Healthy Ireland Survey 2025

Summary Report

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Le ceannach díreach ó
FOILSEACHÁIN RIALTAIS,
BÓTHAR BHAILE UÍ BHEOLÁIN, BAILE ÁTHA CLIATH 8.
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Healthy Ireland Survey 2025

Summary Report

Contents

Introduction

The Healthy Ireland Report 2025 presents the initial topline findings from the eleventh wave of the Healthy Ireland Survey. This survey, commissioned by the Department of Health and conducted by Ipsos B&A, examines the health and health behaviours of people aged 15 and older, living in Ireland.

The survey serves as a core element of the Healthy Ireland Framework and Strategic Action Plan, providing annual data points for tracking population health trends. This eleventh annual publication of the Healthy Ireland Summary report contributes to a valuable data series, enabling analysis of changes in health behaviours over time, and offering comparisons to pre-COVID-19 pandemic behaviours.

The primary purpose of the survey is to inform research, monitoring, and evaluation efforts related to health policy impact. Its key objectives include:

- Providing current and reliable data to enhance the monitoring and assessment of policy initiatives under the Healthy Ireland Framework.
- Strengthening Ireland's capacity to meet international reporting obligations.
- Contributing to the Healthy Ireland Outcomes Framework and the assessment, monitoring, and realisation of benefits from the overall health reform strategy.
- Facilitating targeted, outcomes-focussed monitoring to improve policy responsiveness and agility.
- Supporting the Department of Health in ongoing engagement, awareness-raising activities, and fostering a better understanding of policy priorities across various health areas.

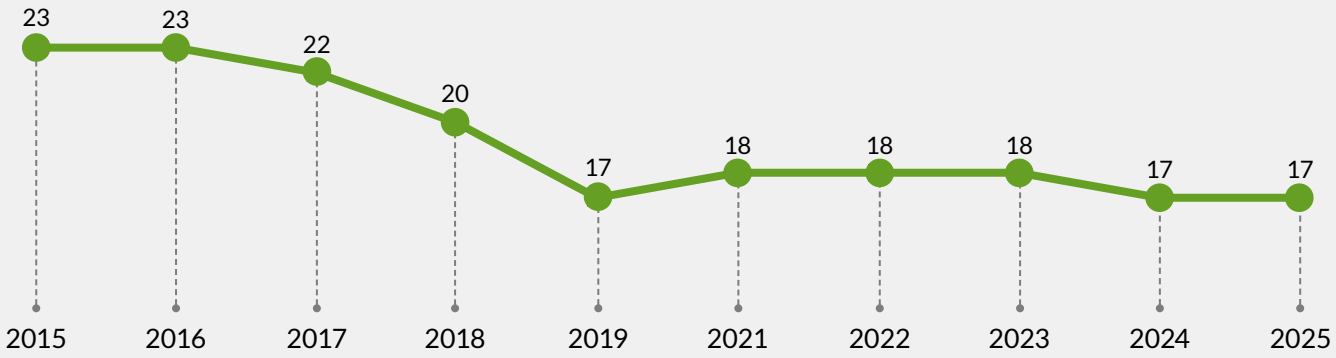
Each wave of the survey involves a sample of approximately 7,500 individuals, representative of the population aged 15 and over. The first five survey waves (2015-2019) were conducted using face-to-face interviews. The 2020 survey was not completed due to the introduction of necessary COVID-19 restrictions in March 2020. A switch to telephone interviewing was made in 2021 to ensure effective infection control during the COVID-19 pandemic and the survey has been conducted by telephone interviewing in the years since (2021-2025). Fieldwork for the 2025 survey took place between November 2024 and April 2025.

This Healthy Ireland Summary Report covers a range of topics including:

- General Health
- Smoking
- E-cigarette and Nicotine Pouches
- Alcohol and Non-Alcoholic drinks
- Harms of Alcohol
- Menopause
- Contraception
- Sleep
- Caring Responsibilities
- Women & Caring Responsibilities
- Healthcare Utilisation
- Technical Details

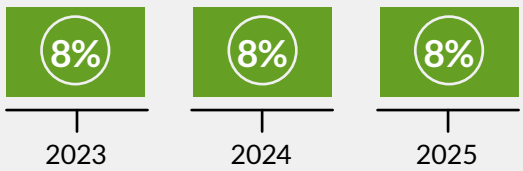
Smoking

Prevalence of smoking by year, 2015-2025 (%)

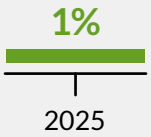


E-cigarette usage

Prevalence of e-cigarette usage by year (%)

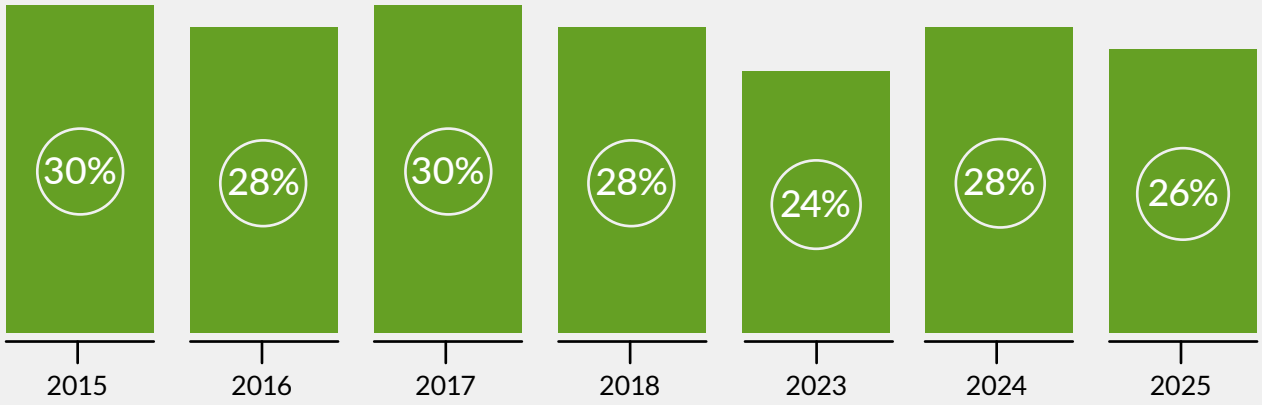


Prevalence of nicotine pouch usage (%)



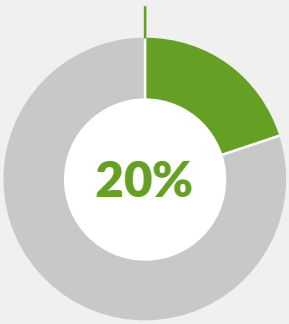
Alcohol use

Incidence of binge drinking in the past 12 months by year (%)



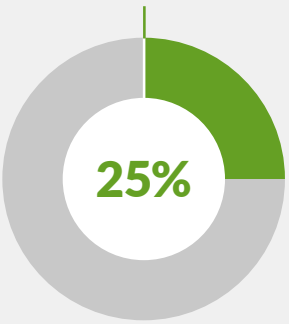
Alcohol use

Hazardous or harmful drinking



At risk of hazardous or harmful drinking (AUDIT ≥8)

*Non-alcoholic drinks**

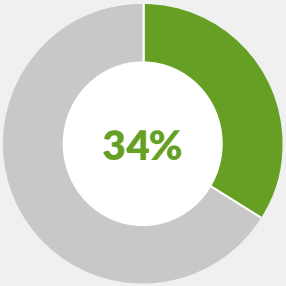


Drink non-alcoholic drinks

*Non-alcoholic or zero alcohol beer, wine, cider or spirits containing less than 0.5% alcohol by volume.

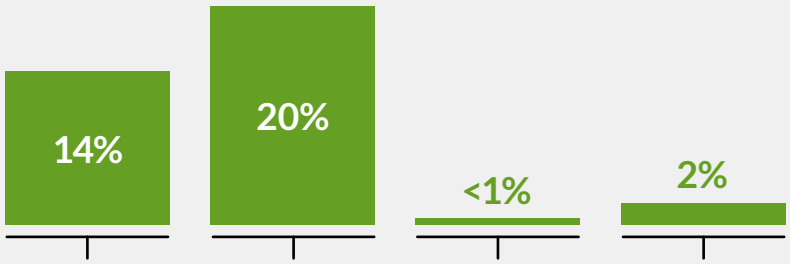
Contraception

Contraception use
(among adults aged 18 or older)



Use a form of contraception or method of family planning

Usage of different forms of contraception
(among adults aged 18 or older)



Barrier methods of contraception

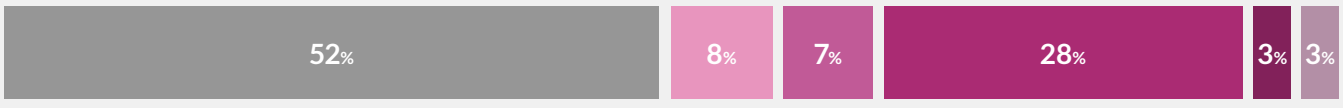
Prescription contraceptives

Natural family planning methods

Sterilisation

Menopause

Proportion of women experiencing menopause



Not going through menopause | Perimenopause | Menopause transition | Post-menopause | Using hormonal coil/ implant | Don't know

Experience symptoms constantly

27% Perminopause

34% Menopause transition

Report severe symptoms that significantly impact their life

11% Perimenopause

13% Menopause transition

See page 38 for definitions used

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1. General Health

1. General Health

Self-reported Health

The Healthy Ireland Survey uses a consistent measurement of self-reported general health. Each year, people are asked "How is your health in general?" and responses are recorded on a five-point scale, from very good to very bad.

- In 2025, 82% of the population report having good or very good health.
- Although reports of good or very good health have decreased since 2019 (85%), this year's result suggests a slight increase over the past two years.
- A similar proportion of men (82%) and women (81%) reported good or very good general health.
- Levels of reported 'good' health decline with age, with people aged 15-24 (92%) reporting the highest level of good or very good health and those aged 75 and older (69%) reporting the lowest rate of general 'good' health.
- The largest improvement in general health perceptions has occurred in older adults. Since 2015, reports of good or very good health have increased by 9 points among those aged 75 and older (2015: 60%, 2025: 69%), with reports among men in this age group increasing by 12 points (2015: 60%, 2025: 72%) and 7 points for women in the same group (2015: 59%, 2025: 66%).
- In contrast, the largest decrease in health perceptions occurred among those aged 55 to 64, seeing a 7-point decline in reported good or very good health since 2015 (2015: 79%, 2025: 72%). Among the 55 to 64 age group, women (2015: 79%, 2025: 71%) reported a larger decrease in perceived 'good' health than men (2015: 79%, 2025: 74%).

Proportion of the population rating their health as good or very good by gender and age, 2015-2025 (%) [1]

	2015	2016	2017	2018	2019	2021	2022	2023	2024	2025	% change since 2015
Total	85	84	84	85	85	84	82	80	81	82	**-3**
Men	85	83	83	84	85	84	83	81	81	82	**-3**
Women	85	84	85	86	85	84	81	79	81	81	**-4**
15-24	92	93	93	93	93	90	92	89	89	92	**<1**
25-34	92	91	91	94	92	93	89	89	90	90	**-2**
35-44	91	90	91	88	92	89	88	86	85	86	**-5**
45-54	86	82	86	88	84	82	81	79	79	82	**-4**
55-64	79	78	76	77	76	75	75	68	72	72	**-7**
65-74	72	71	69	74	73	74	68	71	70	71	**-1**
75+	60	58	61	62	62	69	64	65	68	69	**+9**

[1] *No values are available for 2020 as the Healthy Ireland survey was cancelled due to pandemic restrictions.*

Proportion of men rating their health as good or very good by gender and age, 2015-2025 (%)

	2015	2016	2017	2018	2019	2021	2022	2023	2024	2025	% change since 2015
15-24	92	92	92	93	94	89	93	93	89	91	**-1**
25-34	93	89	91	93	92	93	89	90	92	89	**-4**
35-44	91	90	91	88	94	89	87	85	83	85	**-6**
45-54	85	81	86	87	85	81	81	80	81	83	**-2**
55-64	79	78	73	73	74	75	74	71	71	74	**-5**
65-74	72	71	65	71	71	76	71	70	70	73	**+1**
75+	60	59	60	62	60	68	70	67	67	72	**+12**

Proportion of women rating their health as good or very good by gender and age, 2015-2025 (%)

	2015	2016	2017	2018	2019	2021	2022	2023	2024	2025	% change since 2015
15-24	92	93	93	93	92	92	91	85	89	93	**+1**
25-34	91	94	91	94	92	93	88	87	89	90	**-1**
35-44	91	90	90	89	90	90	89	88	87	87	**-4**
45-54	87	84	86	89	83	84	80	77	78	81	**-6**
55-64	79	78	80	81	79	75	75	66	73	71	**-8**
65-74	73	71	73	76	76	73	65	72	70	71	**-2**
75+	59	57	61	61	64	69	58	63	69	66	**+7**

- Employment status is also indicative of self-reported health, with those who are employed (90%) or students (91%) being more likely to report good or very good general health than those who are unemployed (80%).

Long-term Health Conditions

- 39% reported that they have a long-term health condition confirmed by a medical professional.
- Women (42%) are more likely than men (37%) to report having a long-term health condition.
- High blood pressure (8%), arthritis (7%), high cholesterol (5%), diabetes (5%), asthma (5%) and mental health conditions (3%) are the most common long-term health conditions for which people are reporting they have a medical diagnosis.

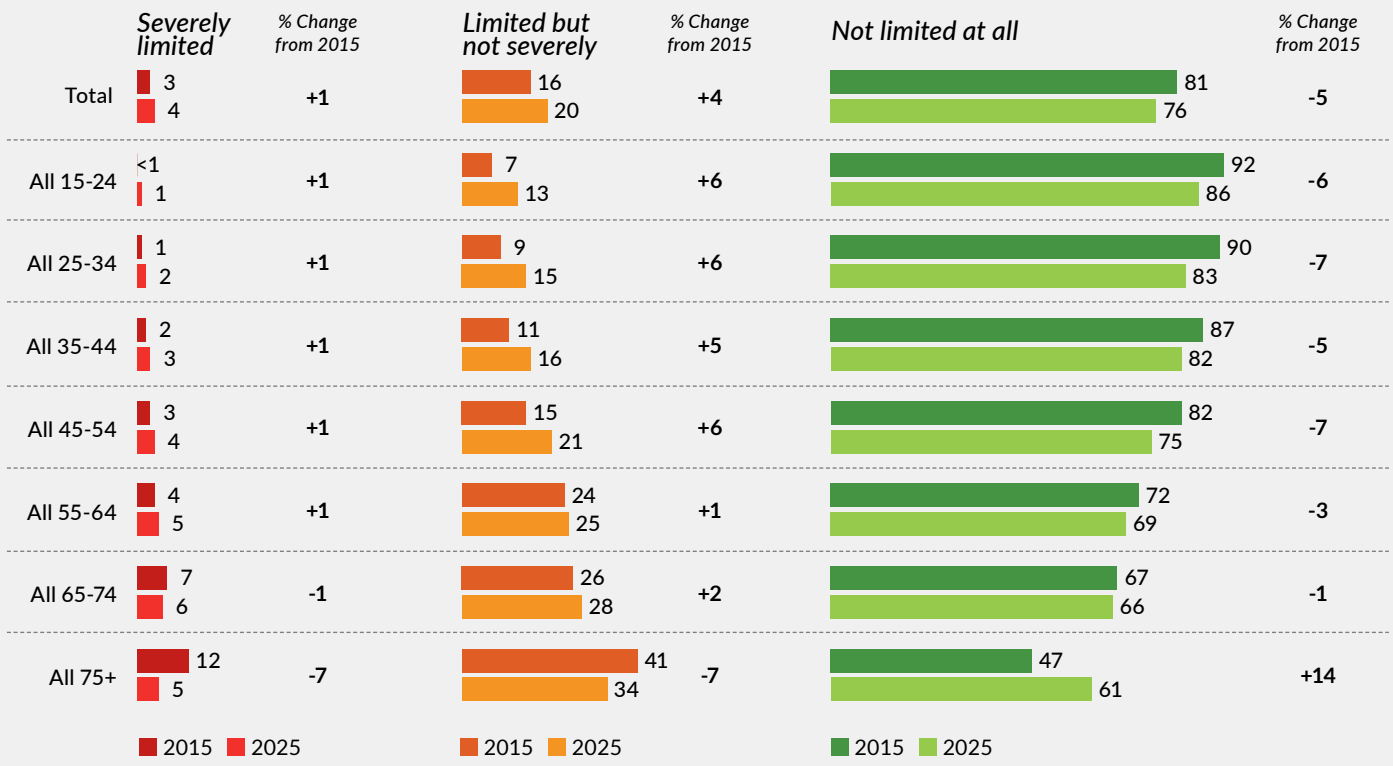
Prevalence of long-term health conditions confirmed by a medical diagnosis by age and gender (%)

	All	Gender	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
High blood pressure	8	Men	7	<1	1	3	6	15	15	15
		Women	10	<1	<1	3	9	15	27	29
Arthritis	7	Men	5	<1	2	2	4	8	9	12
		Women	9	1	2	3	7	13	21	27
High cholesterol	5	Men	3	<1	<1	2	3	6	9	8
		Women	7	1	<1	1	7	14	18	22
Diabetes	5	Men	5	1	1	2	5	9	10	12
		Women	5	<1	1	4	5	8	10	12
Asthma	5	Men	5	6	6	5	4	4	2	4
		Women	4	3	4	4	6	6	5	5
Mental health conditions	3	Men	2	1	4	2	2	2	1	1
		Women	4	3	6	4	5	4	5	1

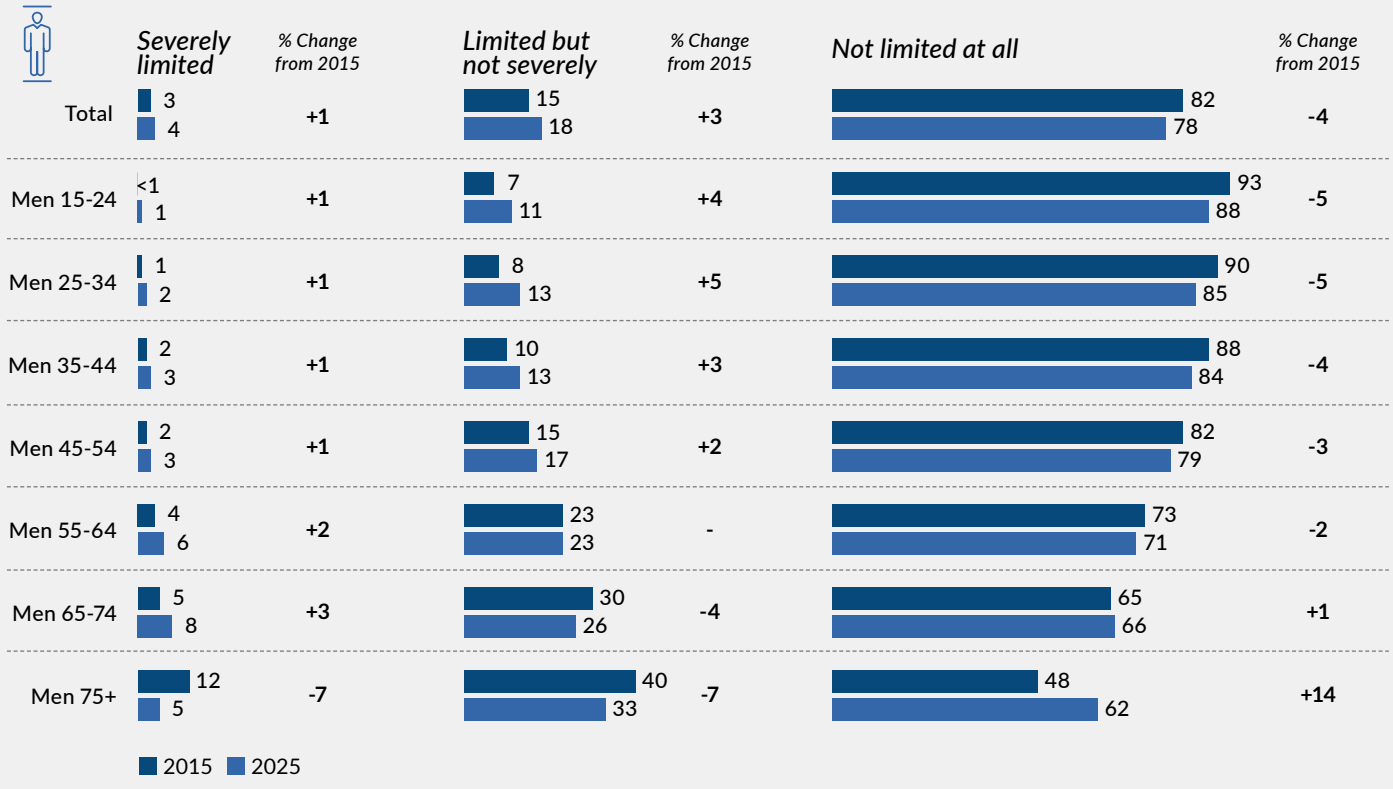
Limitations to Everyday Activities

- 36% of people say they have a long-standing illness or health problem which has lasted at least 6 months.
- 24% of the population say they are at least somewhat limited in their everyday activities by an ongoing physical or mental health problem, illness or disability, of which 4% say they are severely limited.
- Since 2015, the proportion of people who reported their physical or mental health problem, illness or disability at least somewhat limited their everyday activities has increased across almost all age groups except those aged 75 and older.
- The largest increase was found among women aged 25-34 years (Severely limited: 2015: 1%, 2025: 2%; Limited but not severely: 2015: 9%, 2025:17%).
- In contrast, among women and men aged 75 and older, the proportion of those who reported their physical or mental health problem, illness or disability limited their daily activities decreased (Men: Severely limited: 2015: 12%, 2025: 5%; Limited but not severely: 2015: 40%, 2025: 33%; Women: Severely limited: 2015: 13%, 2025: 5%; Limited but not severely: 2015: 41%, 2025: 35%).

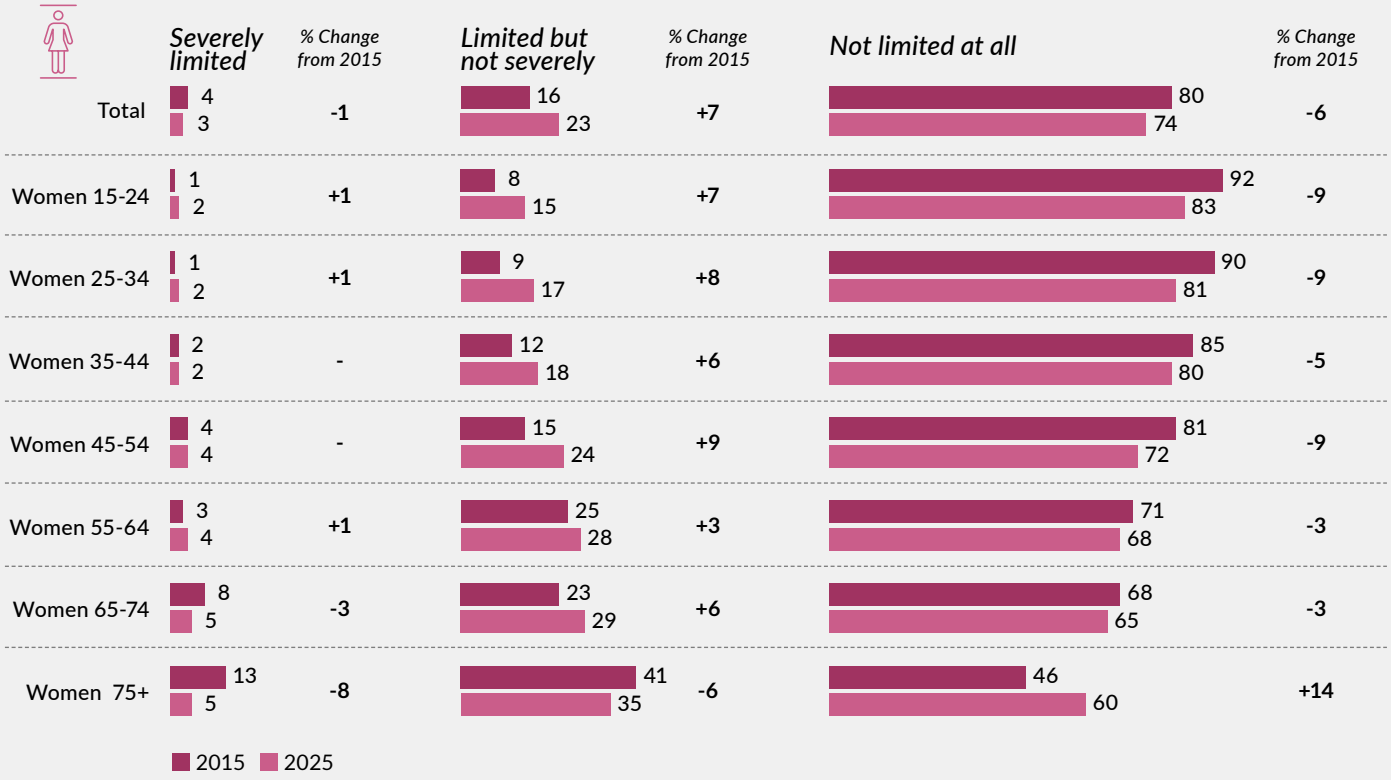
Extent that ongoing physical or mental health problem, illness or disability limits everyday activities by age, 2015-2025 (%)



Extent that ongoing physical or mental health problem, illness or disability limits everyday activities among men by age, 2015-2025 (%)



Extent that ongoing physical or mental health problem, illness or disability limits everyday activities among women by age, 2015-2025 (%)



Long-lasting Conditions or Difficulties

- Since 2023, the Healthy Ireland Survey has asked people if they have any long-lasting conditions or difficulties [2].
- 36% of the population say they have a long-lasting condition or difficulty. This figure is consistent with previous years (2023: 36%, 2024: 37%).
- The proportion of people who report long-lasting conditions or difficulties is more common among men (37%) than women (35%). This diverges from the 2023 and 2024 findings, in which the opposite relationship is found (2024: Men: 35%, Women: 38%; 2023: Men: 33%; Women: 39%).
- As with previous years, the prevalence of long-lasting conditions or difficulties increases with age, with 28% of those aged 15-24 and 58% of those aged 75 and over report having a long-lasting condition or difficulty.

