

## Lifestyles

### Smoking

Unitary authority (UA)	Proportion (%)	Age-standardised ratio (Wales=100)	Significant?
Blaenau Gwent	30.1	111.4	High
Bridgend	26.3	97.3	Low
Caerphilly	27.2	99.8	Low
Cardiff	28.8	105.2	High
Carmarthenshire	26.3	98.8	Low
Ceredigion	24.2	90.8	Low
Conwy	25.5	100.7	High
Denbighshire	27.5	106.7	High
Flintshire	26.4	96.6	Low
Gwynedd	26.7	101.6	High
Isle of Anglesey	30.1	114.8	High
Merthyr Tydfil	31.2	114.6	High
Monmouthshire	23.8	87.9	Low
Neath Port Talbot	25.5	95.5	Low
Newport	27.3	101.2	High
Pembrokeshire	25.8	98.6	Low
Powys	22.2	82.7	Sig. Low
Rhondda Cynon Taff	29.3	107.1	High
Swansea	26.8	100.7	High
The Vale of Glamorgan	26.1	97.2	Low
Torfaen	27.3	101.4	High
Wrexham	25.1	91.7	Low
<b>Wales</b>	<b>26.8</b>	<b>100</b>	

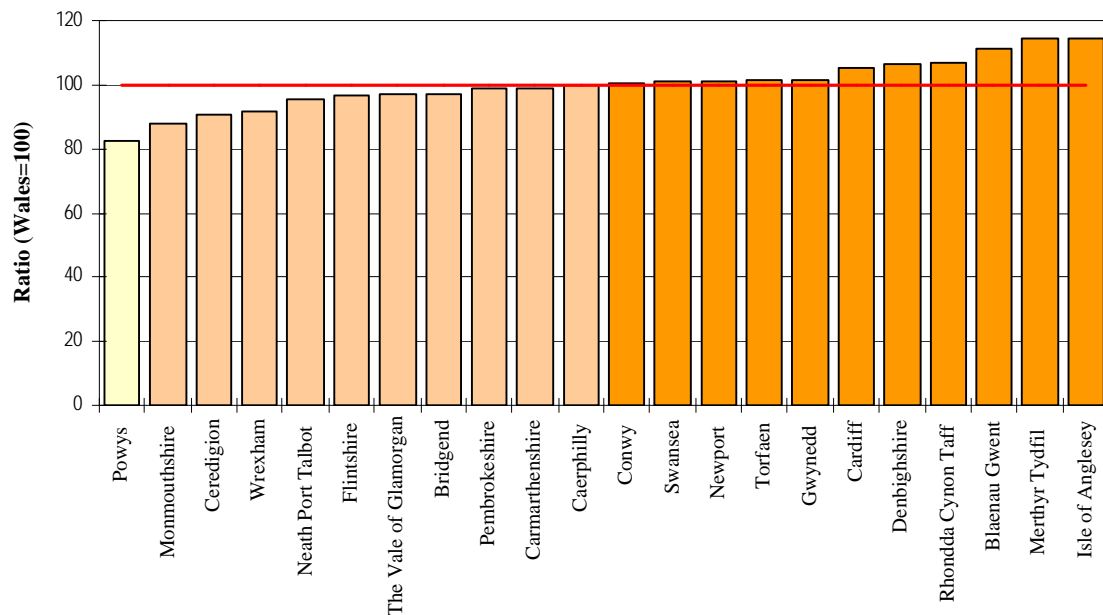
\*Source: Welsh health Survey 1998)

