A Health Promotion Needs Assessment for the **Residents of Darndale and Belcamp Areas** of Coolock in North Dublin

A Community Based Household Study

Dr. Sally O'Driscoll MB, MPH, MFPHMI
Dr. Claire Collins PhD MSocSc BSocSc DipStats

DECEMBER 2003

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GLOSSARY OF ABBREVIATIONS

AIT	Area Implementation Team
CHD	Coronary Heart Disease
CSO	Central Statistics Office
DED	District Electoral Division
GP	General Practitioner
HP	Health Promotion
IT	Information Technology
NAHB	Northern Area Health Board
NDP	National Development Plan
PHN	Public Health Nurse
PPF	Programme for Prosperity and Fairness
RAPID	Revitalising Areas by Planning Investment & Development
SLAN	Survey of Lifestyle, Attitudes & Nutrition
SMR	Standardised Mortality Rate
SPHE	Social, Personal and Health Education

EXECUTIVE SUMMARY

INTRODUCTION

In September 2001 the Northern Area Health Board (NAHB) Health Promotion Service was established. A priority for this service is to work in partnership with other agencies and communities using a multi-sectoral approach. This way of working is in line with the National Health Strategy (Dept. of Health and Children 2001). In the summer of 2002 the NAHB Health Promotion Service commissioned a Health Promotion Needs Assessment in Darndale and Belcamp. The aim of this needs assessment was to provide strategic direction for the development of a community health promotion programme for the population. Particular emphasis was to be on heart health. The study was funded by resources allocated to the NAHB via the Cardiovascular Health Strategy (Dept. of Health and Children, 1999).

This Health Promotion needs assessment consisted of a survey of a sample of households using interviewer administered questionnaires. A total of 314 of 1200 households in the area participated, 194 households in Darndale (62%) and 118 households in Belcamp (38%). This represented an overall 78% response rate. Data was collected on a total of 1364 individuals living within these 314 households.

RESULTS

Demographics

- Two parent households with dependent children living at home accounted for a half of all households (50%).
- 31% of households were lone parent households.
- The mean number of occupants per household was 4.3 persons (median=5 persons).
- The majority of the population (59%) was over 18 years of age.
- Female residents (52%) slightly outnumbered male residents (48%).

Lifestyle issues

- 56% of respondents aged 18 years and older were current smokers.
- 48% of residents aged 12 years and older were current smokers
- Over half of all smokers (59%) were interested in trying to quit smoking.
- Most respondents knew about nicotine replacement therapy.
- 37% of these respondents had tried nicotine replacement therapy.
- 66% would consider trying nicotine replacement therapy.
- 75% of all respondents aged 18 years or over drank alcohol. More males than females reported drinking.
- More than half of respondents (55%) reported taking some form of physical activity. Almost half exercised 3-5 times per week (47%). When asked about television viewing, respondents reported watching a mean of 3.1 hours per day. Most children watched more than four hours per day (78%). The mean number of hours spent by children playing playstation/computer games were 1.6 hours per day. Less than half of respondents reported that their child took part in an organised activity such as a youth club, football etc.

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Women's Health

- In relation to women's health, 82% of female respondents reported having had a cervical smear test and 66% of women had the test within the recommended five year time frame. Nearly half of female respondents (45%) had had a breast check. The mean time was within 21 months. Just over one-third (37%) of female heads of households interviewed had received family planning advice.

Children's Issues

- Almost one in five children had had an accident that required medical attention within the past year. The most common cause of injury was a fall (49%). The most common injuries were fractures to limbs.
- The majority of children under five years of age (89%) had received their primary immunisations, Diphtheria, Tetanus, Pertussis, Polio and Hemophilus Influenza B. A total of 80% of children under five were immunised with the Mumps, Measles and Rubella vaccine. The uptake of Meningococcal C vaccine in the under fives was poor at 69%.

Illness

- When illness among household members was looked at, one in four residents reported having had an illness. The most common illness reported was asthma. A total of 11% of the population was reported to be suffering from asthma.

Health information

- Most residents (59%) reported knowing how to keep healthy. The most common source of health information was the family General Practitioner (GP) (42%). This was followed by magazines and books (36%).
- Many claimed to know very little about the health services in their area (43%). When asked what information would be of interest from a choice of four topics, respondents requested health information on dental health (79%), healthy eating (76%), mental health (62%) and sexual health (46%).

Healthcare cover

- When asked about healthcare cover, 59% of households reported having a medical card. A further 9% of households reported having some form of private medical insurance.

Community issues and priorities

- When asked to choose from a range of 18 issues that respondents felt needed attention in the area, safe play areas for children and tackling joy riding were of the highest concern (99%). Drug abuse by young people, drug dealing and clubs for teenagers were also highlighted as being issues of concern (98% of respondents).

EXECUTIVE SUMMARY

Health promotion priorities

- When asked to choose between a range of programmes or activities, the provision of games/sports programmes for children was the programme most frequently requested (87%). Drugs awareness programmes and children's health, alcohol awareness, accident prevention programmes were also afforded high priority. Smoking cessation programmes were afforded the lowest priority. The majority of residents expressed a preference to attend classes/programmes in the Darndale Village Centre (88%). They identified the evening time as the most suitable time for such classes/programmes.

Educational status

- Excluding those children still in school, more than half of all respondents had left school prior to completion of the Leaving Certificate examination. Only 11% had completed the Leaving Certificate examination.

Employment status

- A total of 43% of household residents were in employment in or outside the home.
- A total of 16.5% of respondents were classified as unemployed.

CONCLUSION

This study has identified areas of specific concern and need in the Darndale/Belcamp area. It highlighted the health promotion issues to be addressed within this community, namely smoking, drug abuse, childhood immunisation and women's health services. Other areas identified as national priorities for health promotion include alcohol, childhood accidents, physical activity among children and nuitrition. The Health Promotion Service in the NAHB will now work with the relevant stakeholders and communities using a multi-agency approach to address the issues and priorities highlighted in this report. It is important to acknowledge that not all needs prioritised can be addressed solely through the Health Promotion Service, NAHB. The Health Promotion Service, NAHB acknowledges that the broader determinants of health are outside the control of a health promotion service. Some of the areas identified will require an ongoing collaborative approach. These can be explored through the RAPID programme for the area via the Area Implementation Team (AIT).

The Health Promotion Service, NAHB will work in partnership with the community to progress this report. The Health Promotion Service NAHB will link strategically with other health service providers, local government and both the voluntary and statutory organisations to progress the recommendations arising from this report. A formal working group will be set up by the Health Promotion Service, NAHB, to develop a Health Promotion Action Plan for the Darndale/Belcamp communities. Steps will be taken to increase levels of awareness of current service provision. Specific recommendations for action are made in relation to smoking, women's health, child health, psychosocial problems and social problems.

BACKGROUND AND PROJECT DESCRIPTION

The Northern Area Health Board (NAHB) is responsible for providing health and social services to approximately half a million residents (486,305) of Dublin City and County north of the River Liffey (CSO 2002). The Health Promotion Service NAHB, is responsible for planning and delivering health promotion services to this population. In September 2001, the first Director of Health Promotion NAHB was appointed. Community Health Promotion was targeted as a priority for service development and in particular health promotion for disadvantaged areas. This was in line with both national and international Health Promotion strategies (Dept. of Health and Children 2000).

Health Promotion is 'the process of enabling people to increase control over and improve their health' (WHO 1986). The purpose of health promotion is to strengthen the skills and capabilities of individuals to improve their health and the capacity of communities to act collectively to exert control or influence over the determinants of health (International Union for Health Promotion and Education 2000). The first phase of any health promotion planning is an assessment of what the population in question needs to improve their health. While national data is useful, data in relation to specified populations and in particular information on the felt needs within these communities are important in order to gain a greater insight into the health needs of target groups. This is of particular importance in areas of most disadvantage. The Darndale and Belcamp areas were identified by the Health Promotion Service NAHB for a specific health promotion needs assessment. The focus of this assessment was to be on cardiovascular health. Funding for the study was provided through the National Cardiovascular Strategy. The study was to encompass the lifestyle factors that contribute to ill health, for example smoking, poor diet, physical inactivity, together with the broader determinants of health, for example economic and social conditions and the environment in which residents live. Such an assessment involves collecting data on social and environmental issues in addition to health status.

Heart disease is the single biggest killer in Ireland and people from disadvantaged areas are most at risk of heart disease (Balanda and Wilde 2001). The Cardiovascular Health Strategy set out to tackle the problem of heart disease in the Irish population (Dept. of Health and Children 1999). Many initiatives were implemented. Specific health promotion initiatives included mass media health promotion campaigns, efforts to reduce the prevalence of cigarette smoking and alcohol consumption, efforts to increase physical activity and to improve nutrition and diet by reducing cholesterol consumption and increasing intake of fresh fruit and vegetables.

Inequalities in Health

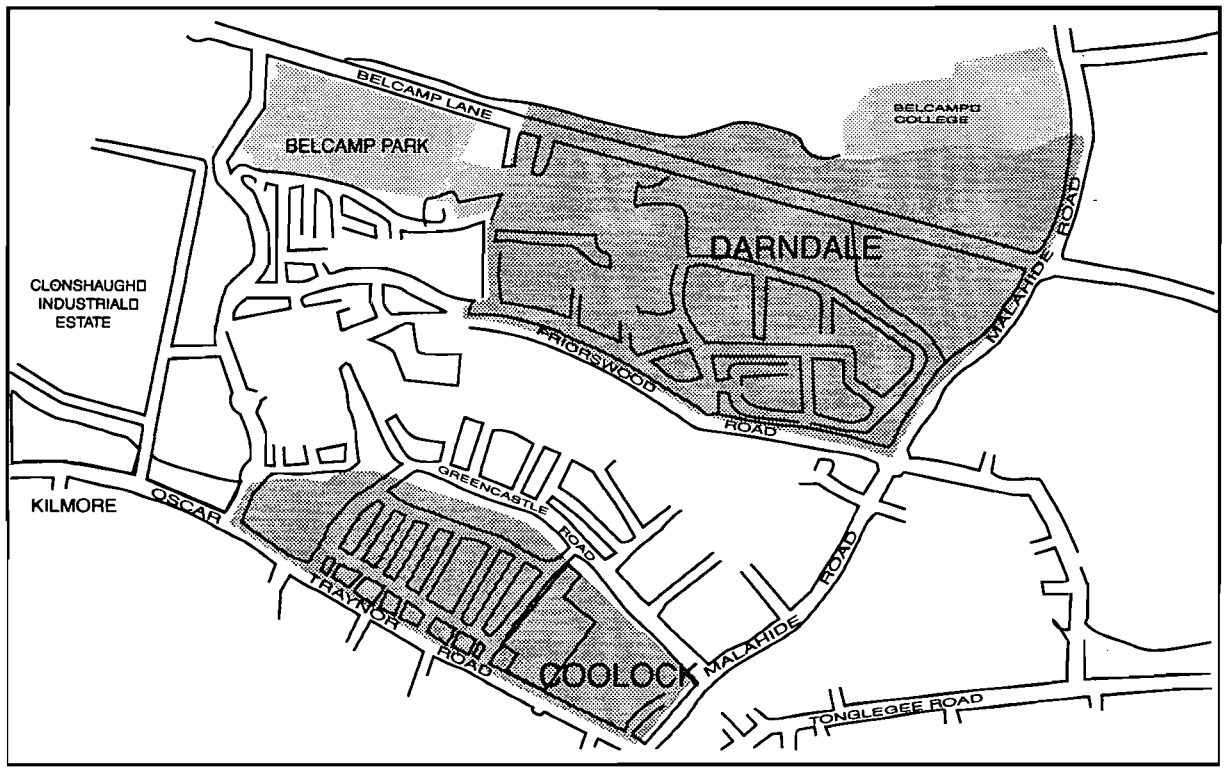
Explanations for health inequalities have tended to polarise around materialist/structural and cultural/behavioural models. However, whichever theory one supports, "there seems to be very little of life in our society which isn't in some way characterised by differences between social classes" (Reid 1989). The relationships between socio-economic status and mortality and morbidity are well documented in Ireland (Dean 1982; Cook 1990; Nolan 1990; Johnson and Lyons 1993; Balanda and Wilde 2001). The Department of Health recognise this effect of socio-economic factors on health and have placed them high on the priority list (Dept. of Health 1994; Dept. of Health 1995).When health is looked at in terms of socio-economic grouping, unskilled manual workers when compared to workers from professional groups have worse health, in all years, for all conditions. In 1996 unskilled manual workers were twice as likely to die prematurely as higher professional men and were eight times more likely to die from an accidental cause. They were four times as likely to be admitted to hospital for the first time for schizophrenia as higher professional workers. In all psychiatric conditions there was an increasing socio-economic gradient in incidence from professional to unskilled manual workers (Balanda and Wilde 2001). Women in the unemployed socio-economic group are twice as likely to give birth to low birth weight babies as women in higher professional groups. Poor men, women and children have poorer health than those of higher socio-economic groups. (Dept. of Social, Community and Family Affairs 1997)

Cardiovascular health

In 2000, 41% of deaths in Ireland were attributed to diseases of the cardiovascular system, coronary heart disease, stroke and blood vessel disease. This demonstrates a notable decline in deaths from cardiovascular disease since 1980 when more than half of all deaths (51%) were attributable to cardiovascular disease. The three principal risk factors for coronary heart disease are smoking, cholesterol and raised blood pressure. The decline in cardiovascular mortality has been most notable in the higher social groups. This can be attributed to primary and secondary prevention and to medical and surgical interventions. The decline in cardiovascular mortality however appears to be confined to the higher socio-economic groups. It has not been seen in the lower social groups.

