Health and Lifestyle in Argyll and Clyde

The Annual Report of the Director of Public Health 2002
Contents

Introduction

Acknowledgements

Information sources
Routinely collected information
Your Health and Wellbeing survey 2001
Lifestyle focus groups

Section 1 - Health in Argyll and Clyde
Self-reported health and ill-health
The 'Big 3'
Oral health
Sexual health
Harm from alcohol misuse
Harm from drug misuse

Section 2 - Lifestyle and action in Argyll and Clyde
Smoking
Diet
Physical activity
Alcohol
Drugs
Sexual lifestyle
Lifestyle: what helps, and what gets in the way?
Have a Heart Paisley

Section 3 - Some other health issues in Argyll and Clyde
Care and issues
Domestic abuse
Health and homelessness
Projecting health

Glossary of terms used

Key references
Introduction

There is a new emphasis in this year's annual report on the health of the population of Argyll and Clyde. The reports for the years 2000 and 2001 presented profiles of health – and factors that affect health – in council areas, and gave accounts of selected major health issues. They placed a strong emphasis on the circumstances in which the people of Argyll and Clyde live their everyday lives, circumstances that have a fundamental bearing on their prospects of health and disease. This report concentrates largely on aspects of lifestyle in Argyll and Clyde and why they are important, reflecting the fact that the Argyll and Clyde Your Health and Wellbeing survey was carried out during 2001.

The 2000 and 2001 reports are still relevant, and this year's report is intended to complement them. Taken together, the three documents examine life circumstances (including deprivation, employment, housing, neighbourhood crime, and education), lifestyles (such as smoking, diet and physical activity), and specific major health topics (for example coronary heart disease and mental health). This fits well with the three action levels for improving health set out in the White Paper on Health, Towards a Healthier Scotland. The three annual reports combine to give us a powerful understanding of our health, what we can do about maintaining and improving it, and importantly what all the public and private agencies can do too.

This annual report is in 3 main sections.

- **Section 1** gives an overview of health in Argyll and Clyde. It includes findings on people's views of their own health and ill-health, from the Your Health and Wellbeing survey. In describing the scale of major health problems, it focuses mainly on diseases in adults that are directly linked to major lifestyle factors. This account is complemented by the coverage of child health and mental health in the earlier reports.

- **Section 2** concentrates on the major lifestyle issues. For each topic, it illustrates the impact on health; gives insights to lifestyle in Argyll and Clyde (using findings from the Your Health and Wellbeing survey where available); draws together important aspects of national policy and strategy; gives examples of action in Argyll and Clyde; and suggests key points for further action. The action points are intended to be a public health input to assist the partners involved in developing local health plans, joint health improvement plans and community plans more widely.

- **Section 3** highlights some topical and important health issues additional to the health topics covered in Section 1. Again the intention is to assist local health planning and community planning, and the interface between these.

I am aware of the risk involved in giving examples of local action. It is clearly impossible to include every single initiative, especially when there is so much being done. The activities cited are intended purely to illustrate the range and scope of what is already going on, and I can but apologise to anyone who is disappointed that particular projects in which they are involved are not mentioned.

As a Director of Public Health I find it very heartening that the need to create good health and a healthy environment, as well as provide services for when we are sick, is now firmly at the forefront of attention in the NHS and beyond. Policy and strategy documents such as Towards a Healthier Scotland and Our National Health, and discussion papers such as The Possible Scot, have led the resurgence of a focus on public health. The Chief Medical Officer’s review of the public health function in Scotland and the Chief Nursing Officer’s review of the contribution of nurses, midwives and health visitors to improving the public’s health (Nursing for Health) have looked at the workforce and capacity required to lead and deliver the public health effort.
A key recommendation of Nursing for Health was the establishment of public health practitioners (PHPs) in local health care co-operatives (LHCCs). NHS Argyll and Clyde embraced that recommendation enthusiastically, and six PHPs are in post and already making big local impacts. Argyll and Bute, Inverclyde, Lomond, Paisley and West Renfrewshire LHCCs each have a full-time PHP, while Lever Valley and Renfrew share a post. The PHPs are providing a visible lead for developing the public health role of the LHCCs. They have key roles in encouraging and enabling staff throughout primary care to develop new ways of working to improve health. They also work in local partnerships, with their communities, local authorities and others, identifying and meeting local health needs.

Another vital piece in the jigsaw is the creation of public health posts within local authorities, jointly funded by the NHS, the councils and the Scottish Executive. These officers will be key figures in developing joint health improvement plans within the community planning process, and in furthering the role of local authorities as public health organisations. Collaboration between them and the PHPs promises a great deal for improving health through planning and action at local levels.

A healthy Scotland – and a healthy Argyll and Clyde – has its roots in a healthy society. I hope that once again the annual report of the Director of Public Health will prove a useful tool to drive progress locally towards this idea. As always, I welcome feedback on the document, and suggestions for the nature and content of future editions.

Lesley Wilkie
Director of Public Health
NHS Argyll and Clyde
August 2002
Acknowledgements

This report has been produced thanks to the efforts of many people within and outwith Argyll and Clyde NHS Board. The core group for the report was led by Andrew Tannahill and included Alison Burtison, Nicholas Scott, Heather Cunningham, Ken Thomson and Oliver Blatchford. Thanks are also due to Clare Beeston, David Bell, Jane Beresford, Kate Brown, Anne Bryce, Clare Campbell, Karen Campbell, Anne Clarke, Lynn Easton, Sandra Ferguson, Elaine Garman, Lynn Girdwood, Rona Hamilton, Jan Henderson, Karen Irvine, Stevie Lydon, Fiona MacDonald, Susan McGory, Ruth McIntyre, Harriet O'Donnell, Norma Robertson, Elaine Small, Imogen Stephens, Patrick Sweeney, Margaret Tannahill, Isabel Tavilian-Exley, Janice Thomson, Kelly Williams and Yoga Velupillai, for their various inputs; to Anne Burns, Angie Docherty, Ann Campbell, Margaret Carlin, Andrina Reid and Sandra Winton who, as local health care co-operative public health practitioners, are acting as focal points for local launches and dissemination, and to the community members and organisations in Argyll and Bute and Inverclyde for making the focus group discussions possible and so valuable.
Information sources

Routinely collected information

Several sources of routinely collected information are used in this report, and are described briefly here.