#### Age standardised ratios - residents who smoke

(daily or occasionally) (Wales=100) Data source: Welsh Health Survey 1998

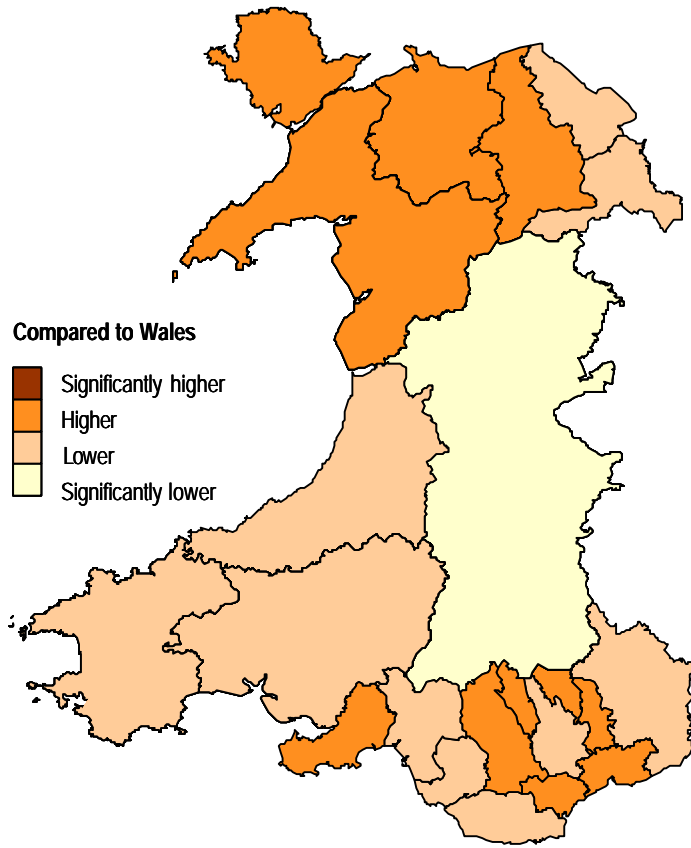
Compared to Wales

Significantly higher  
 Higher  
 Significantly lower  
 Lower



**Age standardised ratios (Wales=100)**  
**Residents who smoke (daily or occasionally)**

Data source: Welsh Health Survey 1998



## **Smoking and passive smoking in Cardiff**

### **Introduction**

There are around 13 million smokers in the UK and smoking kills over 120,000 of them each year.<sup>1</sup> This death rate translates to approximately 330 smokers per day. In 1998, the smoking rate among adults in Wales and in the rest of the UK was 27%. The average smokers life expectancy is shortened by around 8 years and a quarter of all smokers die before the age of 69 years.<sup>2</sup> Smoking is a major cause of increased illness and loss of life in lower socio-economic groups, being nearly four times more common among unskilled workers than professionals<sup>1</sup>. In Cardiff around 29%<sup>3</sup> of the overall population smoke, which is close to the national average of 27%.<sup>4</sup> However this figure conceals wide variations in prevalence in different socio-economic groups, ranging from about 16% in professional groups to about 37% in unskilled manual groups (UK figures). Data from the Cardiff Community Profile<sup>5</sup> confirms this picture in that the EDivs with the highest incidence of lung cancer are those in the more deprived areas: for e.g. the areas with a standardised incidence ratio for lung cancer of >130 are Caerau, Butetown, Splott, Rumney, Llandaff North, Llanrumney, Ely and Adamsdown. A survey of the community health status of the St Mellons area of Cardiff carried out in 1999 showed that higher levels of smoking compared to the rest of Wales with 44.4% smoking daily<sup>6</sup>

### **Black and Minority Ethnic Groups**

Cardiff has the highest Black and Minority Ethnic population in Wales. In most BME groups smoking prevalence is similar or less than the national average, apart from in Bangladeshi and African Caribbean men, where prevalence is estimated at 44% and 35% respectively.<sup>7</sup> Data from the 2001 census states that there are a total of 1,940 Black African and Caribbean males and 867 Bangladeshi males in Cardiff.<sup>7</sup> Smoking prevalence in Pakistani men is 26%, but in both Pakistani and Bangladeshi groups rates of cardiovascular diseases are 60-70% higher than in the general population, and death rates from CHD are 38% higher.<sup>9</sup> According to the 2001 census there are 1,273 Pakistani males in Cardiff.<sup>7</sup> The Health Survey for England found that knowledge of the main diseases associated with smoking is poor: only 47% of Pakistanis and 41% of Bangladeshis identified a link between smoking and lung cancer, and only 27% of Pakistanis and Bangladeshis associated smoking with heart disease. Attempts at giving up smoking were generally high, with 55% of Pakistani and 71% of Bangladeshi men who smoke having tried to quit at least once. However, success is limited, and only 21% of Pakistani and 19% of Bangladeshi men who had smoked regularly succeeded in giving up, compared to 54% of men in the general population.<sup>10</sup>

### **Pregnant women, babies and children**

Passive smoking is harmful to non smokers, particularly babies and children. Mothers who smoke when pregnant increase the risk to their babies of miscarriage, retarded growth and sudden infant death syndrome.<sup>11</sup> In the UK about 1 in 3 pregnant women smoke, i.e about 1,000 of the 3,000 women who give birth in Cardiff every year. Children exposed to passive smoking are more likely to suffer from lower respiratory illnesses and middle ear disease and it is estimated that in the UK today, 42 percent of children live in a household where at least one person smokes.<sup>12</sup>

### **Smoking in the workplace**

Passive smoking increases the risk of lung cancer and heart disease in adult non smokers by around 20-30% and 25-35% respectively. There is no safe level of exposure to second hand smoke and 11% of workers in Great Britain work in places with no smoking restrictions. Two of every five non smokers are exposed to tobacco smoke at work; and one in 5 are exposed either frequently or continually. Workers most likely to be exposed to second hand smoke are those in the lower income groups, especially manual workers and service sector staff.<sup>10</sup> In Cardiff there are an estimated 173,000 people in employment<sup>11</sup>, (about 40% of these being in commuters resident outside Cardiff)

### **Young people**

The most recent figures indicate that 29% of girls and 20% of boys in Wales are regular smokers. This means that over a quarter of Welsh 15 year olds are regular smokers<sup>12</sup>. With regards to experimentation with smoking, amongst girls it can be seen that there has been an increase in reported experimentation, particularly for 15-16 year olds. In 1986, 65 per cent of 15-16 year old girls reported having tried smoking; by 2000 this proportion was 74 per cent. The younger a person starts smoking, the more likely he or she is to smoke for longer and to die early from smoking<sup>1</sup>.

### **Service provision**

#### **Cardiff Health Alliance Tobacco Control Strategy**

The Tobacco Action Group is a partnership group of the Cardiff Health Alliance and includes representation from:-

- Cardiff Local Health Board
- Cardiff Council, Regulatory Services (Trading Standards and Public Protection)
- ASH (Action on Smoking and Health) in Wales
- Cardiff and Vale NHS Trust
- Cardiff Council, Youth Services

This group has developed a Tobacco Control Strategy for Cardiff, incorporating the requirements of Standard 1 of the National Service Framework (NSF) for Coronary Heart Disease (CHD)<sup>13</sup>.

### **Smoking Cessation Service**

Providing support to smokers who wish to quit has been demonstrated to be effective, significantly increasing quit rates. The most effective intervention for smoking cessation is a combination of pharmacological treatment used together with advice and support. The National Institute of Clinical Excellence (NICE) has recommended the use of bupropion (Zyban) and nicotine replacement therapy (NRT) for smokers who have expressed a desire to stop. NRT and bupropion roughly double the chances of success in stopping smoking. Behavioural support significantly increases the chances of success; broadly speaking, more support leads to higher cessation rates<sup>12,15,16</sup>. The Cardiff Stop Smoking Service is part of the Welsh Smoking Cessation Services funded by the Welsh Assembly Government, and is co-ordinated by the Public Health Directorate of Cardiff Local Health Board. The service is provided by one full time counsellor who provides practical support and advice to help smokers quit. The counsellor offers an initial one to one assessment session followed by group sessions from community bases (mainly health clinics) across the City, with the majority of clinics based in more deprived areas.