Profile of the Area included in the study

The Darndale/Belcamp area was designated as one of the 25 most "Disadvantaged Areas" in the Republic of Ireland (Dept. of the Taoiseach 2000). Darndale and Belcamp are suburbs of North Dublin (Figure 1). They are located approximately six and a half miles from Dublin city centre. There are a total of 916 dwellings in Darndale and 347 dwellings in Belcamp. The housing consists mainly of three bedroom units built by Dublin Corporation in the 1970's to relocate families from sub-standard dwellings in Inner City Dublin and the Ballymun area of North Dublin. Darndale comprises the Priorswood C, District Electoral Division (DED) and is made up of five small estates. Belcamp constitutes approximately one half of Priorswood B, DED. It has a total of 347 dwellings. The combined population of the area is approximately 5,300 (CSO 2002). Since 1996 the population has decreased by 200 persons. Many residents are thought to rely on community welfare as their sole source of income (CWO 2002).



Darndale and Belcamp Areas

Study Aim and Objectives

The aim of the study was to identify the health promotion needs of the Darndale and Belcamp communities with a view to developing a comprehensive Community Health Promotion Programme.

The study objectives were:

1. To identify the relevant partners and stakeholders in the area required to progress such a Community Health Promotion initiative.
2. To undertake a community based health promotion needs assessment and identify the felt needs of the community.
3. To identify barriers to health within the community.
4. To make recommendations for the development of a relevant community health promotion programme based on outcomes from the needs assessment.

National Response to Tackling Inequalities

In 2000 the Government, under the auspices of the National Development Plan (NDP) (Dept. of Finance 1999) in conjunction with the Social Partners, placed inequalities in Irish society firmly on the political agenda. A programme was set in motion to tackle such inequalities. This became know as the Programme for Prosperity and Fairness (Dept of Taoiseach 2000). A blue print was devised to help the community/voluntary and statutory sectors tackle these inequalities. The programme was funded by central Government and involved a multi-agency approach to tackling inequality.

A number of the most disadvantaged areas in the country were targeted. Individual Area Implementation Teams (AIT) were set up. In the spring of 2001 an AIT was convened for the Darndale and Belcamp areas of North Dublin. The aim was to Revitalise the Area by Planning, Investment and Development (RAPID) and "to improve life for all residents and especially creating a brighter future for the many young people growing up there". It aimed to increase social, economic and environmental opportunities for all members of disadvantaged communities and to "influence the provision of facilities and services in a way that will realistically increase social, economic and environmental opportunities for all members of the communities".

The RAPID consultation exercise and its findings acted as precursor for this study and gave a valuable insight into the Darndale and Belcamp areas of Coolock. With the assistance of these agencies, it was also possible to recruit and train local persons to conduct interviews for a household study.

This needs assessment was funded through the Cardiovascular Health Strategy. The Cardiovascular Strategy's recommendations are guided by a number of principles pertinent to the development of a Darndale and Belcamp health promotion response. It acknowledges that some interventions such as health promotion and disease prevention initiatives yield results in a longer time frame. However a comprehensive strategy for cardiovascular disease must achieve a balance in the application of resources between those yielding immediate results and those that yield improved outcomes in the longer term. A balance must be achieved between providing a physical and social environment which supports healthy choices and the responsibility of the individual to maintain their own health.

The Cardiovascular Strategy also suggests that service delivery must be clearly assigned as must audit and accountability. It must be made clear at the outset where responsibility lies in respect of implementation of any proposed strategies and in reviewing progress. The National Health Promotion Strategy supports the development of community-based approaches to health promotion (Dept. of Health and Children 2000). It espouses working in partnership with relevant bodies to adapt and develop community-based programmes to meet the needs of subgroups within a population. It advocates identifying models of good practice in particular those that provide a holistic approach to health within disadvantaged areas. Finally, in Quality and Fairness: A Health System For You the vision for our future health system is laid out. The health system is to be "A health system that is there when you need it, that is fair and that you can trust. A health system that encourages you to have your say, listens to you and ensures your views are taken into account". (Dept of Health and Children 2001) This strategy is guided by the four principles of equity, people-centredness, accountability and quality. It sets out to identify and respond to the needs of individuals. It involves the individual in service planning delivery and in decision making. The promotion of health and well-being is intensified by providing a supportive environment to enable people make healthier choices thereby contributing to overall health status. Health inequalities are reduced by ensuring that disadvantaged groups get the help and support needed to ensure all members of society have an equal opportunity to reach their potential.

The Darndale/Belcamp needs assessment is based on a population based health approach. It aims to identify the health promotion needs of the area with a view to developing a comprehensive community health promotion programme.

Community health promotion

A commitment to reducing inequalities in health has been formalised in both National and European Health Strategies. However health education alone is insufficient to improve the health status of the lower socio –economic groups. The cultural context in which one lives is important. Membership and identification with a specific socio-economic group feeds into one's attitude, beliefs and lifestyle. Hence, Shelley (1994) emphasised that priority should be given to making the environment in which one lives more conducive to health enhancing lifestyles. Brannstrom et al. (1993) recommend that a selective preventative strategy is necessary as community oriented programmes contribute to the widening of inequalities. Hence, targeted intervention is required in order to combat the effect of socio-economic differences. However, Collins et al. (1993) point out that transmission methods and language are of paramount importance in affecting change within this targeted approach.

A community development approach to health seeks to empower groups of people by identifying their concerns and working with them to plan a programme of action to address these concerns. Ewles and Simnet (1999) go on to say that this approach involves the health promoter working with groups of the public in a sustained way which will enable them to increase control over and improve their health. Time must be given to building skills and capacity within the community. Community development entails greater participation. This process can, within itself, enhance self confidence, self esteem and feelings of being in control. These are themselves health promoting factors.

The importance of social capital has been considered as an important protective factor. One's sense of belonging and feeling of being part of a community affects illness and morale (Ineichen 1993). Stewart-Brown (1998) suggests that social capital is as important as income differences in relation to health. However, social capital and income may be inversely associated. Kawachi (1997) believes it necessary to work on both to influence health inequalities. In the UK, there has been a move toward community based initiatives. This can also be seen in Ireland with the Healthy Cities and the Healthy Town initiatives. The promotion of partnership, community participation and social networks is vital if the process is to be successful in areas such as Darndale/Belcamp. An accurate analysis and an understanding of the community's needs, resources, social structures and values are necessary for the development of effective community health promotion programmes (Bracht et al. 1999).

A health promotion needs assessment involves the collecting and evaluating of information about the health status and health issues of a community. It is conducted in order to identify the health needs of a community and the specific factors influencing the health of people in the community in order to establish priorities and assist planning. It also considers the role of health promotion in identifying and meeting certain needs.

The concept of need and how this may be perceived varies between different groups and stakeholders. The purpose of a health needs assessment at local level is twofold: to identify which improvements in health should have the greatest priority and to choose which particular groups or communities should have priority. This helps in targeting interventions.

METHODOLOGY

This needs assessment involved a detailed household study to assess the specific health promotion needs of the people of Darndale and Belcamp. It took the form of a household survey using an interviewer-administered questionnaire. Female heads of households were targeted. In the absence of a female head of household the male head of household was interviewed. The questionnaire was piloted to assess the appropriateness of the questionnaire. The questionnaire was then modified to improve ease of understanding and to reflect suggested improvements. Questions on issues highlighted by stakeholders, for example, household facilities were requested by public health nurses. Questions in line with those asked in the National Health and Lifestyle Survey 2002 (Slán) were also included. This was felt appropriate as the Slán survey did not include the Darndale and Belcamp areas of North Dublin. However, the same detail on lifestyle issues was not possible in the current study given the methodology applied, that is, that one person in the household completed the questionnaire on behalf of all members of the household. The final questionnaire contained sections on demographics and household status, access to services, occupation, literacy skills, lifestyle, women's health, childhood accidents, educational attainment, sources of health information, choices of health promoting programmes etc. and choice of location for future service development/provision (See Appendices). Special emphasis was placed on cardiovascular health.

A random sample of 400 of the 1260 households in the Darndale/Belcamp area was selected from Dublin Corporation housing lists. Six locally recruited interviewers were trained to conduct the household study over the summer months. Questionnaires were administered during daylight between the hours of 6-9pm. in the months of July and August. A total of 314 households participated, 196 households in Darndale (62%) and 118 households in Belcamp (38%). This represented an overall 78% response rate. The refusal rate was 10%. It was not possible to make contact with 12% of households (i.e. no one at home despite repeated attempts). Data was collected on a total of 1364 individuals living within these 314 households.

Description of Household and Individual Characteristics

Length of time living in the area

The average length of time resident in the area was 16.7 years. The average number of years Darndale households were established in the area was 17.0 years and that for Belcamp residents was 16.2 years.

Nationality of residents

The majority of residents were of Irish Nationality (99%). The remaining households in the sample were mainly of British nationality.

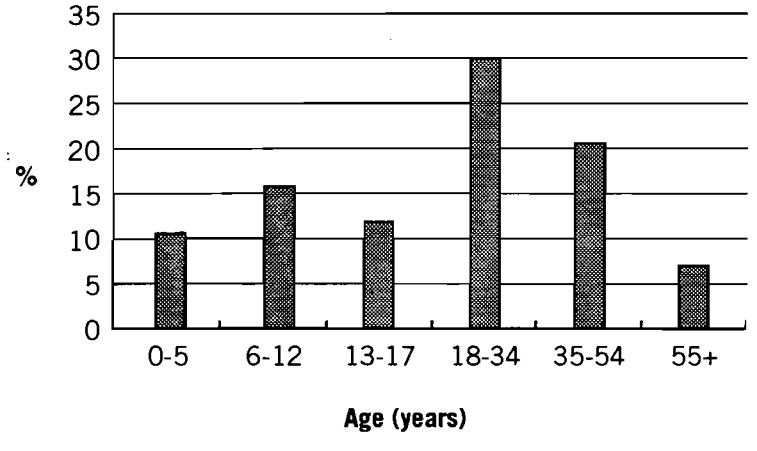
Gender of residents

Similar to the National Census figures of 1996, there were more female than male residents in the Darndale/Belcamp area. Females accounted for (52%) of the total population while males accounted for (48%) of the population.

Age breakdown of residents

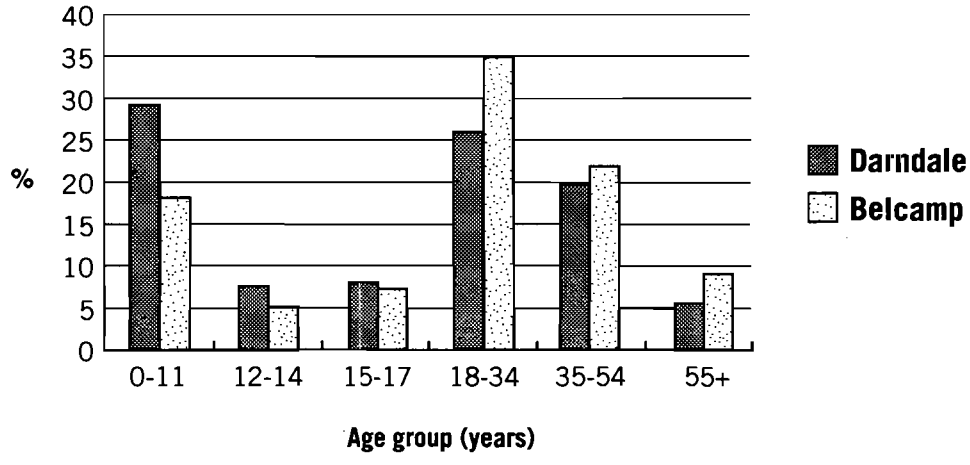
The majority of residents (793/1335) were aged 18 and over (59%). The remainder, 542/1335 (41%) were 17 or under.

Figure 2 Age breakdown among residents.



An analysis of the age profile by area revealed the following, Darndale was found to have a significantly higher proportion (46%) of younger people (under 17) than the Belcamp area (32%) ($p=<0.001$). Figure 3 illustrates the age profile of both areas.

Figure 3 Age profile by area.

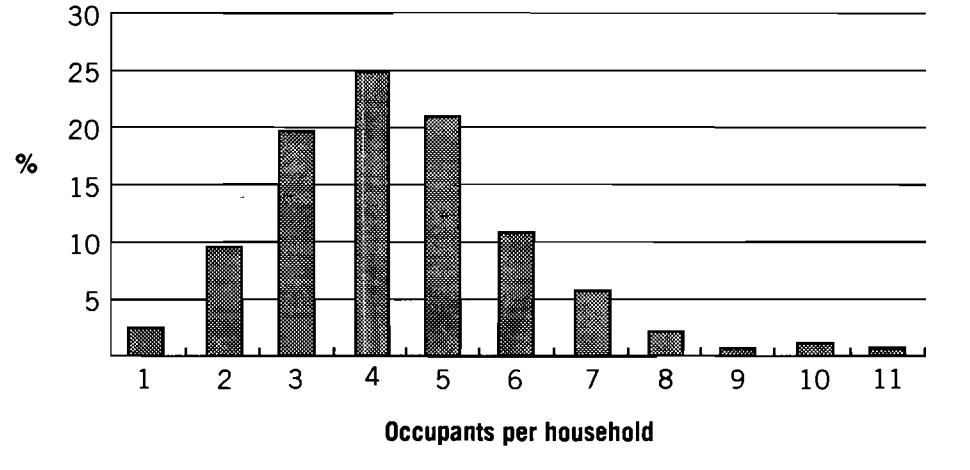


Nationally, 21% of the population is under the age of 15 years (CSO 2003). The figure for Belcamp is slightly higher with 24% of the population under 15. The figure for Darndale is substantially higher with 40% of the population under 15.

Number of occupants per household

The mean number of occupants per household in both areas was 4.3. The range was one to eleven persons per household with a median of five persons per household.

Figure 4 Frequency of occupants per study household.