Prevalence of long-lasting conditions or difficulties by gender and age (%)

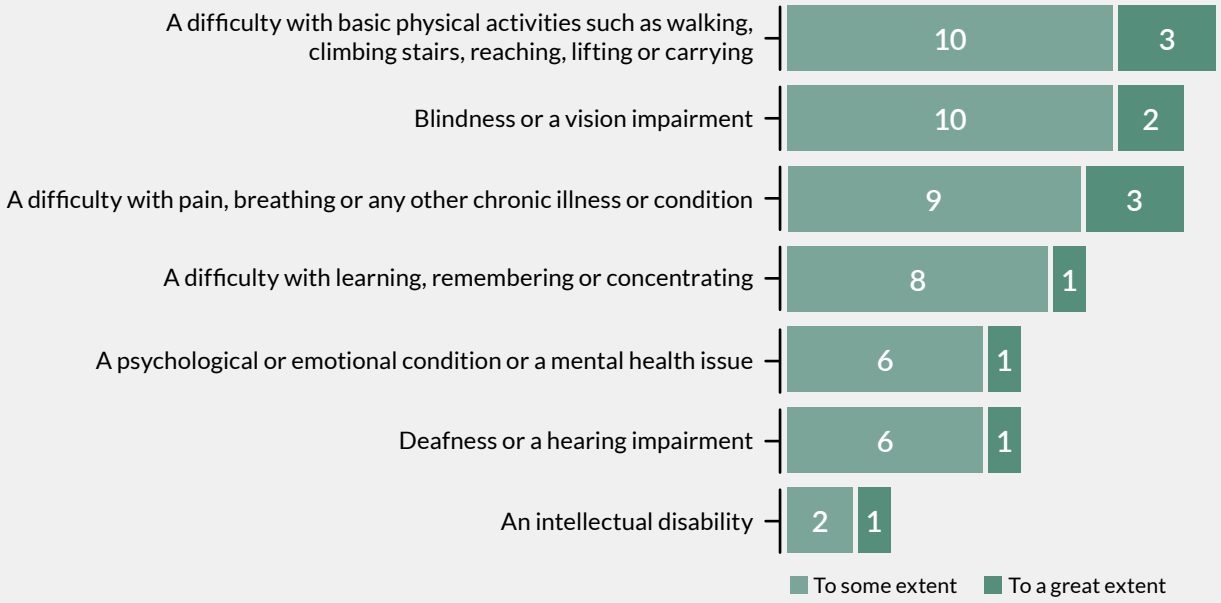
	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	36	28	26	28	35	43	52	58
Men	37	26	28	31	36	46	53	61
Women	35	30	25	25	33	40	51	56

[2] *The long-lasting conditions or difficulties included in the survey were blindness or vision impairment, difficulty with basic physical activities, difficulties with pain, breathing or other chronic illnesses/conditions, psychological or emotional conditions or mental health issues, difficulty learning, remembering or concentrating, deafness or hearing impairment, and intellectual disabilities.*

- Difficulties with basic physical activities (13%), blindness or vision impairments (12%), and difficulties with pain, breathing and other chronic illnesses/conditions (13%) were the most common long-lasting conditions or difficulties.

- People were asked if their long-lasting condition or difficulty impacted their engagement in a range of activities. Overall, 6% of the population reported they had difficulty attending work, school or college because of their long-lasting condition or difficulty. 5% reported they had difficulty dressing, bathing or getting around inside the house and 5% reported they had trouble going outside the home to visit shops or doctors. 6% reported they had trouble participating in other activities, such as for leisure or transport.

Prevalence of different long-lasting conditions or difficulties (%)



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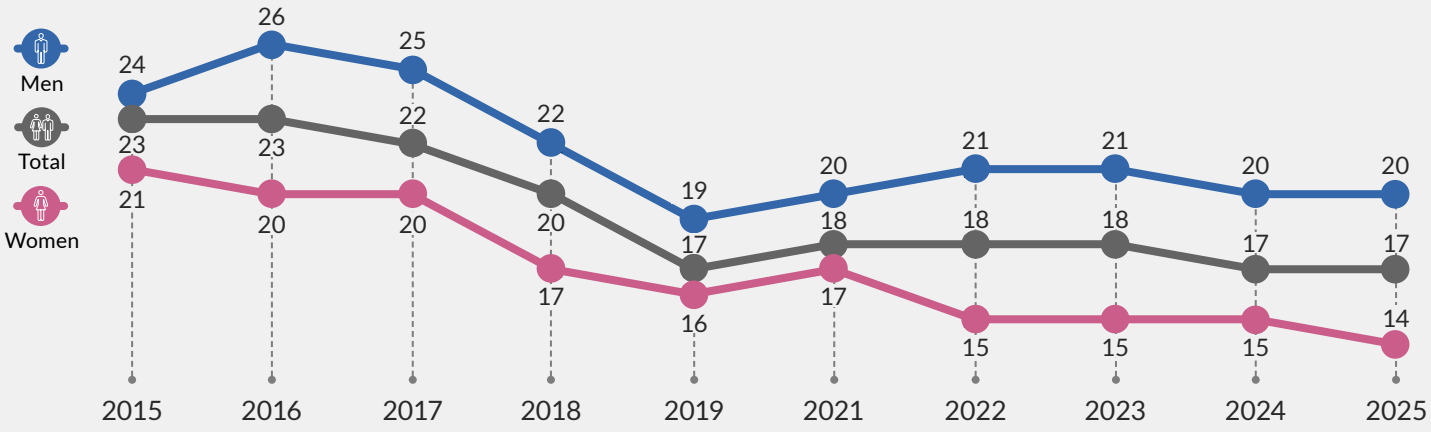
2. Smoking

2. Smoking

- 17% of the population are current smokers, with 13% smoking daily and 4% occasional. Smoking rates have remained broadly static since 2019.

Prevalence of smoking by gender by year, 2015-2025 (%)



Prevalence of smoking by age, 2015-2025 (%)

	2015	2016	2017	2018	2019	2021	2022	2023	2024	2025	*% Change from 2015*
15-24	19	20	19	19	15	15	17	19	18	17	**-2**
25-34	32	33	34	28	26	20	24	22	20	22	**-10**
35-44	26	26	24	22	18	21	21	20	19	18	**-8**
45-54	25	24	21	19	18	24	20	18	19	17	**-8**
55-64	18	18	20	19	16	19	18	17	19	16	**-2**
65-74	15	14	16	13	12	12	12	11	14	15	**<1**
75+	7	9	9	8	8	7	8	9	7	6	**-1**

- Smoking rates are highest among those aged 25 to 34 (Daily: 16%, Occasionally: 6%). Those aged 75 and older are least likely to smoke (Daily: 5%, Occasionally: 1%).

- As with all previous years, men are more likely to smoke than women. Overall, 20% of men and 14% of women smoke daily or occasionally – declines of 4 points for men and 7 points for women since 2015.

- Among both men and women, those aged 25 to 34 have the highest rate of smoking. However, rates of smoking among this age group have declined by 10 points since 2015 (22%, down from 32% in 2015).

- Within the youngest age group (15 to 24), smoking rates have declined for women (from 19% in 2015, to 13% in 2025), while for men they have risen slightly (2015: 19%, 2025: 21%).

- A similar trend can be seen among 35 to 44 year olds with smoking rates declining faster for women (from 25% in 2015, to 13% in 2025) than men (from 28% in 2015, to 24% in 2025).

Prevalence of smoking among men by age, 2015-2025 (%)

	2015	2016	2027	2018	2019	2021	2022	2023	2024	2025	*% Change from 2015*
Total	24	26	25	22	19	20	21	21	20	20	**-4**
15-24	19	18	21	22	17	19	19	22	20	21	**+2**
25-34	35	42	38	32	28	23	35	29	25	27	**-8**
35-44	28	32	27	27	22	24	25	25	22	24	**-4**
45-54	28	25	22	20	19	24	21	21	23	21	**-7**
55-64	18	20	22	21	16	20	17	18	22	18	**-**
65-74	18	14	18	15	12	10	15	13	12	15	**-3**
75+	7	12	11	8	8	8	8	6	5	8	**+1**

Prevalence of smoking among women by age, 2015-2025 (%)

	2015	2016	2027	2018	2019	2021	2022	2023	2024	2025	*% Change from 2015*
Total	21	20	20	17	16	17	15	15	15	14	**-7**
15-24	19	21	17	16	13	11	14	17	16	13	**-6**
25-34	29	25	31	24	24	18	14	16	15	18	**-11**
35-44	25	21	21	17	15	19	17	16	16	13	**-12**
45-54	22	23	20	17	17	23	19	15	16	14	**-8**
55-64	18	16	19	18	15	19	18	16	17	14	**-4**
65-74	13	13	14	11	12	13	10	10	15	14	**+1**
75+	7	7	8	8	8	6	7	11	8	5	**-2**

- Smoking rates are higher among those with a Leaving Certificate or lower level of education (21%) than those who progressed to higher levels of education (11%). This difference is consistent with findings from 2015, although smoking rates have decreased across all levels of education (2015: Leaving Certificate or lower: 25%, post-Leaving Certificate education: 17%).

Smoking and Health Outcomes

- Current smokers (75%) and ex-smokers (78%) are less likely to describe their health as good or very good than those who have never smoked (86%). Daily smokers (73%) are the least likely to describe their health as good or very good. These differences are broadly consistent with those reported in 2015.
- 40% of those who have ever smoked report having a long-standing illness or health problem, compared to 31% of those who have never smoked, indicating a 9-point difference. This gap is slightly narrower than the 12-point difference observed in 2015 when 35% of those who had ever smoked and 23% of those who had never smoked reported long-standing health issues.

Quitting smoking

- 30% of the population are ex-smokers. For those aged 15 to 34, the proportions of smokers (15 to 24: 17%, 25 to 34: 22%) and ex-smokers (15 to 24: 17%, 25 to 34: 21%) are broadly similar. There are more ex-smokers than current smokers in all age groups above the age of 34.
- Since 2015, there has been a small increase in the proportion claiming to be ex-smokers (30%, up from 28% in 2015) or who have never smoked (53%, up from 49% in 2015). The largest increase in incidence of having never smoked is seen among those aged 25 to 34 (57%, up from 47% in 2015).

Smoking trends by age and gender, 2015 - 2025 (%)

	Smokers	*% Change from 2015*	*Ex smokers*	*% Change from 2015*	*Never smoked*	*% Change from 2015*
Total	23 / 17	-6	28 / 30	+2	49 / 53	+4
Men	24 / 20	-4	30 / 31	+1	46 / 49	+3
Women	21 / 14	-7	26 / 29	+3	53 / 58	+5
All 15-24	19 / 17	-2	10 / 17	+7	71 / 66	-5
All 25-34	32 / 22	-10	21 / 21	-	47 / 57	+10
All 35-44	26 / 18	-8	28 / 30	+2	45 / 51	+6
All 45-54	25 / 17	-8	30 / 33	+3	45 / 50	+5
All 55-64	18 / 16	-2	37 / 33	-4	45 / 51	+6
All 65-74	15 / 15	-	40 / 40	-	44 / 45	+1
All 75+	7 / 6	-1	43 / 42	-1	50 / 52	+2
	2015 2025		2015 2025		2015 2025	

- 46% of current smokers have attempted to quit in the past 12 months. This is similar to the figure reported in 2015 (45%).
- During their last attempt to quit, 67% of smokers did so without using any quitting aids. This is higher than in 2015, in which only 48% of smokers said they didn't use any quitting aids in their last attempt to quit.

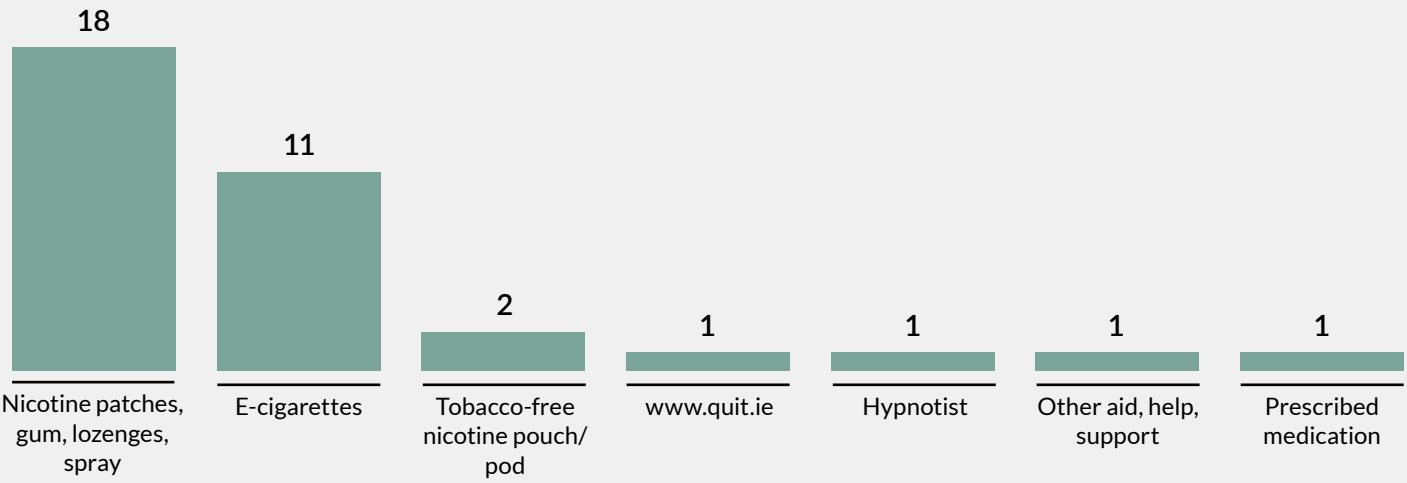
- Of the 33% of people who used at least one quitting aid during their last attempt to quit, 18% used nicotine patches, gum, lozenges or spray, 11% used an e-cigarette and 2% used a nicotine pouch/pod. Only 1% used www.quit.ie to help them quit during their last attempt.

- 30% of smokers are either trying to quit (14%) or actively planning on doing so (16%). The levels reported in 2015 were that 11% of smokers were trying to quit and 21% were actively planning to quit.

- Male smokers (18%) are more likely to say they are trying to quit, compared with 9% of female smokers.

- 19% of those who attempted to quit in the last 12 month are not currently planning on quitting. This is slightly higher than the figure reported in 2015 (15%).

Use of different quitting aids during last quit attempt (%)



Started smoking

- The average age that smokers report having tried their first cigarette was 16 years, while the average age for initiating daily smoking was 18 years. These figures are unchanged since 2023.

- Men reported starting smoking around a year younger than women on average. The average age men reported trying their first cigarette was 15 and 18 for starting daily smoking. For women, it was 16 years and 19 years, respectively.

- The average age that people report trying their first cigarette and smoking daily was higher for those with a degree or higher (16 and 19, respectively). In contrast, those with no formal education or only a primary level of education started smoking earlier on average, trying their first cigarette at age 15 and smoking daily at age 17.

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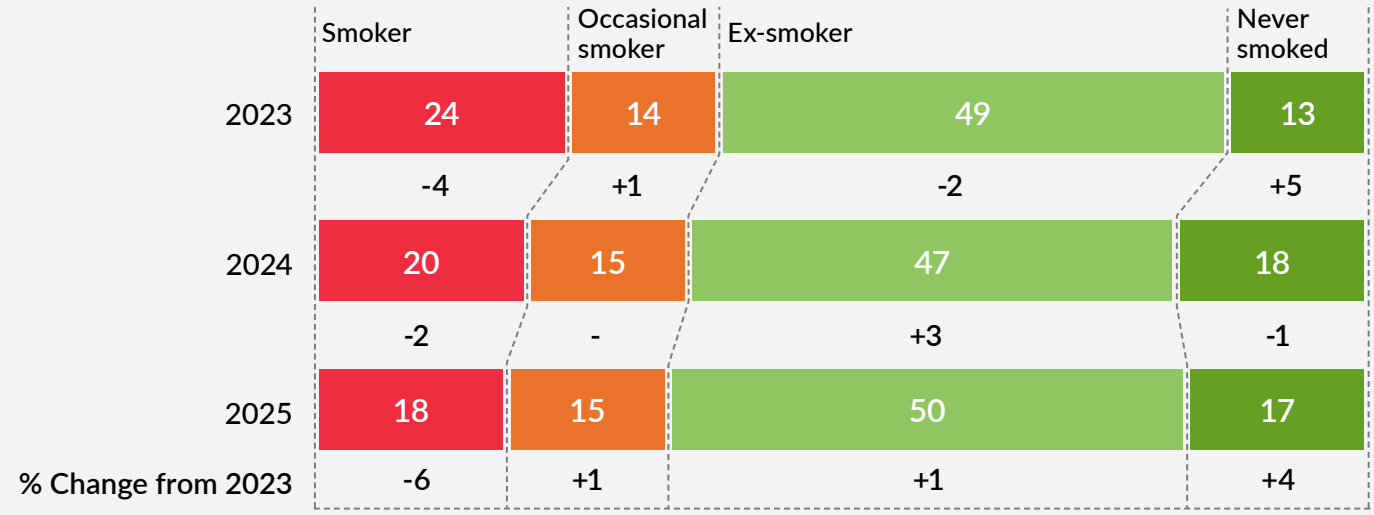
3. E-Cigarettes & Nicotine Products

3. E-Cigarettes & Nicotine Products

- 77% of the population have never tried an e-cigarette. 8% of the population currently use e-cigarettes either daily (5%) or occasionally (3%), with a further 15% saying they have tried them in the past but no longer use them.
- The proportions of daily and occasional users have not changed since 2023, but those who have tried e-cigarettes in the past but no longer use them has increased by 2 points from last year (15%, up from 13% in 2024).
- E-cigarette usage is highest among younger people, with 18% of those aged 15-24 claiming to use one daily (11%) or occasionally (7%). Among this age group, usage is higher among women (19%) than men (16%). This represents a notable change from 2024, with usage among men dropping by 4 points (down from 20%) and increasing by 4 points for women (19%, up from 15% in 2024).
- 50% of all e-cigarette users are ex-smokers, while 33% of e-cigarette users are current smokers (Daily: 18%, Occasionally: 15%). The remaining 17% of e-cigarette users have never smoked.
- Use of e-cigarettes among daily smokers has shown a steady decline over the past 3 years, decreasing by 6 points since 2023 (18%, down from 24% in 2023).

Daily or occasional usage of e-cigarettes by smoking behaviour, 2023-2025 (%)



E-cigarette usage among those that have never smoked

- Of those that have never smoked, 3% use e-cigarettes daily (2%) or occasionally (1%). This figure is unchanged since 2023.
- Among people who have never smoked, e-cigarette usage is highest among those aged 15 to 24, with 8% saying they use e-cigarettes daily or occasionally.
- Among those aged 15 to 24 who have never smoked, women (11%) are more likely than men (4%) to use e-cigarettes. This represents a notable shift from previous years, with men aged 15 to 24 who have never smoked showing a 7-point decrease in e-cigarette usage (down from 11% in 2024), whereas women had a 6-point increase in usage (up from 5% in 2024).

Daily or occasional e-cigarette usage among people who have never smoked by age and gender (%)

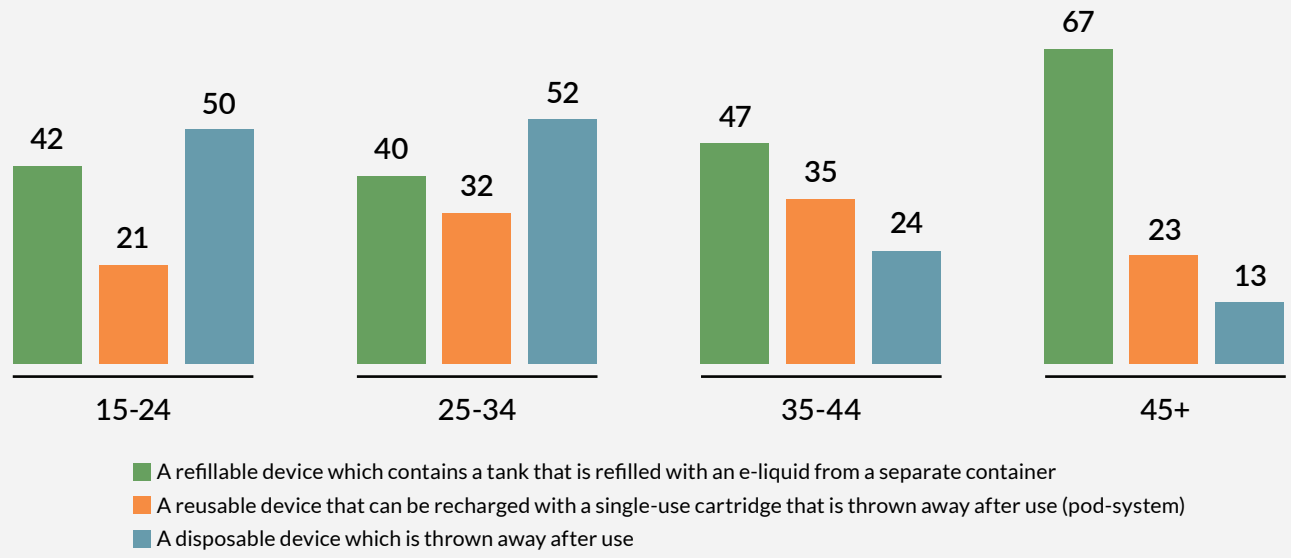
	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	3	8	4	2	1	1	<1	<1
Men	2	4	4	3	1	<1	<1	<1
Women	3	11	4	1	1	1	<1	<1

Types of e-cigarettes used

- Of those that use e-cigarettes daily or occasionally, 36% use disposable devices, 49% use devices that can be refilled, and the remaining 26% use devices that can be recharged with a disposable single-use cartridge.

- Younger people are more likely to use disposable e-cigarette devices, with 50% of e-cigarette users aged 15-24 and 52% of those aged 25 to 34 using disposable devices, compared with only 13% of those aged 45 or older. In contrast, e-cigarette users aged 45 and older are more likely to use devices that can be refilled (45+: 67%, 15-24: 42%).

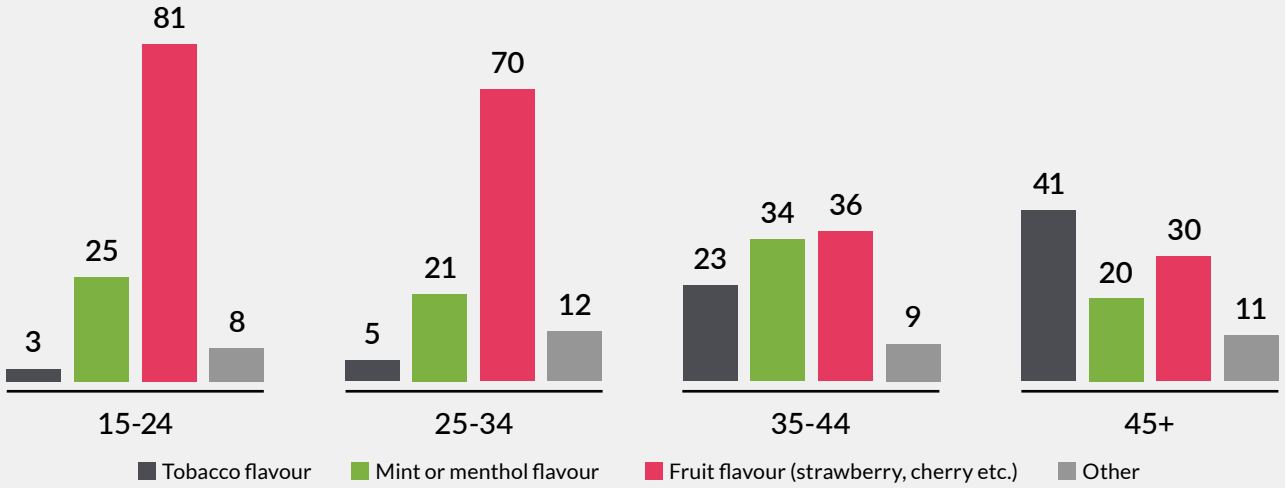
Proportion of e-cigarette users who use different types of e-cigarettes by age (%)



- Fruit flavour is the most common e-cigarette liquid variant. 59% of e-cigarette users reported using a fruit flavoured e-liquid on at least a monthly basis. This is followed by menthol/mint flavour (25%) and tobacco (17%).