**Death registrations** – A database of all deaths registered in Scotland, collated by the General Register Office for Scotland (GROS) based in Edinburgh. Used in this report for analyses for ‘Argyll and Clyde residents’ – based on residents of Argyll and Clyde dying anywhere in Scotland (but not outwith Scotland) plus any non-residents of Scotland who die in Argyll and Clyde (e.g. on holiday). Similarly, analyses of ‘Scottish residents’ will exclude those Scottish residents dying outwith Scotland, and include any non-residents of Scotland who die in Scotland. The database includes information on cause of death, based primarily on the death certificate completed by a doctor. In this report, all analyses are restricted to the primary or underlying cause of death, and are based on year in which the death was registered.

**Cancer registrations** – A database of new cancers diagnosed in Scotland, which is maintained by the Scottish Cancer Registry in Edinburgh. Used to produce numbers, rates and rankings for the different sorts of cancer.

**Community health index (CHI)** – A database of people registered with GPs, or undergoing cervical screening etc, which has many clinical uses and is also used to derive populations for residents of Argyll and Clyde and its various geographical groupings.

The following geographical groupings are referred to in this report:

- deprivation quintiles (depquins)
- council (local authority) areas
- local health care co-operative (LHCC) localities.

Definitions and local details of these groupings are given in the glossary of terms used in this report, on page 85.

Your Health and Wellbeing survey 2001

An important ingredient of this annual report is the insight into lifestyle and some other health-related issues in Argyll and Clyde gained through the *Your Health and Wellbeing* survey, carried out by Argyll and Clyde NHS Board in 2001.

The survey was designed to allow comparisons among various groupings of the Argyll and Clyde population: men and women, age groups, council areas, LHCC localities, and deprivation quintiles.

**Who was included in the survey?**

The survey involved adults, aged 16 and over. There are over 350,000 people aged 16+ in the Argyll and Clyde area. A 3.5% sample of the adult population was randomly selected using the CHI as at 8 January 2001. This provided a sample of 12,400 people aged 16 years and over that was representative of the adult population in Argyll and Clyde by gender, age group, council area, LHCC locality and deprivation quintile.

**How was the survey carried out?**

The survey used a postal questionnaire, with a total of 55 questions covering personal characteristics (e.g. age and sex) and health-related subjects such as general health,
disability, caring for other people, smoking, diet, physical activity, alcohol, dental health and sexual health. Questions were taken from the Scottish Needs Assessment Programme set of core questions for health and lifestyle surveys, and from previous NHS Argyll and Clyde surveys, and some new questions were devised.

The questionnaires were mailed to all those in the randomly selected sample of the adult population in January 2001, and a reminder letter and another copy of the questionnaire were sent out about three weeks later. Attempts were made to obtain local press and radio coverage to promote the survey, but this was not achieved. The questionnaires were treated as strictly confidential and no names were requested. The Data Protection Act (1998) had significant implications for the survey.

How many people completed and returned the questionnaire?

4,837 people returned completed questionnaires, giving a crude response rate of 39%. When carrying out a postal survey, it is logical to remove from the original sample people who did not actually receive the questionnaire because they had moved home or died. In this survey, fewer than expected questionnaires were returned as undelivered, probably because the envelopes in which the questionnaires were sent out did not have a return address printed on them. Other recent postal surveys carried out by Argyll and Clyde NHS Board using samples from the CHI have had around 7% of questionnaires returned as undelivered. If it is assumed that 7% of the people in the Your Health and Wellbeing survey were uncontactable, this gives an adjusted response rate of 42%.

How do the respondents compare with the overall adult population in Argyll and Clyde?

A major consideration in any survey is the extent to which those who took part (the respondents) are representative of the overall population from which they are drawn. This affects the extent to which findings from the survey can be taken to apply to the population as a whole.

An important step in trying to make sure that a survey population is representative of the overall population is to draw the survey sample randomly from the population, as was done with the Your Health and Wellbeing survey. Inevitably, however, some people do not take part in the survey (non-respondents), and there is a need to compare the respondents as a group with the overall population in respect of certain characteristics that can affect the findings, such as gender, age, socioeconomic circumstances and area of residence. Figures 1 to 5 compare the profile of the Your Health and Wellbeing survey respondents with that of the corresponding (CHI) overall adult population in Argyll and Clyde, by gender, age group, deprivation quintile, council area and LHCC locality.

**Gender**

![Figure 1: Profile of the Argyll and Clyde adult population and Your Health and Wellbeing survey respondents, by gender](image-url)
Information sources

It can be seen from Figure 1 that the proportion of males among the survey respondents was lower than in the general adult population of Argyll and Clyde, and that the opposite applied in the case of females. Males were therefore under-represented, and females over-represented, in the survey respondents.

Age

Figure 2 shows that the youngest age group (16-34 year-olds) was under-represented in the survey respondents, while older ages (especially age group 55-74) were over-represented.

Deprivation quintile

As shown in Figure 3, the more affluent deprivation quintiles were over-represented, and the more deprived deprivation quintiles under-represented, in the survey respondents.

Council area

It can be seen from Figure 4 that residents of Argyll and Bute council area were over-represented, and Renfrewshire council area slightly under-represented, in the survey respondents.
**LHCC locality**

Figure 5 shows that Argyll and Bute LHCC locality was over-represented and Paisley LHCC locality under-represented in the survey respondents.

In summary, females, older age groups and people living in more affluent areas were more likely to complete the questionnaire, and were thus over-represented among respondents relative to the overall adult population of Argyll and Clyde.

**Ethnic origin**

Almost all respondents (99%) were of white ethnic origin. This is in line with findings from the 1991 Census.

**Other personal characteristics of respondents**

**Employment status**

52% of respondents were in full-time or part-time employment, 3% were unemployed and looking for work, 6% were unable to work due to sickness or disability, 26% were retired, 4% were looking after the home or family, and 4% were in full-time education.

**Housing tenure**

74% of respondents owned their own home, 21% rented their home from the council or a housing association, and 3% rented their home from a private landlord or their employer.
Possible sources of bias

'Bias' is the term used for any trend in the collection, analysis, interpretation, publication or review of data that can lead to conclusions which differ systematically from the actual situation in the population (e.g. underestimation of the percentage of smokers).

Two important sources of bias need to be considered in this sort of survey: non-response bias and reporting bias.

Non-response bias occurs when non-respondents to a survey, or survey question, tend to differ systematically from respondents with regard to a data item which is collected.