### **Role of primary care**

The evidence shows clearly that GP's and other primary care professional's play a crucial role by initiating and motivating quit attempts. Over 80% of the population visit their GP at least once a year, this figure being higher for smokers. The national smoking cessation service guidelines<sup>14, 15</sup> recommend that GPs raise the issue in consultation at least once a year with their smoking patients. If a patient presents with any illness that can be related to smoking, the subject should be raised and there is evidence that smokers are more receptive to anti-smoking advice under these circumstances. Brief advice from a GP routinely given to all patients who smoke leads to about 40% attempting to stop and about 5% stopping for at least six months. At present 6 practices are funded by Cardiff Local Health Board until March 2004 for extra Practise Nurse time to run smoking cessation clinics. In addition to this electronic guidance on tobacco policies, has been developed for practices.

### **Smoking and pregnancy**

In 1999 smoking prevalence in pregnancy was 30%, (RCP 2000)<sup>17</sup> representing a slight increase from previous figures of around 28% between 1992 – 1997<sup>18</sup> In Wales there is no current data on the number of pregnant women who smoke, but prevalence is estimated to be similar to England. A multi-agency smoking cessation in pregnancy working group, led by Cardiff and Vale Trust, continues to implement activity in order to decrease the percentage of pregnant women who smoke and the amount of infants exposed to environmental tobacco smoke in the home. Action has included the development of a smoking cessation care pathway from in midwifery and health visiting services, including robust departmental statistics, straining of midwives and health visitors in brief interventions in smoking cessation using motivational techniques, and liaison with primary care regarding NRT prescribing for pregnant women. There is a continued need for monitoring and review of the care pathway, training of midwives and health visitors in up-to-date practice and support to the development of standardised practice in NRT provision within primary care.

### **Adolescent smoking cessation scheme**

Research suggests that a substantial proportion of young people who smoke want to quit<sup>19, 20</sup>. According to the 1998 'Young Teenagers and Smoking'<sup>21</sup> report nearly half of all current smokers said they would like to give up smoking. In addition there is also evidence that many young people have attempted at least one quit attempt<sup>21</sup> The 2tuff.2puff adolescent smoking cessation scheme is funded by the Welsh Assembly Government and targets young people in areas of deprivation in a range of youth settings (e.g. youth centres, schools, colleges and Healthy Living Centres) across Cardiff. The overall aim of the scheme is to reduce smoking amongst young people aged fourteen to nineteen. The scheme is based around a series of six-one hour smoking cessation workshops. Peer groups of up to ten young people are recruited to closed workshops facilitated by a Health Promotion Specialist and partners in the settings.

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## Obesity

Unitary authority (UA)	Proportion (%)	Age-standardised ratio (Wales=100)	Significant?
Blaenau Gwent	19.2	118.1	High
Bridgend	17.4	109.7	High
Caerphilly	20.2	124.8	Sig. High
Cardiff	12.8	84.0	Sig. Low
Carmarthenshire	16.4	103.1	High
Ceredigion	14.7	98.2	Low
Conwy	12.8	81.9	Sig. Low
Denbighshire	15.6	98.2	Low
Flintshire	12.8	79.8	Sig. Low
Gwynedd	14.2	92.3	Low
Isle of Anglesey	15.7	95.9	Low
Merthyr Tydfil	18.6	114.6	High
Monmouthshire	14.9	93.9	Low
Neath Port Talbot	19.7	122.9	Sig. High
Newport	16.3	102.1	High
Pembrokeshire	16.3	101.9	High
Powys	14.3	90.2	Low
Rhondda Cynon Taff	18.5	119.2	Sig. High
Swansea	14.7	94.2	Low
The Vale of Glamorgan	13.6	85.4	Low
Torfaen	16.6	104.7	High
Wrexham	15.5	96.7	Low
<b>Wales</b>	<b>15.8</b>	<b>100</b>	

(Source: Welsh health Survey 1998)