- Younger e-cigarette users are more likely to use fruit flavoured e-cigarette liquid (15 to 24: 81%, 25 to 34: 70%) and less likely to use tobacco flavour liquid (15 to 24: 3%, 25 to 34: 5%). In contrast, e-cigarette users aged 45 or older are more likely to choose tobacco flavoured e-cigarette liquids (41%) and less likely to choose fruit flavoured ones (30%).

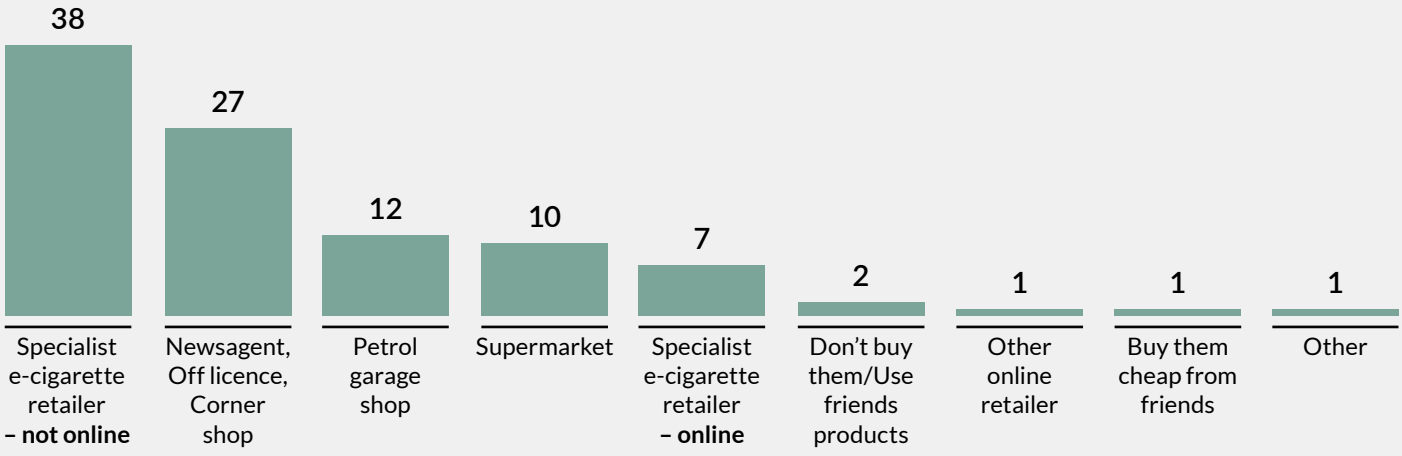
Proportion of e-cigarette users who use different flavours of e-cigarettes by age (%)



Purchasing e-cigarettes

- 38% of e-cigarette users buy e-cigarettes, e-liquids or cartridges in specialist e-cigarette retailers and 27% buy them from newsagents, off-licences, or corner shops. Other less common but notable locations people buy e-cigarettes include petrol stations (12%), supermarkets (10%), and specialist online e-cigarette retailers (7%).

Where e-cigarette users usually buy e-cigarettes, liquids or cartridges (%)



Perceptions of health impacts of e-cigarette usage

- All who took part in the survey were asked to compare the health impact of smoking regular cigarettes alone to the health impact of smoking both e-cigarettes and regular cigarettes at the same time.

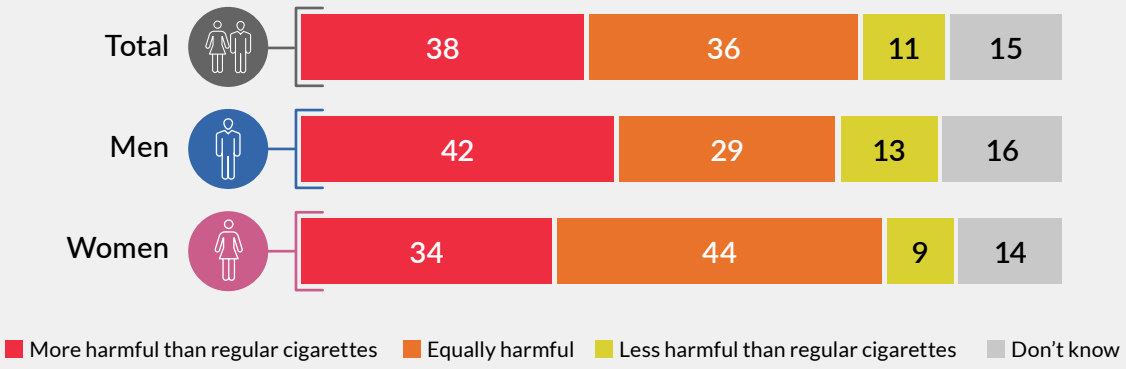
- Men (42%) are more likely than women (34%) to suggest that e-cigarettes are more harmful than regular cigarettes, while women are more likely than men to say they are equally harmful (Women: 44%, Men: 29%).

- People aged 15 to 24 (43%) are more likely to believe that e-cigarettes are more harmful than regular cigarettes.

- Current smokers are more likely than ex-smokers and those who have never smoked to perceive e-cigarettes as more harmful. 48% of all current smokers believe that e-cigarettes are more harmful than regular cigarettes, while 34% of ex-smokers and 37% of those who have never smoked believe the same.

- Respondents who use e-cigarettes daily (39%) or occasionally (18%) are more likely to think that e-cigarettes are less harmful than regular cigarettes.

Health perceptions of e-cigarettes compared to regular cigarettes by gender (%)

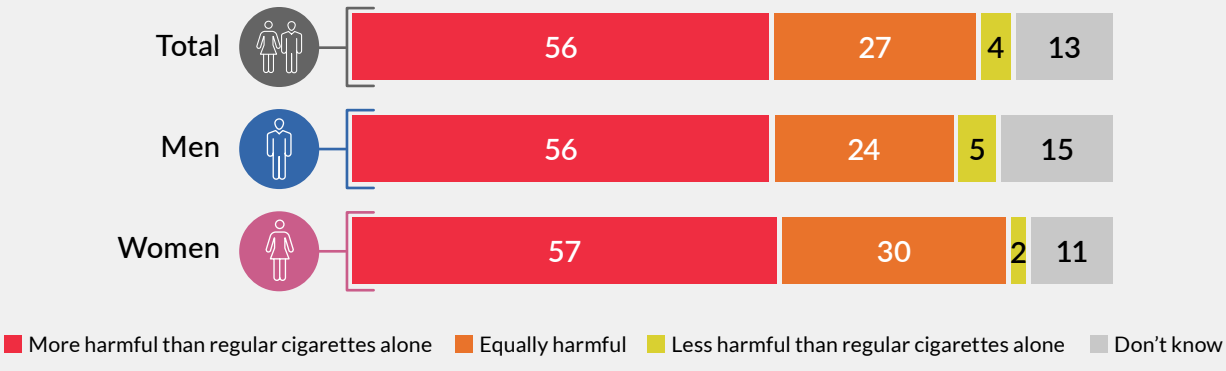


- All who took part in the survey were asked to compare the health impact of regular cigarettes to e-cigarettes and regular cigarettes at the same time. 56% believe the combination of both types is more harmful than smoking cigarettes alone, 27% feel they are equally harmful, and 4% feel combination is less harmful than cigarettes alone. The remaining 13% said they didn't know.

- People aged 15 to 24 (69%) are more likely than older age groups to believe that combining e-cigarettes and regular cigarettes is more harmful than regular cigarettes alone.

- Current smokers (62%) are more likely than ex-smokers (55%) or people who have never smoked (55%) to believe combining e-cigarettes and regular cigarettes are more harmful than regular cigarettes.

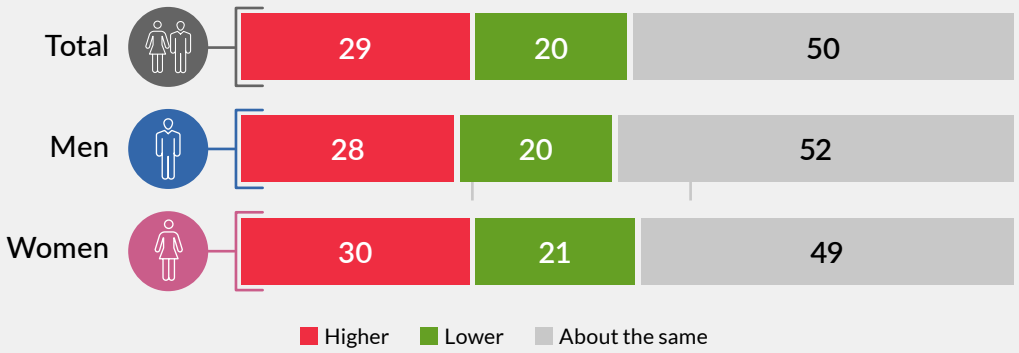
Health perceptions of e-cigarettes combined with cigarettes compared to regular cigarettes alone by gender (%)



Appeal of e-cigarettes

- E-cigarette users were asked to rate the appeal of e-cigarettes compared to a year ago. 29% of e-cigarette users said e-cigarettes had a higher appeal compared to the previous year, while 20% said they had a lower appeal and the remaining 50% said they had about the same appeal.
- People aged 15 to 24 (32%) are more likely to say e-cigarettes had a lower appeal to the previous year.

Appeal of e-cigarettes compared to a year ago among e-cigarette users by gender (%)



Nicotine pouch usage

- 93% of the population have never tried a nicotine pouch. 1% of the population currently use nicotine pouches either daily (1%) or occasionally (<1%), with 6% saying they have tried them in the past but no longer use them.
- Men (2%) are more likely than women (<1%) to be current users of nicotine pouches.
- Younger people are more likely to use nicotine pouches, with 3% of people those 15 to 24 saying they use them daily or occasionally, with usage being highest among men in this age group (5%).
- Current smokers (3%) and ex-smokers (2%) are more likely to use nicotine pouches than those who have never smoked (<1%).
- People who previously tried e-cigarettes but don't use them anymore (3%), and those who use them daily (4%) or occasionally (12%) are more likely to use nicotine pouches compared with those who have never used them (<1%).

Daily or occasional users of nicotine pouches by age and gender (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	1	3	2	1	1	<1	1	<1
Men	2	5	3	2	2	<1	1	<1
Women	<1	1	1	1	<1	<1	<1	<1

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Ireland

4. Alcohol Use

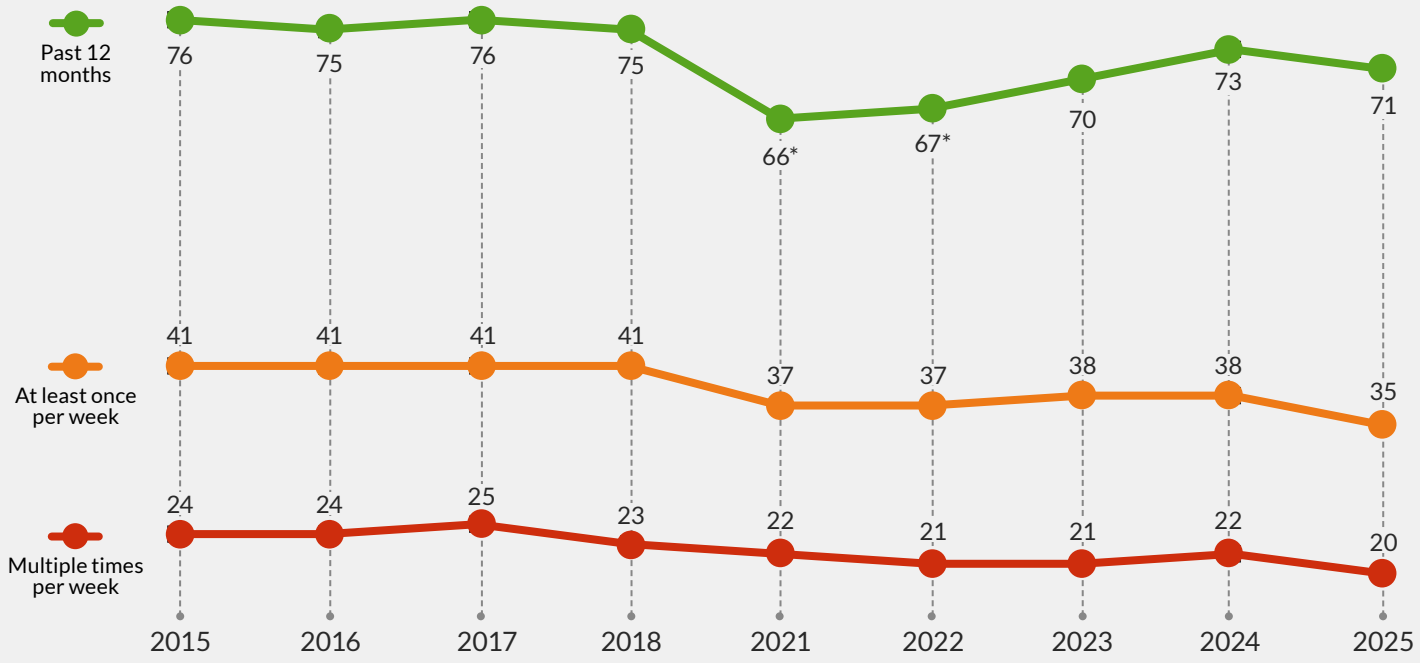
4. Alcohol Use

Alcohol Use

- 71% of people aged 15 or older report consuming alcohol during the past 12 months. This is a 2-point decrease from 2024 (73%) and 5-points down since 2015 (76%)

- The proportion of people drinking weekly and multiple times per week have also declined since 2015, with 35% drinking at least once per week and 20% drinking multiple times each week.

Frequency of drinking among the population 2015-2025[1] (%)



**The 2021 and 2022 figures represent people's intake of alcohol over the past 6 months instead of 12 months.*

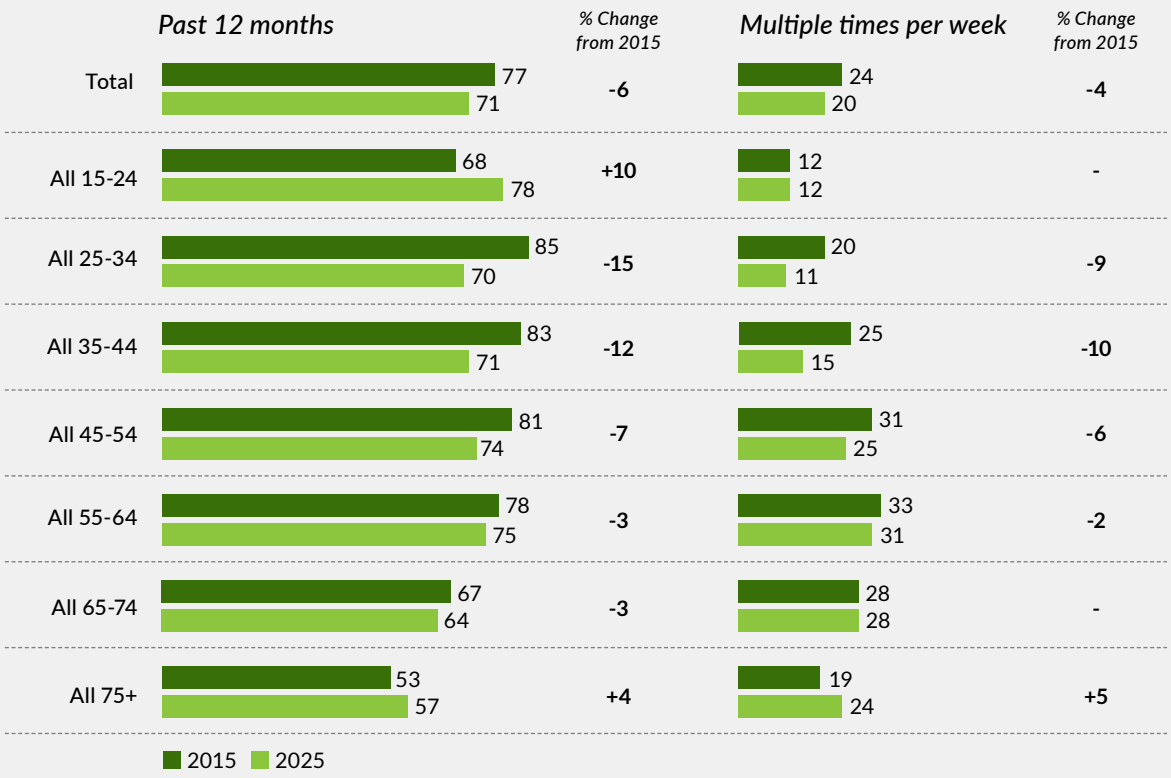
- Since 2015, a divergent shift in drinking habits has occurred between people aged 15 to 24 and 25 to 34. In 2015, those aged 25 to 34 had the highest rate of alcohol consumption in the past 12 months (85%), while 15 to 24 year olds were among the lowest (68%). By 2025 this pattern had reversed, with 15 to 24 year olds now reporting the highest rate of alcohol consumption in the past 12 months (78%) and those aged 25 to 34 among the lowest (70%).

- People aged 75 and older are the least likely to say they drank alcohol in the past 12 months (57%). While this is consistent with 2015, the proportion of people aged 75 and older who drank in the past 12 months has increased by 4 points (2015: 53%).

- Consistent with the findings from 2015, people aged 55 to 64 are still the most likely to drink multiple times per week (2015: 33%, 2025: 31%).

[1] *No data on alcohol intake was collected in 2019 or 2020.*

Frequency of drinking by age, 2015-2025 (%)



- A higher proportion of men drink alcohol across all frequency levels compared with women. 73% of men report that they drank alcohol in the past 12 month, whereas 70% of women report this. The difference between men and women is larger at more frequent intakes. For instance, 40% of men said they drink at least weekly compared with 31% of women and 24% of men said they drink multiple times per week compared with 17% of women.

- At an overall level, alcohol consumption has declined for both men and women since 2015, however some age groups have seen increased drinking rates. Women aged 15 to 24 had the largest increase in alcohol consumption in the past 12 months, increasing by 16 points since 2015 (64% to 80%).

Frequency of drinking among men by age, 2015-2025 (%)

	Past 12 months		% Change from 2015	Multiple times per week		% Change from 2015
Total	80	73	-7	30	24	-6
Men 15-24	71	77	+6	14	13	-1
Men 25-34	88	74	-14	27	14	-13
Men 35-44	84	73	-11	28	16	-12
Men 45-54	82	75	-7	37	29	-8
Men 55-64	81	72	-9	40	34	-6
Men 65-74	71	68	-3	38	37	-1
Men 75+	62	67	+5	26	32	+6

2015 2025

Frequency of drinking among women by age, 2015-2025 (%)

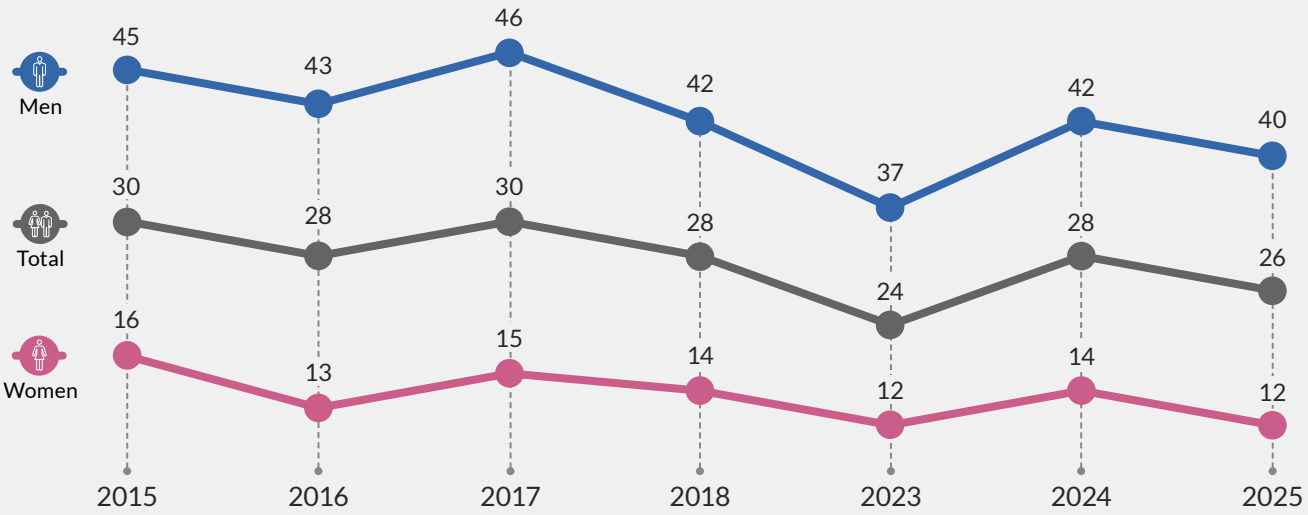
	Past 12 months		% Change from 2015	Multiple times per week		% Change from 2015
Total	74	70	-4	19	17	-2
Women 15-24	64	80	+16	11	11	-
Women 25-34	81	66	-15	15	8	-7
Women 35-44	82	70	-12	22	14	-8
Women 45-54	80	73	-7	25	23	-2
Women 55-64	75	79	+4	25	28	+3
Women 65-74	64	62	-2	20	21	+1
Women 75+	46	48	+2	13	16	+3

2015 2025

Binge Drinking

- 26% of the population are binge drinkers on a typical drinking occasion (i.e. drink at least standard 6 units of alcohol). This is 2 points above the lowest recording of 24% in 2023 but is 4 points down from the first wave in 2015 (30%).

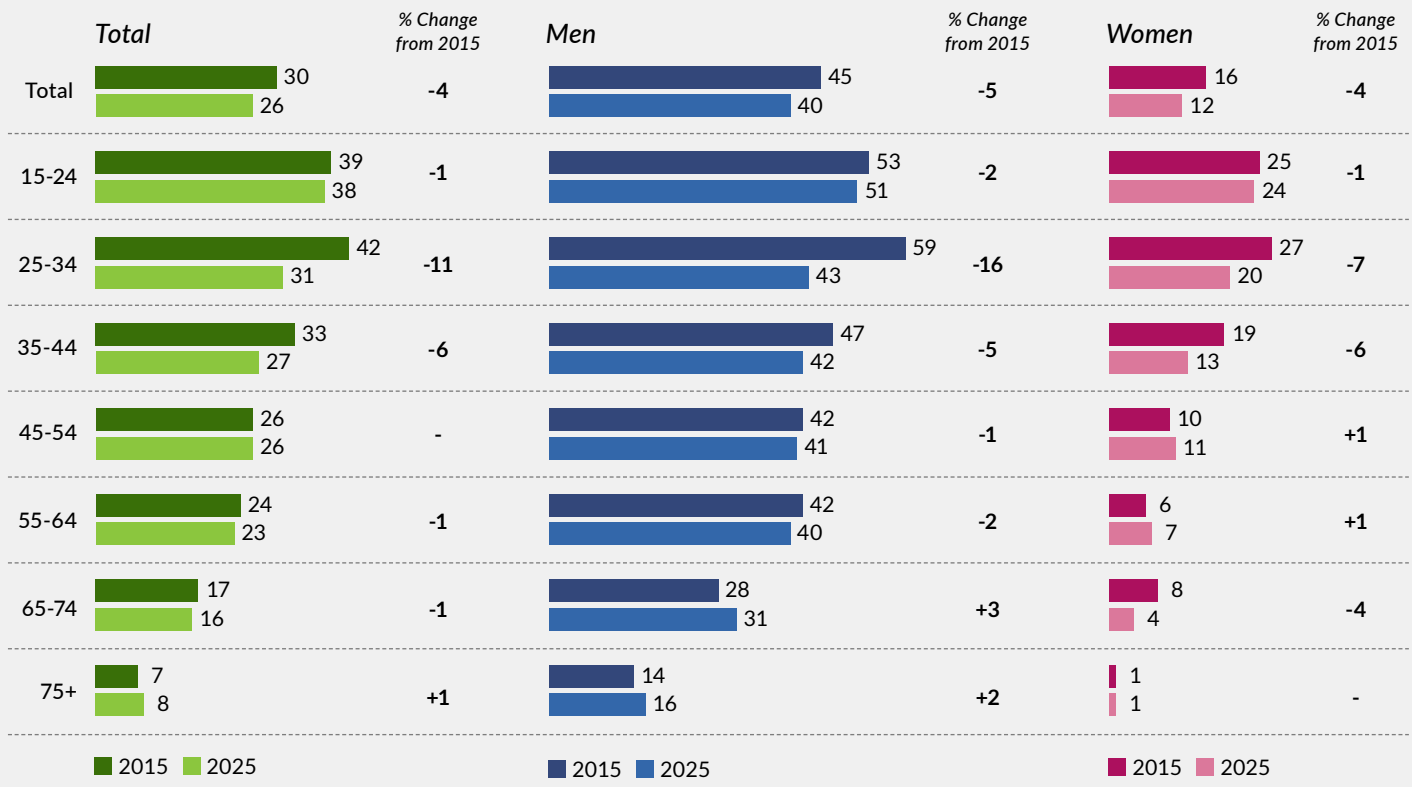
Proportion of the population who are considered binge drinkers on a typical drinking occasion by gender, 2015-2025[2] (%)



- As with previous years, men of all ages are more likely than women to binge drink on a typical drinking occasion. The largest gap is found among people aged 55 to 64, with 40% of men binge drinking on a typical occasion compared with 7% of women – a 33-point gap.
- Since 2015, rates of binge drinking have declined among men and women aged under 45, with the largest decline seen among men aged 25 to 34 (43% compared with 59% in 2015).
- Men aged 65 to 74 saw the largest increase (up 3 points) in binge drinking rates since 2015 (31% compared with 28% in 2015).
- Men aged 15 to 24 (51%) are the most likely to binge drink on a typical occasion. This is a shift since 2015, in which men aged 25 to 34 (59%) had the highest rate of binge drinking.
- People in employment (30%) and students (36%) are more likely to binge drink on a typical drinking occasion, but those engaged in home duties (10%) and retired people (12%) are less likely to do so.