This compares to a mean of 2.6 in Dublin city overall and 3.2 in the Fingal area. The median number of household members in the Darndale/Belcamp areas is higher than that reported in two other 'disadvantaged' areas in Dublin (Collins and Lyons 2002; NAHB 2003). These both had a median of three residents per household. Figure 4 shows the frequency of occupants per study household.

Household composition

Fifty per cent of households (155/313) were two parent households with dependent children/child living at home. A further 31% of households were lone parent households with a dependent child/children living at home (96/313). Other types of living arrangements accounted for less than 5% of household types (Table 5).

Table 5 - Frequency of Household type.

Household Type	N	%
Living alone	11	3.5
Lone parent/dependent child/children at home	96	30.7
Lone parent where child/children have left home	3	1.0
2 parents/dependent child/children at home	155	49.5
2 parents where child/children have left home	9	2.9
2 parents with adult/non-dependent child/children at home	17	5.4
Lone parent with adult child	7	2.2
Adults only	6	1.9
Other	9	2.9

Similar studies from other "disadvantaged areas" have reported 13% lone-parents in Finglas (TCD 2003) to 44% lone-parents in Fatima Mansions (Collins and Lyons 2002). The proportion of people reported to be living alone in the Darndale/Belcamp area is substantially lower than that reported in Fatima Mansions (26%) (Collins and Lyons 2002).

Relationship of household occupants to respondent

Children accounted for 77% of household residents related to the main survey respondent (732/956). The remaining relationships are shown in Table 6.

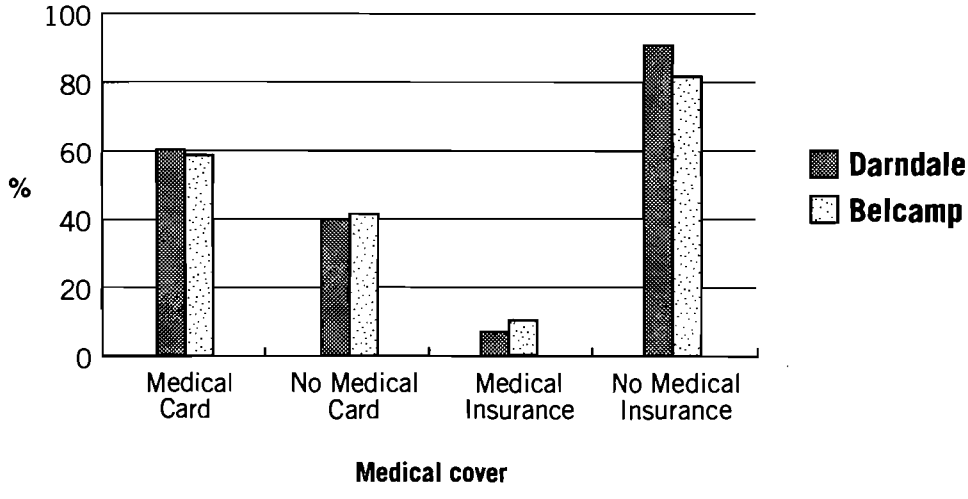
Table 6 - Relationship of household occupants to respondent.

Relationship to Respondent	n (956)	%
Child	732	76.6
Spouse	164	17.2
Partner	24	2.5
Parent	15	1.6
Grandparent	12	1.3
Grandchild	7	0.7
Niece	1	0.1
Girlfriend	1	0.1

Health insurance

Over half (59%) of the households surveyed (182/308) had a medical card. This is higher than reported in Finglas (35%; TCD 2003) but lower than reported in Fatima Mansions (73%; Collins and Lyons 2002). It is however substantially higher than the National and the Dublin rates of those holding a medical card, 34.5% and 26.7% respectively (CSO, 1996). Only 9% (28/308) of households had private medical insurance. No statistical difference was found between the proportion of households having medical cards in each area. A statistical difference was found however in the number of households having private medical insurance between the two areas. Twice as many households in Belcamp as Darndale had private medical insurance ($p = 0.05$).

Figure 5 Proportion of households in Darndale and Belcamp in possession of public and private medical cover.



Employment profile

A total of 43% of household residents were in employment in or outside the home (545/1262) – with 36% of all respondents employed outside the home and 7% of all respondents engaged in home duties (Figure 6). The occupations listed by those in employment in or outside the home are presented in Table 7. A total of 16.5% of respondents were recorded as 'unemployed'

Figure 6 Occupational profile of household residents.

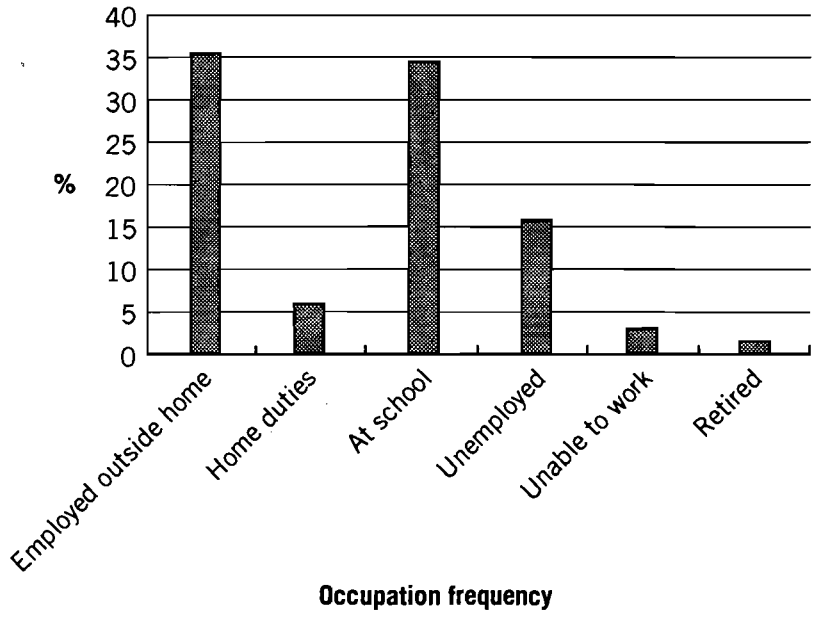


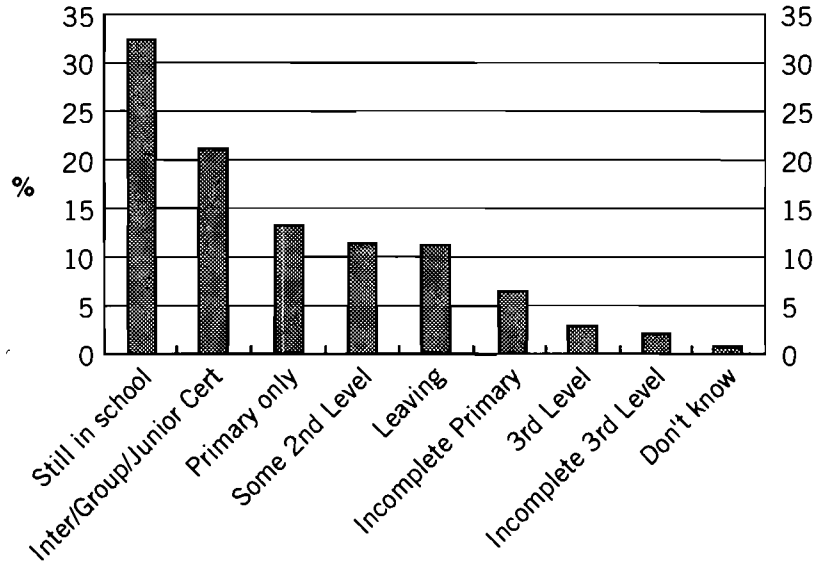
Table 7 - Employment profiles of household occupants.

Employment Profile	n (545)	%
Homemaker/Housewife	86	15.8
Warehouse/Factory	69	12.7
Retail Sector	53	9.7
Clerical	46	8.4
Construction Sector	45	8.3
FAS/Apprenticeship	37	6.8
Transport	35	6.4
Cleaner	32	5.9
Catering Sector	31	5.7
Carer/Hospital/Voluntary	27	5.0
Security	16	2.9
Supervisor/Manager	16	2.9
Other	16	2.9
Childcare	12	2.2
Printer	8	1.5
Self-employed	8	1.5
Hairdressing	5	0.9
Teacher	3	0.6

Educational attainment

Excluding children still in school, more than half of respondents (58%) left school prior to their Leaving Certificate examination (492/846). Only 11% of respondents had completed the Leaving Certificate/Senior examination. Of those (4% of respondents) that had started 3rd level education only half (2% of respondents) had completed their third level education. The full schooling profile of respondents is shown in Figure 7.

Figure 7 Educational achievements of respondents.



Reading and writing

A small proportion of adults (that is, those aged 18 years or older) were recorded as having difficulties with reading and/or writing (5%; 39/785). No difference was observed between the proportion of males and females with such problems.

These figures are lower than the national findings which indicate that 25% of adults have difficulty with reading and writing. This may be explained by the fact that this survey was completed by one person in the household on behalf of all household members. It is possible that the person completing the survey is unaware of reading and writing difficulties experienced by other household members.

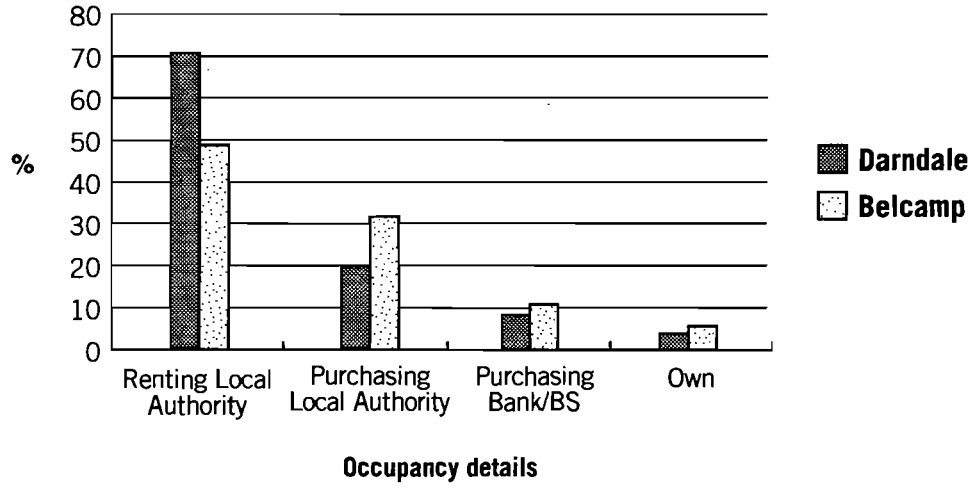
HOME OWNERSHIP/HOUSEHOLD FACILITIES

Home Ownership

Almost two thirds of heads of households (63%) were renting their house from the Local Authority (195/312). A quarter of heads of households (25%) were in the process of purchasing their homes from the Local Authority. A further 9% were purchasing from a Bank/Building Society and 3% already owned their house.

A significant statistical difference was found between house rental and home ownership rates when comparing the Darndale and Belcamp areas ($p<0.01$). The main difference was in the proportion of householders renting from the Local Authority, (71%) in Darndale 139/196 and (49%) in Belcamp 58/118. Figure 8 highlights the difference in occupancy in each area.

Figure 8 Occupancy details for households in Darndale and Belcamp.

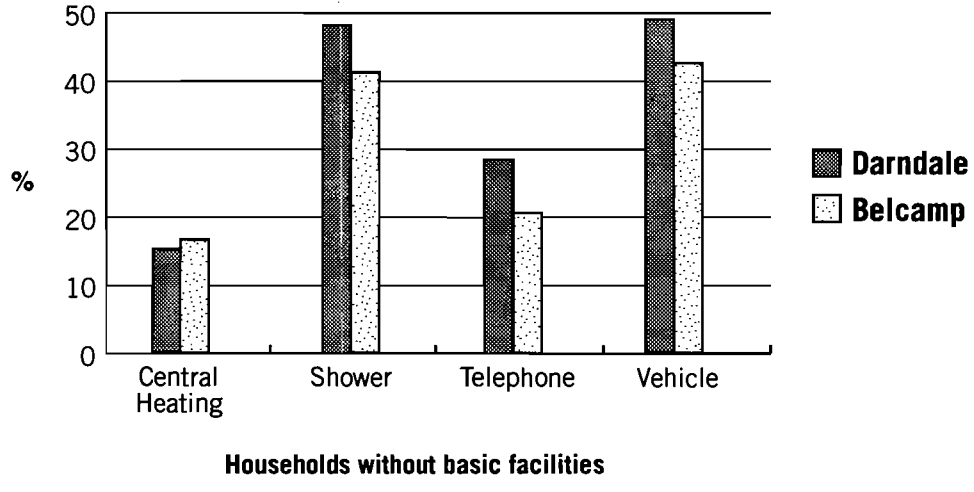


Household facilities

A total of 16% (49/311) of households had no working central heating, 47% had no working shower (145/309) while 26% (80/312) had no telephone. The low rates of home telephones may be attributable to increasing mobile telephone ownership. A total of 48% of households did not have access to private transport in terms of a car or van (148/310).

No statistical difference was found between the availability of these household facilities in each area. The proportion of households without central heating, shower facilities, telephone and motorised transport are summarised in Figure 9.

Figure 9 Proportion of households in Darndale and Belcamp without specified household facilities.