### Age standardised ratios - residents who are obese i.e. BMI>=30

(Wales=100) Data source: Welsh Health Survey 1998

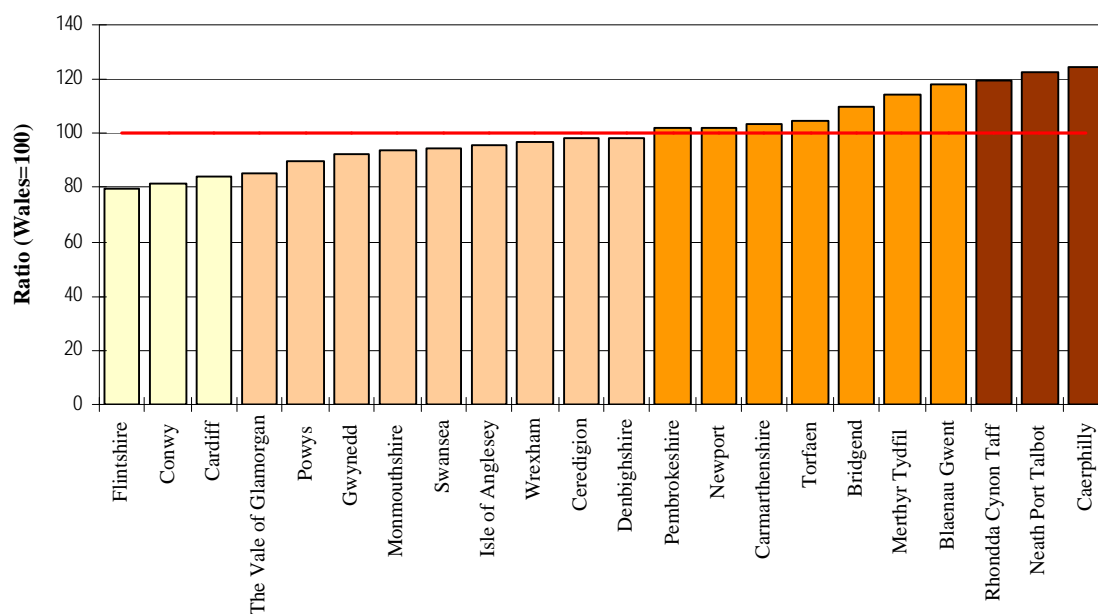
Compared to Wales

Significantly higher

Significantly lower

Higher

Lower





## Sexual Health

### Teenage conceptions

The National Assembly for Wales *A Strategic Framework for Promoting Sexual Health in Wales*<sup>1</sup> highlights teenage pregnancy as an important public health issue that requires to be addressed. Teenage parents and their children are more likely to experience health and social disadvantage.<sup>2</sup> Teenage pregnancy rates are higher in disadvantaged areas and amongst vulnerable young people including those who have been excluded from school and those in care.<sup>2</sup> Within the UK, Wales since 1974 has consistently had a higher rate of conceptions in 15 - 19 year olds compared with England.<sup>3</sup> Whilst under-age conceptions (13 - 15 year olds) since 1992 in Wales have been consistently higher and risen more rapidly than in England,<sup>3</sup> more recent statistics show that the drop in under-age conception rates between 1996 - 98 and 1999 - 2001 has been greater in Wales than in England, with a percentage drop of 18% and 10% respectively.<sup>4</sup> Taking a ten-year view the Office for National Statistics points out that within England and Wales as a whole teenage conceptions fell in the early 1990s, rose between 1995 and 1998, and dropped between 1999 and 2001.<sup>5</sup>

Considering data in Wales by unitary authority for under 16 conceptions from 1999 - 2001, Cardiff has a low rate compared to Wales and sits 11<sup>th</sup> out of 22 unitary authorities with a rate of 8.1 per 1000<sup>6</sup> (please refer to following table and graph). Please note that within the calculations below the numerator is for all females under 16 years of age whilst the denominator is for females aged 13-15. In addition, caution should be exercised when dealing with small numbers of events (see Appendix A for further details). Whilst numbers of births are available at the EDiv level for the various age groups within Cardiff, they are statistically too small to be used as the basis for meaningful policy recommendations.

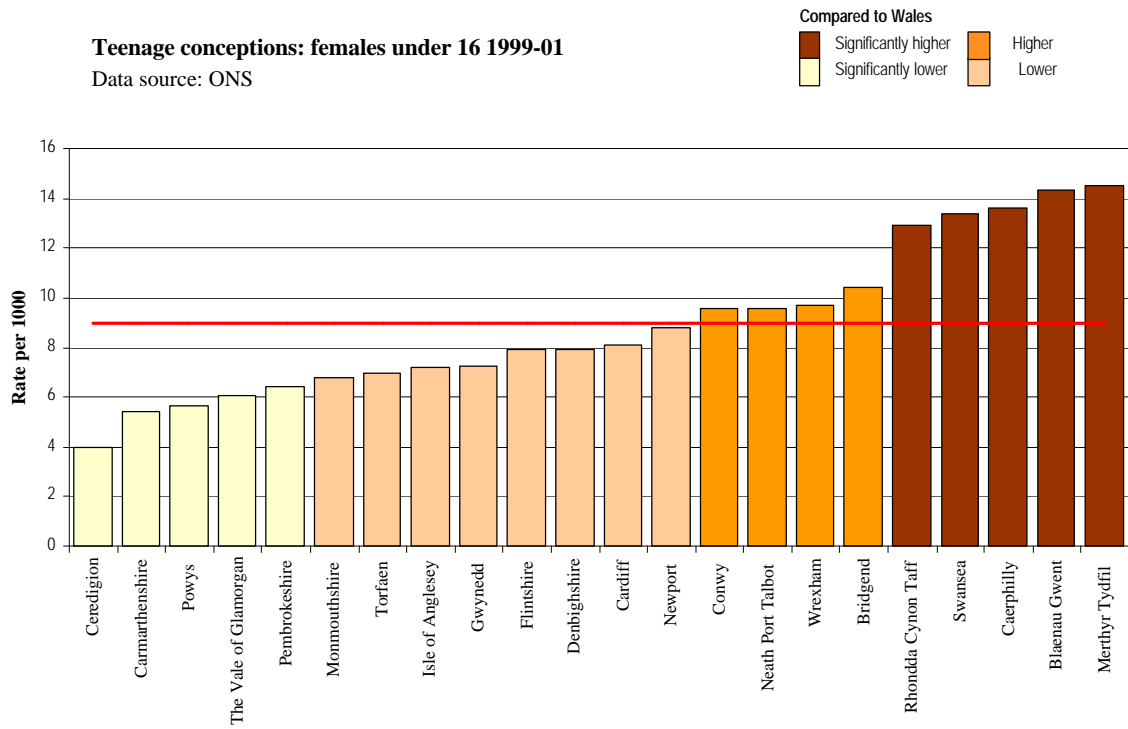
### Teenage conceptions, females under 16: 1999-01\*

UNITARY AUTHORITY (UA)	Average annual conceptions**	Rate per 1000***	Significant?
Blaenau Gwent	21	14.3	Sig high
Bridgend	26	10.4	High
Caerphilly	46	13.6	Sig high
Cardiff	50	8.1	Low
Carmarthenshire	23	5.4	Sig low
Ceredigion	6	4.0	Sig low
Conwy	18	9.5	High
Denbighshire	13	7.9	Low
Flintshire	22	7.9	Low
Gwynedd	15	7.2	Low
Isle of Anglesey	9	7.2	Low
Merthyr Tydfil	17	14.5	Sig high
Monmouthshire	11	6.8	Low
Neath Port Talbot	25	9.5	High
Newport	25	8.8	Low
Pembrokeshire	14	6.4	Sig low
Powys	13	5.6	Sig low