For example, under-representation of disadvantaged people and over-representation of affluent people in a survey can contribute to non-response bias, with a tendency towards lower figures for unhealthy lifestyles and higher figures for healthier lifestyles. The Your Health and Wellbeing survey team carried out calculations to adjust the overall survey figure for the percentage of people who smoke to make up for the differences in gender, age and deprivation profiles between the survey respondents and the population as a whole. Even when all three of these factors were allowed for, the figure only went up from 25% to 26%. This gave reassurance that these known differences in make-up between the group of survey respondents and the Argyll and Clyde population overall were unlikely to have biased the survey findings to any substantial extent.

However, there remains a possibility that people with different lifestyles will have different likelihoods of completing a lifestyle questionnaire, and that this will lead to non-response bias. Research from elsewhere in the UK has found higher percentages of smokers among non-respondents to lifestyle surveys than among respondents, and this has been found to apply in both manual and non-manual social groups. This suggests that lifestyle surveys are likely to underestimate the percentage of smokers in the population. The extent to which this is an issue with other lifestyle behaviours, such as drinking alcohol to excess or eating unhealthily, is not clear, although there is evidence from one research study that non-respondents are more likely than respondents to be physically inactive.

Reporting bias arises if people underestimate or play down particular aspects of lifestyle behaviour, or conversely if they overestimate or overstate particular aspects. For example, people might under-report their alcohol consumption because they drink more than they think, or because they do not want to admit to drinking as much as they know they do. On the other hand, people might over-report the amount of exercise they take, or the amount of fruit and vegetables they eat. This sort of bias can happen even in anonymous surveys, and even where the response rate is high. It is difficult to assess how much this applies in a given survey unless responses can be checked against other pieces of evidence (e.g. evidence of smoking from saliva or urine tests). No such additional evidence was obtained for the Your Health and Wellbeing survey.

Dealing with possible bias

The low response rate in the Your Health and Wellbeing survey makes it all the more important to take non-response bias into account in considering the levels of lifestyle behaviours found in the survey. The most consistent evidence of the possible extent of non-response bias is found in the case of smoking. As reported on page 29, the percentage of respondents in the Your Health and Wellbeing survey who said they smoke was 25%. Using figures from two research studies elsewhere in the UK to try to remove the effects of non-response bias, the survey team calculated two adjusted rates – 31% and 35%. The higher of these figures is given on page 29, as a reminder of how far the survey figure may be from the true rate in the Argyll and Clyde population.

Also, the team was able to calculate an adjusted figure for the percentage of people who do not take any significant exercise in an average week (see page 42), using figures from one of the research studies.
It is important to stress that these adjusted figures are intended only as illustrations of the possible effects of non-response bias, to encourage people to be cautious in using ‘headline’ figures from the survey. They cannot be seen as precise adjustments. No such adjusted figures are available for other lifestyle indicators in the survey. Also, no adjustments are available for reporting bias. The possibility of non-response bias and reporting bias needs to be borne in mind in reading all of the survey findings.

Presenting the survey findings

Findings from the part of the survey concerned with self-reported health and ill-health are presented in Section 1 of this report. Section 3 includes information on the self-reported health of those survey respondents who can be defined as carers (see page 75). The findings relating to particular aspects of lifestyle (smoking, diet, physical activity etc) are set out in Section 2.

The following two points should be borne in mind when reading the survey findings:

- Not all of the survey respondents answered all of the questions in the questionnaire. Unless otherwise indicated, the percentages given for a particular question relate to the number of eligible respondents who actually answered that question.
- Although the survey was carried out in 2001, the present tense is used in reporting answers that applied at the time people filled in their questionnaire. This is in the interests of a clear distinction between current lifestyle (at the time of completing the questionnaire) and previous lifestyle. For instance, it is reported on page 36 that almost two-thirds of respondents said that they eat breakfast every day, rather than ate breakfast every day.

Lifestyle focus groups

As can be seen from Section 2, the Your Health and Wellbeing survey provided a wealth of information on aspects of lifestyle in Argyll and Clyde. If NHS Argyll and Clyde, local authorities and other partners are to help people to take up and maintain healthier lifestyles, they need to understand what sorts of things in people’s everyday lives help them to do so, and what hinders them. It was therefore decided that it would be helpful to have informal discussions along these lines with focus groups made up of members of local communities. The focus group approach was chosen because it is a good way of enabling people to express their personal views and discuss ideas and opinions put forward by others. This helps build up a picture of how strongly particular views are held, and the extent to which they are shared by group members.

How were the focus groups set up?

Four focus groups were set up, two in an urban area and two in a rural area within Argyll and Clyde. This reflected the possibility that people in the two types of area might differ with regard to the things that help and hinder them. All of the groups were recruited from social inclusion partnership (SIP) communities, in view of the influence of life circumstances on lifestyle, and the importance of tackling inequalities in health.

One group in each area was intended to be made up of people who had made a healthy lifestyle change in relation to smoking, eating or physical activity, and the other to involve people who wanted to make such changes but found it difficult to do so. The idea was that the discussion in the first type of group would concentrate on the things that had helped people to make healthy changes, while the second type of group would focus on the things that get in the way of healthy lifestyle changes. In practice, however, all four focus groups chose to discuss both.
The group members were recruited using local posters and with the help of locally-based community workers who could provide information, reassurance and encouragement. The aim was to have 8 people in each of the four groups. In the end, a total of 21 people (18 women, 3 men) took part. They were aged between 20 and 35. Although the Your Health and Wellbeing survey involved people aged 16 and over, a narrower age band was chosen for the focus groups to help people to feel relaxed enough in each other’s company to talk freely.

The focus group sessions were run by a small team of staff from Argyll and Clyde NHS Board. The findings are presented in Section 2 (see page 66).
Section 1

Health in Argyll & Clyde
Section 1 - Health in Argyll and Clyde

The main focus of this report is lifestyle in Argyll and Clyde. To set this in context, Section 1 presents a brief overview of health problems that have been directly linked to smoking, unhealthy diet, physical inactivity, alcohol misuse, drug misuse or sexual lifestyle. Tying in with the Your Health and Wellbeing survey, the section focuses mainly on health in the over-16s. It also presents information from the survey on how people in Argyll and Clyde rate their own health, on long-standing illness or disability, and on aspects of oral health and use of dental services.