[2] *Alcohol intake was not collected in 2019 or 2020 and figures from 2021 and 2022 are excluded as they used different measures of binge drinking.*

Binge drinking on a typical drinking occasion by age and gender, 2015-2025 (%)



Consumption of non-alcoholic drinks

- 25% of the population said they drink non-alcoholic wine, beer or spirits. Younger adults are more likely to say they drink non-alcoholic drinks, whereas the opposite was found for older adults. Around a third of people aged 25 to 34 (31%) and 35 to 44 (32%) said they drink non-alcoholic drinks. In contrast, only 17% of those aged 65 to 74 and 10% of those aged 75 and older said they drank non-alcoholic drinks.
- People who drank alcohol in the past 12 months (30%) are more likely to say they also drink non-alcoholic drinks compared with those who haven't drank in the past 12 months (12%). Among alcohol drinkers, those who drink multiple times per week (32%) are more likely to drink non-alcoholic drinks compared with those who drink monthly or less (27%).
- 56% of people who drink non-alcoholic drinks said they do so when they need to drive home. 29% said they drink them to reduce their alcohol consumption for health reasons and 16% said they do when they need to get up early the next day and don't want a hangover. 13% said they drink non-alcoholic drinks because they prefer them to regular alcoholic drinks.
- The reasons people drink non-alcoholic drinks differ by gender and age. Men (62%) are more likely than women (50%) to say they drink non-alcoholic drinks when they need to drive home. Women (34%) are more likely than men (25%) to say they drink them to reduce their alcohol consumption for health reasons. Women (15%) are also more likely than men (10%) to say they prefer them to regular alcoholic drinks.
- People aged 45 to 54 (65%) or 55 to 64 (62%) are more likely to drink non-alcoholic or low alcoholic drinks when they need to drive home. In contrast, younger adults aged 15 to 24 (39%) are less likely to say they drink them when they need to drive home.

Non-alcoholic drinks refer to wine, beer, cider or spirits that contain less than 0.5% alcohol.

Most common reasons people drink non-alcoholic or low alcoholic drinks by gender (%)

	Total	Men	Women
When I need to drive home	56	62	50
To reduce my alcohol consumption/for health reasons	29	25	34
When I need to get up early the following morning/ next day/don't want a hangover	16	17	16
I prefer them to alcohol	13	10	15
To be sociable/fit in	4	3	5

Most common reasons people drink non-alcoholic drinks by age (%)

	15-24	25-34	35-44	45-54	55-64	65-74	75+
When I need to drive home	39	53	58	65	62	51	54
To reduce my alcohol consumption/for health reasons	30	35	32	24	25	28	20
When I need to get up early the following morning/ next day/don't want a hangover	20	22	18	17	12	5	3
I prefer them to alcohol	18	11	11	13	11	14	10
To be sociable/fit in	6	4	4	2	5	6	4

5. Harms from Alcohol

5. Harms from Alcohol

The Alcohol Use Disorders Identification Test (AUDIT) was used to measure hazardous and harmful patterns of alcohol consumption and potential alcohol dependence. The AUDIT is a 10-question tool developed by the World Health Organisation that covers three areas of alcohol use: how much and how often someone drinks (e.g. "How often have you consumed alcohol in the past 12 months?"), signs of alcohol dependence (e.g. "How often during the last year have you found that you are not able to stop drinking once you had started?"), and alcohol-related problems or harm (e.g. "Have you or somebody else been injured as a result of your drinking?").

Answers to each of the 10 questions are scored from 0 to 4, depending on the level of risk indicated by the response. The scores from each question are then added together to give a final score, resulting in a total score from 0 to 40. The higher the score, the greater the likelihood that someone is drinking in a harmful way.

Scoring system used for assessing the risk level of AUDIT scores

Score Range	Risk Level	Meaning
0-7	Low Risk	Light or no drinking, low likelihood of harm
8-15	Increasing Risk	Hazardous or harmful drinking, higher risk for problems
16-19	Higher Risk	High risk, possible existing alcohol-related harms
20-40	Possible Dependence	Likely alcohol dependence with significant negative impact

Hazardous or harmful drinking (AUDIT)

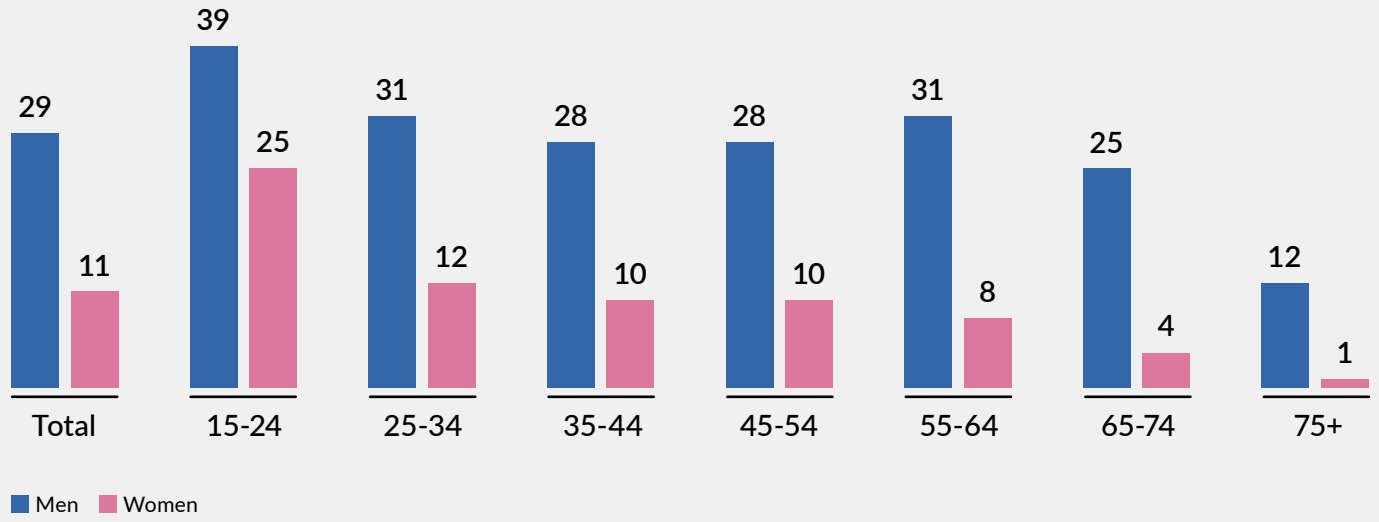
- 20% of the population are at risk of hazardous or harmful drinking (i.e. they have AUDIT scores of 8 or higher). Of these, 18% have AUDIT scores between 8 to 15, 1% have scores between 16 to 19 indicating higher risk and a further 1% have scores of 20 or more indicating a possible alcohol dependence.

- Men (29%) are more likely than women (11%) to be at risk of hazardous drinking (i.e. AUDIT score of 8 or higher). People aged 15 to 24 have the highest rate of hazardous drinking for both men (39%) and women (25%).

- People educated to a degree level or higher (17%) are less likely to be at risk of hazardous drinking, whereas people educated to upper secondary level (25%) are more likely to be at risk.

- Students (46%) are more likely to be at risk of hazardous drinking, whereas those engaged in home duties (7%) and people in retirement (10%) are less likely to be at risk.

Proportion of people at risk of hazardous or harmful drinking (e.g. AUDIT scores of 8 or higher), by gender and age (%)



Harmful level of alcohol consumption (AUDIT-C)

- To allow for comparisons with previous Healthy Ireland surveys, a separate AUDIT-C score was calculated to assess changes in harmful levels of alcohol consumption overtime.

- AUDIT-C is a shortened three-question version of the AUDIT, including the three questions relating to how much and how often someone drinks. Each question is scored from 0 to 4 and added together to get a final score, giving a total range of 0 to 12.

Scoring system used for assessing the risk level of AUDIT-C scores

Score Range	Risk Level	Meaning
0-4	Low Risk	Drinking within recommended limits
5-7	Increasing Risk	Above low-risk levels, may be harming health
8-10	Higher Risk	Likely to be harming health
11-12	Possible Dependence	Indicates possible alcohol dependence

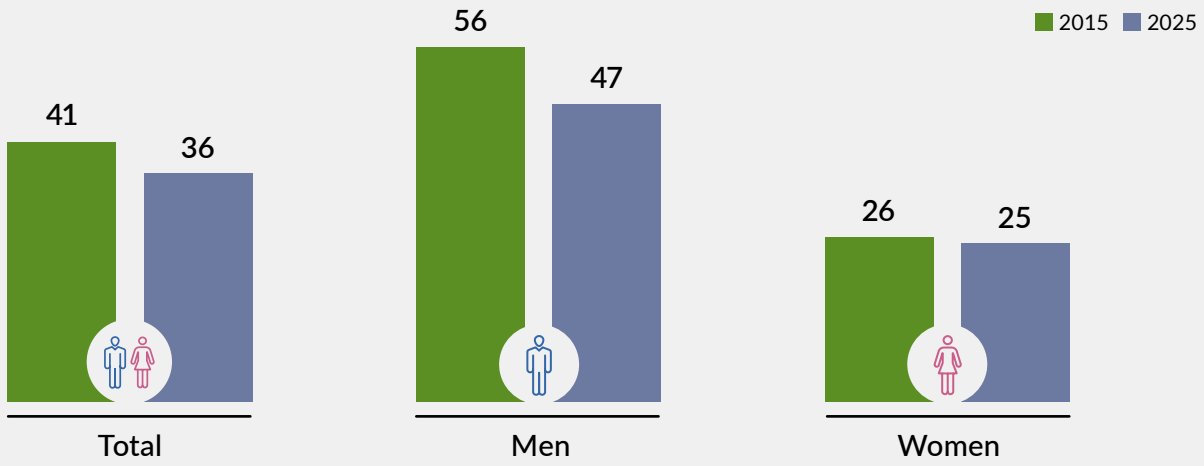
- 36% of people (51% of drinkers) drink alcohol at a harmful level (i.e. have an AUDIT-C score of 5 or higher). Men (47%) are more likely than women (25%) to drink at a harmful level.

- As with overall alcohol consumption, harmful drinking rates have decreased for both men and women since 2015. However, this decrease is not equally shared across all ages or genders. For instance, while both men and women aged 25 to 34 saw a considerable decrease in harmful drinking rates (22 points down for men and 13 points down for women), among those aged 15-24 there is an 8-point increase for women and no change for men in this age group.

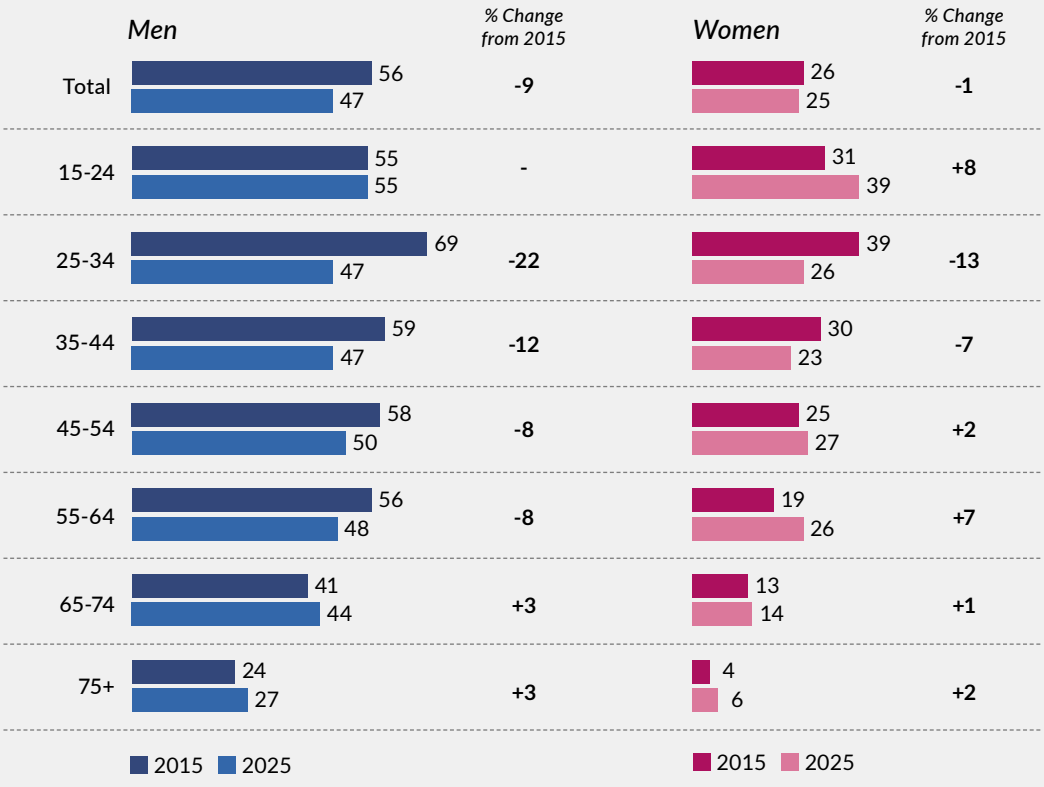
- People educated to a degree level or higher (35%) are less likely than average to consume alcohol to a harmful level, whereas people educated to upper secondary level (41%) are more likely to do so. This differs from 2015, in which people with a degree or higher were more likely than average to drink to a harmful level as with those educated to an upper secondary level (Upper secondary: 46%, Degree or higher: 44%).

- People in employment (40%) and students (46%) are more likely to consume alcohol to a harmful level, but those engaged in home duties (18%) and retired people (22%) are less likely to do so.

Proportion of people who are drinking at a harmful level (i.e. AUDIT-C scores of 5 or higher) by gender 2015-2025 (%)



Proportion of people who are drinking at a harmful level (e.g. AUDIT-C scores of 5 or higher) by gender and age 2015-2025 (%)



6. Menopause

6. Menopause

Introduction

For the first time, the Healthy Ireland Survey included a module focusing on women's experiences with menopause and related symptoms. It also examines which, if any, supports they sought to help with symptoms and their use of medication to relieve them.

Menopause is usually diagnosed if[1]:

- you're over 50 and have not had a period for more than 12 months
- you're under 50 and have not had a period for more than 2 years
- you've stopped having periods and are no longer able to get pregnant naturally

Although menopause usually occurs in mid-life (generally between the ages of 45-55 and typically around 51-52), premature menopause can affect a minority of women in their 20s, 30s and 40s. Premature menopause can also sometimes be caused by medical treatment for serious conditions.

For these reasons, all female respondents aged 18 and older were asked if they would be comfortable answering questions on menopause. Over three-quarters (78%, 2,837) agreed to participate in this module. It is important to note that all results are based on self-reported experiences with perimenopause or menopause and may not have been clinically verified by a medical professional. While self-reported data provides valuable insights into personal experiences, it may differ from clinically verified findings due to differences in how people perceive and interpret symptoms as well as the effect of recall bias.

Definitions of terms used throughout this chapter

Perimenopause: The lead-up to menopause when the signs and symptoms of menopause are first observed and ends one year after the final menstrual period. In this phase, women are still having periods, but they are experiencing symptoms. Women often start to experience perimenopausal symptoms in their mid-forties.

Menopause transition: Menopause itself is a retrospective diagnosis, occurring after periods have stopped for at least a year as outlined above. However, in recognition of the reality that menopause symptoms can take years after the cessation of periods to ease, we are using a working definition of menopause transition to describe the early years after the cessation of periods, in which many women experience debilitating symptoms. For the purposes of analysis, therefore, we are defining 3 cohorts; **perimenopause** (as defined above), **menopause transition** (1–5 years after the cessation of periods), and later **post-menopause** (defined below).

Post-menopause: As soon as a woman has been through menopause, she immediately becomes post-menopausal and will remain so for the rest of her life. Women are in the post-menopause phase when they have had 5 years or more without a period. It is common for a woman to continue to experience symptoms for a further five to seven years, and in some cases even longer.

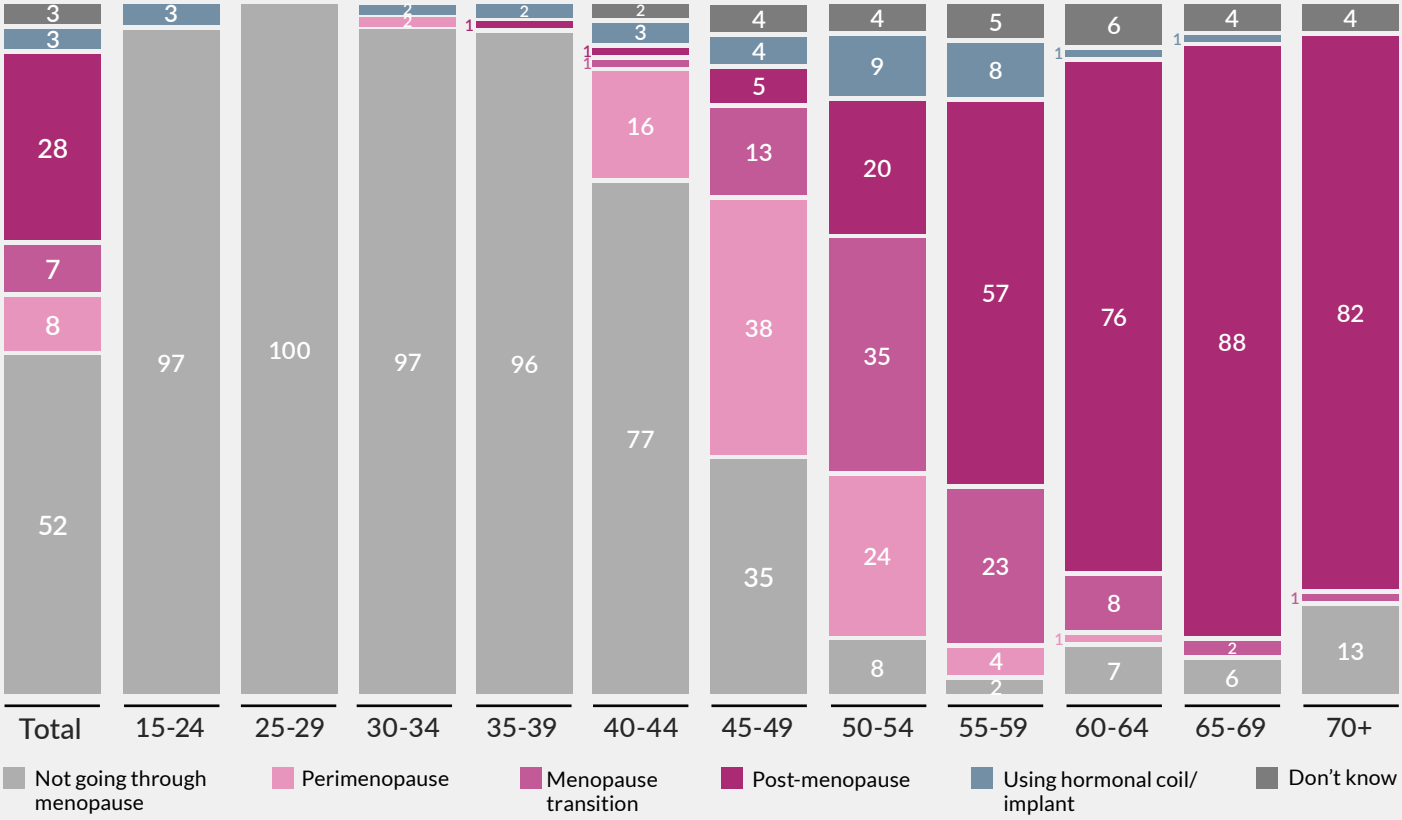
[1] *https://www2.hse.ie/conditions/contraception-and-menopause/*

Experience of Menopause

- 8% of women reported that they are in the perimenopause phase, 7% said they are in the menopause transition phase, 28% said they are in the post-menopause phase (i.e. 5 years or more without a period). 3% said they are using a hormonal coil or implant so couldn't tell and 3% didn't know if they were experiencing menopause.

- Women aged between 45 and 54 are the most likely to be experiencing menopause symptoms. Among women aged 45 to 49, 38% said they are in the perimenopause phase and 13% said they are in the menopause transition phase. Among women aged 50 to 54, 24% said they are in the perimenopause phase and 35% said they are in the menopause transition phase.

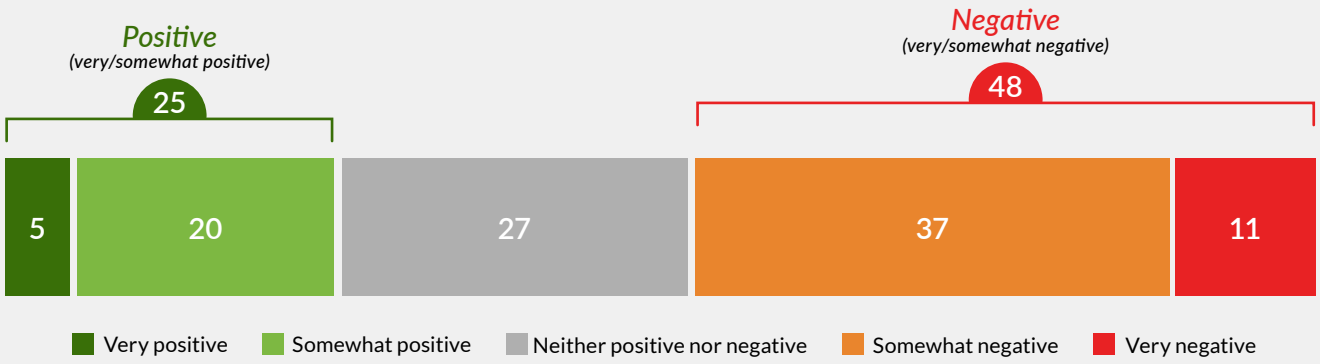
Proportion of women who said they are in the perimenopause, menopause transition, and post-menopause phases by age (%)



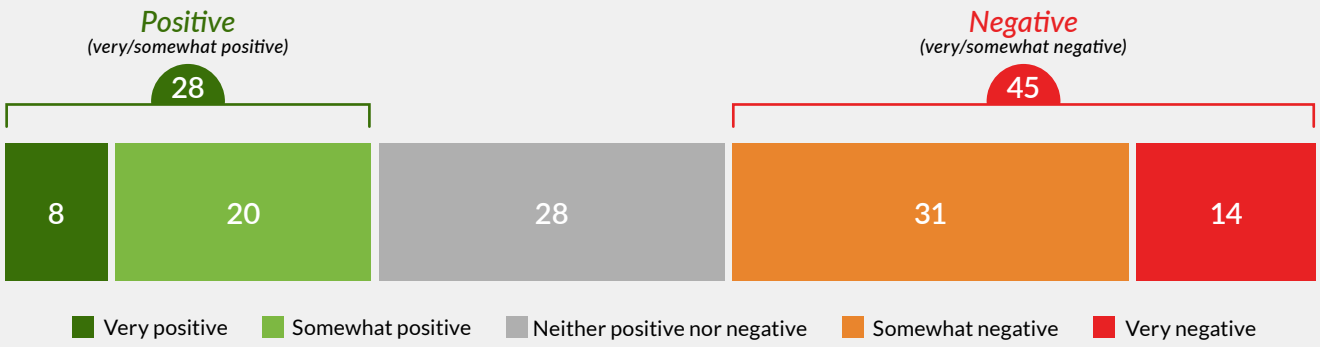
- Women who said they are in the perimenopause or menopause transition phase reported mixed experiences. 48% of women in the perimenopause phase and 45% of those in the menopause transition phase reported a somewhat negative or very negative experience. However, 25% of women going through perimenopause and 28% of those going through menopause transition reported a somewhat positive or very positive experience.

- Women in the post-menopause phase (i.e. more than 5 years without a period) are more positive about their experience than those currently going through it. Of those in the post-menopause phase, 46% reported having a very positive or somewhat positive experience and 29% said they had a somewhat negative or very negative experience. A further 25% felt neither positive nor negative about their experience with menopause.