Rhondda Cynon Taff	60	12.9	Sig high
Swansea	44	13.4	Sig high
The Vale of Glamorgan	15	6.0	Sig low
Torfaen	13	7.0	Low
Wrexham	23	9.7	High
<b>Wales</b>	<b>509</b>	<b>9.0</b>	

\* data for 2001 provisional / \*\*average annual number of conceptions in females <16

\*\*\* rate per 1,000 females aged 13-15

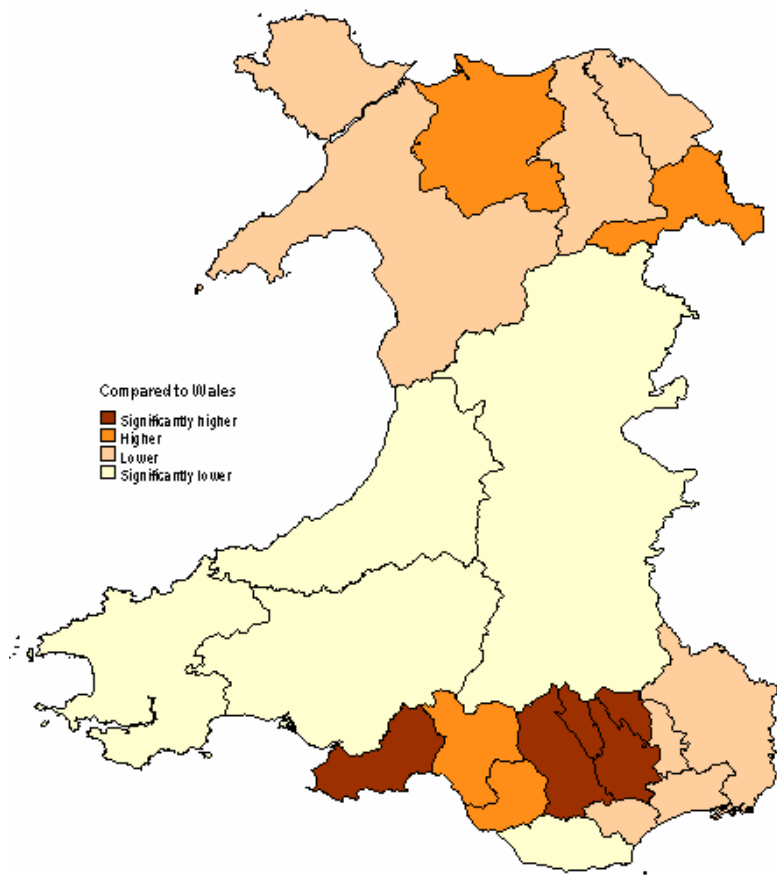


(Source: ONS)

### Teenage Conceptions: females under 16 1999-01

Rate per 1000 population aged 13-15

Data source: ONS



## **Associated issues**

### ***Terminations of pregnancy***

Most pregnant teenagers become pregnant accidentally - often the first conscious decision that has to be made around their pregnancy is whether to continue with it or whether to have an abortion.<sup>7</sup> The UK has lower abortion rates than Scandinavian countries, for example the number of abortions per 1000 live births (women under 20) for 1994 or the latest year available were around 640 in the UK compared to 1640 in Denmark.<sup>7</sup> Abortion rates are strongly influenced by levels of disadvantage – young women in the poorest areas have fewer abortions and are more likely to disapprove of abortion.<sup>7</sup> There is some evidence to show that girls from lower socio-economic backgrounds continue with their pregnancies because their family and local communities are opposed to abortion.<sup>8</sup>

Cardiff and Vale NHS Trust is commissioned to provide termination of pregnancy (TOP) services up to and including 15 weeks of pregnancy. Beyond 15 weeks of pregnancy and up to 24 weeks, patients are referred to the British Pregnancy Advisory Service. In the financial year of 2001 – 2002, Cardiff and Vale Trust carried out a total of 698 TOPs. In 2001 – 2002 the total amounted to 942 (information provided by Cardiff and Vale NHS Trust 17/09/03). No data were available at the time of writing in terms of numbers of TOPs by area of residence.

### ***Emergency Hormonal Contraception***

Emergency Hormonal Contraception (EHC) is effective in preventing pregnancy within 72 hours of having unprotected sex, although it is more effective the earlier it is taken within this time period. EHC is available in Cardiff from Cardiff and Vale NHS Trust family planning clinics, young people's clinics, the GUM clinic, GPs who provide contraceptive services, pharmacies and in some instances in Accident & Emergency Departments. Data were only available at the time of writing on GP prescribing data in Cardiff (provided by Cardiff LHB Pharmacy Advisors 17/09/03). A total of 2022 prescriptions were written in 2001, 1704 in 2002 and 1706 in 2003. No interpretation can be made of EHC use as a whole over time as there is a lack of data available on administration via other sources.

