoking?
- Less than 6 months
- 6 – 12 months
- 1 – 5 years
- 5 – 10 years
- 10 – 15 years
- Over 15 years
29. why did you decide to give up smoking? (Please tick all that apply)
- Advice from GP or Health Professional
- Government TV, radio or advert
- Stop Smoking Clinic
- Increased prices of tobacco
- Smoking Ban in public places
- Worried about future health problems
- Worried about the effect on my children and family
- Self motivation
- Other, specify below

30. Approximately, how often do you have an alcoholic drink? (Please tick one box only)
- Never
- Occasionally (once a month or less)
- 2 to 4 times a week
- 4 or more times a week

The next few questions are about the number of standard drinks you normally have. One standard drink is:
- 1/2 pint of ordinary strength beer, lager or cider
- 1 small glass of wine (as served in a pub)
- 1 single measure of spirits (as served in a pub)
- 1 small glass of sherry

31. In an average week, how much alcohol do you normally drink? (For each type of drink, please fill in how many drinks you normally have. If you have not had one of the drinks below, please fill in 0.)
- Low alcohol beer or lager
- Normal strength beer, lager, cider
- Strong (6% or more) beer, lager, stout and cider
- Spirits, liqueurs and aperitifs
- Wine
- Fortified wine
- Ales
- Other (please write here)

32. How often do you have six or more standard drinks on one occasion e.g. in one evening? (Please tick one box only)
- Never
- Less than once a month
- Monthly
- Weekly
- Daily or almost daily

33. Do you think your current level of alcohol drinking could be harmful to your health? (Please tick one box only)
- Yes
- No
- Not sure

34. How important is suntan to you personally?
- Very important
- Fairly important
- Not important
- No opinion

35. Do you use sunbeds?
- Yes
- No

36. Which factor level of sunscreen do you use most regularly?
- I don't normally use sunscreen
- Not in the last 12 months
- Four or more times
- Three times
- Twice
- Once

37. During the last twelve months, how many times have you had sunburn causing redness and soreness of the skin lasting for at least 1-2 days?
- Not in the last 12 months
- Four or more times
- Three times
- Twice
- Once

38. How important do you think each of the following is in preventing skin cancer?

<table>
<thead>
<tr>
<th>Action / Importance</th>
<th>Very important</th>
<th>Fairly important</th>
<th>Not important</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trying to keep babies out of the sun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wearing broad collar clothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using a sun cream</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoiding the midday sun</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staying in the shade as much as possible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

About you

39. What sex are you?
- Female
- Male

40. How old are you? (Last birthday)
- Write in the box:_________ Years

41. How tall are you?
- Feet
- Meters
- Inches
- Centimeters

42. Approximately how much do you weigh?
- Stones
- Kilograms
- Pounds

43. What is your current marital status?
- Single (never married)
- Married
- Divorced or separated
- Widowed
- Living with a partner as a couple

44. What type of housing do you live in?
- Own home or buying
- Government housing
- Private rental
- Other (e.g. accommodation provided with job)

45. Including yourself, how many people live in the house? (Please write in the box)
- People

46. How would you describe your current employment status?
- Retired
- Full-time education
- Not in paid work (long term illness or disability)
- Not in paid work (looking after home/family)
- Unemployed and available for work
- Doing unpaid / voluntary work

Thank you for taking part in this survey
The Questionnaire for the Survey used to inform this Report was compiled by a Gibraltar Health Authority team comprising:

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Director of Public Health

Miss Rachelle Anne Asquez
Public Health Information Analyst

Mrs Daya Dewfall
Health Promotion Officer

Copywrite, an independent company specialising in advertising and marketing, carried out the Fieldwork including pilot studies, doorstep interviews and data gathering.

Micro Business Systems, Gibraltar, carried out the Data capture and automated data processing.

Miss Rachelle Anne Asquez, who also substantially authored the 2008 Survey Report, carried out the Analysis and Interpretation of the data in this report.

The Report was substantially written by Miss Rachelle Anne Asquez.

Consultancy on Statistics was provided by Ms Sally Rickson (who substantially authored the 2008 Survey Report).

The Report was edited and produced by Dr. Vijay Kumar, Director of Public Health.

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APPENDIX IV
Acknowledgements

APPENDIX III
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