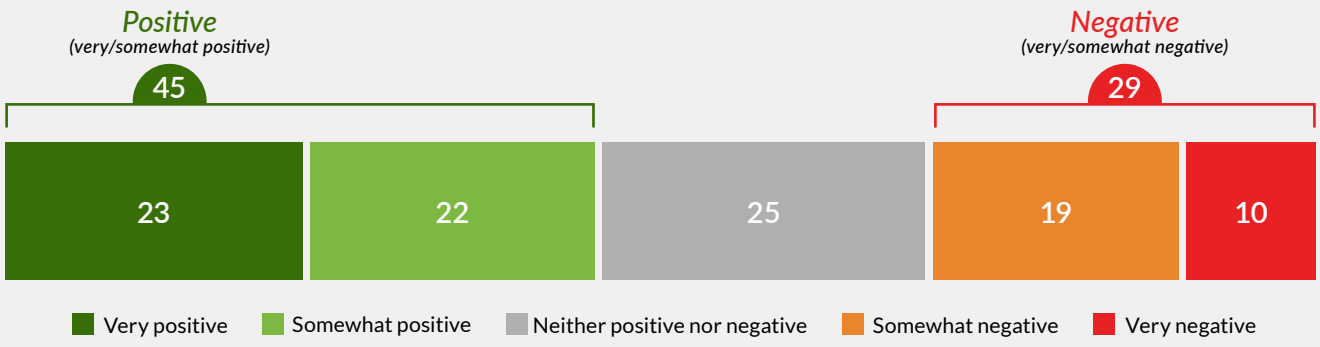
Attitude towards their experience with menopause so far among those currently in the perimenopause phase (%)



Attitude towards their experience with menopause so far among those currently in menopause transition phase (i.e. between 1 to 5 years without a period) (%)



Attitude towards their experience with menopause among those in the post-menopause phase (i.e. +5 years without a period) (%) [1]



[1] *Some figures won't add up to 100 due to rounding.*

Types of Symptoms

- 77% of women who are experiencing or have experienced menopause reported temperature regulation issues. Other symptoms reported by most women are changes in menstruation/ periods (67%), fatigue (66%), difficulty sleeping or insomnia (56%), increases in low mood or rapid mood changes (56%), difficulty with memory or concentration (i.e. brain fog) (53%), and changes in weight or body shape (51%).
- The proportion of women who reported certain symptoms varied by menopause stage. Women in the perimenopausal phase are more likely to report difficulty with memory or concentration (73%), joint issues or pain (60%), increased headaches or migraines (39%), and fatigue (75%) and less likely to report temperature regulation issues (69%).
- Women in the menopause transition phase are more likely to report difficulty with memory or concentration (65%), increases in low mood or rapid mood changes (67%), joint issues or pain (56%), and heart palpitations (40%).
- Women in the post-menopause phase are more likely to report they experienced temperature regulation issues (79%) and less likely to report difficulty with memory or concentration (43%), increases in low mood or rapid mood changes (50%), heart palpitations (27%), joint issues or pain (38%), increased headaches or migraines (21%), and fatigue (62%).

Proportion of women who experienced different symptoms by menopause phase (%)

	Total	Peri-menopause	Menopause transition	Post-menopause
Temperature regulation issues: feeling unusually hot/cold during the day or night	77	69	77	79
Changes in menstruation /periods	67	69	59	68
Fatigue feeling unusually tired orlack of energy	66	75	70	62
Increases in low mood or rapid mood changes	56	63	67	50
Difficulty sleeping or insomnia	56	51	62	55
Difficulty with memory or concentration – brain fog	53	73	65	43
Changes in weight or body shape	50	55	51	48
Joint issues or joint pain	46	60	56	38
Changes in libido (sex drive) or discomfort/pain during sex	38	44	39	36
Vaginal dryness itching or discomfort	36	36	36	37
Dry or itchy skin	33	38	39	30
Heart palpitations (fast-beating fluttering or pounding heart)	31	35	40	27
Increased headaches or migraines	26	39	29	21
Urinary issues: recurring infections or incontinence issues	19	18	20	19

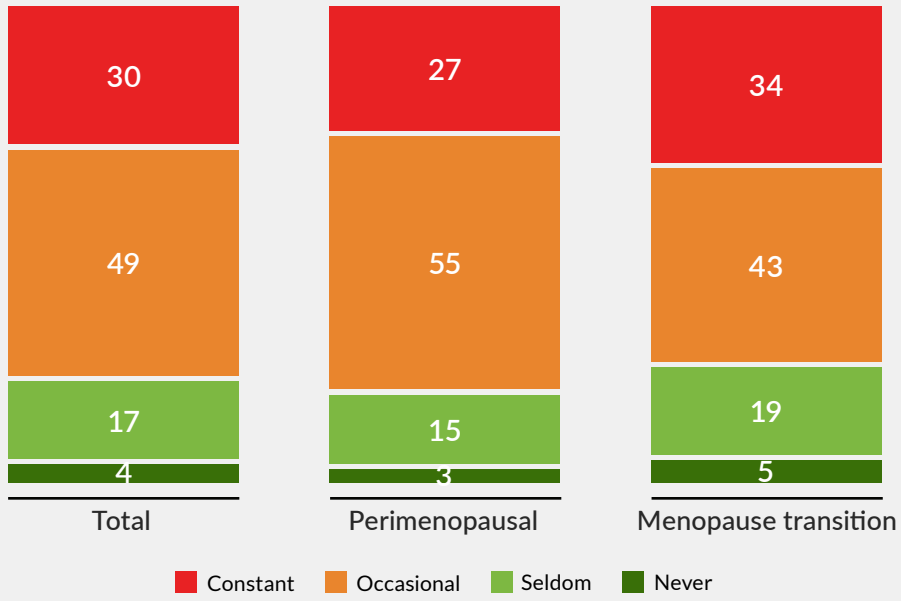
Severity and Impact of Symptoms

- The frequency and severity of menopause symptoms varied between women. 30% said they felt symptoms constantly, 49% said they experienced them occasionally and 21% said they experienced symptoms seldom (17%) or never (4%).

- Women in the perimenopause phase are more likely to report having symptoms occasionally (55%), compared with 43% of women in the menopause transition phase.

- Women in the perimenopause or menopause transition phase aged 50 to 54 are more likely to report feeling symptoms constantly (39%) and those aged 40 to 44 are more likely to report having symptoms occasionally (68%).

Proportion of women who experienced different symptoms by menopause phase (%)

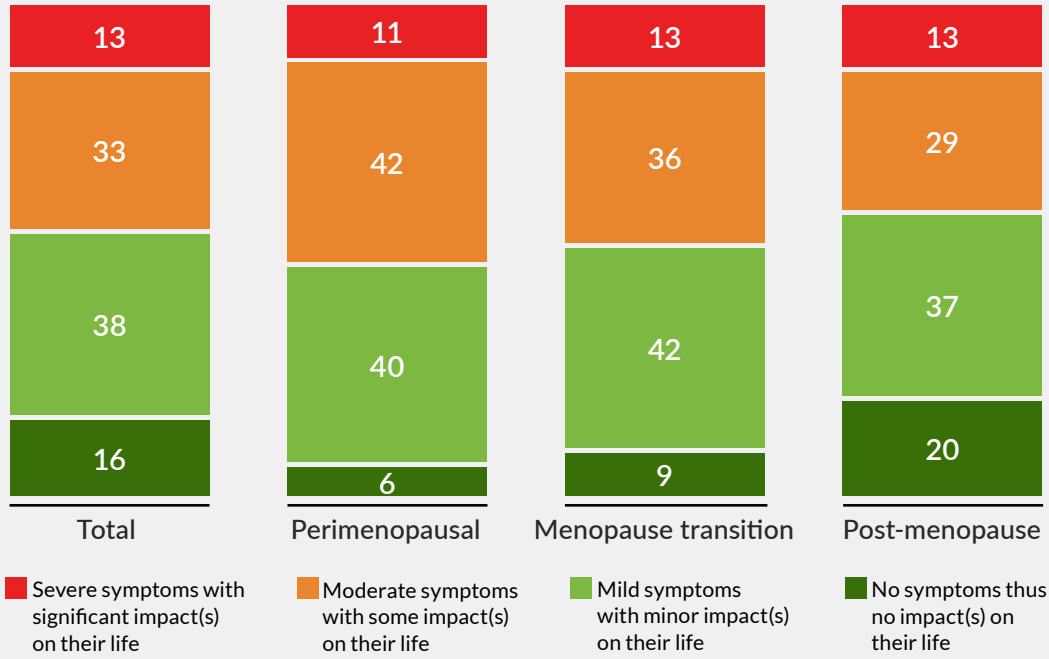


- 84% of women who are currently going through or have gone through menopause said they experienced symptoms. Of these, 13% reported that their symptoms are severe and significantly impacted their life, 33% felt they had/ have a moderate impact on their life, and 38% reported that their symptoms are mild and had a mild impact on their life.

- Women going through perimenopause are more likely to say their symptoms have a moderate impact on their life (42%) and are less likely to say they had no symptoms (6%). In contrast, women who are in the post-menopause phase are less likely to say their symptoms had a moderate impact on their life (29%) and are more likely to say their symptoms had no impact on their life (20%).

- Those with severe symptoms are less likely to report Good or Very good general health (64%) and more likely to say their health was Fair (29%).

Perceived severity of symptoms by menopause stage (%)



- Women experiencing perimenopause or menopause who reported feeling symptoms constantly are more likely to say they had a severe (25%) or moderate (55%) impact on their life.

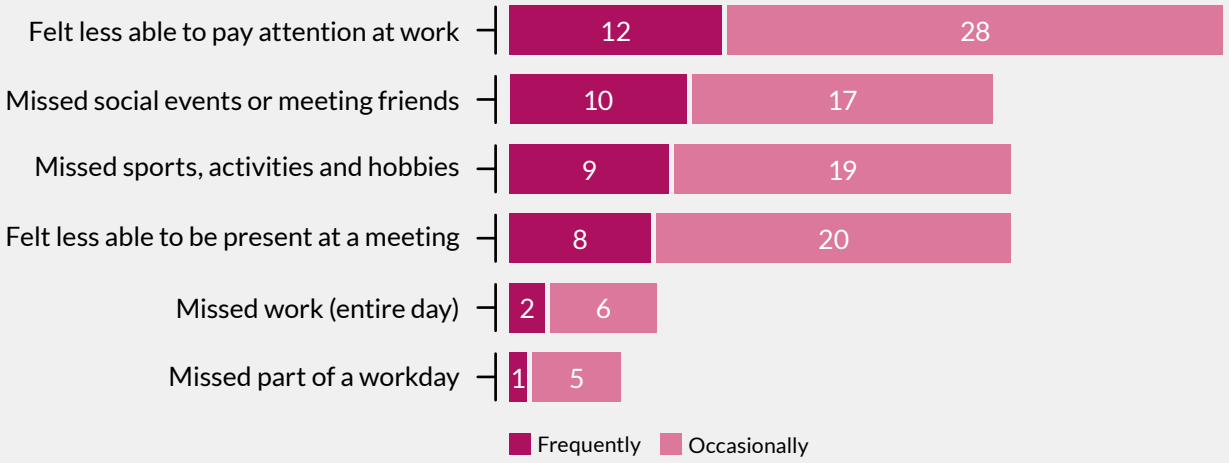
Frequency by impact of symptoms among women experiencing perimenopause or menopause (%)

	Impact of Symptoms			
Frequency of Symptoms	Severe	Moderate	Mild	No symptoms
Constant	25	55	20	<1
Occasional	6	42	50	1
Seldom	7	12	57	23
Never	4	3	9	82

- Women in the perimenopause phase were asked how frequently their symptoms impacted a list of different activities. 40% said they frequently (12%) or occasionally (28%) felt less able to pay attention at work because of their symptoms. 28% said they frequently (8%) or occasionally (20%) are less able to be present at meetings. 8% said their symptoms made them frequently (2%) or occasionally (6%) missed an entire workday and 6% said they frequently (1%) or occasionally (5%) made them miss part of a workday.

- Menopause symptoms also affected social activities, with 27% of women in perimenopause phase reporting they frequently (10%) or occasionally (17%) missed social events or meeting friends, and 28% reporting that they missed sports, activities and hobbies frequently (9%) or occasionally (19%) because of their symptoms.

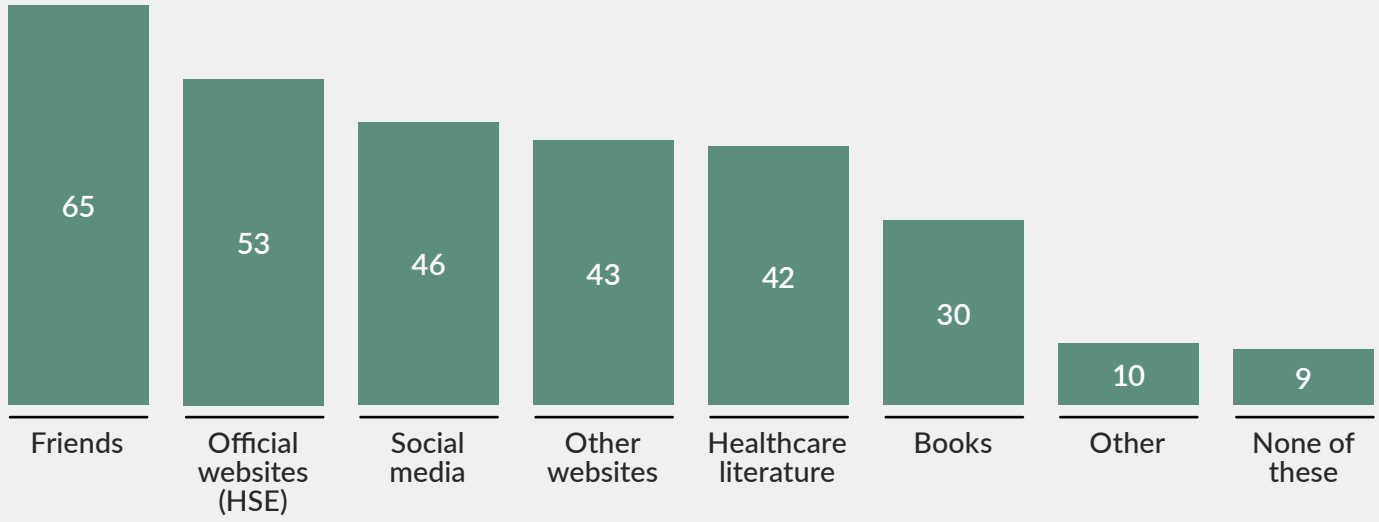
Frequency that symptoms impacted different activities among women who said they are in the perimenopause phase (%)



- 69% of women in the perimenopause phase said they sought medical support for their symptoms. Of the women who sought support[2], 84% accessed support from a general practitioner, 17% accessed support from a specialist menopause clinic, 13% from other health professionals and 5% assessed support from an alternative medicine practitioner.

- Women in the perimenopause phase were also asked if they looked for information on their symptoms. 65% said they looked for information on their symptoms from friends. 53% looked for information on official websites like the HSE and 46% looked for information from social media.

Where women in the perimenopause phase say they look for information on their symptoms (%)



[2] *Some women in the perimenopause phase accessed support from multiple services which means the percentages will add up to more than 100%.*

Menopause medication

- 51% of women in the perimenopause phase said they have taken medication for their symptoms.

- Women who reported more frequent and severe symptoms are more likely to take medication. 81% of women in the perimenopause phase who said their symptoms were constant take medication for them. This compared with only 42% of those who experienced symptoms occasionally. Similarly, women who said their symptoms had a severe (84%) or moderate (63%) impact on their life are more likely to take medication for them.

Use of medication among women in the perimenopause phase for symptoms by self-reported symptom frequency and severity (%)

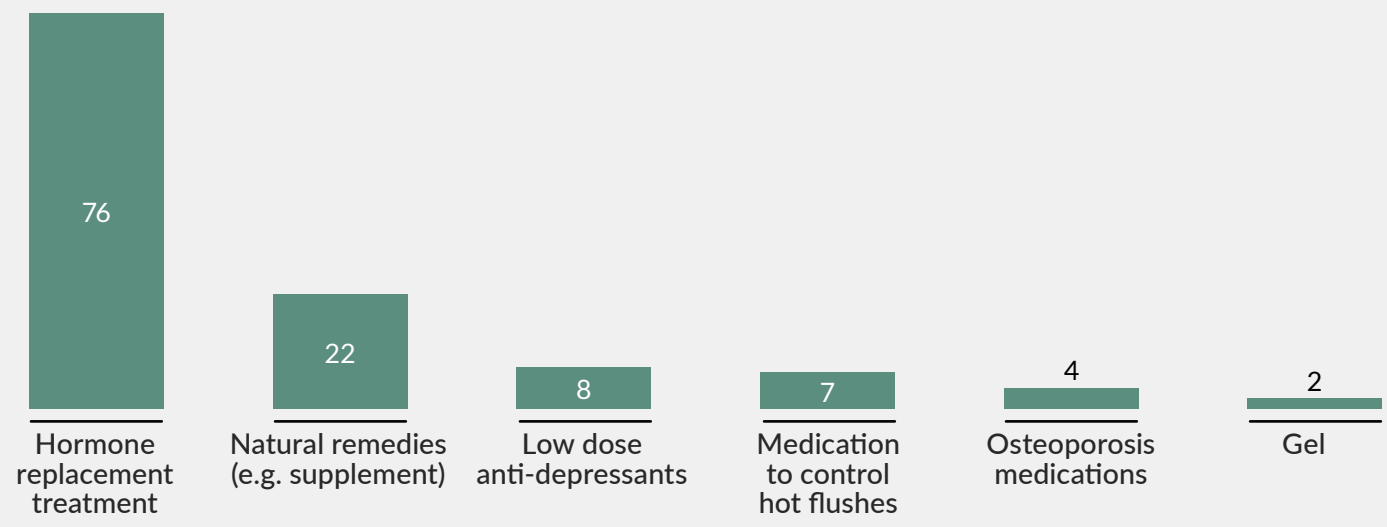
Symptom frequency	Medication use
Constant	81
Occasional	42
Seldom	39
Never	26

Symptom severity	Medication use
Severe symptoms	84
Moderate symptoms	63
Mild symptoms	33
No symptoms	33

- Of the women in the perimenopause phase who take medication (n=146), 76% take hormone replacement treatment (HRT). 22% said they take natural remedies like supplements and/or probiotics for their symptoms.

- Of the 76% (n=107) of perimenopausal women who said they take HRT, 93% said it is either very (55%) or somewhat (38%) effective.

Types of medication perimenopausal women said they took for their symptoms (%)



7. Contraception

7. Contraception

This year's Healthy Ireland Survey included a section on contraception. In this module, respondents were asked about their use of contraception and their awareness and use of the Free Contraception Scheme. This scheme provides contraceptive prescriptions and contraception related medical appointments, free of charge to women aged 17 to 35. This module was only asked to people aged 18 or older. Overall, 72% (5,429) of respondents agreed to take part in this module.

Contraception use

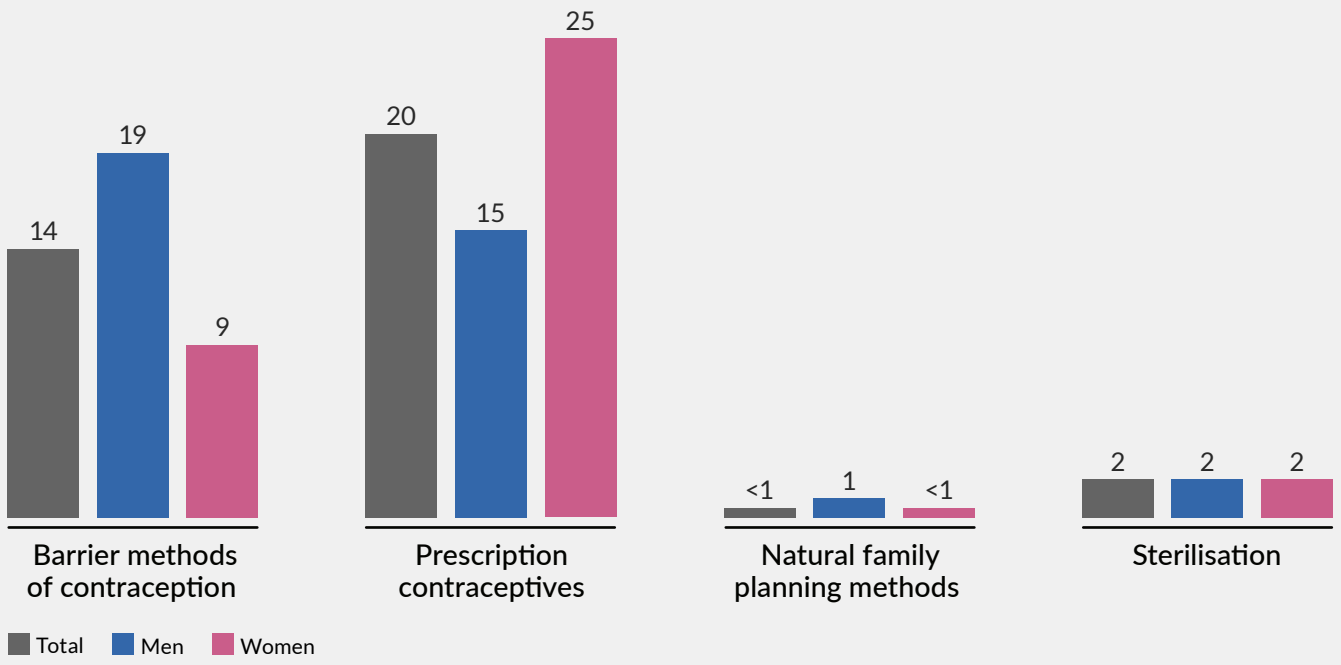
- 34% of said they or their partner currently use a form of contraception or method of family planning. 66% do not currently use any form of contraception (3% don't do so because they are trying to conceive).
- Overall, men (34%) and women (35%) are equally likely to say they use a form of contraception, although women aged between 25 and 54 are more likely than men in the same age group to use contraception (50% and 46% respectively).
- 45% of heterosexual women aged 18 to 55 say they do not currently use any form of contraception.

Contraception use by gender and age (%)

		18-24	25-34	35-44	45-54	55-64	65-74	75+
Use a form of contraception or method of family planning	Men	57	55	48	36	11	2	<1
	Women	58	58	53	40	4	<1	<1
Don't currently use any form of contraception or family planning	Men	43	38	45	61	89	98	100
	Women	41	35	41	58	96	99	100
Don't use any form of contraception because they are trying to conceive	Men	<1	7	7	3	<1	<1	<1
	Women	1	7	6	1	<1	1	<1

- 20% use prescription contraceptives, 14% use barrier contraception, 2% use sterilisation, and less than 1% use natural family planning methods.
- Of the barrier methods used, male condoms are the most common (13%). Men aged 18 to 24 (42%) are the most likely to say they used this form of contraception.
- For prescription contraceptives, the contraceptive pill (10%) is the most common, followed by the hormonal coil (5%) and copper coil (3%). Women aged 18 to 24 and 25 to 34 are the most likely to use the contraceptive pill (18 to 24: 26%, 25 to 34: 23%).
- The hormonal coil is more commonly used by women aged 35 to 44 (12%) and those aged 45 to 54 (15%). Women over 35 using these may also be relying on them to help treat peri-menopause symptoms, in addition to their contraceptive function. Notably, women who said they are experiencing perimenopause (18%) or menopause transition (10%) are more likely to say they use the hormonal coil.