### ***Sexually transmitted infections***

Sexually Transmitted Infections (STIs) are infections whose primary route of transmission is through sexual contact. STIs can cause serious reproductive morbidity and poor health outcomes (please refer to [www.phls.co.uk](http://www.phls.co.uk) for general information on the morbidity of a range of STIs). The Public Health Laboratory Service (PHLS) reports that young heterosexuals, men who have sex with men and minority ethnic groups are at increased risk of acquiring an STI in a description of the epidemiology of STIs in England, Wales and Northern Ireland.<sup>9</sup> In particular there has been a rise between 1991 and 2001 in England, Wales and Northern Ireland in new episodes of STIs such as genital chlamydia.<sup>9</sup> It is thought that better diagnostic techniques and increased awareness amongst professionals and the public have contributed

to the rise in chlamydia diagnoses, however PHLS also points out that the rise in bacterial STIs is probably a reflection of the general deterioration in sexual health amongst young people and men who have sex with men.<sup>9</sup> The official incidence rates for such STIs understate the overall burden of disease within the general population due to the asymptomatic nature of many of them.<sup>10</sup> In relation to black and minority ethnic groups, reasons for high rates of infection are thought to result from inequalities in socio-economic status, variations in sexual behaviour and sexual mixing, and access to and use of health services.<sup>9</sup>

The sex industry in Cardiff is concentrated considerably in Adamsdown and Plasnewydd in the Central locality, Butetown in the South East and Riverside in the West locality. There is no published data available as to the incidence of STIs in this population group.

Patterns of STI epidemiology differ depending on the STI – some of the main STIs will be discussed in the following paragraphs.

### **Chlamydia**

Chlamydia is the most common curable bacterial STI. Reports of genital chlamydial infection in Wales continue to rise in line with UK trends.<sup>11</sup> In 2002 the rates in Wales were highest in 15 – 24 year-olds with rates of 798 per 100, 000 population for females and 248 per 100, 000 population for males. In contrast rates for 25 – 34 year olds were 182 per 100, 000 population for females and 123 per 100, 000 population for males.<sup>12</sup> Data from the STI clinic in Cardiff for both 2001 and 2002 indicates that within this age range, the number of diagnoses is higher in the 20 – 24 year old age group (personal communication with Cardiff GUM 05/03). Whilst the number of cases of uncomplicated chlamydial infection in 2001 was highest in the STI clinic in Cardiff, recent increases in cases are evident throughout Wales.<sup>12</sup> PHLS in Wales points out that whilst increases in the known incidence of chlamydia reflect increased awareness and testing, as mentioned previously, it is not known whether such statistics reflect increased transmission.<sup>13</sup>

### **Gonorrhoea**

*Neisseria gonorrhoeae* is the second most common bacterial STI in England and Wales.<sup>14</sup> Gonorrhoea may show quickly in men and can be picked up more quickly by health services, therefore it can be used as a proxy indicator of sexual behaviour (communication with PHLS in Wales 5/6/03). Whilst diagnoses of gonorrhoea made at GUM clinics in England and Wales decreased in the early 1990s, they have increased substantially since 1995.<sup>14</sup> In Wales in 2001, reports of cases of gonorrhoea fell. However in homosexual men reports increased between 2000 and 2001.<sup>11</sup> Rates of gonorrhoea in Wales are highest in 16 – 19 year olds.<sup>13</sup> In 2001 in the 15 – 24 year old age range, the rate for females was 28 per 100, 000 population and for males 25 per 100, 000 population.<sup>13</sup> The highest number of cases of gonorrhoea reported in Wales in 2001 was in the STI clinic in Cardiff.<sup>11</sup> This was however an absolute number rather than a population rate, so direct comparisons cannot be made with other areas of Wales. Data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP), a sentinel

surveillance programme in England and Wales commenced in 2000, supports studies which indicate that gonococcal infection is concentrated in population sub groups at increased risk of infection, namely females aged between 16 – 19 years, heterosexual males or men who have sex with men aged 25 – 34 years, and black and ethnic minorities, particularly Black Caribbean.<sup>14</sup> PHLS highlights the variations between Britain's ethnic groups in terms of sexual attitudes and lifestyles, economic status, access to and use of health care services and outcomes of partner notification.<sup>14</sup>

### **Syphilis**

PHLS in Wales points out that whilst acute cases of syphilis are rare in Wales, there has been a recent increase, reflecting an increase in other parts of the UK.<sup>11, 12</sup> Eight episodes of primary and secondary infectious syphilis were reported by GUM clinics in Wales in 2001, as well as 3 reports of early latent syphilis and 22 cases of other acquired syphilis.<sup>12</sup>

### **Hepatitis**

Hepatitis B is a blood borne viral infection, preventable through vaccination. The virus can be spread through sexual transmission, amongst other routes. Laboratory reports of acute hepatitis B infection in Wales have risen slightly over the past 10 years, from 16 cases in 1991 to 45 cases in 2001.<sup>15</sup> The UK statistical picture indicates that, whilst total numbers of viral hepatitis B diagnoses previously showed much higher numbers in males than in females, cases in females now account for over a third of total cases.<sup>16</sup> It is thought that sexual transmission of Hepatitis C virus is relatively rare.<sup>17</sup>

### **HIV/AIDS**

Human Immunodeficiency Virus (HIV) belongs to a group of viruses called retroviruses. The diagnosis of AIDS is only made when a patient develops an opportunistic infection or cancer, which indicates the presence of severe underlying immune deficiency.<sup>10</sup>

Diagnoses of asymptomatic HIV in the UK have risen by 24% over the last 10 years.<sup>16</sup> The PHLS has recently reported that "HIV continues to be the most important communicable disease in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and, since it affects mainly younger adults, high numbers of potential years lost".<sup>18</sup> In cumulative terms, the majority of HIV infections reported to the CDSC in the UK have occurred in homosexual men.<sup>10</sup> However at the UK level, although not reflected in statistics for Wales, HIV diagnoses acquired through heterosexual contact surpassed those acquired through sex between men in 1999, the majority of the former having been acquired abroad, particularly from sub Saharan Africa.<sup>19</sup> In addition, approximately 25% of HIV men who have sex with men and almost 50% (estimated) of all HIV infections acquired heterosexually are presently undiagnosed.<sup>10</sup>

In Wales the number of newly diagnosed HIV positive patients had remained fairly constant over the years, until recently, at around 40 cases per year.