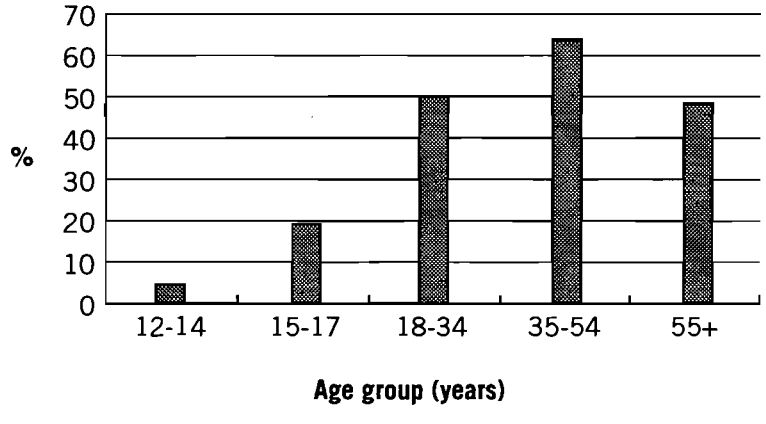
LIFESTYLE ISSUES

Smoking habits

Smokers accounted for 48% (463/973) of respondents aged 12 years and over and 56% of respondents aged 18 years and over. This is substantially higher than the national average of 27% for those aged 18+ years reported by the National Health and Lifestyle Survey (Slán 2003). This figure is also higher than that of areas – Finglas (28%; TCD 2003), Tallaght (40%; Long et al. 2002) and Fatima Mansions (45%; Collins and Lyons 2002).

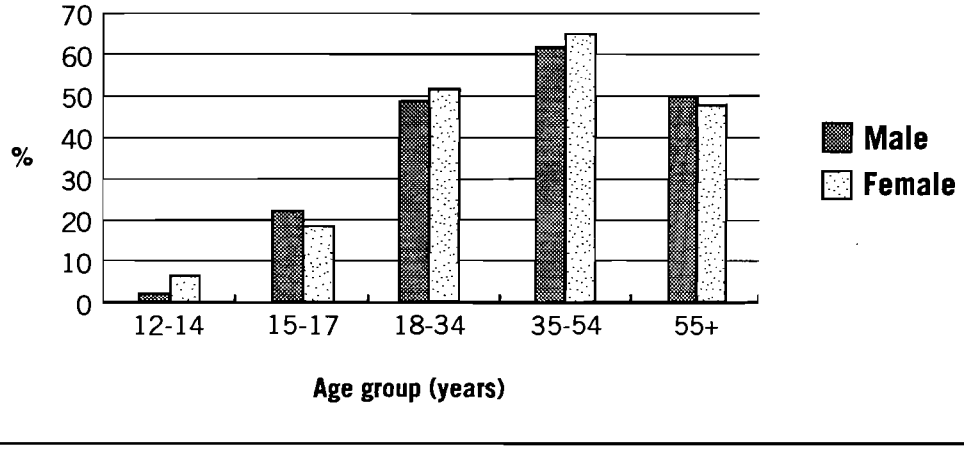
The proportion of smokers in each age group is shown in Figure 10 – this is higher for all ages over 18 compared to national figures but lower for those under 18 years. Although no significant difference was noted between areas, the proportion of smokers was slightly lower in Belcamp than Darndale (47% compared to 48% of those aged 12+ years; 54% compared to 57% of those aged 18+ years).

Figure 10 Smoking prevalence by age group.



Although not significant, a higher proportion of females over 18 years smoked compared to males (58% compared to 54%).

Figure 11 Smoking prevalence by age group and gender.

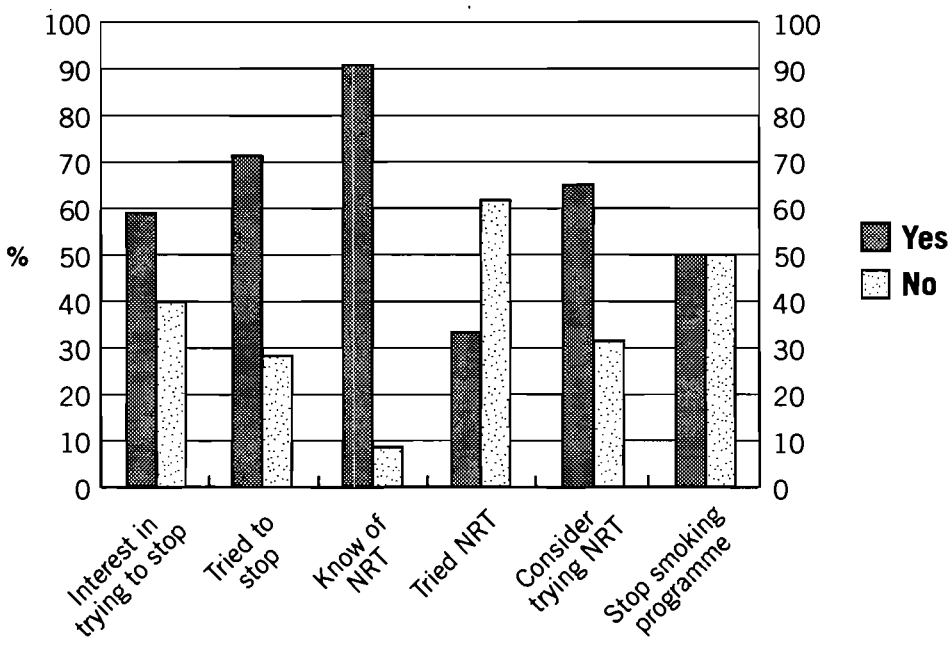


The mean number of cigarettes smoked per day was 30 cigarettes. The range was 2-89 cigarettes with a median of 20 cigarettes per day.

Smoking cessation

If the respondent was a smoker, she/he was asked about smoking cessation. More than half of smokers (59%; 115/196) were interested in trying to stop smoking. Nearly three quarters of these smokers (72%; 141/196) had tried to stop. Of these, 58 had tried more than once. Most smokers knew about nicotine replacement therapy (NRT) (91%; 177/195). A total of 37% (66/177) of these had tried nicotine replacement therapy. Just over two thirds of smokers would consider trying NRT (66%; 125/189) and 49% would attend a "Stop Smoking Programme".

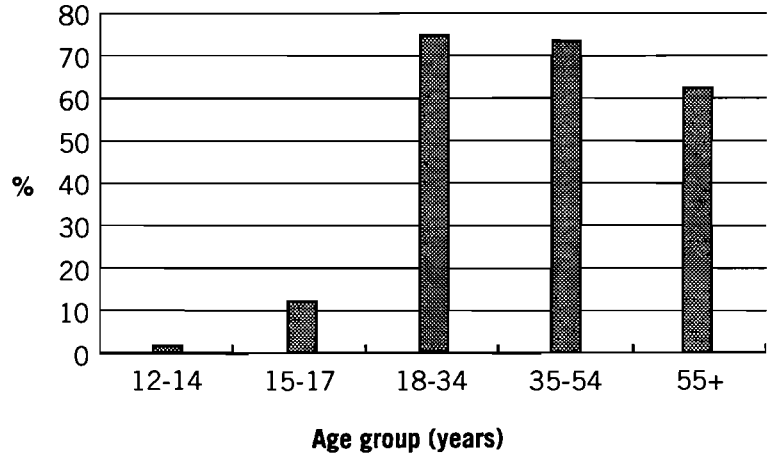
Figure 12 Breakdown of smoking cessation response.



Alcohol consumption

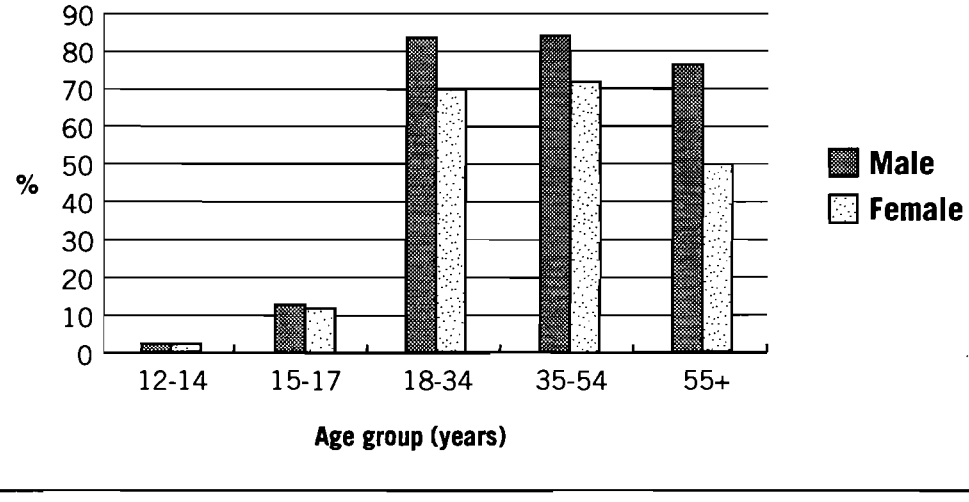
Three-quarters (75%) of respondents aged 18+ years drink alcohol (62% of those aged 12 years and over). The equivalent figure from Fatima Mansions was 70% and the Slán survey of 2002 reported alcohol consumption in the last month to be 78% (Centre for Health Promotion Studies 2003). The rate of alcohol consumption by age group is shown in Figure 13. Although not significant, there was a higher proportion of people who consumed alcohol in Belcamp (65%) compared to Darndale (60%).

Figure 13 Alcohol consumption prevalence by age group.



More males (83%) than females (68%) aged 18+ years were current alcohol drinkers. These proportions are similar to those reported by the Slán survey of 2002 - 83% for males and 74% for females (Centre for Health Promotion Studies 2003). The alcohol consumption by age profile for males and females is shown in Figure 14.

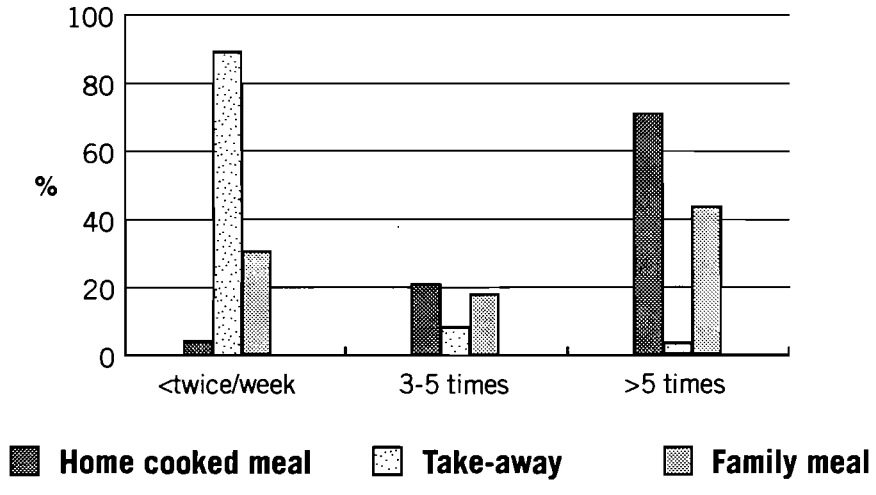
Figure 14 Drinking prevalence by age group and gender.



Dietary Habits

Analysis of the data on eating habits shows that the majority 73% (225/308) of households eat a home cooked meal from fresh produce greater than five times per week. This study did not obtain detailed information in relation to the type of diet consumed. Weekly frequencies of eating a home-cooked meal from fresh produce, of eating take-aways and of eating meals as a family are presented in Figure 15.

Figure 15 Eating habits of respondent households.



Over three quarters 77% (241/312) of households reported eating their meals in the kitchen/dining room while 23% ate in the TV/sitting room*.

Physical activity

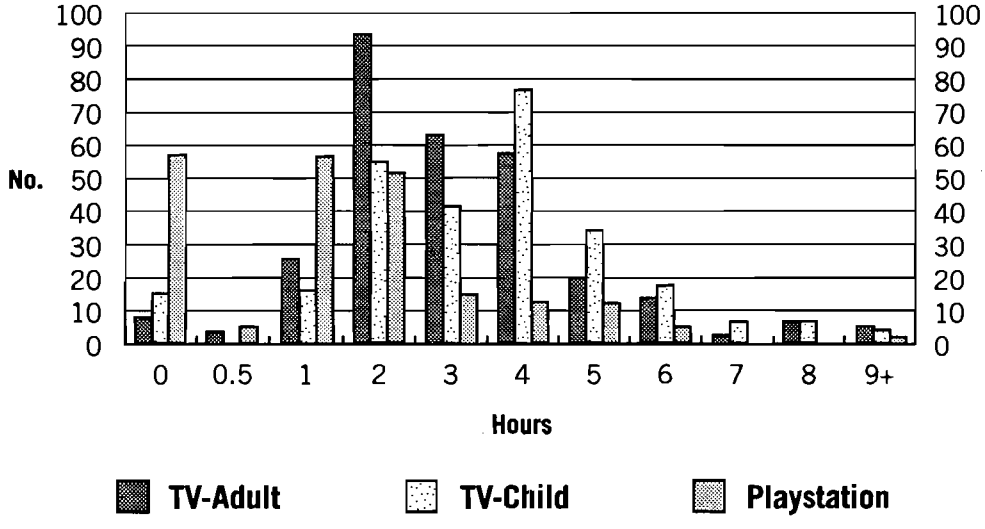
Just over half 55% (171/312) of the respondents who completed the questionnaire reported engaging in physical activity. This is higher than the figure reported for all respondents (51%) and for women only (53%) from the National Health and Lifestyle Survey (2002). The frequency of exercise lasting for more than 30 minutes for the 139 respondents answering this question was less than twice per week for 22 persons (13%), 3-5 times per week for 81 persons (47%) and more than 5 times for 71 (41%) respondents.

* *This question was included at the request of Public Health Nurses as anecdotally it was felt that families were eating meals in living rooms in front of Televisions.*

Television viewing and computer use

Respondents reported watching a mean of 3.1 hours of television per day (range 0-15 hours; median=3). Respondents reported that their children watched a mean of 3.6 hours of television per day (range 0-15 hours; median=4). The mean number of hours spent by children playing with a playstation/computer games was 1.6 (range 0-10 hours; median=1). The frequency of hours spent watching television by adult respondents and children and playing the Playstation/computer games is shown in Figure 16.