Usage of different forms of contraception by gender (%)



Usage of different forms of contraception by age (%)

	Total	18-24	25-34	35-44	45-54	55+
Barrier methods of contraception	14	29	24	19	12	3
External (male) condoms	13	28	23	17	12	3
Internal (female) condoms	<1	1	1	1	<1	<1
Gels and sprays etc.	<1	<1	<1	<1	<1	<1
Diaphragm	<1	<1	<1	<1	<1	<1
Prescription contraceptives	20	33	35	29	23	3
Contraceptive Pill	10	19	19	13	7	1
Emergency Pill (Plan B)	<1	<1	<1	<1	<1	<1
Patch	<1	<1	1	<1	<1	<1
Ring	<1	<1	<1	<1	<1	<1
Hormonal coil	5	3	5	9	10	1
Copper coil	3	4	5	4	4	1
Implant	2	6	3	2	1	<1
Injections	<1	<1	<1	<1	<1	<1
Natural family planning methods	1	1	1	1	1	<1
Withdrawal	<1	<1	<1	<1	<1	<1
Abstinence	<1	<1	<1	<1	<1	<1
Natural family planning – rhythm or Billings methods	<1	<1	<1	<1	<1	<1
Cycle tracking apps	<1	<1	<1	<1	<1	<1
Sterilisation	2	<1	1	4	4	2
Male sterilization/vasectomy	2	<1	<1	4	3	2
Female sterilization/tubal ligation	<1	<1	<1	<1	1	<1

Usage of different forms of contraception among men by age (%)

	Total	18-24	25-34	35-44	45-54	55+
Barrier methods of contraception	19	42	32	23	16	5
External (male) condoms	18	42	30	21	15	5
Internal (female) condoms	<1	<1	1	1	<1	<1
Gels and sprays etc.	<1	<1	<1	<1	<1	<1
Diaphragm	<1	<1	<1	<1	<1	<1
Prescription contraceptives	15	20	27	25	18	4
Contraceptive Pill	8	11	15	13	8	2
Emergency Pill (Plan B)	<1	<1	<1	<1	1	<1
Patch	<1	1	1	1	<1	<1
Ring	<1	<1	<1	<1	<1	<1
Hormonal coil	3	1	3	6	5	1
Copper coil	3	3	5	4	3	<1
Implant	1	3	2	1	<1	<1
Injections	<1	<1	1	<1	1	<1
Natural family planning methods	1	2	2	2	1	<1
Withdrawal	<1	<1	<1	<1	<1	<1
Abstinence	<1	<1	<1	<1	<1	<1
Natural family planning – rhythm or Billings methods	<1	<1	<1	<1	<1	<1
Cycle tracking apps	<1	<1	<1	<1	<1	<1
Sterilisation	2	<1	1	2	4	4
Male sterilization/vasectomy	2	<1	1	2	3	4
Female sterilization/tubal ligation	<1	<1	<1	<1	1	<1

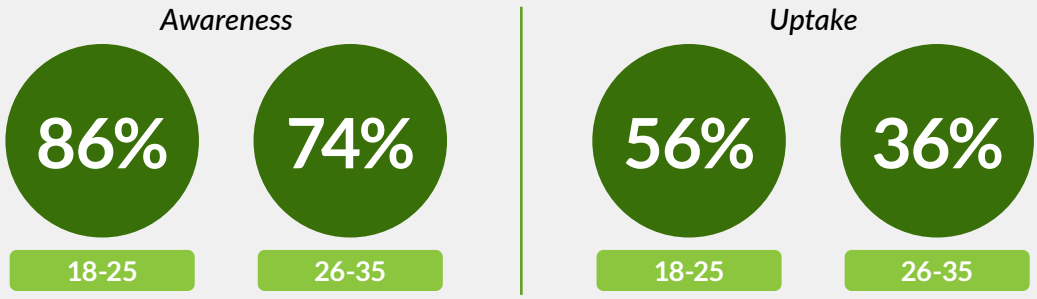
Usage of different forms of contraception among women by age (%)

	Total	18-24	25-34	35-44	45-54	55+
Barrier methods of contraception	9	16	17	15	9	<1
External (male) condoms	9	14	16	14	9	<1
Internal (female) condoms	<1	2	<1	1	<1	<1
Gels and sprays etc.	<1	<1	<1	<1	<1	<1
Diaphragm	<1	<1	<1	<1	<1	<1
Prescription contraceptives	25	46	43	33	28	3
Contraceptive Pill	11	26	23	14	6	<1
Emergency Pill (Plan B)	<1	<1	<1	1	<1	<1
Patch	<1	<1	1	<1	<1	<1
Ring	<1	<1	<1	<1	<1	<1
Hormonal coil	7	5	7	12	15	2
Copper coil	3	4	6	3	6	1
Implant	3	10	5	2	1	<1
Injections	<1	<1	<1	<1	<1	<1
Natural family planning methods	<1	<1	<1	<1	1	<1
Withdrawal	<1	1	1	<1	1	<1
Abstinence	<1	<1	<1	<1	<1	<1
Natural family planning – rhythm or Billings methods	<1	<1	<1	1	1	<1
Cycle tracking apps	<1	<1	<1	<1	<1	<1
Sterilisation	2	<1	<1	5	4	<1
Male sterilization/vasectomy	2	<1	<1	4	3	<1
Female sterilization/tubal ligation	<1	<1	<1	1	1	<1

Awareness and use of the Free Contraception Scheme

- 61% are aware of the Free Contraception Scheme. Awareness is higher among women (75%) than men (46%).
- Awareness is also higher among younger people, particularly young women. 87% of women aged 18 to 24, and 76% of those aged 25 to 34 are aware of the scheme, compared with 62% and 51% respectively of men in these age groups.
- Women aged 18-35 and heterosexual men aged 18-50 were asked if they or their partner accessed the Free Contraception Scheme. Overall, 36% reported that they or their partner accessed the scheme.
- Women aged 18 to 25 are more likely to say they use the scheme (56%) compared with those aged 26 to 35 (36%).
- Only 4% of those who said they used the Free Contraception Scheme experienced issues with it. This included issues relating to types of contraception available on the scheme, eligibility issues and side-effects or risks with the hormonal contraception available on the scheme.

Awareness and uptake of the Free Contraception Scheme among women aged 18 to 35 (%)



8. Sleep

8. Sleep

Sleep plays a crucial role in overall wellbeing, mental health, and metabolism, making it an essential part of a healthy lifestyle. While the ideal target is eight hours each night, most people need somewhere between five and nine hours to feel their best. The quality of our sleep matters just as much as the quantity. Poor sleep can take a toll on mental health, increase the risk of weight gain, and lead to lower levels of physical activity, among other negative effects.

To better understand how much sleep people get and how well they're able to rest, questions about sleep were included in the Healthy Ireland Survey in 2019 and 2024. To evaluate trends in this area, these questions have been repeated in 2025.

Amount of sleep

- On average, people report sleeping for 6.9 hours on a regular weeknight or worknight. This is consistent with the finding from 2024 (average of 6.9 hours), but is slightly lower than in 2019 (average of 7.1 hours).
- 32% of the population report sleeping for six-hours or less. This is consistent with last year's figures, but is 7 points higher than in 2019 (2024: 33%, 2019: 25%).
- 35% report sleeping for six-to-seven hours and 28% of people report sleeping between seven-to-eight hours. The proportion of people sleeping six-to-seven hours is higher than in 2024 and 2019 (2024: 31%, 2019: 32%). For those sleeping seven-to-eight hours, figures are consistent with last year but are 6 points lower than in 2019 (2024: 29%, 2019: 34%).
- 5% of the population sleep for more than 8 hours on an average weeknight. This is 2 points lower than 2024 and 5 points down from 2019 (2024: 7%, 2019: 10%).
- There is no notable difference in the average reported sleep between men (6.9 hours) and women (6.8). Younger adults aged 15 to 24 have the longest average sleep duration (7.1 hours) and those aged 55 to 64 have the shortest average sleep duration (6.7 hours).
- Women aged 55 to 64 (44%) are the most likely to say they sleep for six hours or less and men aged 15 to 24 (19%) are the least likely to report this.

Hours of sleep reported on an average weeknight by gender and age (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Six or less	32	20	29	33	35	39	35	36
More than six up to seven	35	41	34	37	37	32	28	25
More than seven up to eight	28	32	33	27	24	24	29	30
More than eight hours	5	7	4	3	4	4	8	9
Average (hours of sleep)	6.9	7.1	7.0	6.8	6.8	6.7	6.9	6.9

Hours of sleep reported on an average weeknight among men by age (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Six or less	30	19	29	32	33	35	29	28
More than six up to seven	36	40	36	38	39	37	29	24
More than seven up to eight	30	37	31	27	25	23	34	36
More than eight hours	5	5	4	3	3	5	8	12
Average (hours of sleep)	6.9	7.2	6.9	6.8	6.8	6.8	7.0	7.2

Hours of sleep reported on an average weeknight among women by age (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Six or less	35	22	28	33	36	44	41	44
More than six up to seven	33	42	32	37	36	28	27	26
More than seven up to eight	27	27	35	27	24	25	25	24
More than eight hours	5	9	5	3	4	4	7	6
Average (hours of sleep)	6.8	7.2	6.9	6.8	6.8	6.8	7.0	7.2

- People engaged in home duties (6.8 hours) report the shortest hours of sleep on average, while students report the highest average hours of sleep (7.1 hours).
- People who report very good or good general health sleep longer (7.0 hours), on average, than those who rate their health as fair (6.1 hours) or bad (6.1 hours). Moreover, people who reported having a long-standing illness or health problem slept less (6.8 hours) on average than those without any health conditions (6.9 hours).
- The average number of hours of sleep is similar among parents (6.8 hours) and non-parents (6.9 hours). This is similar to 2019 for parents but slightly lower for non-parents (Parents: 6.9 hours, Non-parents: 7.1 hours). Parents of a teenager (13-17: 6.8 hours) or child under the age of 6 (6.8 hours) sleep less hours on average. The shortest average sleep time is reported by parents of children aged 1 or younger (6.5 hours).
- People who provide regular unpaid personal help to a friend or family member with a long-term illness, health problem or disability sleep less on average than those who do not have caring responsibilities (Carers: 6.7 hours, Non-Carers: 6.9 hours).

Sleep duration and quality among parent and non-parents

	Age of children				
	All parents	Under 6	6-12	13-17	Non-parents
Average amount of sleep	6.8	6.8	6.9	6.8	6.9
% rating sleep as good or very good	66	64	69	66	68

Sleep duration and quality among carers

	Carer	Non-carer
Average amount of sleep	6.7	6.9
% rating sleep as good or very good	58	69

Quality of Sleep

- 67% of the population rate the quality of their sleep during the past month as very good or fairly good. The proportion of people who rate their sleep very good or fairly good has declined by 9 points since 2019 (76%).
- Men (71%) are more likely than women (64%) to rate their quality of sleep as very or fairly good. Since 2019, the proportion of men and women reporting good quality sleep has reduced by 7 points and 9 points, respectively (2019: Men: 78%, Women: 73%).
- Since 2019, the proportion of people reporting very good or fairly good sleep has declined among all age groups except in men aged 65 to 74 and women aged 75 and older. However, levels of quality sleep among men aged 65 to 74 (78%) and women aged 75 and older (72%) are lower than last year (2024: Men 65-74: 82%, Women 75+: 78%).
- The poorest quality of sleep is reported by women aged 45 to 54, with only 58% saying they had a very good or fairly good sleep.
- The largest decrease in sleep quality is among men aged 15 to 24, with 69% reporting very good or fairly good sleep in 2025, a 17 points reduction since 2019 (86%).

Rate quality of sleep as very good or fairly good by gender and age, 2019-2025 (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
2019	76	83	77	74	75	72	74	74
2024	72	71	74	70	70	68	78	79
2025	67	68	69	66	63	64	70	74
% change since 2019	**-9**	**-15**	**-8**	**-8**	**-12**	**-8**	**-4**	**-**

Rate quality of sleep as very good or fairly good, gender by age, 2019-2025 (%)

	Gender	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
2019	Men	78	86	81	74	78	75	78	78
	Women	73	80	73	74	73	69	71	71
2024	Men	75	73	75	71	74	73	82	81
	Women	69	69	72	69	66	63	74	78
2025	Men	71	69	73	68	68	68	78	77
	Women	64	67	66	64	58	60	63	72
% change since 2019	**Men**	**-7**	**-17**	**-8**	**-6**	**-10**	**-7**	**-**	**-1**
	Women	**-9**	**-13**	**-7**	**-10**	**-15**	**-9**	**-8**	**+1**

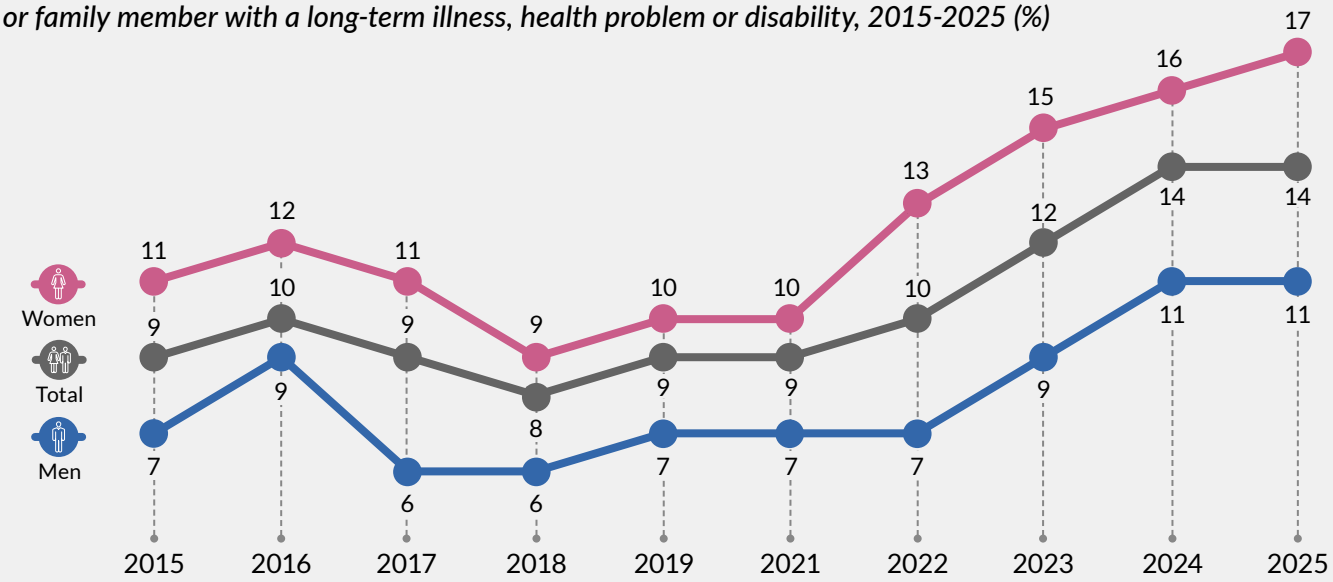
- Retired people (73%) and those at work (70%) are more likely to rate their sleep as very good or fairly good, compared with those who engaged in home duties (56%) or people who are unemployed (63%).
- People who say they have very good or good health are more likely to report very good or fairly good sleep (71%) compared with those who say their health is fair (51%) or bad (31%). Similarly, people who report having a long-standing illness or health problem (62%) are less likely to say their sleep is good quality compared with those without any long-standing illness or health condition (70%).
- Parents are less likely than non-parents to rate the quality of their sleep as good or very good, compared with non-parents (Parent: 66%, Non-parents: 68%). Parents of a teenager (66%) or child under the age of 6 (64%) are less likely to report good quality sleep.
- Carers report lower quality sleep than non-carers, with 58% of carers reporting good or very good quality sleep compared with 69% of non-carers.

9. Caring Responsibilities

9. Caring Responsibilities

- 14% of the population say they provide regular unpaid personal help to a friend or family member with a long-term illness, health problem or disability[1].
- The proportion of people who say they are carers has increased steadily since 2019 (2019: 9%) but remains consistent with last year (2024: 14%).
- Women (17%) are more likely than men (11%) to say they are carers. This 6-point gap is the largest found between men and women, aligning with findings from 2022 and 2023, which also noted 6-point differences (2023: Men, 9%, Women 15%; 2022: Men, 7%, Women 13%).

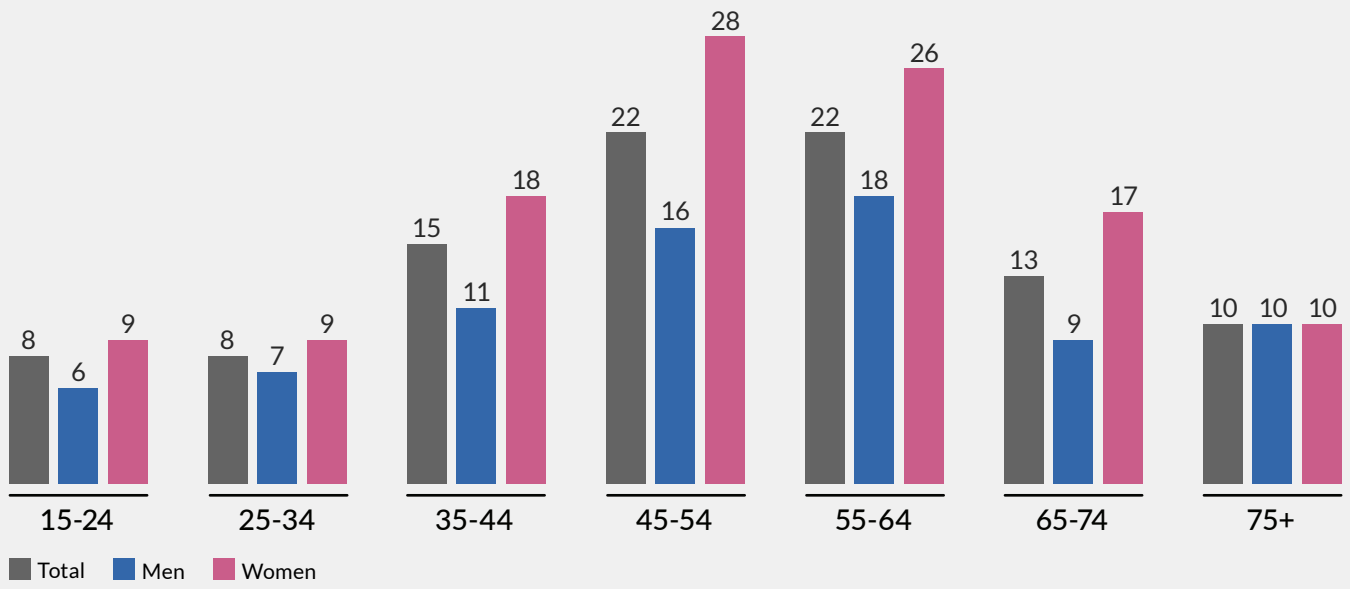
Proportion of the population that say they provide regular unpaid personal help to a friend or family member with a long-term illness, health problem or disability, 2015-2025 (%)



- Women aged between 45 and 54 (28%) and 55 and 64 (26%) are the most likely to report being carers and men aged 15 to 24 (6%) and 25 to 34 (7%) are the least likely to say they are carers. These findings are broadly consistent with those from 2015, however, the proportion of people identifying as carers was much lower in 2015 (2015: Women 45 to 54: 15%, Women 55 to 64: 17%, Men 15-24: 7%, Men 25-34: 5%).

[1] *The 2022 Census found that 6% of the population provided unpaid personal help. The Healthy Ireland Survey used the same question as the Census but was administered by a telephone interviewer who provided additional context to respondents, instructing them to "Include problems which are due to old age. Personal help includes help with basic tasks such as feeding or dressing." This additional context may have caused an increase in the number of respondents saying they provided personal help at this question. Additionally, the Healthy Ireland Survey figure only includes people aged 15 or older, whereas the census figure relates to the entire population, contributing to the gap between the 2022 Census and Healthy Ireland Survey figures.*

Proportion of men and women that say they provide regular unpaid personal help to a friend or family member with a long-term illness, health problem or disability by age (%)

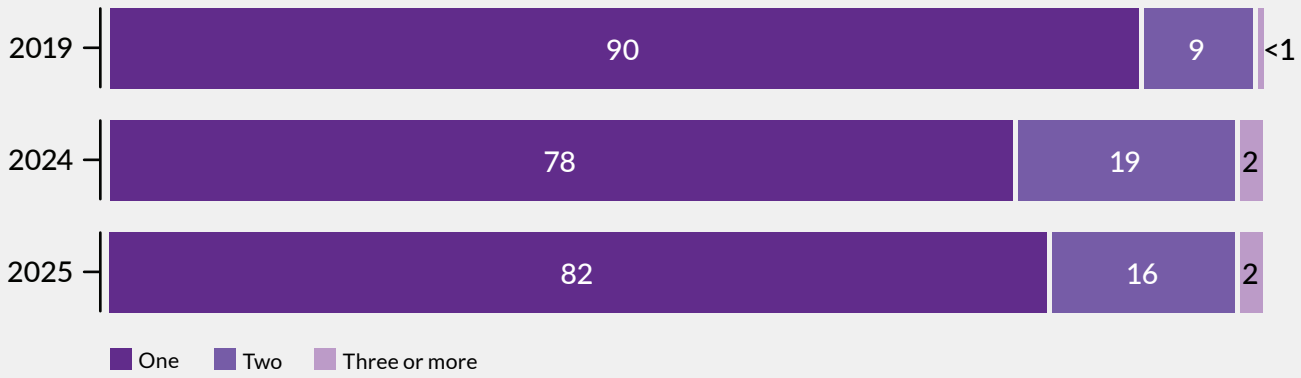


Care recipients

- 82% of carers say they provide care for one person and 18% say they care for multiple people (2 people: 16%, 3 or more people: 2%). The proportion of carers who say they care for 2 or more people has decreased slightly from last year (2024: 21%) but is still considerably higher than in 2019 (2019: 10%).

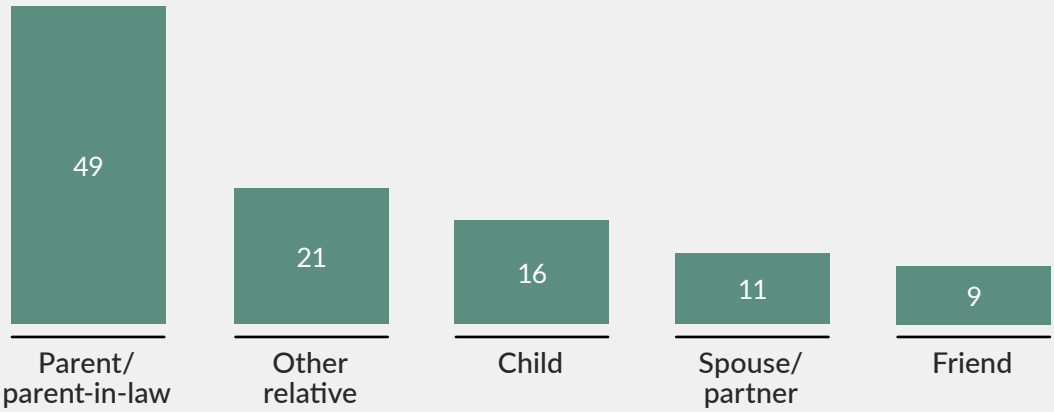
- Women aged between 45 and 54 (30%) are the most likely to report caring for multiple people. Although women aged 45 to 54 were also the most likely to report being carers in 2019, the proportion of those caring for more than one person was less than half of this year's figure (2019: 14%).

Number of people carers say they provide unpaid personal help to, 2019-2025 (%)



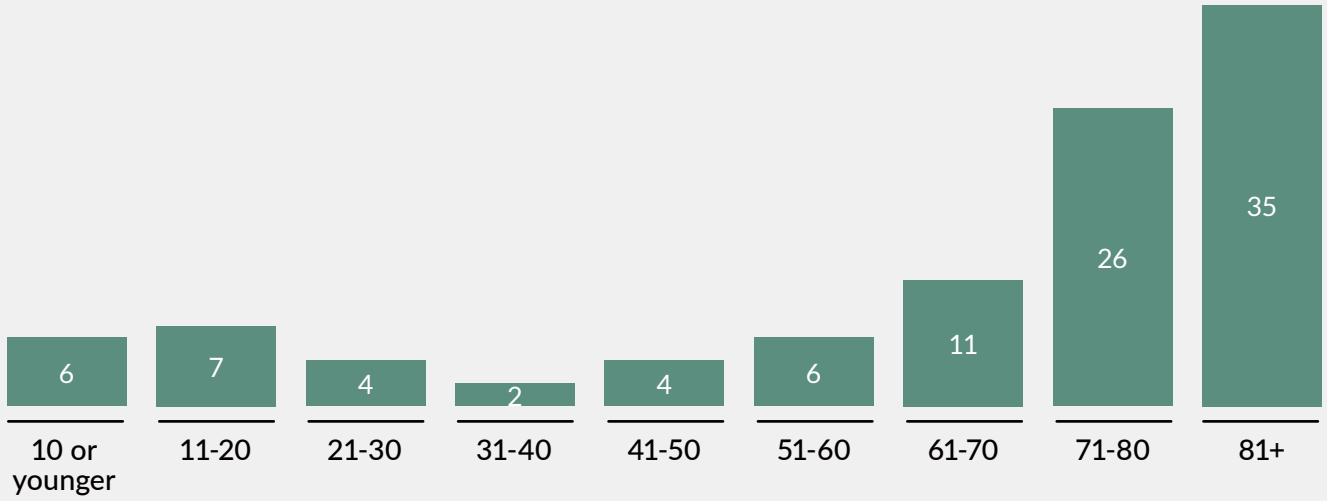
- 49% of all carers provide care to a parent or parent-in-law, 16% provide care to a child, 11% to a spouse/ partner, 21% to another relative and 9% to a friend.

Relationship of care recipient to carer (%[2])



- 69% of carers provide care for a person aged 65 or older, with 27% providing care to someone aged between 71 and 80 and 38% provide care to someone aged 81 or older.
- 76% of carers aged 45 or older provide care to someone aged 65 or older, compared with 58% of carers younger than 45.
- In contrast, carers younger than 45 (10%) are more likely than those aged 45 or older (5%) to care for a child aged 10 or younger.

Age of care recipients (%[3])



- Carers are most likely to report providing care to someone with difficulties relating to age (41%), difficulty with basic physical activities (31%) and difficulty with pain, breathing or any other chronic illness/condition (22%).

[2] *Percentages will add up to more than 100% as some carers care for multiple people (e.g. a parent and a child).*

[3] *These values represent the percentage of care recipients in each age group. As some carers will provide unpaid help to more than one person (e.g. someone aged 10 or younger and someone aged between 61 and 70), these values capture the age distribution of all those that are receiving care. These values will therefore differ slightly from the percentage of carers who provide care to someone in a particular age group.*

- Women are more likely than men to care for someone with difficulty with basic physical activities (Women: 35%, Men: 25%), difficulty with pain, breathing or any other chronic illness/condition (Women: 27%, Men: 15%), difficulty with learning or concentrating (Women: 15%, Men: 9%), and mental health issues (Women: 14%, Men: 5%).

Proportion of carers who care for someone with different types of illnesses, health conditions, or disabilities by gender (%[4])

	Total	Men	Women
Difficulties relating to age	41	45	39
A difficulty with basic physical activities such as walking climbing stairs reaching lifting or carrying	31	25	35
A difficulty with pain breathing or any other chronic illness or condition	22	15	27
A difficulty with learning remembering or concentrating	13	9	15
A psychological or emotional condition or a mental health issue	10	5	14
An intellectual disability	10	9	11
Blindness or a vision impairment	5	5	5
Deafness or a hearing impairment	4	3	4
Brain disorders - Dementia/Alzheimer's/Parkinsons/Motor Neuron/Stroke/MS/ Epilepsy	1	<1	2
Addiction	<1	<1	<1
Genetic/neurological disorders (included Down Syndrome/Angelman Syndrome/ Alpha-1 antitrypsin deficiency)	<1	<1	<1
Other	35	33	37

- Care recipients aged 30 or younger are more likely to have an intellectual disability (31%), a mental health issue (19%), or a difficulty with learning, remembering or concentrating (24%). In contrast, care recipients aged 60 or older are more likely to have difficulties related to age (52%) and/or difficulty with basic physical activities (33%).