Self-reported health and ill-health

The Your Health and Wellbeing survey asked people how their health was over the preceding 12 months, on a scale from 1 ('excellent') to 5 ('poor'). Taking 1 and 2 together as representing 'good' health, 3 as 'fair', and 4 and 5 together as 'poor', the findings are as shown in Table 1.

<table>
<thead>
<tr>
<th>Health rating</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good (rating level 1 or 2)</td>
<td>60%</td>
</tr>
<tr>
<td>Fair (rating level 3)</td>
<td>26%</td>
</tr>
<tr>
<td>Poor (rating level 4 or 5)</td>
<td>14%</td>
</tr>
</tbody>
</table>

These results are broadly in line with those from surveys in Scotland as a whole and from the Argyll and Clyde Apple a Day survey of 1996.

The percentage of respondents who rated their health as good decreased with increased age (16-34 year-old age group 71%, 75+ age group 35%). It can be seen from Figure 6 that the percentage rating their health as good was lower among respondents from the more deprived communities, with a downward gradient from deprivation quintile (depquin) 1 to 5. Conversely, the percentage of respondents rating their health as poor was higher among those from the more deprived communities.
The questionnaire also asked people whether they have any long-standing illness, disability or infirmity. 35% of respondents said they do (compared with 40% in the 1998 Scottish Health Survey). The percentage was higher for men (41%) than women (31%), increased greatly with increased age (16-34 year old age group 18%, 75+ age group 66%), and was higher in the more deprived sections of the population (41% in depquini 5, 29% in depquini 1).

Those who said they have a long-standing illness, disability or infirmity were asked to say what illness or disability they have. Over two-thirds (68%) of those who gave details mentioned a single problem, the rest mentioning more than one.

As can be seen from Table 2, the most common type of problem mentioned was musculoskeletal (ie affecting the joints, soft tissues or bones), followed by circulatory (including heart disease and stroke). The figures given in the table have been calculated in two ways: as a percentage of those who gave details of their long-standing illness or disability; and as a percentage of all survey respondents. The latter percentage is intended to give some insight to the possible situation in the general population, but the potential for non-response bias and reporting bias (see page 8) needs to be remembered.

<table>
<thead>
<tr>
<th>Type of problem</th>
<th>Percentage of those who gave details of long-standing illness or disability</th>
<th>Percentage of all survey respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal (joints,</td>
<td>43%</td>
<td>14%</td>
</tr>
<tr>
<td>soft tissues or bones – eg arthritis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory (including heart disease and</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>stroke)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory (lungs and airways – eg asthma,</td>
<td>13%</td>
<td>4%</td>
</tr>
<tr>
<td>bronchitis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Endocrine (glandular) or metabolic</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Eye or ear</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Digestive system</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td>Nervous system</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>Reproductive or urinary systems</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Cancer</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Alcohol-related</td>
<td>1%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

The survey respondents who said they have a long-standing illness, disability or infirmity were asked whether or not it limits what they are able to do for themselves. 52% said yes, 48% no. The percentage whose problem limits them increased with increased age (41% in the 16-34 age group, 66% in the 75+ age group), and was higher in the more deprived sections of the population (55% in depquini 5, 44% in depquini 1).

Those whose problem limits what they can do for themselves were asked to indicate in what way or ways, from the list shown in Table 3.
Table 3: Percentages of respondents with a limiting problem who are limited in particular ways

<table>
<thead>
<tr>
<th>Type of limitation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility outside the home</td>
<td>65%</td>
</tr>
<tr>
<td>Housework</td>
<td>61%</td>
</tr>
<tr>
<td>Stairs</td>
<td>55%</td>
</tr>
<tr>
<td>Cooking</td>
<td>41%</td>
</tr>
<tr>
<td>Bathing</td>
<td>39%</td>
</tr>
<tr>
<td>Dressing</td>
<td>31%</td>
</tr>
<tr>
<td>Mobility in the home</td>
<td>31%</td>
</tr>
<tr>
<td>Toilet</td>
<td>15%</td>
</tr>
<tr>
<td>Feeding self</td>
<td>10%</td>
</tr>
</tbody>
</table>

The ‘Big 3’

As in Scotland as a whole, the ‘Big 3’ killers in Argyll and Clyde are cancer, coronary heart disease (CHD) and stroke. Lifestyle plays an important part in causing — or helping to prevent — CHD, stroke and some forms of cancer. Smoking, an unhealthy diet and lack of physical activity all increase the risk of falling victim to the Big 3. Alcohol misuse has been linked to a number of types of cancer, and to stroke.

Figure 7: Cancer and coronary heart disease (CHD) deaths Argyll and Clyde residents, all ages, 1980 - 2000

Source: GROS.
Cancer has overtaken CHD as the most common cause of death in Argyll and Clyde in recent years, due mainly to a welcome fall in CHD deaths (Figure 7). As can be seen from Figure 8, the Big 3 together accounted for 60% of all deaths in the area in the year 2000:

- cancer: 25% of all deaths
- CHD: 22%
- stroke: 13%

Figure 8: Major causes of death in Argyll and Clyde residents, all ages 2000 (5,224 deaths)

* Cancers of the respiratory and digestive system are included under the heading cancer.

Source: GROS.

Figure 9: Cancer, coronary heart disease (CHD) and stroke – standardised death rates for 1994 - 2000 and targets for 2010, for residents of Scotland and Argyll and Clyde, 0-74 years

1 Targets for 2010 based on reductions of 20% (cancer) or 50% (CHD and stroke) in the 1994-96 pooled directly age-standardised rates (based on European population). Dotted lines show reductions from 1994-96 required to achieve targets.

Sources: GROS death registrations and mid-year population estimates.
Rates from ISD – Performance Assessment Framework Dec 2001 (cancer and CHD) and SKIPPER (stroke).
A range of other causes made up the remaining 40% of deaths. Respiratory disease (excluding cancer) accounted for 11% of deaths, and smoking is a major causal factor in this also.

The picture is broadly similar for deaths in the under-75s, but there is a higher proportion of deaths from cancer in this age group (34% in 2000) and a lower proportion of deaths from stroke (7% in 2000).

The White Paper on Health, *Towards a Healthier Scotland*, set the following national targets for reducing death rates in the under-75s from cancer, CHD and cerebrovascular disease (essentially stroke), between 1995 and 2010:

- **cancer:** reduce age-standardised death rate by 20%  
- **CHD:** reduce age-standardised death rate by 50%  
- **cerebrovascular disease:** reduce age-standardised death rate by 50%.