Figure 16 Frequency of hours spent watching television and/or playing a playstation/computer games.

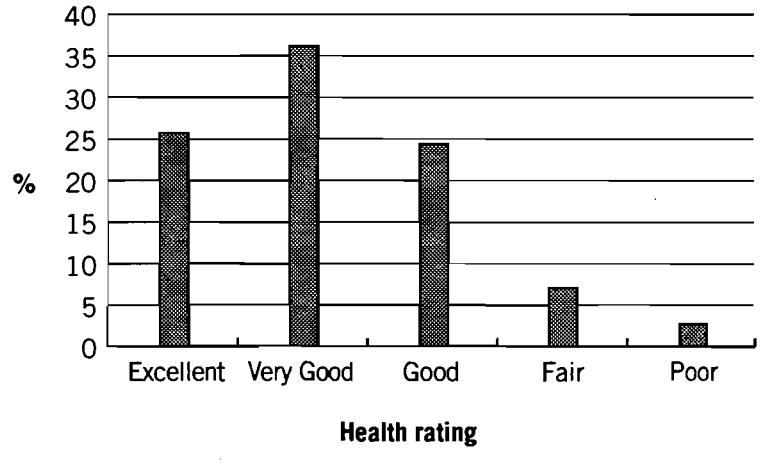


HEALTH PROFILE

Health rating

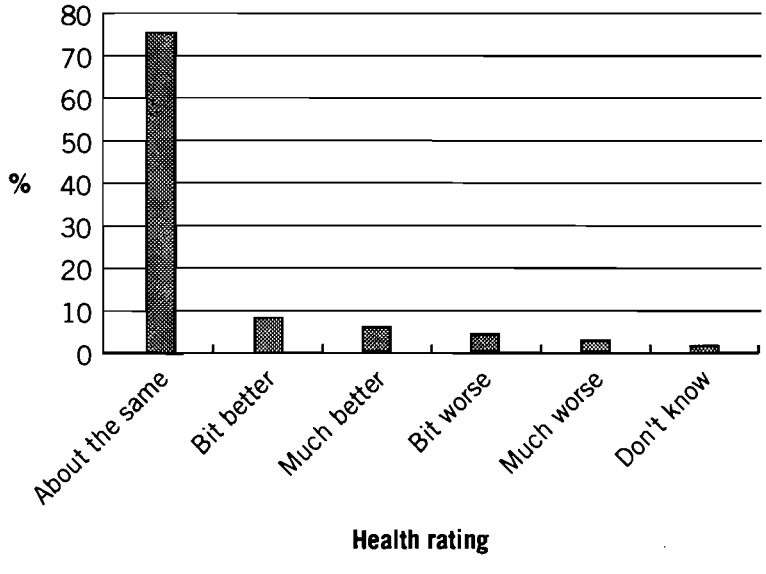
Respondents were asked to rate the health of all household members. The majority of household members' health (88%; 1198/1357) was as at least 'good' with 11% (153/1357) rated poor to fair. The individual health ratings are shown in Figure 17.

Figure 17 Current health ratings of household occupants.



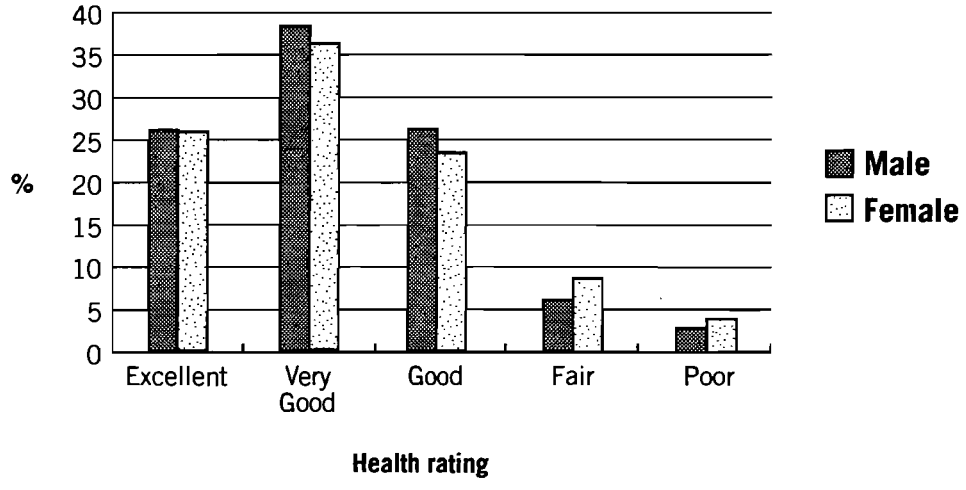
The majority of respondents rated the health of household members (92%; 1246/1349) as the same or better compared to one year ago. However, 7% (100/1349) of household members' health was rated as worse than one year ago. The individual health ratings compared to one year ago are shown in Figure 18.

Figure 18 Respondent health rating compared to one year ago.



There was very little gender difference in health status ratings. A breakdown of health ratings is shown in Figure 19.

Figure 19 Health ratings of male and female respondents.



Women's health

Where the female head of household completed the questionnaire, a number of questions regarding women's health were asked.

Cervical smear testing

A high proportion of female respondents (82%; 212/259) reported having had a cervical smear test. The mean time since having a smear test was 45 months (median=17 months). The minimum time since the last smear was one month and the maximum time was 360 months (30 years). Overall 66% of women had a smear test within the recommended five-year time-frame. This is high when compared with reports from others studies – 52% in Finglas (TCD 2003) and 58% in Tallaght (Long et al. 2002).

Breast examination

Almost a half of female respondents (45%; 116/260) had a breast examination. The mean time since having a breast check was 21 months (median = 9 months). The minimum time since having a breast check was one month and the maximum time was 264 months (22 years). Overall, 39% of women had this examination within the previous five years. This is low when compared to data from other areas - 50% in Finglas (TCD 2003).

Family planning

Just over one-third of women (37%; 96/258) had received family planning advice. Of those who received advice, 45% of women had received this advice from a family planning centre, 35% from a GP, 11% from a hospital (mostly Rotunda), 7% from a PHN and 2% from other sources.

CHILDREN AND THEIR HEALTH

Injuries in children

Within the past year of the study period, 18% (53/290) respondents reported that one of their children had an injury which required medical attention. The most common cause of injury was a fall (26/53, 49%) which is similar to data reported by the Injury in Ireland report (Scallan et al. 2001). The most common injuries received were to the limbs 38% (20/53), the majority of which were fractures. This is similar to data from the national report (Scallan et al. 2001). The frequencies of accident cause and injuries suffered are shown in Figures 20 and 21 respectively.

Figure 20 Cause of injuries in children.

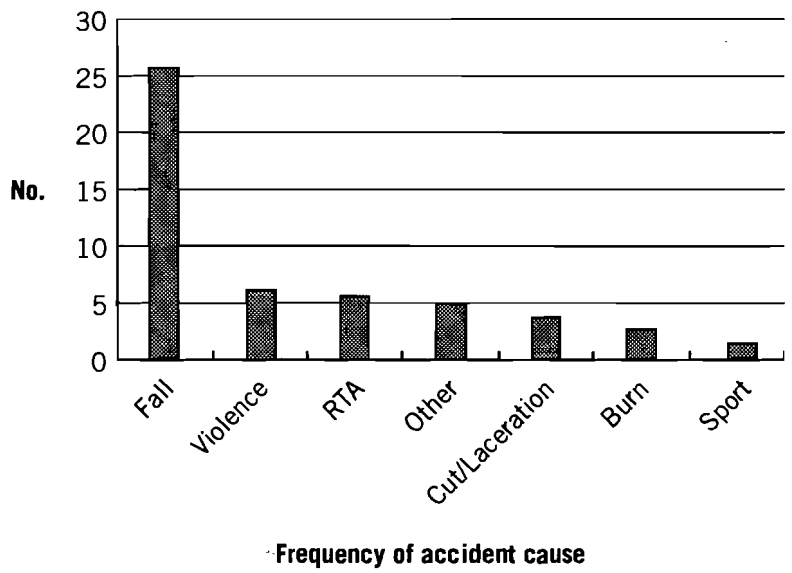
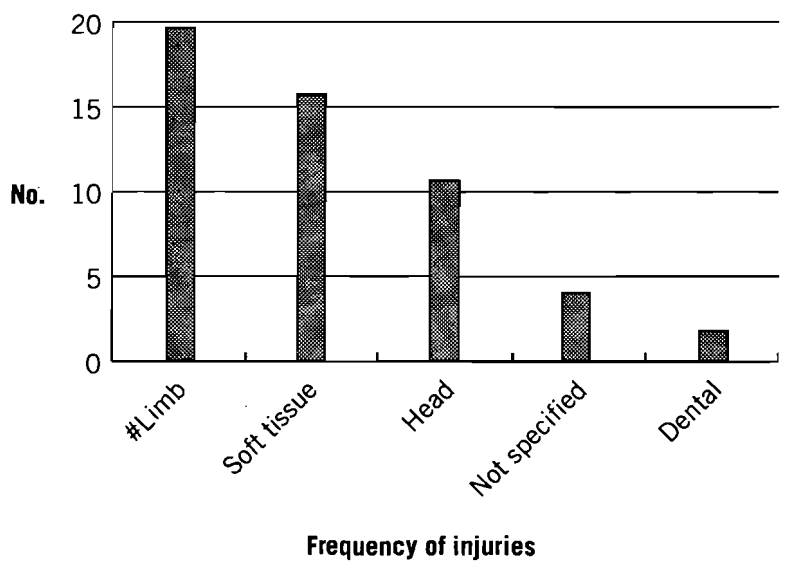


Figure 21 Injuries suffered by children.



Childhood immunisation uptake

In relation to immunisation uptake rates, 89% of children under 5 years of age had received their primary immunisations (Diptheria, Tetanus, Pertussis, Polio, Haemophilus Influenza B). A total of 80% of children had received the Mumps, Measle and Rubella vaccine. The uptake of Meningococcal C vaccine was 69% (Figure 22). These rates of uptake are similar to those reported in Tallaght (Long et al. 2002) and Finglas (TCD 2003). Belcamp had a higher uptake of the primary immunisation (90%) than Darndale (88%). The uptake of MMR was higher in Darndale (80%) than Belcamp (78%). The meningococcal vaccine uptake was higher in Darndale (70%) than Belcamp (67%) (Figure 23).

Figure 22 Immunisation profile of under 5's.

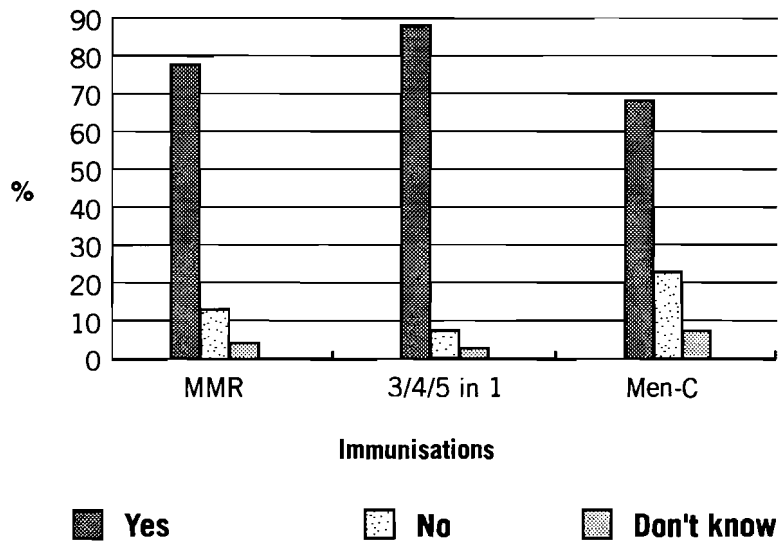
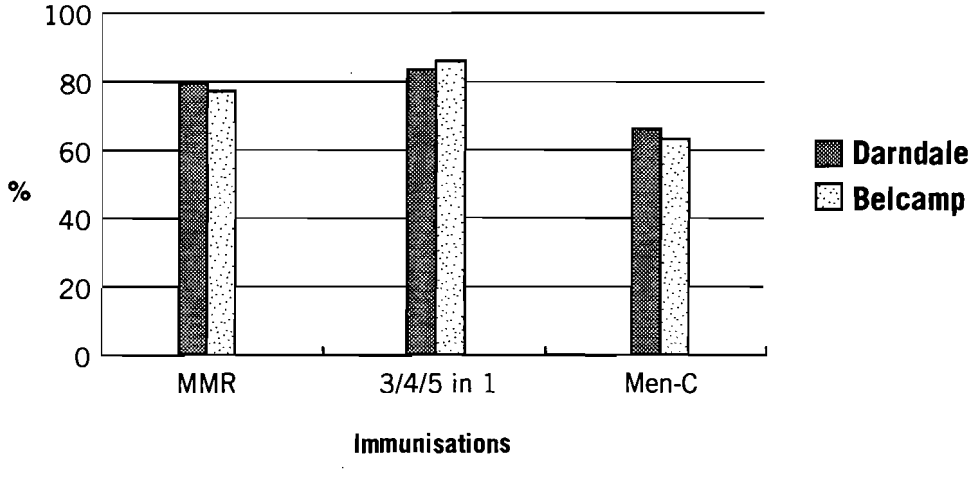


Figure 23 Immunisation profile for children under 5 for each area.