[4] *The response options used to assess the type of illness, health condition or disability care recipients have is different from previous Healthy Ireland surveys. This means direct comparison with previous surveys is not possible.*

Type of illness, health condition, or disability care recipients are reported to have by age (%)

	Age of care recipient		
	30 or younger	31-60	>60
Difficulties relating to age	4	10	52
A difficulty with basic physical activities such as walking climbing stairs reaching lifting or carrying	15	20	33
A difficulty with pain breathing or any other chronic illness or condition	14	20	21
A difficulty with learning remembering or concentrating	24	8	10
A psychological or emotional condition or a mental health issue	19	15	7
An intellectual disability	31	13	4
Blindness or a vision impairment	3	4	4
Deafness or a hearing impairment	1	3	4
Brain disorders - Dementia/Alzheimer's/Parkinsons/Motor Neuron/Stroke/MS/ Epilepsy	<1	2	1
Addiction	<1	1	<1
Other	41	46	24

Time dedicated to care

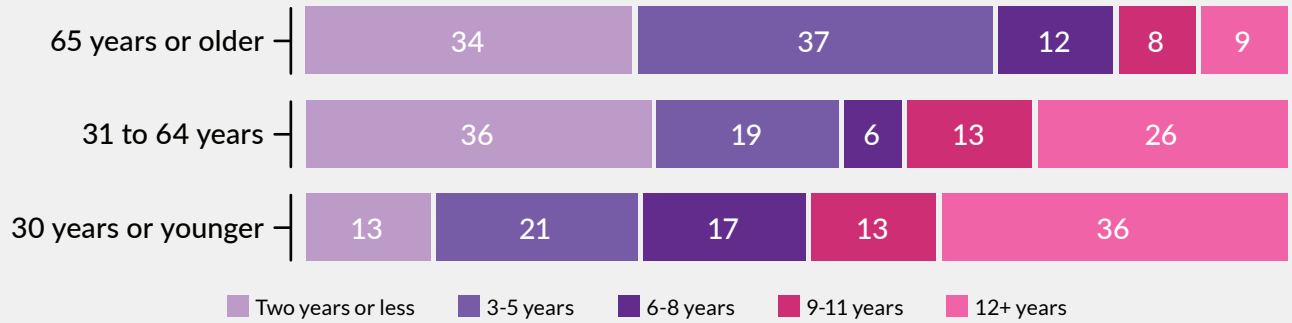
- 24% of carers say they provide around the clock care for someone they live with. This is highest among those aged 75 and over (Total 75+: 62%, Men 75+: 55%, Women 75+: 69%).
- 28% of carers have been providing care to someone for 2 years or less and 17% have been providing care to someone for 12 years or longer.

Number of years carers have been providing care to someone[5] (%)

[5] *When a carer provided care to multiple people, we used the highest number of years they have been providing care to someone. In other words, if a respondent has been providing care to someone for 2 years and someone for 5 years, they are recorded as providing care to someone for 5 years.*

- On average, care recipients age 65 or older (average of 5.2 years) have been receiving care for less time than younger care recipients (31 to 64: average of 10 years, 30 or younger: average of 10.2 years).

Number of years[6] carers have been providing care to someone (%)



Forms of support provided by carers

- The most common forms of support that carers say they provide as part of their caring responsibilities are emotional support (66%), transport (58%), cooking (53%) and cleaning (48%).

- There was a significant gender imbalance in types of support provided. Women are more likely than men to report providing support across most categories of care.

Form of support carers say they provide to a friend or family member with a long-term illness, health problem or disability (%)

	Total	Men	Women
Emotional support - social visit/keep company	66	59	70
Transport	58	55	59
Cooking	53	38	62
Cleaning	48	40	53
Medical	39	28	46
Administrative	38	34	40
Washing	37	28	42
Dressing	29	22	34
Feeding	24	20	27
Financial	20	20	20
Other	15	14	15

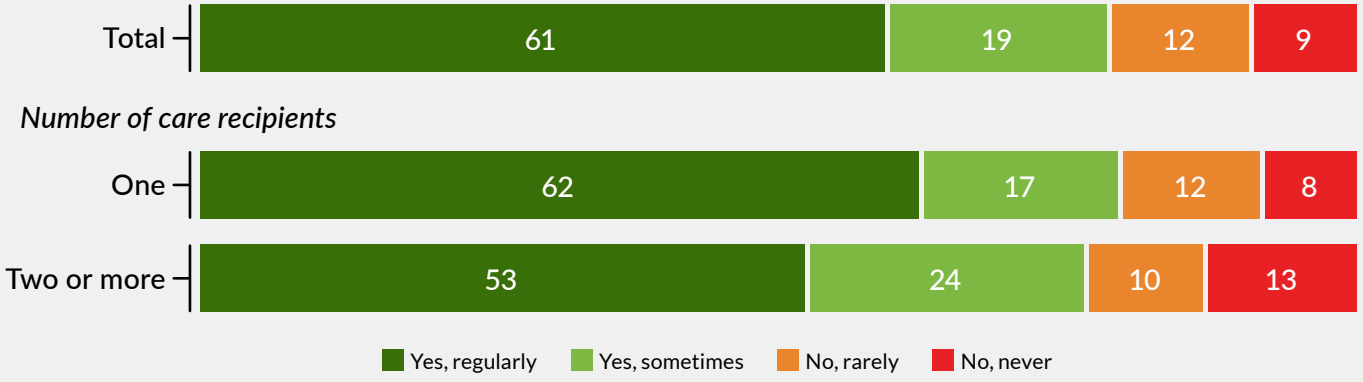
[6] *Carers provided estimates to the nearest year. For example, if a carer said they have been providing care to someone for 2 years and 7 months, this was recorded as 3 years.*

Ability to cope with caring responsibilities

- 61% of carers feel they regularly get adequate breaks from their caring responsibilities, with a further 19% saying they sometimes do. However, 21% of carers say they rarely (12%) or never (9%) get adequate breaks from their caring role.

- Carers who care for more than one person (53%) are less likely to say they regularly have adequate breaks from their caring responsibilities than those that care for one person (62%).

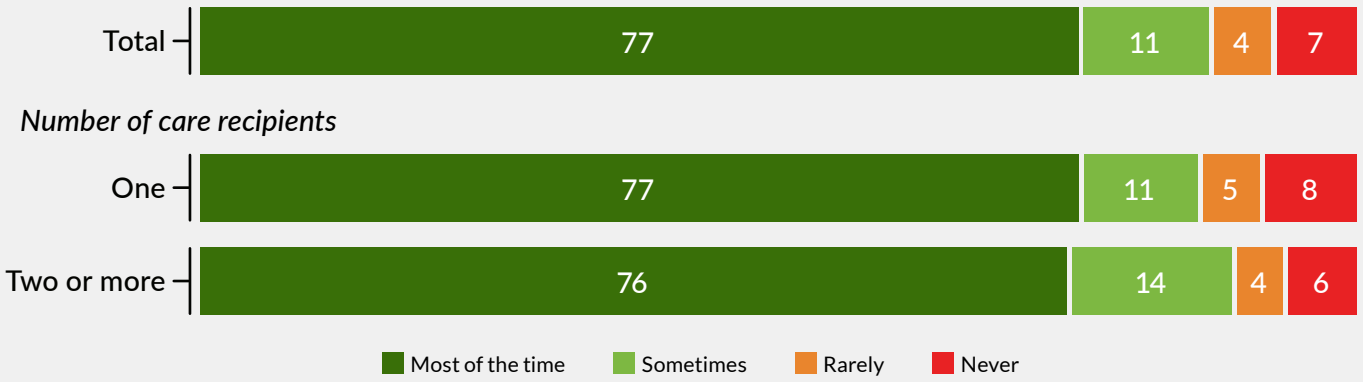
Extent carers feel they have adequate breaks from caring their responsibilities (%)



- 77% of carers feel they can cope with their caring responsibilities most of the time, while 11% say they can cope sometimes. The remaining 11% say they feel they can rarely (4%) or never (7%) cope with their caring role.

- Men (13%) are more likely than women (4%) to say they are never able to cope with their caring responsibilities.

Extent carers feel they can cope with their caring responsibilities (%)



10. Women & Caring Responsibilities

10. Women & Caring Responsibilities

Summary

- This section explores the caregiving responsibilities of mid-life women carers. This term is being used for ease of reference and is defined as women aged between 35 and 54. It considers their caring responsibilities and the impact it has on their health and wellbeing. It explores caregiving in two contexts – firstly solely as a parent, and secondly those with additional caregiving role to another family member or friend ("parent-carer").

- Women comprise 60% of all carers, rising to 65% among parent-carers; midlife women account for 27% of adult carers and 55% of parent-carers. Among women aged 35–54, 18% care for another family member or friend and 12% are also a parent; higher than men of the same age (11% and 7%).

- While the number of hours of care provided is lower than for carers overall (31.9 hours per week vs. 51.4 hours among carers overall), paid employment is more common among mid-life women carers (72% are in paid work vs. 58% of carers overall). It also indicates that they are almost as likely as women of the same age generally to be in paid employment (75%).

- Self-reported good health is similar to other women in this age group, but longstanding illness is slightly higher (40% vs. 37% among all women 35-54).

- Health behaviours are mixed: 13% of midlife women carers smoke and 5% use e-cigarettes. This is in line with other women of the same age. However, alcohol consumption is higher: 25% of mid-life women carers drink several times a week (vs. 18% of all women in this age group). Also, 22% of mid-life women carers who drink, binge drink on a typical occasion (vs. 17% of all women in this age group).

- Mid-life women carers also report poorer quality sleep with 52% reporting good/very good sleep compared to 61% generally among mid-life women.

Introduction

The 2024 survey report included a section exploring the caregiving responsibilities that many parents have in addition to their regular parental responsibilities. It identified that a significant proportion (17%) of parents also provide additional care to a friend or family member with a long-term illness, health problem or disability, including due to old age. This is higher than in the general population with 14% overall reporting that they are a carer.

Caring responsibilities, although essential and fulfilling, often add extra stress on carers, forcing them to balance personal priorities. This stress can lead to neglect of self-care, negatively impacting their health.

This analysis found that parent-carers, despite reporting similar levels of good health to parents at large, face distinct health challenges. They are more likely to suffer from longstanding illnesses, such as asthma, and experience greater limitations in daily activities. Mental health issues are also more prevalent among caregivers, with a higher prevalence of probable mental health problems.

Broader lifestyle challenges were also identified in the 2024 analysis; while obesity rates are comparable, family commitments hinder physical activity more for caregivers, and they smoke more but express a stronger desire to quit. Alcohol consumption is notably lower. Additionally, caregivers in 2024 report significant disturbances in sleep quality and quantity, indicating a need for targeted support to address these specific health hurdles.

The analysis also found that the majority (64%) of parent-carers were women, with 84% aged between 35 and 54. This year's report takes a specific focus on this cohort looking at women aged between 35 and 54 in respect of their caring responsibilities and the impact it has on their health and wellbeing. For ease of reporting this group is described as midlife women carers throughout.

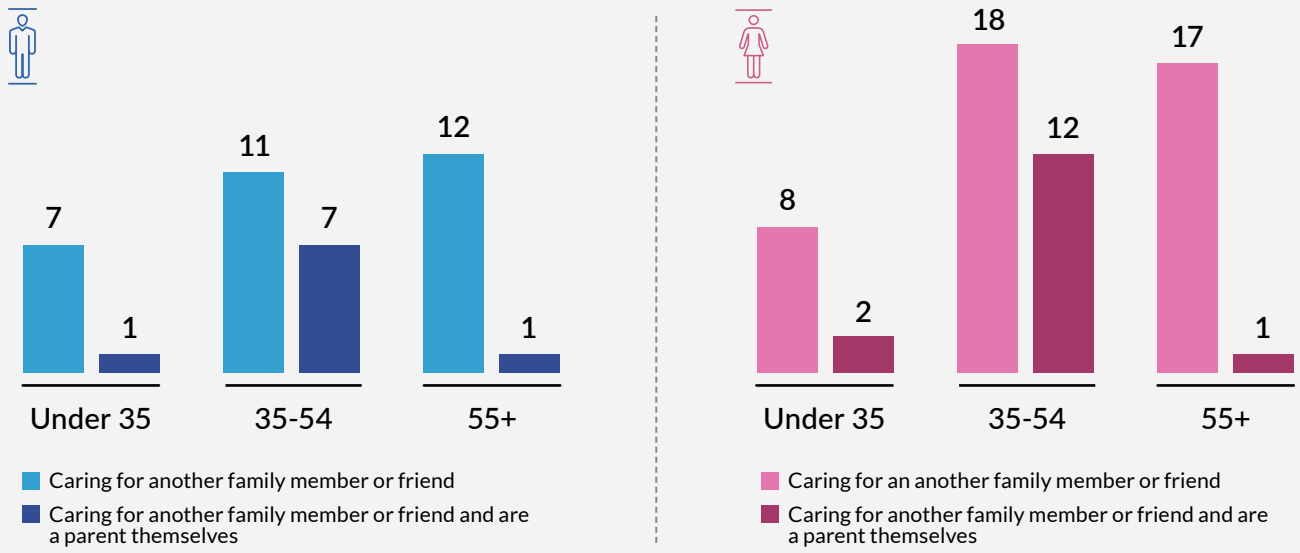
Characteristics of midlife women carers

Analysis of caring responsibilities overall identifies that 30% of adults have a child under the age of 18, while 12% undertake the responsibility of caring for another family member or friend. Notably, 4% manage both these demanding roles simultaneously.

An important consideration is the significant contribution of women, who make up 60% of carers overall. This representation increases further to 65% when considering women who also have parenting duties. Within this group, women aged between 35 to 54 years emerge as pivotal contributors, as they constitute 27% of caring for other family members or friends and a striking 55% among those are both parents and carers for another family member or friend. These figures highlight the extensive involvement of midlife women in the intricate balance of caregiving responsibilities.

Looking at it from another perspective, 18% of all women aged between 35 and 54 are involved in caregiving for another family member or friend. Furthermore, 12% are immersed in the dual responsibility of managing both parenting and caregiving for another family member or friend. These statistics reveal a broader engagement compared to their male counterparts within the same age group, where 11% are caregivers for another family member or friend, and 7% play both roles.

Caring responsibilities by gender and age (%)



Midlife women carers of non-child family members or friends dedicate an average of 31.9 hours weekly to their caregiving duties, while those who are also parents spend slightly less time at 29.7 hours, not including their parenting responsibilities. This is less than the typical 51.4 hours per week spent by carers in general. Additionally, fewer midlife women carers (13%) provide constant care for someone they live with compared to carers in general (24%). Regarding breaks from caregiving, about 59% of midlife women carers overall – similar to the 58% who are also parents – feel they receive adequate breaks, which is close to the 61% seen among all carers.

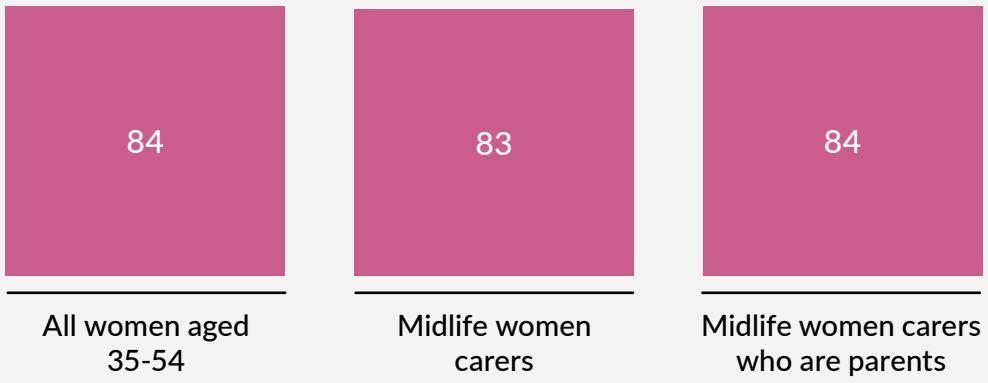
However, an additional layer to consider is that 72% of these women manage to balance their caregiving obligations with paid employment, highlighting their multifaceted roles and the challenges therein. This is close to the overall average among women in this age group with 75% of all women in this age group in paid employment. It is also higher than the employment rate of carers generally (58%). This is reflective of the fact that many carers are older and have retired from paid employment.

The dual engagement in both employment and caregiving is more pronounced in this demographic, setting them apart from other groups in terms of workload and responsibility.

Midlife Women Carers and their own Physical Health

Midlife women carers of non-child family members or friends exhibit similar self-rated good health levels, with 83% reporting good health. This closely aligns with both midlife women carers who are also parents at 84%, and the general population of women aged 35 to 54 at the same percentage. In terms of long-standing illnesses, 40% of midlife women carers report this, slightly higher than the 38% of those who are also parents within this group and above the 37% of general women in the same age range.

Proportion of midlife women rating their health as good or very good (%)



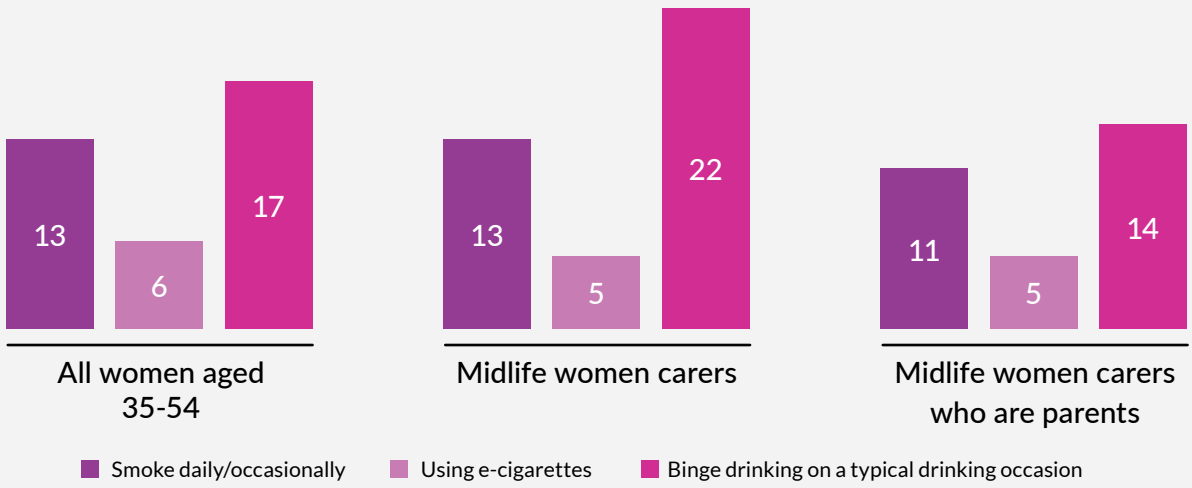
Concerning long-term health conditions confirmed by a medical diagnosis, 41% of midlife women carers are affected. This incidence slightly exceeds the 38% reported by those who also shoulder parental responsibilities, which is aligned with the 38% prevalence in the general female population of this age category.

When examining specific health conditions, differences are minor. For example, thyroid issues affect 6% of midlife women carers of non-child family members or friends who are parents, compared to 4% of carers and 2% of all women aged 35 to 54. Similarly, 6% of midlife women carers with parenting duties report emotional or psychiatric issues, compared to 5% of carers and 4% of all women in this age group.

Midlife Women Carers and Healthy Lifestyles

The proportion of midlife women carers of non-child family members or friends who smoke is 13%. This figure closely aligns with the smoking rates for women aged 35 to 54 in general but is slightly higher when compared to the 11% observed among those who simultaneously manage their caregiving and parenting roles. The usage of e-cigarettes remains consistent at 5% among midlife women carers as well as those who are both parents and carers. This is generally aligned with the 6% recorded within the broader demographic of women in the same age bracket. When examining alcohol consumption, further complexities emerge. Notably, 25% of midlife women carers report consuming alcohol several times a week, aligned with the 24% documented among dual-role individuals – those who engage in both caregiving and parenting. However, this is notably higher than the 18% among the general population of women aged 35-54. Furthermore, 22% of midlife women carers of non-child family members or friends who drink alcohol engage in binge drinking on a typical occasion. This is a noteworthy difference from the 14% identified among those managing both caregiving and parenting responsibilities, and it slightly exceeds the 17% measured in the general cohort of women this age.

Proportion of midlife women who smoke, use e-cigarettes, and binge drink on a typical occasion (%)



One lifestyle aspect where significant differences emerge is in terms of sleep habits. Midlife women carers of non-child family members or friends rate their sleep quality much lower than general with 52% reporting their sleep quality as good or very good. A slightly higher proportion (56%) of midlife women carers who are also parents rate their sleep quality as good. In both cases this is behind the 61% of women generally in this age group reporting good sleep.

Analysis of the reported number of hours slept on an average weeknight shows that both midlife women carers of non-child family members or friends with and without children sleep an average of 6.6 hours per night, compared with an average of 6.8 hours generally among women in this age group.

CCCSÉ
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Irish Statistical System Code of Practice

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11. Health Service Utilisation

11. Health Service Utilisation

General Practitioner (GP) Usage

- 80% of people report having visited a GP in the previous 12 months, with an average of 4.1 visits per person among all aged 15 and older. This average includes those who have not visited a GP.

- The proportion of people who said they attended a GP in the previous 12 months is now at the highest point since reporting began in 2015. This new peak follows a consistent, year-on-year rise that began in 2021, reversing a temporary drop caused by necessary pandemic restrictions in place at the time.

GP attendance by year

	2015	2016	2018	2019	2021	2022	2023	2024	2025
All									
% attending a GP in previous 12 months	71	72	74	73	66	71	76	79	80
Average number of visits per person	4.3	4.5	3.8	4.5	3.3	3.8	4.0	4.4	4.1
Men									
% attending a GP in previous 12 months	66	67	68	68	60	64	70	74	74
Average number of visits per person	3.6	3.8	3.3	3.5	2.8	3.3	3.1	3.7	3.4
Women									
% attending a GP in previous 12 months	77	78	79	79	72	78	83	85	86
Average number of visits per person	5.0	5.2	4.3	5.5	3.9	4.3	4.9	5.1	4.8

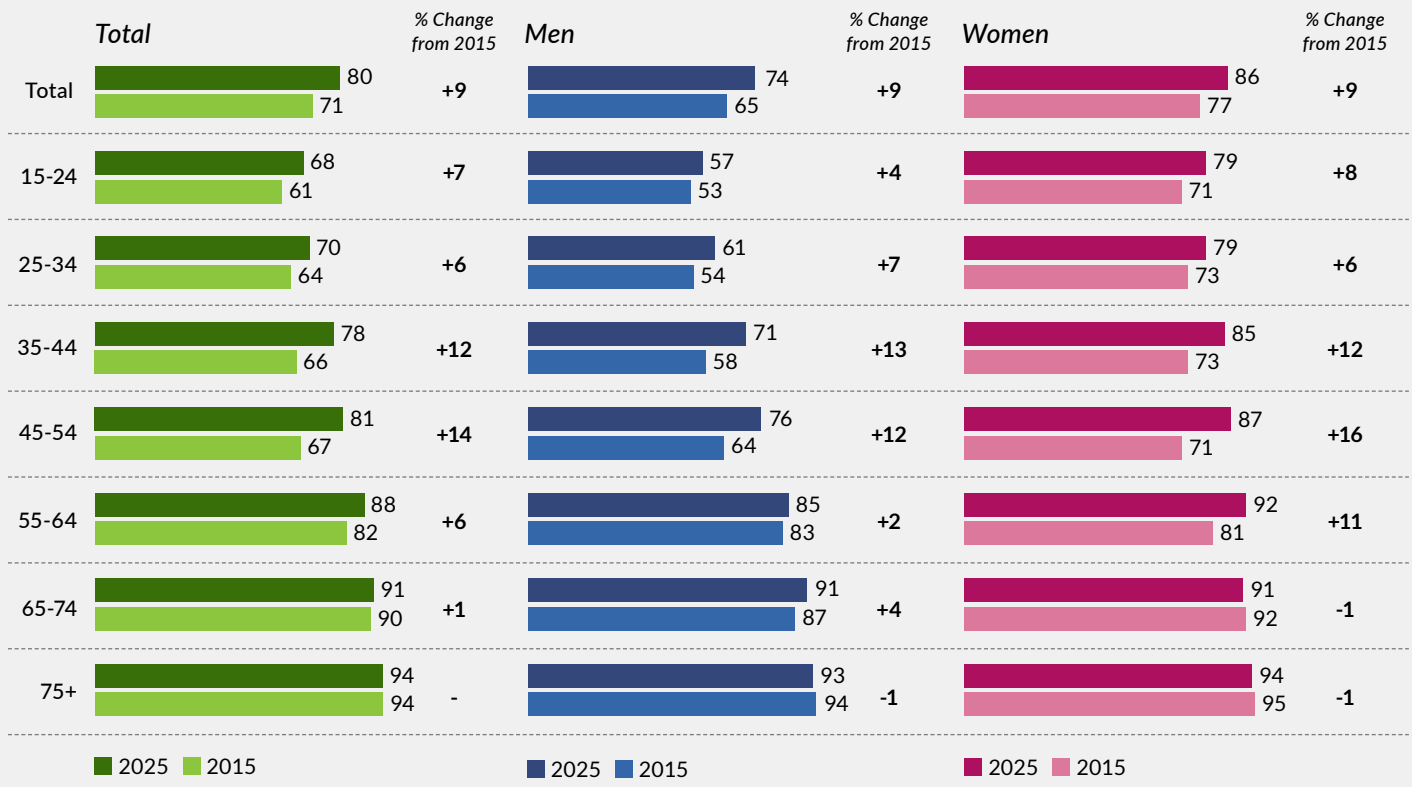
- The proportion of both genders visiting the GP is broadly unchanged since last year with women remaining more likely than men to have visited a GP during the past 12 months (women: 86%, men: 74%).