### Table 4: Numbers of deaths for selected causes  
Residents of Argyll and Clyde  
2000

<table>
<thead>
<tr>
<th></th>
<th>Cancer ICD10 C00-C07</th>
<th>Coronary heart disease ICD10 I20-I25</th>
<th>Stroke ICD10 I60-I69</th>
<th>All causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,319</td>
<td>1,146</td>
<td>669</td>
<td>5,183</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>647</td>
<td>594</td>
<td>244</td>
<td>2,416</td>
</tr>
<tr>
<td>Female</td>
<td>672</td>
<td>552</td>
<td>425</td>
<td>2,767</td>
</tr>
<tr>
<td><strong>Age group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>0 to 14</td>
<td>0</td>
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<td>39</td>
</tr>
<tr>
<td>15 to 34</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>103</td>
</tr>
<tr>
<td>35 to 54</td>
<td>117</td>
<td>75</td>
<td>19</td>
<td>440</td>
</tr>
<tr>
<td>55 to 74</td>
<td>535</td>
<td>407</td>
<td>146</td>
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<td>118</td>
<td>863</td>
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<tr>
<td>Depquin2</td>
<td>304</td>
<td>253</td>
<td>150</td>
<td>1,138</td>
</tr>
<tr>
<td>Depquin3</td>
<td>257</td>
<td>213</td>
<td>134</td>
<td>1,007</td>
</tr>
<tr>
<td>Depquin4</td>
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<td>221</td>
<td>147</td>
<td>1,076</td>
</tr>
<tr>
<td>Depquin5 (deprived)</td>
<td>284</td>
<td>259</td>
<td>120</td>
<td>1,099</td>
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<td><strong>Council area</strong></td>
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<td></td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>310</td>
<td>259</td>
<td>146</td>
<td>1,139</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>506</td>
<td>437</td>
<td>281</td>
<td>2,043</td>
</tr>
<tr>
<td>East Renfrewshire (A&amp;C part)</td>
<td>68</td>
<td>56</td>
<td>28</td>
<td>271</td>
</tr>
<tr>
<td>West Dunbartonshire (A&amp;C part)</td>
<td>139</td>
<td>136</td>
<td>57</td>
<td>569</td>
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<tr>
<td>West Renfrewshire</td>
<td>199</td>
<td>172</td>
<td>95</td>
<td>758</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>236</td>
<td>199</td>
<td>115</td>
<td>874</td>
</tr>
<tr>
<td>Lomond</td>
<td>213</td>
<td>196</td>
<td>88</td>
<td>834</td>
</tr>
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<td>51</td>
<td>23</td>
<td>207</td>
</tr>
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<td>Levern Valley</td>
<td>68</td>
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<td>271</td>
</tr>
<tr>
<td>Paisley</td>
<td>243</td>
<td>220</td>
<td>167</td>
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<tr>
<td>Inverclyde</td>
<td>297</td>
<td>252</td>
<td>153</td>
<td>1,143</td>
</tr>
</tbody>
</table>

The use of "age-standardised" rates makes allowances for changes in the age make-up of the population over time, which would otherwise give a false picture. Also, they allow comparisons between geographical areas with different population age structures, e.g. Argyll and Clyde compared with Scotland as a whole.

Figure 9 shows progress over time towards the above targets in Argyll and Clyde, and in Scotland as a whole. For each of the Big 3, Argyll and Clyde consistently has higher rates than Scotland, but both nationally and locally there appear to be downward trends between 1994 and 2000, especially for CHD.

Table 4 gives a detailed breakdown of numbers of deaths from the Big 3 and from all causes, by gender, age band, deprivation, council area and LHCC locality in 2000 (the most recent year for which data were available at the time of writing).

As the coding classification for causes of death changed on 1 January 2000 and the old and new systems are not entirely comparable, the corresponding deaths data for previous years are shown in a separate table (Table 5). The 7-year period 1993-1999 is used so that the numbers are large and robust enough for calculating standardised