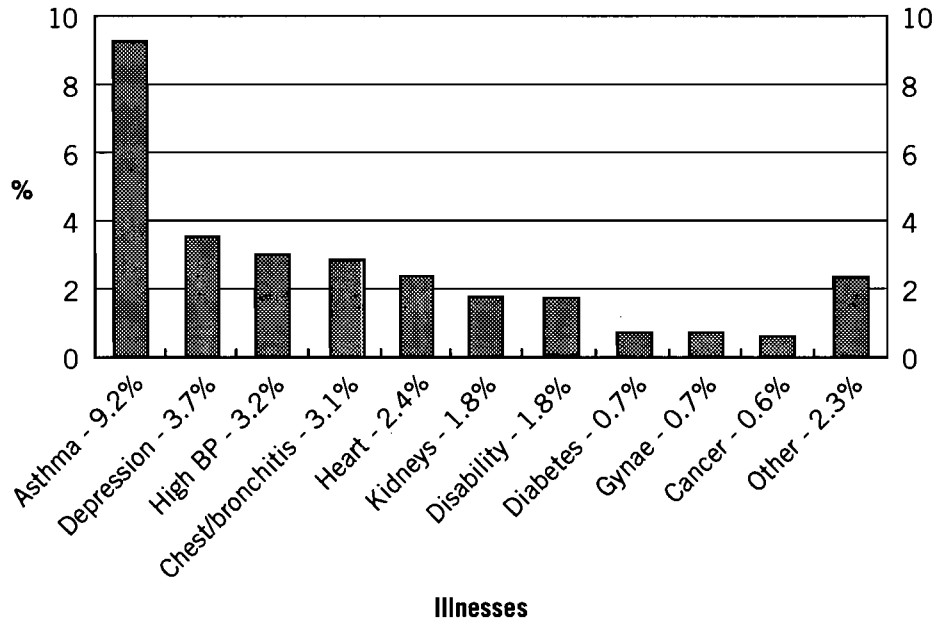


Illness profile

Self reported illness

Three hundred and twenty-six people out of 1364 respondents (24%) reported having an illness. Figure 24 shows the frequency of the illnesses. The proportion of residents reporting an illness was similar to results from Tallaght (22%; Long et al. 2002) and Finglas (29%; TCD 2003).

Figure 24 Proportion of total residents who reported each illness.



The age and gender distribution of the five most common illnesses are shown in Table 8. A greater proportion of sufferers of asthma, depression, high blood pressure and chest problems were female. The majority of those suffering heart problems were male. The highest proportion of those with depression, high blood pressure and chest problems were found in the 26–55 age group. The 6–15 year age group had the highest number of asthma sufferers. The 55+ age group had the highest number of people with heart problems.

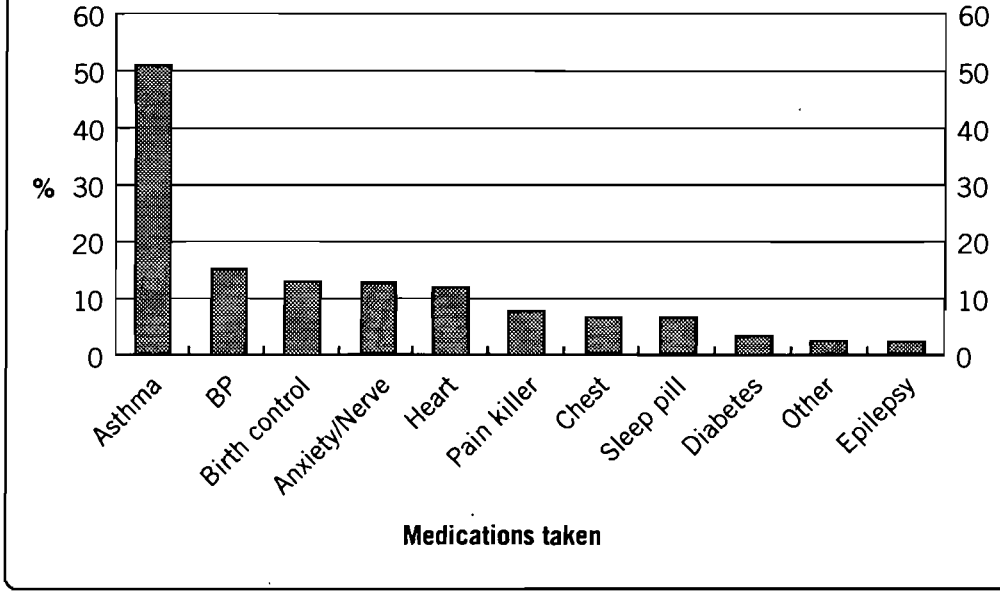
Table 8 - The five most often mentioned illnesses by gender and age group.

Gender N (%)	Asthma	Depression	High BP	Chest problems	Heart problems
	N = 125	N = 50	N = 44	N = 42	N = 33
Gender					
Male	52 (41.6)	15 (30.0)	8 (18.2)	14 (34.1)	22 (66.7)
Female	73 (58.4)	35 (70.0)	36 (81.8)	27 (65.9)	11 (33.3)
Age					
0 – 5	18 (14.5)	0	0	4 (9.5)	3 (9.7)
6 – 15	44 (35.5)	2 (4.1)	0	3 (7.1)	2 (6.5)
16 – 25	22 (17.7)	6 (12.2)	1 (7.4)	2 (4.8)	2 (6.5)
26 – 55	35 (28.2)	35 (71.4)	26 (61.9)	25 (59.5)	8 (25.8)
55+	5 (4.0)	6 (12.2)	15 (35.7)	8 (19.0)	16 (51.6)

Prescriptions

Two hundred and thirty-four respondents reported currently taking one or more prescriptions for greater than one month. The breakdown of medication prescription is presented in Figure 25.

Figure 25 Prescription profile of survey respondents.

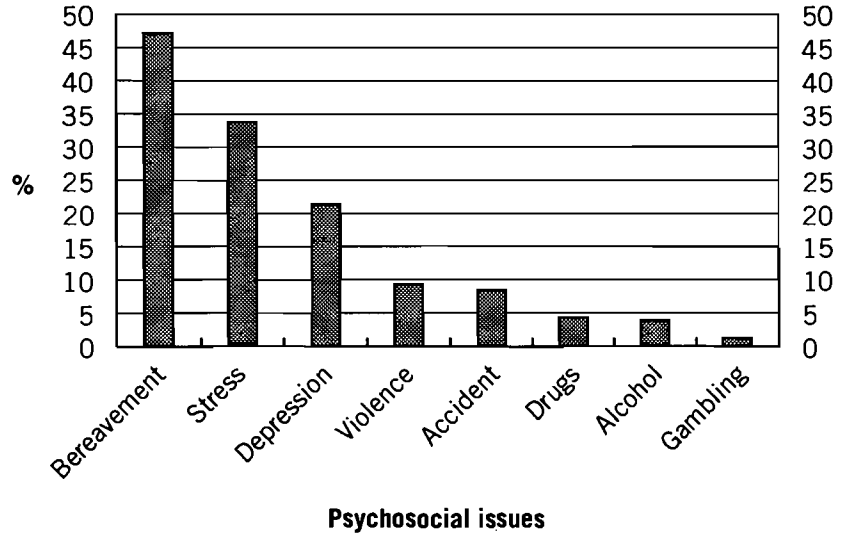


Specified psychosocial problems

Respondents completing the questionnaire were given a list of psychosocial issues and asked to record for each member of the household if the problem was experienced (See Q21 on questionnaire).

Two hundred and forty respondents out of 1364 (18%) were reported to have one or more specified issues. Bereavement was the most common issue identified (47%) whereas gambling was the least common (0.4%). The full breakdown of psychosocial stresses is shown in Figure 26.

Figure 26 Psychosocial issues affecting respondents.

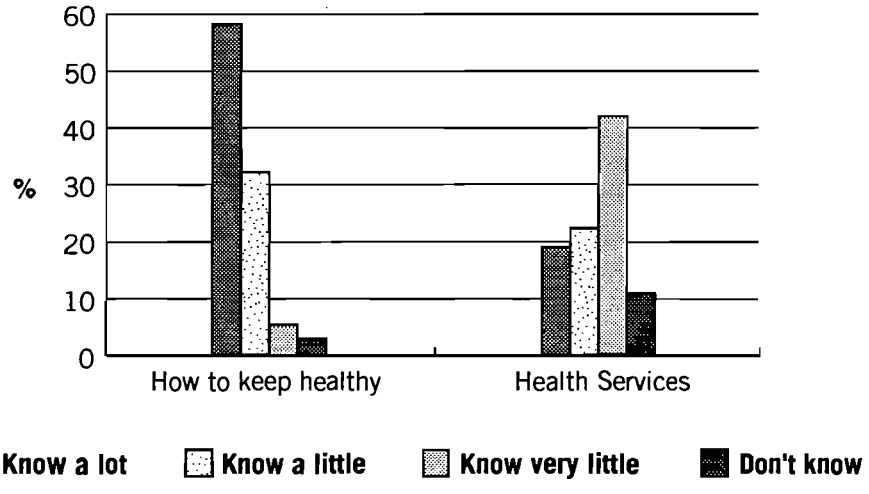


HEALTH INFORMATION

Knowledge of health

While the majority of respondents 59% (176/298) knew a lot about how to keep healthy, on the issue of information about health services in the area, 43% (129/301) claimed to know very little.

Figure 27 Frequency of respondents knowledge of how to keep healthy and local health services.

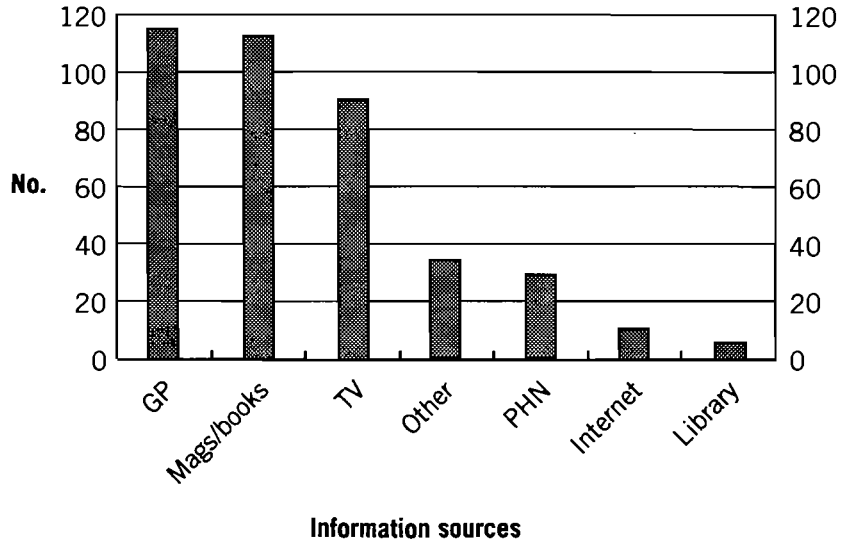


Sources of health information

When asked about usual sources of health information concerning health issues. The most common source of health information for household participants was the General Practitioner. The second most common source of health information was magazines and books.

Figure 28 demonstrates the frequency of sources of health information. The most common source (13/36, 36%) of information in the "Other" category was "word of mouth/friends/family". This was followed by "leaflets" (7/36, 19%). Six people reported not seeking any health information.

Figure 28 Sources of health information for study households.



Areas of interest for future health information

Respondents completing the questionnaire were given four health topics, namely, dental health, sexual health, mental health and healthy eating and asked would information on these topics be of interest to the respondent. An interest in obtaining information on dental health and healthy eating was expressed by over three quarters of household respondents - 79% and 76% respectively. Mental health information was specified by 62% of household respondents and information on sexual health by 46%.

COMMUNITY ISSUES AND PRIORITIES

Table 9 shows the breakdown of issues that household respondents felt were of concern in their area. The results displayed in Table 9 indicate the high level of concern expressed by residents on a variety of social and health related issues.

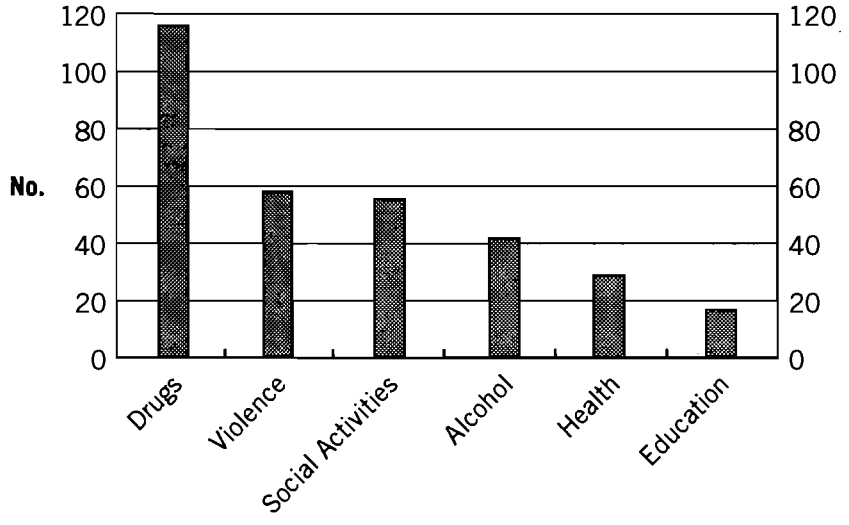
Safe play areas, tackling joy riding, drug abuse by young people, drug dealing and clubs for teenagers are highlighted as the most important issues requiring action.

Table 9
Issues respondents felt needed attention in their area.