- Equally, as with previous years the persistent gender gap remains up to the age of 55, with broadly equal levels of GP attendance above this age.

- Compared with 2015, the proportion visiting a GP has increased across all age groups up to the age of 65. The most notable increase is among those aged between 35 and 54, with women aged 45 to 54 showing a largest increase during this period (2015: 71%, 2025: 87%).

- The increases are broadly the same across both men and women.

GP attendance by gender, age and year (%)



- 88% of those with a full medical card and 90% of those with a GP visit card attended a GP in the previous 12 months, with an average of 6.2 and 4.8 visits respectively. This compares to 74% among private patients with an average of 2.9 visits.
- Those with a GP visit card show the largest increase in GP attendance since 2015, with a 17-point increase to 90%. The proportion of those with a medical card attending a GP has also increased, by 6 points to 88%.
- The proportion of private patients visiting a GP has increased by 3 points from 2015 (2015: 71%, 2025: 74%).

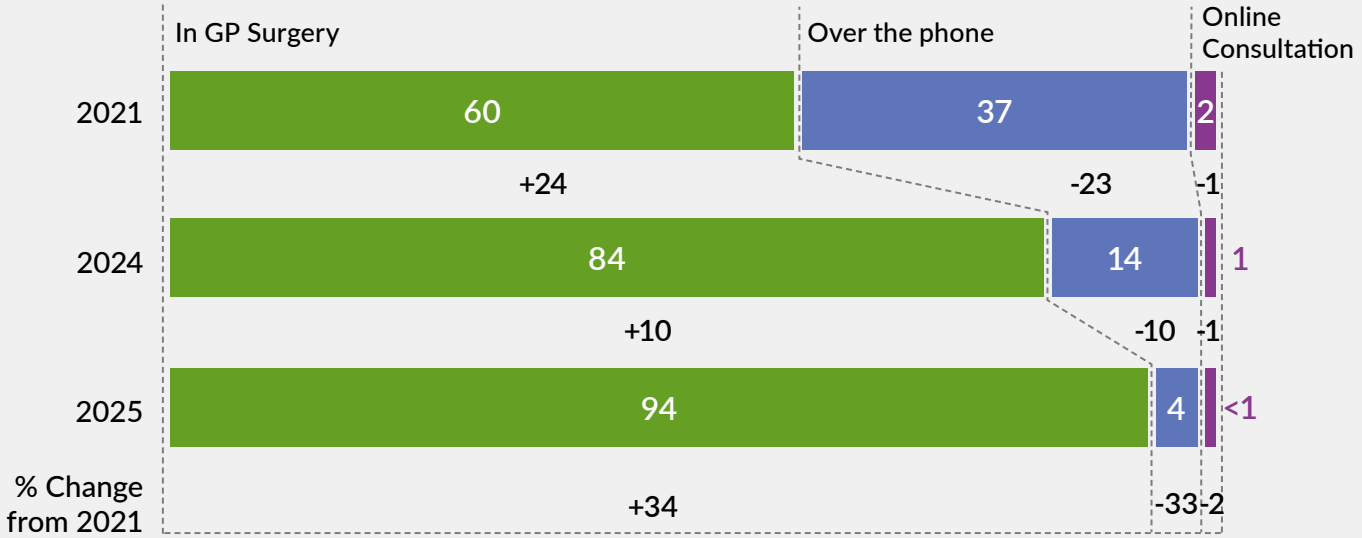
GP attendance among medical card, GP visit card and private patients (%)

	2015	2016	2018	2019	2021	2022	2023	2024	2025
Medical Card									
% attending a GP in previous 12 months	82	85	84	85	76	82	85	89	88
Average number of visits per person	6.3	7.6	6.2	7.6	4.9	5.6	5.8	6.7	6.2
GP Visit Card									
% attending a GP in previous 12 months	73	74	75	82	74	77	80	87	90
Average number of visits per person	4.4	4.1	3.6	4.6	4.2	4.6	3.8	4.3	4.8
Private Patient									
% attending a GP in previous 12 months	71	64	67	67	52	64	72	73	74
Average number of visits per person	2.9	2.6	2.4	2.9	2.4	2.8	3.1	3.2	2.9

- Respondents were asked to identify the location of their most recent GP consultation. 94% of those attending a GP reported that their most recent consultation took place in a GP surgery, with 4% reporting that it took place over the phone and less than 1% reporting an online consultation.

- The proportion of consultations taking place at the GP surgery has risen significantly from 2021 (60%), when in person attendance was temporarily curtailed by the necessary public health restrictions in place at the time.

Location of GP visit (%)



Referrals to other healthcare professionals

- This year's survey included a new module in relation to referrals to other healthcare professionals. Respondents were asked if they were referred by any healthcare professional to another healthcare professional in the past 12 months (for example, a consultant, physiotherapist, psychologist etc.).

- Those who had received a referral were asked about their most recent referral. This included whether or not they had already been seen by that professional, the length of the wait time for an appointment and whether they were referred to a public or private service.

- In total, 37% have been referred to another healthcare professional. The extent of referrals is higher among women (43%), than men (31%).

Referrals to other healthcare professionals in past 12 months by age and gender (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Total	37	31	30	36	38	42	48	36
Men	31	23	24	31	29	39	40	38
Women	43	39	37	40	47	46	54	34

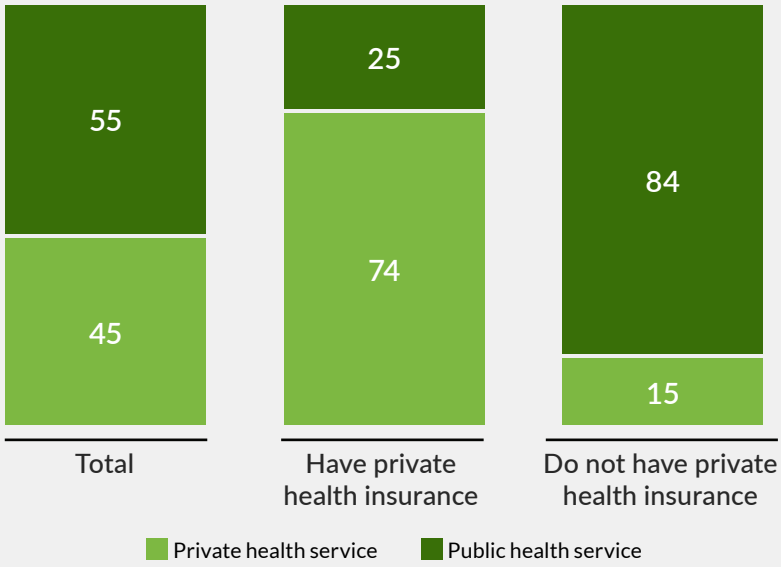
- Referrals are most common among those aged between 65 and 74, with 48% referred to another healthcare professional during the previous 12 months. A majority (54%) of women in this age group have received a referral, compared with 40% of men.

- Across all age groups, women are more likely than men to have received a referral. The only exception is among those aged 75 and older, with 38% of men in this age group receiving a referral, compared with 34% of women.

- Those with a medical card and GP visit card are most likely to have received referrals (44% and 46% respectively). 32% of private patients have received a referral.

- There is no difference between those with and without private health insurance, with 37% of both groups being referred to another healthcare professional.

Service referred to by ownership of health insurance (%)



- 55% of referrals were made to a public service, and 45% to a private service. The majority (74%) of those with private health insurance were referred to a private service, and the majority (84%) without private health insurance were referred to a public service.

- Of those who received a referral in the past 12 months, 75% have already been seen by the healthcare provider they were referred to, with 25% still waiting to be seen. Those referred to a public service are more likely to still be waiting compared with those referred to a private service. Of those referred to a public service, 52% are still waiting to be seen compared with 26% of those referred to a private service.

Extent and length of waiting by service referred to (%)[1]

	Service referred to					
	Total		Public		Private	
	Already seen	Still waiting to be seen	Already seen	Still waiting to be seen	Already seen	Still waiting to be seen
Incidence	75	25	49	52	74	26
Average wait time	3.1 months	6.7 months	4.4 months	7.6 months	1.9 months	3.7 months
% waiting 12 months or longer	5	20	10	22	1	10

- The incidence of not having yet been seen is highest among those without health insurance (33%). Also, 28% of women who received a referral are still waiting to be seen, compared with 21% of men.

- The average wait time for those who have been seen by the healthcare professional they were referred to is 3.1 months. This rises to 4.3 months for those without private health insurance compared with 2.1 months for those with private health insurance.

- The average wait time for those not yet seen by the professional they have been referred to is 6.7 months. This rises to 7.6 months for those referred to a public service and reduces to 3.7 months for those referred to a private service.

Other healthcare services used

- Respondents were asked if they used a selection of different healthcare services, including public health/community nursing, chronic disease management or community intervention team services, and vaccination or screening services (e.g. Cervical Check Bowel Screen Breast Check flu vaccine).

- 6% report using public health/ community nursing, 3% report using chronic disease management or community intervention team services, and 34% said they used vaccination or screening services. Usage of vaccination or screening services is higher among women (38%) than men (30%).

- Usage of public health/ community nursing is higher among those aged 75 and older (11%). Similarly, use of vaccination or screening services is higher among those aged 55 and older.

[1] *Some figures do not add up to 100 due to rounding.*

Other healthcare services used by age and gender (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Public health/community nursing								
Total	6	4	7	6	4	5	7	11
Men	6	4	7	4	4	7	9	12
Women	6	5	8	8	5	4	5	10
Chronic disease management or community intervention team services								
Total	3	1	2	2	3	4	4	4
Men	2	1	1	2	2	4	3	5
Women	3	2	2	2	3	4	4	3
Vaccination or screening services								
Total	34	17	26	27	33	47	52	56
Men	30	20	18	23	27	39	53	56
Women	38	14	33	32	40	55	51	56

- Respondents were also asked to report whether or not they had used primary/community care services or dentists/orthodontists during the previous 12 months. This excludes any services reported above (e.g. specific referrals received).

- Overall, 39% report using dentists/orthodontists, and 18% report using primary/community care. For both services, usage is higher among women (42% and 21% respectively) than men (37% and 15% respectively).

- Usage of primary/community care services is broadly similar across all age groups, with usage of dentists/orthodontists higher among those aged under 65 than those older than this.

Other healthcare services used by age and gender (%)

	Total	15-24	25-34	35-44	45-54	55-64	65-74	75+
Usage of dentists/orthodontists								
Total	39	44	37	40	41	43	37	27
Men	37	46	35	38	35	38	34	27
Women	42	41	39	42	47	49	39	27
Usage of primary/community care services								
Total	18	20	17	17	17	18	18	20
Men	15	19	14	13	13	13	16	19
Women	21	22	19	22	21	23	20	21

- Respondents were asked to indicate which healthcare service they have used most recently. Of the range of primary/community care services available, physiotherapy is the most used, with 42% of those accessing services during the past 12 months reporting that they used this service most recently. 14% used ophthalmology services and 13% accessed psychology/counselling services most recently.

- 31% of women aged between 15 and 34 who have accessed primary/community care services have used psychology/counselling services most recently, with 14% of men in the same age group using this service most recently.

Other healthcare services used most recently by age and gender (% of all accessing primary/community care in past 12 months)

		Men			Women		
	Total	15-34	35-54	55+	15-34	35-54	55+
Physiotherapy	42	53	52	45	27	35	45
Ophthalmology	14	12	8	13	13	18	17
Psychology/ Counselling	13	14	12	2	31	15	3
Dentist/Orthodontist	9	4	11	7	11	9	9
Dietetics	3	<1	2	8	1	4	4
Podiatry	3	2	2	4	1	2	6
Occupational Therapy	3	3	1	3	4	2	4
Audiology	2	<1	2	3	1	1	4

- Of those that have used a healthcare service in the past 12 months, 57% said they paid for this service. People without a medical card (71%) and/or private health insurance (71%) are more likely to say they paid for the healthcare service they received in the past 12 months.

- The median price paid for a healthcare service was €70.

Technical Details

Technical Details

The eleventh wave of the Healthy Ireland Survey was conducted between October 2024 and April 2025. The survey was conducted using an interviewer-administered questionnaire via telephone interviews on a nationally representative sample of 7,556 individuals aged 15 and over living in Ireland.

Ethical approval for the Healthy Ireland Survey was granted by the Research Ethics Committee at the Royal College of Physicians of Ireland. All personal data collected and used for the survey is stored securely by Ipsos B&A in their data centres and servers located within Ireland, the UK, and the European Economic Area, in compliance with the General Data Protection Regulation (GDPR). Ipsos B&A only retains this data for the duration necessary to support the research project and its findings.

This is the eleventh wave of the Healthy Ireland Survey, following nine previous waves conducted between 2015 and 2024. During the first six waves of the survey (2015-2019), data collection was conducted using in-person interviews in respondents' homes. The the sixth wave (2020) of the Health Ireland survey began with this in-person approach in October 2019, but it was discontinued due to the COVID-19 pandemic and resulting public health restrictions.

Starting with the seventh wave in 2021, the Department of Health and Ipsos B&A revised the survey methodology in response the pandemic restrictions, opting for a telephone administered interview approach using Random Digit Dialling (RDD). This method has been used for all surveys after 2020, including 2021, 2022, 2023, and 2024 surveys.

The previously published Healthy Ireland Summary reports and questionnaires from 2015 through to 2024 can be accessed through the following link: https://www.gov.ie/en/collection/231c02-healthy-ireland-survey-wave/

Telephone approach to Healthy Ireland Survey interviewing

When moving to telephone interviewing, the Department of Health and Ipsos B&A engaged in extensive consultations to ensure the revised methodology met key requirements of the survey. These included achieving a broad representation of the target population (aged 15+), employing robust random sampling techniques, maximising response rates, and ensuring accessibility for all population groups.

After careful consideration of the key requirements, a two-stage telephone approach using Random Digit Dialling (RDD) was implemented. A mobile-phone-only sampling frame was adopted due to the near-universal mobile phone ownership among Irish adults (98% of those aged 18 and over).

Employing a mobile-only approach mitigated potential biases inherent in mixed mobile and landline samples, where individuals with access to both devices have a higher probability of selection. Furthermore, the individual ownership of mobile handsets eliminates selection bias associated with shared household landlines.

A Random Digit Dialling approach is preferred to using lists of numbers, which may be limited by their coverage areas. RDD can result in some calls to non-working numbers which means some of the sample is wasted, however, this method of sampling ensures comprehensive area coverage when selecting mobile phone numbers

To minimise calls to non-working numbers and associated costs, the RDD process uses number blocks allocated to mobile operators by the Commission for Communications Regulation (ComReg). As an example, as ComReg does not issue any 083 prefixes beginning with 21 (e.g., 083 21XXXXX), this number series is excluded from the RDD sampling frame.

Ipsos B&A's trained Computer Assisted Telephone Interviewing (CATI) interviewers made calls to randomly generated mobile numbers. Ipsos B&A has CATI units in Blackrock and Milltown Co. Dublin and Belmullet. Mayo. To maximise response rates, up to three call attempts (including the initial call) were made at varying times and days throughout the week, if a number was not initially answered.

Once connected, the interviewer screens the respondent to confirm eligibility (aged 15 or older) and provides a brief introduction to the Healthy Ireland Survey topics. Potential participants are then asked if they are willing to participate in the survey. Those who agree are informed that a Healthy Ireland interviewer will conduct the survey interview via a follow-up call in the coming days. To maximise the comfort of participants in answering questions relating to menopause, all interviews with female respondents were conducted by female interviewers.

To maintain consistency and leverage the extensive experience of our CATI team, the majority of interviewers for this wave of the Healthy Ireland Survey were also involved in previous waves, including those conducted in person prior to the 2021 survey. This ensured the current wave benefited from the team's long-standing experience on the project.

Prior to commencing the interview, interviewers obtained informed consent from respondents who agreed to participate. For participants aged under 18, informed parental consent was also obtained.

Limitations of the Telephone Approach to the Healthy Ireland Survey

Two key limitations arise from the telephone-based interviewing approach compared to the face-to-face approach previously used in the Healthy Ireland Survey.

First, reporting by deprivation index is no longer feasible. Before 2021, the Healthy Ireland Survey included reporting based on the Pobal HP Deprivation Index, developed by Haase and Pratschke. The Pobal HP Deprivation Index 2011 was used for wave 1 to 3 and the Pobal HP Deprivation Index 2016 was used for wave 4 and 5. This index uses the census data and CSO Small Area codes (CSAs) derived from exact addresses to assess the relative affluence or disadvantage of geographic areas. As accurate CSA assignment requires Eircodes (and postal addresses are insufficient due to inconsistencies and shared addresses, particularly in rural areas), this analysis was only possible during the in-person interview phase of the survey (2015-2019).

To mitigate this limitation, respondents were asked to provide their Eircode. A clear explanation for why this information was requested was given to each respondent. However, only 56% of respondents provided their Eircode, and on inspection some of the Eircode information was found to be invalid, meaning that the majority could not be assigned accurately to the deprivation index. This contrasts sharply with the face-to-face interviews (pre-2021), where 100% of respondents had an assigned Eircode. Due to this lower response rate, analysis by deprivation index is considered unreliable and is therefore omitted from this report. This contrasts sharply with the face-to-face interviews (pre-2021), where 100% of respondents had an assigned Eircode. Due to this lower response rate, analysis by deprivation index is considered unreliable and is therefore omitted from this report.

Instead, at the end of the telephone interview, respondents were asked whether they would be willing to complete an optional module on suicide/cannabis. Those who opted to participate were asked for an email address to receive a link to an online version of the survey module. Those who opted in received an email invitation a few days later, followed by a reminder email approximately one week later if they had not yet completed the survey.

To safeguard respondent wellbeing, contact information for GPs and support services were provided at the open and close of the online survey for anyone affected by the survey's content.

Survey Response Rates

As with each wave since 2021, this wave of the survey followed a two-stage telephone sampling process, as previously outlined. The breakdown of outcomes at each stage are provided below.

			Percentage of known eligible numbers
Stage 1 - Screening	Working telephone numbers	33,841	
	Refusal at stage 1	3,330	10%
	Recruited to stage 2	12,494	37%

			Percentage of known eligible numbers
Stage 2 – Consent and interview	Completed interviews	7,557	22%
	Refusal at stage 2	1,798	5%
	No contact after 3 attempts	442	1%
	Ineligible (unwilling to provide consent, claimed age under 15)	2,697	8%

The survey participation rate (the percentage of individuals agreeing to take part in the survey at stage one, who fully complete a survey at stage two) is 60% (7,556 divided by 12,494).

All respondents were asked if they had used cannabis in the past 12 months. Those that said 'yes' were asked if they were willing to provide their email and completed an online survey module on their cannabis use. Of the 420 respondents that were eligible to complete this module, 66 (16%) provided their email and completed the module. As this sample size is insufficient for meaningful analysis, the results are not presented in this report.

Potential Mode Effects

A key strength of the Healthy Ireland Survey lies in its long-term tracking of health behaviours, enabling assessment of policy initiatives' impact. This is achieved through robust and consistent measurement, facilitating reliable comparisons between survey waves. While both face-to-face and telephone methodologies provide accurate population-level data, it's important to consider their differences and how switching between them might influence observed trends.

When transitioning from face-to-face to telephone interviewing, substantial efforts were made to maximise compatibility with previous waves of the Healthy Ireland Survey. These included a thorough questionnaire review by experienced researchers at Ipsos B&A and the Department of Health, along with pilot testing and cognitive testing of the revised survey instrument.

While significant efforts were made to maintain comparability between the face-to-face and telephone survey methodologies, some impact on observed trends is inevitable. It can be difficult to distinguish genuine changes in behaviour from the "noise" introduced by this methodological shift. Two specific mode effects – social desirability and satisficing – warrant consideration when interpreting the survey results.

Social desirability bias, where respondents provide socially acceptable answers rather than truthfulness, can be more pronounced in telephone surveys. This is attributed to the reduced rapport between interviewer and respondent compared to face-to-face interactions, potentially making respondents less likely to disclose socially undesirable behaviours. Satisficing, where respondents provide convenient or easily accessible answers without fully considering the question, is more prevalent in telephone surveys due to the less engaging interaction with the interviewer. The relative discomfort of silences and pauses during a telephone interview may lead respondents to answer more quickly and with less consideration.

Our interviewers are trained and experienced in conducting telephone interviews and make an effort to build rapport and gain the trust of respondents when conducting telephone interviews. These efforts help to minimise the impact of mode effects such as social desirability bias and satisficing, but this does not guarantee these effects are eliminated.

A practical challenge introduced by the shift to telephone interviewing was the inability to use showcards, which were previously employed to present answer categories during the survey (e.g., lists of long-term health conditions). Telephone surveys rely on aural communication, and reading out extensive answer lists has been shown to negatively impact respondent engagement. Consequently, questions previously reliant on showcards had to be modified for the telephone approach to interviewing.

This change required a comprehensive questionnaire redesign and testing process, resulting in a revised instrument. This adaptation process has been repeated annually as modules originally designed for in-person interviews are modified for telephone administration, to do this some questions had to be asked in slightly different ways. Additionally, telephone questionnaires are generally shorter to maintain respondent engagement, and this is taken into consideration when the questionnaire is designed for each wave.

While researchers believe the steps taken have minimised the potential impact of mode effects, it remains possible that individual questions may not be fully comparable with previous waves using a face-to-face interview approach. Furthermore, the significant societal and behavioural changes during the COVID-19 pandemic add another layer of complexity, making it difficult to isolate genuine behavioural changes from those arising from the methodological shift.

Users of the survey data need to be conscious of the potential mode effects when considering trend data and comparing the findings of survey waves 2021 to 2025 against those conducted in 2015 to 2019.

Data Cleaning and Validation

The interviewing software used during fieldwork included automated survey routing and built-in logic checks. The use of this software minimises the need for extensive post-fieldwork data cleaning. To ensure the accuracy of the final data, thorough data checking and editing are performed on the interim and final data outputs, to identify any issues that were not caught during the fieldwork stage.

Survey validation was also conducted on a random selection of interviews across the fieldwork period. This involved re-contacting respondents and reviewing interview recordings to verify the interview process and assess its quality.

Data Weighting

While the sampling process aims to achieve a nationally representative sample, differential response rates mean the survey sample does not accurately reflect the demographic profile of the population. Non-response bias can occur in surveys if non-participants systematically differ from participants. For instance, young men are often less likely to participate in social research, necessitating adjustments for age and sex in weighting schemes. Weighting on known demographic factors (e.g., age, sex) helps mitigate potential biases in survey measurements. Therefore, data weighting is applied to align the respondent profile with the actual population profile.

This survey wave uses three weighting schemes: one for the main survey and two separate weights for the menopause and contraception modules.

Main survey weight

The main survey weight involves weighting adjustments that were made using known population statistics published by the Central Statistics Office (Census 2022 data and Labour Force Survey data from Q4 2024). The weighting variables used include age by gender, education, work status, and region.

This is the third wave of the Survey to be weighted using the results of Census 2022 (the data was also used to weight the 2023 and 2024 surveys). Previous waves would have used 2011-2016 Census results, depending on when the data was analysed. It is important to note that there has been significant demographic change in the population since the first wave of survey data was collected in 2014 and 2015.

Weights for Menopause and Contraception modules

A separate set of weights were used for the menopause and contraception modules to address differences in participation rates – the differences in participation rates compared to the main survey have been outlined earlier in this section.

Weighting was applied to adjust for non-response to each module. A logistic regression model was fitted for those respondents that were eligible to complete the module (e.g. for the menopause module, women aged 18 or older). The outcome variable was whether or not they agree to take part in the module. The covariates in the model were age, gender (contraception model only), education, work status, and region. The agreeing to take part weights were calculated as the reciprocal of the predicted probability estimated from the regression models. These weights were trimmed at the 0.25% tails to remove extreme values. The final weights for each module were then calculated by multiplying the agreeing to take part weights by the main survey weight. The weights were re-scaled so that the size of the final weight was the same as the achieved sample size.

Data Analysis and Reporting

This Healthy Ireland Survey summary report outlines the key findings and data trends from the eleventh wave of the survey. Where appropriate, the report compares data to the previous 10 waves of the survey[1]. During the data analysis and reporting stage for the previous Healthy Ireland Survey in 2023, it was agreed that all respondents who selected "Don't know" or "Refused" were removed from the sample at each question. This analysis step has been retained for the reporting of the eleventh wave of the survey. It is important to bear this analysis step in mind when analysing using the Healthy Ireland Survey data associated with this report.

[1] *except for wave 6 which wasn't completed due to the COVID-19 pandemic.*

Notes

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