Numbers reported rose in 2001, where total newly diagnosed cases amounted to 62.<sup>12</sup> In 2002, 83 new HIV positive cases were diagnosed, with 65% of these diagnosed in the Bro Taf area. Sixty-five per cent of the 83 cases occurred through heterosexual contact, primarily through people living overseas or having contact with a person who had lived overseas (communication with National Public Health Service Health Protection Unit 17/09/03). Transmission through heterosexual contact has continued to steadily increase over the years.<sup>12</sup> Risk of HIV infection in Wales however remains higher in men who have sex with men rather than other groups.<sup>13</sup>

Numbers of people living with diagnosed HIV infection in the UK are rising, due to new treatments and a consequent decline in deaths, and a rise in the number of new diagnoses.<sup>20</sup> Whilst more effective therapy requires fewer hospital admissions, these patients require ongoing outpatient monitoring via GUM clinics, so that an increasing HIV-prevalence pool will require increased GUM service provision.<sup>20</sup> In 2002 there were 272 diagnosed HIV-infected adults over 18 years of age attending HIV services in the Bro Taf area, with 72% of these residing in Cardiff (communication with National Public Health Service Health Protection Unit 17/09/03). It has been noted however that this is a mobile population, who may use services out with their area of residence. HIV drug therapy costs on average £10 – 12, 000 per annum per client. For certain clients, particular drug therapies are required which may amount to a cost of £20, 000 per annum per person (communication with National Public Health Service Health Protection Unit 17/09/03).

### **Summary of this section**

Teenage pregnancy rates in Wales are higher than those in England and the rest of Europe, although there has been a drop in rates in the late 1990s. The clear links between teenage pregnancy and disadvantage highlight that interventions in Cardiff should be targeted at areas of particular need. Issues such as termination of pregnancy rates affect teenage pregnancy rates – rates are lower in areas of disadvantage. There is also a general deterioration in sexual health amongst young people in England, Wales and Northern Ireland, with a rise in bacterial STIs such as chlamydia and gonorrhoea, although for chlamydia the rate is affected by better diagnostic techniques and increased awareness amongst professionals and the public. Whilst data might not be available showing the association between disadvantage, exclusion and STI incidence at the locality level within Wales, research elsewhere highlights the strong link between them. Lastly, the pattern of HIV incidence is changing in Wales with an increase in heterosexual transmission. In addition, numbers of people living with diagnosed HIV infection in the UK are rising, due to new treatments and a consequent decline in deaths, and a rise in the number of new diagnoses. There is therefore a gradual increase in the demand for chronic disease management for those living with HIV. A substantial percentage of cases in Wales live in the Cardiff area.

## **SEXUAL HEALTH SERVICES IN CARDIFF**

Cardiff and Vale NHS Trust Contraceptive (family planning) services are provided in a range of contraceptive clinics for all ages across Cardiff, some of which attract young people in particular. There also are several clinics that specifically target young people, two of which are provided within youth settings. These clinics deal with sexual health as well as other youth health issues. In addition to specialist provision, certain contraceptive services, such as contraceptive advice and prescription, pregnancy testing, emergency hormonal contraception and STI advice are also provided by GP Practices, although provision may differ across practices. Sexual health information, condoms and referral to primary care and specialist services are also provided through trained workers in some Cardiff Council youth settings, and partnership projects such as Llanrumney Healthy Living Centre, St Mellons Healthy Living Project and the Bee Healthy initiative.

Cardiff and Vale NHS Trust Genito-urinary Medicine services are currently provided in the GUM clinic in the West Wing of Cardiff Royal Infirmary. The clinic provides advice and treatment for people who have contracted STIs and allied conditions. A weekly young person's clinic is operated in conjunction with the Contraceptive Service. There are also extensive facilities and staff who provide support to HIV and AIDS patients. A chlamydia urine testing pilot is currently being carried out with the Contraceptive Service (certain family planning and young people's clinics) and certain GP Practices in Cardiff, where young people under 25 attending these services are offered a test. The aim of the pilot is to examine the most effective models of treatment out with the GUM service.

Condom distribution currently takes place through the aforementioned specialist services, partnership projects and some Cardiff Council youth clubs. The East Cardiff Condom Distribution Project, funded by Cardiff Local Health Board, consists of free condom provision to patients from a group of 7 GP Practices in the East of Cardiff. In 2001, 78% of contacts were in the 16 – 30 year old age range. Cardiff Local Health Board, in partnership with a range of statutory and voluntary organisations is currently setting up a condom-card scheme for young people under 25, which will train youth workers to provide a network of free condom access points, sexual health information and referral to primary care and specialist services. This will in the first instance target the Southern arc of Cardiff.

Cardiff and Vale NHS Trust is currently undertaking a review of specialist sexual health services. A ten-year strategic vision and service specification has been proposed in order to provide an integrated model of service. It is currently acknowledged that there is scope for contraceptive and GUM services to work more closely together, and for the decentralisation of certain services. Suggested reconfiguration includes a move to a targeted model of care, with level 1 providing a basic level of sexual health service targeting young people in youth and other settings; level 2 providing integrated sexual health clinics, with both a contraceptive and limited range of GUM services; and level 3 providing 3 specialist (hub) centres within the Trust, which would

offer a range of specialist gynaecology, GUM and contraceptive services as well as other specialist services. It is envisaged that one of the specialist centres would consist of the development of a Primary Care Resource Centre, which could provide, as well as those services already mentioned, licensed premises able to offer early termination of pregnancy to appropriate patients including pre and post nurse led counselling.

The current review of women's services in Cardiff will take into account proposals for sexual health services. It will also be important to consider the role of primary care and the voluntary sector in providing sexual health services. Lastly the forthcoming GP contract may influence which sexual health services are provided within primary care and where across Cardiff.