Issue of Concern	n	%(yes)
Safe play areas	295/297	**99.3**
Clubs for teenagers	290/297	**97.6**
Shops close to estate	158/239	66.1
Fruit and veg	201/245	82.0
Early-school leaving	232/269	86.2
Unemployment	260/277	93.9
Litter/Dumping	267/283	94.3
Mugging/Street violence	219/266	82.3
Domestic violence	217/261	83.1
Joy-riding	305/307	**99.3**
Drug-dealing	293/300	**97.7**
Drug abuse by adults	278/289	96.2
Drug abuse by young people	290/295	**98.3**
Alcohol abuse by adults	265/277	95.7
Alcohol abuse by young people	280/290	96.6
Smoking by adults	234/271	86.3
Smoking by young people	263/283	92.9

Less than half of respondents 46% (130/286) reported that their children took part in organised activities such as a youth club, football club etc. Only 22% (61/283) of respondents with children said they had a playground in their area. Thus 78% of children were reported to have had no playground in their area. Just over half of respondents with children reported having concerns about their children. Their greatest concern was drugs (119) and of least concern was education (18). The frequency of issues concerning parents is shown in Figure 29.

Figure 29 Frequency of issues concerning parents.

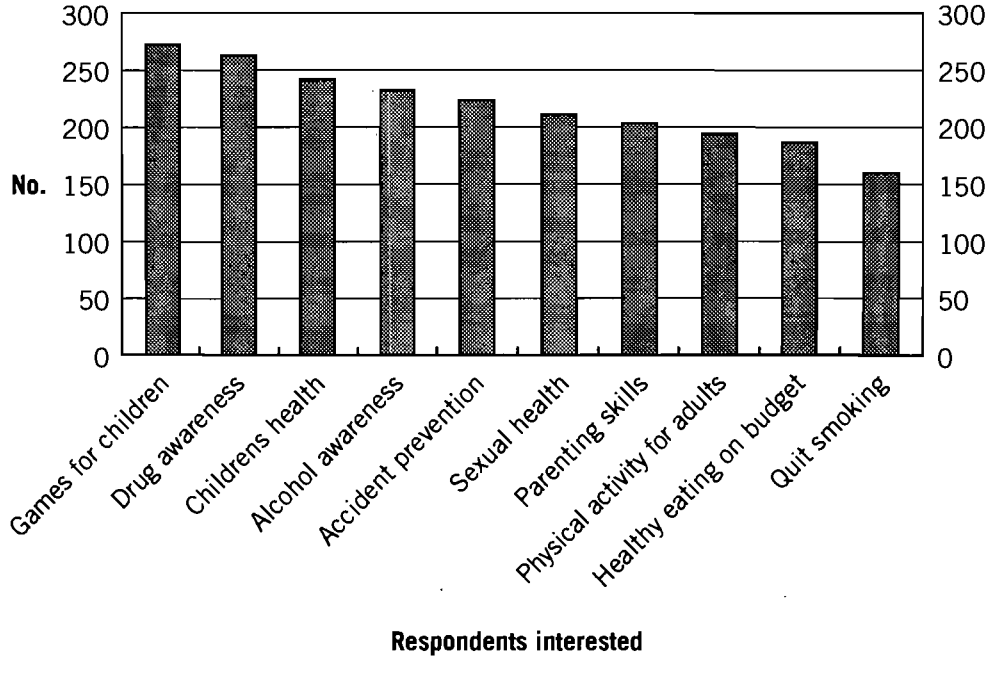


HEALTH PROMOTION PRIORITIES

Nature of programme/classes requested by respondents

Respondents were given a list of possible topics that might be included in programmes/classes run in their area (See Q38 on the questionnaire). They were asked to tick which topics they would like to see included. The provision of games/sport programme for children was listed most frequently by respondents 87% (271/313). In excess of 49% of respondents expressed an interest in seeing each of the ten topics listed included in programmes/classes. Figure 30 shows the level of interest for each topic.

Figure 30 Interest expressed by respondents in each topic.



Preferred location of proposed services

Respondents were asked their preferred location for such programmes/classes. The majority of respondents 88% (268/306) expressed a preference to attend the above sessions in the Village Centre, Darndale. The other venues mentioned were Coolock Health Centre (5%; 15/306), local schools (5%: 14/306) and the hospital (3%; 9/306).

Preferred Time of day for proposed services

A total of 44% of the respondents surveyed (134/307) identified the evening as the time most suitable for attending programmes/classes. Other times identified were morning 29% (88/307), anytime 16% (50/307) and afternoon 11% (35/307).

DISCUSSION

This study showed that the majority of households both in the Darndale and Belcamp areas are now well established with a settled population. Most households are two parent households (50%) with just under one third of households being one-parent households. The unemployment rate for the Darndale/Belcamp area is three to four times the national average at 16.5%. This may indicate a greater need in this area for health and social services. The Belcamp area has a predominantly adult population whereas the Darndale has a much larger child and adolescent population. This demonstrates the need for child and adolescent health and social services for Darndale. The need for long-term health and social service planning in relation to the elderly in the Belcamp area is also indicated.

The focus in this health promotion needs assessment was largely on risk factors associated with cardiovascular health, for example, smoking, alcohol consumption and physical inactivity. Ireland has the highest rate of premature mortality from CHD in the European Union. Cardiovascular disease remains the single largest cause of mortality nation-wide (Balanda and Wilde 2001). Persons from the lower socio-economic groups have higher levels of coronary heart disease.

The adult residents of Darndale/Belcamp displayed high levels of smoking when compared to recent national data. Over half of the adults in Darndale and Belcamp smoke (56%) compared to the national figure of 27% (Centre for Health Promotion Studies 2003). Given that the death rate for smokers of all ages is two to three times that of non-smokers this is an issue which must be addressed. Cigarette smoking is a major risk factor for coronary heart disease. The effect of passive smoking on family members and in particular children is an issue that will also need to be addressed.

Alcohol consumption in the Darndale/Belcamp area is approximately equivalent to the national rate (75% and 78% respectively). However, alcohol consumption has increased dramatically in Ireland in recent years as reported in the Strategic Task Force on Alcohol (Dept. of Health and Children 2003). The most dramatic increase has been amongst the teenage population. The problems associated with alcohol such as violence, homicides, suicides, marital difficulties, family breakdown etc. are all on the increase nationally. The longer-term effects of alcohol in terms of liver disease, cancer of the oesophagus, accidents of all types including road traffic accidents, suicides and homicides are now evident in the health statistics (Dept. of Health and Children 2003). This can be seen in terms of presentations to accident and emergency departments, hospital admissions, mortality statistics specifically suicides and accidents related to alcohol intake. There are no detailed figures on alcohol related morbidity and mortality for the Darndale/Belcamp areas. This information would be required in order to compare the area with the national situation in this respect.

Women's health is also an area of concern. Almost two thirds of women surveyed (63%) had not received family planning and 18% of women had never had a cervical smear. More than half of female respondents (55%) reported never having had a breast examination. There are a number of service providers providing these services for the area, including the General Practitioners and the Well Woman Centre. The poor uptake may be related to the lack of knowledge in relation to current service provision. Efforts to improve the uptake of such services among women in the area should be made.

This study also highlighted a number of child health issues. Immunisation is a safe effective means of protecting children and the population at large from a range of childhood communicable diseases. Immunisation is free. Protection is afforded to the individual immunised and immunity is conferred on the wider population. It is important to state that there are a small number of children who for medical reasons such as immuno-suppression and childhood cancers are unable to receive immunisation. These children are at increased risk of contracting communicable disease hence the importance of widespread coverage*. To achieve widespread coverage a 95% immunisation uptake rate is required. The rates in Darndale/Belcamp fall well below the target level. These low uptake rates are a major cause for concern. They place the community at risk of epidemics. The Measles outbreak in North Dublin in 2000 with 1,600 reported cases, 100 hospital admissions and three deaths clearly demonstrates the importance of achieving widespread coverage (Virus Reference Lab 2000).

The rates of injury among children in the Darndale/Belcamp area are similar to the national figures presented in the Injury in Ireland report (Scallan et al. 2001). Scallan et al. (2001) call for a National Injury Strategy and comprehensive health promotion for all mothers of young chidren.

It is of concern that 43% of heads of households claimed to know little or nothing about existing health service provision in the area. This is an issue that needs to be addressed as a priority. There is little point in providing services if people are unaware of their existence and do not subscribe to them.

Education and awareness are important elements in health promotion. However, health education alone is not sufficient. It has been recommended that priority should be given to making the environment in which one lives more conducive to health enhancing lifestyles (Shelley 1994). The health and social issues in Darndale and Belcamp are multi-factorial and hence require a multi-agency approach.

The provision of the new Village Centre with its many services is hoped will serve to strengthen the sense of community in the area**. It is important that the many agencies involved in the Darndale and Belcamp areas build on the work done and provide the services and supports necessary to make Darndale and Belcamp better places to live and bring up families. Given the lack of car ownership, access to services is an issue. It is important that the area is served by adequate public transport and that services where possible are provided locally. At the request of residents, these services should be provided in the Darndale Village Centre preferably in the evening to ensure maximum uptake.

* *The medical term for this is known as "herd immunity"*

** *The Discovery Training Centre sponsored by FAS and the Dublin VEC, The Resource Centre for Community Services, The Jigsaw Centre for Childcare services, The Dublin City Council Regional Offices and the recruitment of a General Practitioner for the Village Centre.*

RECOMMENDATIONS

The following are the recommendations arising from this report. They can be divided into general and specific recommendations:

GENERAL RECOMMENDATIONS

1. The Health Promotion Service will continue to work in partnership with the community, local government and the statutory and voluntary agencies to develop, implement and evaluate community based specific health promotion initiatives. As stated earlier, health promotion programmes targeting whole communities are thought to be more effective in changing health behaviour of communities. Future models for achieving health and social gain will be dependent on locally based initiatives expressly planned to meet local needs. Such models focus efforts away from the traditional lifestyle approach to health towards a community approach to health. To effect this, all stakeholders including the residents of Darndale and Belcamp, local government and the statutory and voluntary organisations must work together. Such an approach to health and wellbeing, which actively engages the local community will be fostered in an effort to enhance the health of the residents of Darndale and Belcamp. It is proposed to adopt a multi-sectoral approach to progress the recommendations from this report

2. The Health Promotion Service in the NAHB will continue ongoing public consultation with the residents of Darndale and Belcamp. This will include focus group discussions and one-to-one consultations in an effort to determine the community's requirements in relation to their health promotion needs. The aim of this is to develop appropriate community health initiatives which seek to improve the health of the residents of Darndale and Belcamp communities in the long term.

3. The Health Promotion Service in the NAHB will develop a Health Promotion Action Plan with the Darndale and Belcamp communities. A formal working group will be set up to address community health promotion issues, as identified in this report.

4. The Health Promotion Service in the NAHB will link strategically with other health service providers to ensure a wider comprehensive response from the Northern Area Health Board to the overall health needs of the residents of Darndale and Belcamp.

5. Steps will be taken to increase levels of awareness of current service provision. It is proposed to explore various methods of communication such as a newsletter, leaflets and word of mouth via community groups and voluntary groups and using local media such as local radio.

SPECIFIC RECOMMENDATIONS

1. Smoking: High smoking rates were identified in the Darndale/Belcamp area. The people of Darndale and Belcamp did not however identify smoking as a problem. More than half of all smokers (59%) expressed an interest in trying to quit smoking and two thirds of smokers (66%) would consider trying nicotine replacement therapy.

   Smoking cessation services currently in place for residents include one to one counselling. The service is free and with no appointment necessary. At present this service is poorly subscribed. Reasons for this are unclear and need further study. The people of Darndale and Belcamp have stated their preferred times for service provision. Efforts should be made to provide such services locally at times convenient to residents.

   It is also proposed to provide training for youth workers on 'Brief Intervention and Motivational Interviewing for Smokers' to support young people in their efforts to stop smoking. The possibility of linking smoking cessation programmes to games and sports programmes in the area is currently being explored. Given that over two thirds of children in the area leave school before the age of 16, this intervention is of particular relevance to the area.

   Social, Personal Health Education (SPHE), which was introduced in the late 1990's to drive post primary education in relation to lifestyle choices, is currently being provided in many post primary schools serving the Darndale and Belcamp areas. Teacher training in relation to SPHE, including a tobacco component, will continue with assistance from the Health Promotion Service in the NAHB.

   All work places will be designated smoke free from January 2004. The Health Promotion Service in the NAHB is actively involved in preparing for the introduction of this legislation.

   Health promotion leaflets on smoking and smoking cessation are widely available in health centres, libraries etc. throughout the NAHB. Efforts will be made to make this information more widely available.

2. Women's Health: Women's health is also an issue that needs to be addressed. The poor uptake of family planning services is an area that needs further exploration. It is proposed to promote the increased uptake such services by joint work with various agencies.

3. Children's health: This study highlighted issues in relation to childhood immunisation. Efforts will be made to increase immunisation uptake rates by joint working with the relevant health professionals in the area.

   Due to the high level of injuries amongst children generally, the NAHB is involved in developing a pilot childhood accident prevention programme. The Health Promotion Service in the NAHB will forge links with Dublin City Council and Local Voluntary Groups in an effort to raise awareness and tackle childhood injury.

CONCLUSION

This health promotion needs assessment was conducted for the people of Darndale and Belcamp. This study set out to identify the health promotion needs of the community. It profiled the population, documented key health promotion issues and identified priorities for future service provision. Some areas, namely alcohol intake, nutrition and physical activity, were not investigated in great detail here as the NAHB is carrying out more detailed work in these areas under a separate study. National data and the specific findings of this study will be used to inform the health promotion services and other service provision within the NAHB. Ongoing consultation with the community is required to identify how best to progress a comprehensive community health promotion programme. Strategic partnerships and alliances with other agencies are clearly required if the issues identified in this study are to be addressed in the Darndale/Belcamp area.