---

**Table 5: Numbers of deaths and standardised mortality ratios (SMRs) for selected causes**

Residents of Argyll and Clyde

<table>
<thead>
<tr>
<th>7-year period 1993 - 1999</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number of deaths</th>
<th>Coronary heart disease</th>
<th>Coronary cancer</th>
<th>All causes</th>
<th>Stroke</th>
</tr>
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<td>9,190</td>
<td>4,765</td>
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<tr>
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<td>4,841</td>
<td>1,774</td>
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<td>0 to 14</td>
<td>16</td>
<td>0</td>
<td>2</td>
<td>318</td>
</tr>
<tr>
<td>15 to 34</td>
<td>50</td>
<td>21</td>
<td>12</td>
<td>699</td>
</tr>
<tr>
<td>35 to 74</td>
<td>638</td>
<td>554</td>
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<td>2,824</td>
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<td>75+</td>
<td>3,789</td>
<td>4,891</td>
<td>3,408</td>
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<td>1,566</td>
<td>916</td>
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<tr>
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<td>1,974</td>
<td>1,950</td>
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<td>Depquint3</td>
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<td>1,834</td>
<td>907</td>
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<tr>
<td>Depquint4</td>
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<td>848</td>
<td>7,126</td>
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<tr>
<td>Depquint5 (deprived)</td>
<td>2,134</td>
<td>2,092</td>
<td>861</td>
<td>7,988</td>
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<td>Council area</td>
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<td></td>
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<tr>
<td>Argyll and Bute</td>
<td>2,065</td>
<td>2,045</td>
<td>1,236</td>
<td>8,692</td>
</tr>
<tr>
<td>Renfrewshire</td>
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<td>3,534</td>
<td>1,886</td>
<td>14,472</td>
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<td>998</td>
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<td>3,998</td>
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<td>2,179</td>
<td>1,045</td>
<td>8,472</td>
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<td></td>
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<td>395</td>
<td>178</td>
<td>1,545</td>
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<td>Paisley</td>
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<td>1,801</td>
<td>1,070</td>
<td>7,692</td>
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<tr>
<td>Inverclyde</td>
<td>2,107</td>
<td>2,148</td>
<td>992</td>
<td>8,285</td>
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<th>Coronary heart disease</th>
<th>Coronary cancer</th>
<th>All causes</th>
<th>Stroke</th>
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<td>108 *</td>
<td>111 *</td>
<td>106 *</td>
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<td>108 *</td>
<td>108 *</td>
<td>114 *</td>
<td>107 *</td>
</tr>
<tr>
<td>Female</td>
<td>104 *</td>
<td>108 *</td>
<td>110 *</td>
<td>104 *</td>
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<tr>
<td>Age group</td>
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<tr>
<td>0 to 14</td>
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<td>15 to 34</td>
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<td>163</td>
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</tr>
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<td>35 to 74</td>
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<td>127 *</td>
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<td>116 *</td>
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<tr>
<td>75+</td>
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<td>105 *</td>
<td>109 *</td>
<td>103 *</td>
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<tr>
<td>Deprivation quintile</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depquint (affluent)</td>
<td>94 *</td>
<td>96</td>
<td>109 *</td>
<td>95</td>
</tr>
<tr>
<td>Depquint2</td>
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<td>99</td>
<td>118 *</td>
<td>100</td>
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<td>111 *</td>
<td>114 *</td>
<td>115</td>
<td>113 *</td>
</tr>
<tr>
<td>Depquint5 (deprived)</td>
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<td>126 *</td>
<td>108</td>
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<tr>
<td>Council area</td>
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<tr>
<td>Argyll and Bute</td>
<td>93 *</td>
<td>92</td>
<td>103</td>
<td>94</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>108 *</td>
<td>110 *</td>
<td>121 *</td>
<td>109 *</td>
</tr>
<tr>
<td>East Renfrewshire (A&amp;C part)</td>
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<td>104</td>
<td>93</td>
<td>99</td>
</tr>
<tr>
<td>West Dunbartonshire (A&amp;C part)</td>
<td>113 *</td>
<td>115 *</td>
<td>96</td>
<td>111 *</td>
</tr>
<tr>
<td>Inverclyde</td>
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<td>122 *</td>
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<td>115 *</td>
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<td></td>
</tr>
<tr>
<td>West Renfrewshire</td>
<td>106</td>
<td>111 *</td>
<td>120 *</td>
<td>107 *</td>
</tr>
<tr>
<td>Argyll and Bute</td>
<td>95</td>
<td>92</td>
<td>110 *</td>
<td>96</td>
</tr>
<tr>
<td>Lomond</td>
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<td>91</td>
<td>101</td>
</tr>
<tr>
<td>Renfrew</td>
<td>104</td>
<td>105</td>
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<td>100</td>
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<td>Lomond</td>
<td>109</td>
<td>112</td>
<td>102</td>
<td>106</td>
</tr>
<tr>
<td>Paisley</td>
<td>109 *</td>
<td>108 *</td>
<td>127 *</td>
<td>112 *</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>114 *</td>
<td>121 *</td>
<td>113</td>
<td>114 *</td>
</tr>
</tbody>
</table>

* Denotes an SMR which is significantly low compared with Scotland (P<0.01).
* Denotes an SMR which is significantly high compared with Scotland (P<0.01).
Based on indirect standardisation to Scotland. Scotland = 100.
SMR = 100 x Observed number of deaths / Expected number of deaths.

mortality ratios (SMRs - see glossary, page 36), shown on the right-hand side. SMRs remove effects of different population age, and sex structures, and allow comparisons with Scotland as a whole (for which the SMR for any given cause of death is 100).

For cancer, CHD and stroke, Argyll and Clyde as a whole had relatively high SMRs (at 105, 108 and 111, they were respectively 6, 8, and 11% higher than for Scotland). Breaking down the figures for Argyll and Clyde, the SMRs for cancer and CHD were significantly high (relative to Scotland) in the more deprived depuqins. This is a good example of inequalities in health. It is well known that adverse life circumstances (see page 1) impact on health through links with lifestyle. However, even allowing for inequalities in lifestyle, deprivation and disadvantage are associated with an excess of ill-health and premature death. The two main messages from this are that action on health inequalities needs action on life circumstances, and that action on lifestyle needs to take account of people's life circumstances.

In the case of stroke, the picture in Table 5 is more complicated. With depuqins 1 and 2 (the most affluent categories) as well as depuqin 4 (the second most deprived) showing significantly high SMRs.

We need to take a more detailed look at cancer, not only because it is the biggest of the Big 3 killers, but because it is made up of so many different types. By the age of 74 years, about 1 in 3 men and 1 in 4 women in Scotland can expect to have been diagnosed with cancer of some sort.

Cancer registrations suggest that the main cancer sites among males in Argyll and Clyde are lung, skin, large bowel and prostate (Table 6). Lung cancer is at the top of the list for both registrations and deaths, accounting for over a fifth of all cancer registrations and over a third of all cancer deaths. It has a relatively low survival rate.

| Table 6: Registrations of, and deaths from, the most common cancers (malignant neoplasms) Argyll and Clyde residents, all ages, by sex |
|---|---|---|---|
| Registrations | Registrations | Registrations | Registrations |
| ranking | Cancer site | Annual numbers |Deaths | % of all sites | Deaths | % of all sites |
| 1 | Lung | 267 | 238 | 21% | 35% |
| 2 | Skin | 236 | 8 | 19% | 1% |
| 3 | Large bowel | 134 | 67 | 11% | 10% |
| 4 | Prostate | 124 | 63 | 10% | 9% |
| All sites | 1,252 | 682 | 100% | 100% |
| FEMALES | | | | | |
| 1 | Breast | 275 | 105 | 21% | 16% |
| 2 | Skin | 247 | 8 | 19% | 1% |
| 3 | Lung | 164 | 151 | 12% | 23% |
| 4 | Large bowel | 139 | 75 | 11% | 11% |
| All sites | 1,316 | 654 | 100% | 100% |

1 Includes both malignant melanoma and non-melanoma skin cancer (although the latter may be under-recorded on registrations).

Sources: SMR06 cancer registrations and GROS death registrations (from ISO Online).

Among females, breast cancer is the most commonly diagnosed type of cancer, but it has a relatively high survival and thus accounts for only 16% of all female cancer deaths (Table 6). Lung cancer kills more women than breast cancer (151 deaths per year in Argyll and Clyde, compared to 105).

Clearly, for both sexes one of the key messages from Table 6 is the high rates of diagnosis and deaths from lung cancer. This is very largely a preventable disease, with smoking accounting for some 90% of cases (see page 29). A worrying trend in deaths...
from lung cancer is the steady rise in females, as shown in Figure 10. In the 20 years from 1980, the rate more than doubled (from 32 to 83 per 100,000 population). This reflects historical increases in smoking among women, and underlines concerns over continuing levels of smoking among females.