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## **Young People and Substance Misuse: Evidence of need**

ERYL POWELL, Public Health Directorate, *Cardiff Local Health Board*

This paper outlines children and young peoples substance misuse needs, incorporating both licit drugs (alcohol, cigarettes, solvents, prescribed and over the counter drugs) and illicit drugs, including volatile substances. It also identifies the groups of young people particularly at risk of substance misuse.

### *Alcohol*

In terms of alcohol, the Welsh Assembly Government Health Behaviour in School-aged Children study (WAG 2002a) provides a picture of young peoples' regular drinking and drunkenness in Wales between 1986 and 2000. Results indicate that whilst the proportion of 11–12 year olds drinking at least on a weekly basis has decreased since 1986, among 15–16 year olds the proportion has risen in this time period. The most recent figures show that nearly three-fifths of boys and half of girls aged 15-16 reported that they drank alcohol at least weekly in 2000. This figure has decreased slightly since 1996.

### *Smoking*

Empirical evidence suggests that smoking rates amongst young people and adolescents are continuing to rise. According to the Health Behaviour in School-aged Children study (WAG 2002a), 29 percent of girls and 20 percent of boys aged 15-16 in Wales reported smoking on a weekly basis. Moreover the numbers of girls aged 15-16 reporting having tried smoking increased from 65 percent in 1986, to 74 percent by 2000. It is estimated that half the children and young people who now smoke will die prematurely from smoking-related diseases. Many researchers have noted a significant association between tobacco use, other drug and alcohol misuse/dependence and disruptive behaviours, with tobacco being viewed as a 'gateway drug', preceding the initiation and subsequent use of illicit drugs (The Health Advisory Service, 2001)

### *Illicit drugs (including volatile substances)*

Our knowledge of the prevalence of illicit drug use is less robust than for other more common behaviours such as cigarette smoking because of the illicit nature of drug use. Changing trends through population surveys may reflect a whole range of issues rather than changing prevalence of drug use (Aujean et al 2002 ). Population survey trends should therefore be interpreted with caution.

Overall there has been an increase in the numbers of 15 and 16 year olds ever having used and currently using illicit substances during the 1990s (WAG, 2002b), with 41percent of girls and 42 percent of boys aged 15-16 years reporting 'ever having used illicit drugs'. Whilst there was a slight decline in these proportions between 1996 and 1998, further data are required to establish whether these rates have peaked. The pattern of current drug use is similar, with proportions at 23 percent for boys and

22 percent for girls in 1998 (WAG 2002b). The most commonly used drug used in “the last month” was cannabis with 38 percent of boys and 34 percent of girls having experimented with cannabis. Around 15 percent of girls and boys have experimented with amphetamine, nitrates or volatile substances.

DrugScope (2002), points out that illegal drug use is only an occasional activity for most people. Thus most use of illegal drugs is on a relatively controlled, recreational basis with most young people either moderating or stopping using illegal drugs completely by their mid to late twenties when they take on adult responsibilities. There are a small but significant number of people who continue to use illegal drugs, (in particular cannabis) into their thirties and beyond.

Aujean et al (2002) point to a significant increase in cocaine use between 1998 and 2000, with 10 percent of 16-29 year olds having tried the drug in 2000 compared with 6 percent in 1998. Studies show that cocaine is now seen as more socially acceptable than ecstasy and amphetamine (Aujean et al 2002). Of those who use drugs and alcohol a proportion will meet criteria for abuse and/or dependence. Many studies report the rate of substance use disorders increase with age, ranging from 1.5 percent in fourteen year olds to 8.7 percent among 18 year olds (e.g. Cohen et al, 1993, Lewinsohn et al 1993). Cohen et al 1993 found that those young people who use alcohol, tobacco and drugs frequently are likely both to meet the criteria for a diagnosis of a substance use disorder and to report a wide range of other psychological and psychiatric problems.

### *Vulnerable young people*

It should be noted that the risk of substance misuse is not uniformly distributed through the youth population. Lloyd (1998) identifies the homeless, those looked after by local authorities or in foster care, those taking part in prostitution, school truants or those excluded from school, young offenders, those from families who misuse drugs or alcohol, and young people with mental health and disruptive behavioural disorders as being particularly vulnerable to the risk of substance misuse. Although these relationships should be seen as correlational rather than causal. There is an absence of any national data on substance use in excluded school pupils but according to Bamford et al (2000) excluded young people are nearly twice as likely to drink regularly as school attendees. Excluded pupils also more likely to use drugs - with over 60 percent reporting the use of cannabis, and 20 percent use of amphetamine and ecstasy.

### Substance use/misuse education in schools

A review of substance use education carried out in fifty secondary schools in South Wales (Bishop et al 2000) indicated that many schools lacked a clear overall philosophy and written policy underpinning the delivery of substance use education, which therefore impacted upon the schools ability to achieve the maximum potential from the time invested in substance use education. The Personal and Social Education (PSE) curriculum has recently been made statutory within schools in Wales and this should begin to address these deficits in substance misuse education.

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## **Physical Activity**

Physical inactivity and sedentary lifestyles contribute significantly to the ill – health of people in Wales. There is strong evidence which indicates that an active population meeting current recommendations of 30 minutes of moderate activity on most days of the week, experience lower rates of obesity (Cooper, 2000), coronary heart disease (Bidgen, 1994), Type 2 diabetes (Manson, 1991), cancers,(Shepherd, 1992), fewer injuries to the elderly (Evans, 1999) and less mental health problems (Fox, 2000).

High levels of inactivity and a poor diet can contribute to individuals becoming overweight and obese. Being overweight is linked to raised blood pressure, raised blood cholesterol, and glucose intolerance/ non-insulin dependant diabetes.

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