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Directory of Services offered by NAHB to the residents of Darndale/Belcamp

1. Community Welfare Services.
2. Adult Psychology Services.
3. Public Health Nursing Services (Nurses Treatment Clinic).
4. Public Health Medical Services (Developmental Clinic & Child Health Clinic).
4. Speech & Language Therapy Service.
5. Mater Child & Adolescent Mental Health Service for Children Adolescents & their Families. Services include psychiatry, social work, clinical psychology and speech and language therapy.
6. Dental Services.
7. General Practitioner Services
8. Community Mental Health Services
9. Social Work Services
10. Occupational Therapy
11. Home Help Services
12. Addiction Services
13. Rehabilitation and Training Services
14. Well Woman Services
15. Pharmacy Services
16. Health Promotion Services

Directory of Voluntary and Community Groups operating within Darndale/ Belcamp

1. Senior Citizens Group.
2. Lifelong Learning Group.
3. Environmental Group.
4. Enterprise &Employment Group.
5. Community Playgroup.
6. Community Mothers Programme.
7. Boxing Club.
8. Sport and Leisure groups.
9. Drugs Awareness group.
10. Tenants and Residents Associations.
11. Joyriding Task Force.
12. Literacy Group.
13. Priorswood Football Club.
14. The Springboard Project Family Support Group.
15. Tuas Family Centre.
16. Meals on Wheels.
17. Jigsaw Childcare Centre.
18. St. Vincent de Paul Society.
19. MABS Money Advice Service.
20. Alcohol Addiction Counselling Services.
21. Housing advice, Dublin City Council.
22. Youth Services.
23. Educational Support Services e.g. Early School Leaver Initiative.

Interviewer: ☐☐ Household ID number: ☐☐☐☐

Northern Area Health Board

Health Promotion Needs Assessment

Darndale/Belcamp Area

Questionnaire should be completed with the female head of household.

In her absence any other adult living in the household can complete the questionnaire.

Q1. **Area** Darndale❒1 Belcamp❒2

Q2. **How long have you lived in this area?** ____ years ____ months

Q3. **How many people are normally resident in this household?** ☐☐

Q4. **Type of household**

Single individual living alone ..... ❒1
Lone parent with dependent child/children at home ..... ❒2
Lone parent where child/children have left home ..... ❒3
Two - parents with dependent child/children at home ..... ❒4
Two - parents where child/children have left home ..... ❒5
Other (specify) _____

Q5. **Are you renting or purchasing this house?**
Is that from the Local Authority or a landlord/bank or building society?

Renting from Local Authority ..... ❒1 Purchasing from Local Authority ..... ❒3
Renting privately from landlord ❒2 Purchasing from Bank/Building Society ❒4
Other (specify) _____

Q6. Do you have each of the following in this house?

Working central heating ..... Yes❒1 ..... No❒2
A working shower ..... Yes❒1 ..... No❒2
A telephone ..... Yes❒1 ..... No❒2
Access to a car/van ..... Yes❒1 ..... No❒2

Q7. **Do you have a medical card?** ..... Yes❒1 ..... No❒2

Q8. **Do you have private medical insurance?** ..... Yes❒1 ..... No❒2

Q9. **What is your Nationality?** _____

Please complete for each person currently living in household. (Record children from the oldest to the youngest).

		Q10	Q11	Q12	Q13	Q14	Q15	Q16	Q17
	First name or initial	Sex	Age	**Relationship (to respondent)**	**Occupation**	**Does X smoke? If yes, how many per day?**	**Does X drink alcohol?**	**In general would you say your/X's health is:**	***Compared to one year ago*, how would you rate your/X's health:**
1.	Respondent								
2.									
3.									
4.									
5.									
6.									
CODES		Male=1 Female=2		Spouse = 1 Partner = 2 Child = 3 Parent = 4 Grandparent = 5 If other, write in	At School = 84 Unemployed = 85 Unable to work = 86 Retired = 87 If employed, write in details of job held	Not a smoker = 0 Don't know if smoke=88 Don't know amount=89	Yes = 1 No = 2 Don't Know=88	Excellent = 1 Very good = 2 Good = 3 Fair = 4 Poor = 5 Don't Know=88	Much better = 1 A bit better = 2 About the same = 3 A bit worse = 4 Much worse = 5 Don't Know=88

SECTION S: QUESTIONS FOR *SMOKERS* ONLY If respondent is not a smoker, skip this section and continue with the table on page 3.

QS1. **Have you any interest in trying to stop smoking?** ... Yes❑$_1$.....No❑$_2$

QS2. **Have you ever tried to stop?**..... Yes, more than once❑$_1$..... Yes, once❑$_2$.....Never❑$_3$

QS3a. **Do you know about nicotine replacement therapy?**..... Yes❑$_1$ ..... No❑$_2$ →*Go to QS4*

If Yes: QS3b. Have you ever tried it?..... *Yes❑$_1$* →Go to QS5 *No❑$_2$* →Go to QS4

QS4. Nicotine Replacement Therapy is available free on the medical card and is an effective method of stopping smoking. It consists of wearing nicotine patches and over time, the amount of nicotine in the patches is reduced. Would you consider trying it?..... Yes❑$_1$.....No❑$_2$.

QS5. **Would you attend a 'STOP SMOKING' programme in your neighbourhood?**..... Yes❑$_1$.. No❑$_2$

		Q18			Q19	Q20			Q21				Q22	Q23
	First name or initial	**For children under 5: Has the child had these immunisations?**			**Does X suffer from any illnesses?**	**Does X have a repeat prescription (>1 month)?**			**Has X experienced any of these problems recently?**				**At what level did *X* complete formal education? Did X return as an adult learner to complete any of these exams?**	**Does X have problems with reading and/or writing?**
		MMR	3/4/5 in 1	MenC	(Show Card A)	1st	2nd	3rd	(Show Card B)					
1.	Respondent													
2.														
3.														
4.														
5.														
6.														
C O D E S		Yes = 1 No = 2 Don't Know = 8 MMR = Mumps, Measles & Rubella 3 in 1 = D.T.P. 4 in 1 = D.T.P.P. 5 in 1 = D. T.P.P.H. MenC = Meningoccal C			Asthma = 1 Chest/bronchitis = 2 Diabetes = 3 High BP = 4 Heart Problems = 5 Depression = 6 Kidneys = 7 Cancer = 8 Disability = 9 Gynaecological=10 Don't know = 88 If other, write it in	Asthma drugs = 1 Chest drugs = 2 Diabetic drugs = 3 BP tablets = 4 Heart tablets = 5 Sleeping pills = 6 Anxiety/nerve tablets = 7 Pain killers = 8 *Birth control = 9* Don't know = 88 If other, please write in			An accident = 1 Stress = 2 Alcohol problems = 3 Drug problems = 4 Depression = 5 Bereavement = 6 Violence in or outside the home=7 Gambling = 8 Write in code of the first 4 mentioned If other, write in				Did not complete primary = 1 Completed primary = 2 Some secondary, no exam = 3 Completed inter/group/junior cert only = 4 Completed leaving/senior = 5 Started third level = 6 Completed third level = 7 Still in school (children only) = 8 Returned to do exam = XY X is level originally completed and Y is the highest exam they returned to do e.g. if did inter and left and then returned to do leaving, code would be 45. Don't know = 88	Yes = 1 No = 2 Too young=89 Don't Know=88

SECTION F: QUESTIONS FOR *FEMALE* RESPONDENTS ONLY

QF1a. **Have you ever had a smear test?** ..... Yes❑$_1$ ..No❑$_{2 \rightarrow \text{Go to QF2a}}$

QF1b. **If yes, how long ago?** _____ months

QF2a. Have you ever had a breast check? ..... Yes❑$_1$ ..... No❑$_{2 \rightarrow \text{Go to QF3a}}$

QF2b. If yes, how long ago? _____ months

QF3a. **Have you ever received family planning advice?** ..... Yes❑$_1$ ..... No❑$_{2 \rightarrow \text{Go to QC1}}$

QF3b. **Did you obtain it from..?** *(tick all that apply)*

GP❑$_1$ PHN❑$_2$ Family Planning Centre❑$_3$ Other (specify) _____

SECTION C: QUESTIONS FOR RESPONDENTS *WITH CHILDREN* ONLY

QC1a. **Have any of your children had an accident, either in or outside the house, in the past year which required medical attention?** ..... Yes❑$_1$ ..... No❑$_{2 \rightarrow \text{Go to QC2}}$

QC1b. **How did this accident occur?** _____

QC1c. **What injury did your child suffer as a result of this accident?** _____

QC2. **Do your children participate in any organised activities such as a youth club, football club etc.?**

Yes❑$_1$ No❑$_2$

QC4. **Do your children have a playground in the area to play in?** ..... Yes❑$_1$ ..No❑$_2$

QC3a. **Do you have any concerns about your children?** .... Yes❑$_1$ ..... No❑$_{2 \rightarrow \text{Go to Q24}}$

QC3b. **If Yes: What concerns do you have?** *(tick all that apply)*

Health ..... ❑$_1$ Violence ..... ❑$_5$
Education ..... ❑$_2$ Social Activities ..... ❑$_6$
Alcohol ..... ❑$_3$ Other (specify) _____
Drugs ..... ❑$_4$ Other (specify) _____

QUESTIONS FOR *ALL* RESPONDENTS

Q24. **How often each <u>week</u> do you cook a hot evening meal from fresh produce?**

Less than twice❑$_1$ 3 – 5 times❑$_2$ More than 5 times❑$_3$

Q25. **How often each <u>week</u> do you have a take-away for the evening meal?**

Less than twice❑$_1$ 3 – 5 times❑$_2$ More than 5 times❑$_3$

Q26. **How often each <u>week</u> do you sit down as a family to eat an evening meal?**

Less than twice❑$_1$ 3 – 5 times❑$_2$ More than 5 times❑$_3$

Q27. **Where do you and your family eat <u>most</u> of your meals?**

Kitchen/Dining room❑$_1$ TV/Sitting room❑$_2$ Other (specify) _____ ❑$_3$

Q28a. **Do <u>you</u> take part in any physical activity, for example, walking, running, aerobics, swimming etc.?**

Yes❑$_1$ No❑$_2$

Q28b. **How many times per week would you do this?**

Less than twice❑$_1$ 3 – 5 times❑$_2$ More than 5 times❑$_3$

Q28c. **How many times per week would you do this for more than 30 minutes?**

Less than twice❑$_1$ 3 – 5 times❑$_2$ More than 5 times❑$_3$

Q29. **How many hours per day do <u>you</u> usually watch TV?** _____ hours

Q30. **How many hours per day do <u>your children</u> usually watch TV?** _____ hours

Q31. **How many hours per day do <u>your children</u> usually play computers/playstation?** _____ hours

Q32. **How well informed are you regarding how to keep healthy?**
Know a lot☐1 Know a little☐2 Know very little☐3 Don't Know☐8

Q33. **How well informed are you about the health services available in your area?**
Know a lot☐1 Know a little☐2 Know very little☐3 Don't Know☐8

Q34. **How could the health services in your area be improved?** Don't Know☐88

_____

_____

Q35. **Where do <u>you</u> usually get information about health issues?** *(tick all that apply)*
TV☐1 Magazines/Books☐2 Internet☐3 Library☐5 GP☐6 PHN☐7

Other (specify) _____ *Have never looked for any☐88*

Q36a. **Would information on any of the following be of interest to you?** *(call out & tick all that apply)*
Dental health..... Yes☐1 No☐2
Sexual health..... Yes☐1 No☐2
Mental health..... Yes☐1 No☐2
Healthy eating..... Yes☐1 No☐2

Q36b. **Are there any other area on which you would like to receive information?**

_____

_____

Q37. **Which of the following do you feel need attention in your area?** *(show card C & tick all that apply)*
The availability of safe play areas for children..... Yes☐1 No☐2
The availability of clubs etc. for teenagers..... Yes☐1 No☐2
Shops closer to the estate..... Yes☐1 No☐2
The availability of fruit and vegetables..... Yes☐1 No☐2
Early-school leaving..... Yes☐1 No☐2
Unemployment..... Yes☐1 No☐2
Litter/Dumping..... Yes☐1 No☐2
Crime/Vandalism..... Yes☐1 No☐2
Muggings/Violence on the street..... Yes☐1 No☐2
Domestic violence..... Yes☐1 No☐2
Joy-riding..... Yes☐1 No☐2
Drug-dealing..... Yes☐1 No☐2
Drug abuse by adults..... Yes☐1 No☐2
Drug abuse by young people..... Yes☐1 No☐2
Alcohol abuse by adults..... Yes☐1 No☐2
Alcohol abuse by young people..... Yes☐1 No☐2
Smoking by adults..... Yes☐1 No☐2
Smoking by young people..... Yes☐1 No☐2

Q38. The Health Board in your area intends to run health promoting programmes or classes or have a drop-in service in your area. They want to find out which topics you would like to see included in this.
Which of the following programmes or classes would you be interested in?
(show card D & tick all that apply)

Quit Smoking ..... ❑1
Healthy Eating on a budget ..... ❑2
Physical Activity for Adults ..... ❑3
Games/Sport for Children ..... ❑4
Children's Health ..... ❑5
Parenting Skills ..... ❑6
Drug Awareness ..... ❑7
Alcohol Awareness ..... ❑8
Accident Prevention ..... ❑9
Sexual Health ..... ❑10

Are there other programmes/classes you would be interested in?

Other _____
Other _____
Other _____

Q39. **Where you prefer to attend such sessions?** *(call out all and tick one only)*

Hospital ..... ❑1
Health centre, Coolock ..... ❑2
Village Centre, Darndale ..... ❑3
Local schools ..... ❑4
Other (specify _____)

Q40. **What time would suit you best to attend such sessions?** *(tick one only)*

Morning ..... ❑1
Afternoon ..... ❑2
Evening ..... ❑3
Anytime ..... ❑4

Thank you for Completing this Questionnaire.
You will be entered into a draw for 250 Euro. Winners will be notified in December.

Interviewer: Remember to fill in the RESULT on the your QUOTA SHEET and to record if the respondent wants to be entered into the draw.

NOTES

northern area
health board
bord sláinte an
limistéir thuaidh

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