Lifestyle has also been linked to cancer of the large bowel. The main lifestyle risk factor is the ‘Western world’ pattern of diet (see page 34). Smaller increases in risk have been associated with physical inactivity, smoking (in males) and beer drinking (in males, in relation to cancer of the rectum).

Figure 10: Lung cancer crude death rates for Argyll and Clyde residents – all ages, by gender, 1980 - 2000

In addition to the above, smoking, an unhealthy diet and alcohol misuse have been linked to some other types of cancer (see pages 29, 34 and 49). There is some evidence to suggest that a change in population lifestyles, involving a reduction in dietary fat intake, increased exercise, weight loss and a reduction in alcohol intake, would lower the incidence of breast cancer. There are currently no identified prospects for preventing prostate cancer through lifestyle change.

Table 6 shows that skin cancer ranks second in the list of cancer registrations for both males and females in Argyll and Clyde, but accounts for a low proportion of cancer deaths. The figures shown are for malignant melanoma and non-melanoma skin cancer combined, and it is likely that the numbers given are an undercount due to under-reporting of non-melanoma cancers. Skin cancer is very much lifestyle-related. The major preventable factor is excessive exposure to ultraviolet (UV) light, whether natural sunlight or from sunbeds. A problem is that people often think of a tan as a sign of good health, when it is a sign of damaging exposure to UV light that can age the skin, cause unsightly blemishes and lead to cancer. Nationally, a significant increase in malignant melanoma has been giving rise to particular concern. Melanoma is rarer than non-melanoma skin cancer, but tends to be fatal if not treated early. Early detection is very important. The fact that deaths from melanoma have risen less than the incidence rate points to benefits from better surgical treatment, earlier diagnosis or both.
Oral health

'Oral health' means the health of the mouth, and includes dental health (the health of the teeth and gums). Good oral health is an essential part of good general health, and is influenced by both life circumstances and lifestyle. Key lifestyle factors for the protection and promotion of oral health include a diet that is low in high-sugar food and drink, regular tooth brushing, and regular trips to the dentist. Neglect of these can lead to dental decay, gum disease, pain, difficulty in eating and speaking, tooth loss, reduced self confidence, and damage to people's interactions with others and their social life.

Oral cancer

On average, 27 people in Argyll and Clyde die each year from cancer in and around the mouth. The incidence is increasing, and the main identified risk factors are smoking and alcohol misuse. There is a clear association between life circumstances and oral cancer, with higher rates in more deprived areas. It is important to detect oral cancer early, and examination of the soft tissues of the mouth by a dentist is recommended for adults at least once a year.

Dental health in the Your Health and Wellbeing survey

In the Your Health and Wellbeing survey, 59% of respondents said that they have 20 or more natural teeth, 22% between 1 and 19 natural teeth, and 18% none. Across deprivation quintiles, the percentage with no natural teeth ranged from 14% in depquint 1 (the most affluent) to 24% in depquint 5 (the most deprived), with a fairly steady gradient in between. The percentage of respondents with no natural teeth increased with increased age (from less than 1% in 16-34 year-olds, to 59% in those aged 75+).

The White Paper on Health, Towards a Healthier Scotland (1999), set a target that less than 5% of 45-54 year olds should have no natural teeth by 2010. The findings from the Your Health and Wellbeing survey suggest that the target has not yet been met in Argyll and Clyde. 10% of respondents aged 45-54 reported having no natural teeth. This compares with figures of 13% in the Argyll and Clyde 1996 Apple A Day survey and 13% for Scotland in a 1998 UK survey. However, among the 35-44 year-old respondents to the Your Health and Wellbeing survey (who will be approaching 45-54 years in 2010), only 2.8% reported having no natural teeth. This suggests that Argyll and Clyde may achieve the target by 2010. In looking at the results from the survey, we need to remember the possibility of non-response bias (see page 8). It is possible that the figures from the survey are lower than in the Argyll and Clyde population as a whole.

The Oral Health Strategy for Scotland (1995) has a further target for adults, which is that at least 80% of those 35-44 year olds who have one or more natural teeth should have 21 or more natural teeth by 2008. Results from the Your Health and Wellbeing survey suggest that the target may already have been met in Argyll and Clyde: 83% of respondents in that age group said they have 20 or more natural teeth. Again, however, the possibility of non-response bias has to be borne in mind.

Dental check-ups

In the Your Health and Wellbeing survey, 68% of respondents said they visited the dentist for a check-up within the preceding 15 months, 17% that they last did so between 16 months and five years previously, and 10% that their last check-up was more than five years ago. 1% had never been for a check-up, and 4% did not know whether they had or not.

The percentage who had a check-up within the preceding 15 months was higher in female respondents and among those from the more affluent depquins, and decreased with increased age. This last finding is likely to be related to more older people having...
no natural teeth and therefore perhaps not considering that they need regular dental
check-ups. However, older people are more at risk of developing oral cancer. Check-ups
are vital even if you have no natural teeth.

Registration with a dentist

The survey asked people whether they are currently registered with a dentist. 80% of
respondents answered ‘yes’. The actual figure in the overall population registered with
an NHS dentist is believed to be lower. People who are registered with an NHS dentist
but do not visit the dentist for more than 18 months are automatically removed from the
list and no longer registered. It is likely that a number of Your Health and Wellbeing
survey respondents have become unregistered without being aware of this. Some of
those who are not registered with the NHS will be receiving private dental care, but the
number of such people is not known.

Sexual health

Sexual health is another important aspect of general health. Sexual health problems
include unwanted pregnancy (which may lead to unplanned parenthood or termination
of pregnancy), infertility, sexually transmitted infections (STIs) and psychological
suffering.

Having multiple sexual partners is known to increase the risks of STIs and cancer of the
cervix. Chlamydia is a common STI and a major cause of pelvic inflammatory disease,
infertility and ectopic pregnancies (which develop outside the womb and may endanger
the life of the pregnant woman). There are concerns that STIs, including chlamydia,
gonorrhoea and syphilis, have increased rapidly in recent years, both locally and across
Scotland. Figure 11 shows the situation for chlamydia. The rise in the rate in Argyll and
Clyde in 2000/01 is thought to be partly due to greater awareness of these conditions
and the introduction of new services for their detection and management. Blood-borne
viruses (see also page 81), including human immunodeficiency virus (HIV), hepatitis B
virus and hepatitis C virus, can be transmitted sexually and carry serious risks to both
general and sexual health.

![Figure 11: Chlamydia diagnosed in Scotland and in Argyll and Clyde laboratories, both sexes, all ages, 1997/98 - 2000/01](image)

Teenage pregnancy rates are another important indicator of sexual health. The rates in
Argyll and Clyde are not high relative to Scotland as a whole (Figure 12), but there are
variations amongst LHCC localities within the area.
Figure 12: Teenage pregnancy rates for residents of Scotland, Argyll and Clyde and its 7 LHCC localities, by age group, 8-year period 1991 - 1998

Source: ISD (SMR1/01 and SMR2/02).

Harm from alcohol misuse

Problems caused by alcohol misuse are described in Section 2 (see page 48). Alcoholic cirrhosis and other types of alcoholic liver disease are important indicators of alcohol problems. Figure 13 shows time trends for deaths from alcoholic liver disease/cirrhosis. Argyll and Clyde has a high rate compared to Scotland, and it has increased markedly over the last decade.

These trends are repeated for other diseases caused by alcohol misuse, both for deaths and for hospital admissions, indicating a serious and growing problem in Argyll and Clyde. Misuse of alcohol has been estimated to have cost hospital and ambulance services in NHS Argyll and Clyde in the region of £19m in the year 2000. This does not include the costs to primary care, eg for GPs, community nurses and prescribed drugs. Additional costs will be borne by other organisations, eg voluntary agencies, social work, the police, fire service, and industry. Even if we could add all these costs up, we would still be missing out the enormous, and no doubt growing, toll of social misery, family disruption and wasted lives caused by alcohol misuse.

Figure 13: Alcoholic liver disease and cirrhosis – crude death rates – residents of Scotland and Argyll and Clyde, all ages, 1980 - 2000

Source: GROS.
Harm from drug misuse

Examples of the wide-ranging harm associated with drug misuse are given in Section 2 (see page 58). This includes many types of ill-health, some of which can be fatal. Hepatitis C and 'drug-related deaths' are considered here as only a partial illustration of drug-related ill-health in Argyll and Clyde.

**Hepatitis C**

The link between drug misuse and blood-borne viruses (BBVs), including hepatitis C (HCV), is described on page 59. HCV was first identified in 1989. The major route of transmission in the UK is by sharing equipment for injecting drug misuse, mainly via blood-contaminated needles and syringes. Spoons, water and filters used in preparing drugs for injecting may also act as vectors for the spread of the infection.

Contact with HCV can be detected by a blood test for antibodies to the virus. Table 7 shows the number of people reported as being HCV antibody-positive in Argyll and Clyde.

*Table 7: Persons in Argyll and Clyde reported to be hepatitis C antibody-positive, by year of earliest positive specimen*  

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-1991</td>
<td>5</td>
<td>31</td>
<td>38</td>
<td>16</td>
<td>28</td>
<td>54</td>
<td>52</td>
<td>80</td>
<td>120</td>
<td>160</td>
<td>147</td>
<td>127</td>
</tr>
</tbody>
</table>

Source: Scottish Centre for Infection and Environmental Health (2002)

It is likely that the true number of antibody-positive people is several times greater than the number detected.

Around 20% of people who become infected with HCV clear the virus within 2 to 6 months of infection. This means that 80% continue to have the virus. A report in 2000 estimated that 0.7% of the population of Scotland were infected with the virus. If the same percentage were to apply in Argyll and Clyde, that would mean that there would be nearly 3,000 people in the area infected with HCV.

The likely consequences of HCV for infected individuals and for the NHS are discussed on page 59.

**Drug-related deaths**

Table 8 shows the numbers of officially-defined 'drug-related deaths' among Argyll and Clyde residents over recent years.

*Table 8: ‘Drug-related deaths’ in Argyll and Clyde residents, 1996-2001*  

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>18</td>
<td>16</td>
<td>23</td>
<td>30</td>
<td>31</td>
<td>22</td>
</tr>
</tbody>
</table>

Source: General Register Office for Scotland (2002)

The definition of drug-related deaths used by the General Register Office for Scotland (GROS) in compiling the above figures is a tight one. It concentrates on deaths in which psychoactive drugs or drugs listed under the Misuse of Drugs Act (1971) are considered to have contributed directly to death. It excludes deaths resulting from...
infections associated with drug misuse (such as BBVs and, recently in Scotland, clostridium bacterial infection); deaths from accidents occurring under the influence of drugs, and homicides related to the misuse or supply of drugs (other than those resulting from assault by drugs). The GROS definition was devised as a headline indicator rather than as a comprehensive count of all deaths to which drug misuse contributes in some way. Even if a more complete account of such deaths and drug-related ill-health were available for Argyll and Clyde, that would not capture the considerable amount of social harm caused to individuals, families, communities and society (see page 58).
Section 2

Lifestyle and action in Argyll and Clyde
Section 2 - Lifestyle and action in Argyll and Clyde

Smoking

Introduction

Smoking remains a major cause of serious illness and premature death in Scotland – and in Argyll and Clyde. It has been estimated that 13,000 people in Scotland die every year as a result of their smoking. That amounts to 1 in 5 of all deaths. One in two long-term smokers will die before their time because they smoked, half of these in middle age.

Research has suggested that smoking accounts for:

- 90% of deaths from lung cancer
- 23% of deaths from coronary heart disease in men, and 11% in women
- 13% of deaths from stroke in men, and 9% in women.

In addition, smoking is linked to a number of other types of cancer, and to other serious diseases affecting the blood vessels. It also increases the risk of many other health problems, including chronic bronchitis and emphysema, stomach and duodenal ulcers, cataracts and hearing loss.

The figures given above relate to harm caused to people by their own smoking. They do not include the damage that results from breathing in other people’s smoke (passive smoking). Research has linked passive smoking to a wide range of health problems, including lung cancer, heart disease and stroke. For babies and children, it increases the risk of bronchitis, pneumonia, asthma attacks, middle ear infection (including ‘glue ear’) and sudden infant death syndrome (‘cot death’). One of the best things parents can do for the health of their children is stop smoking.

The risk to babies starts even before birth. Smoking in pregnancy has been linked to stillbirth, prematurity, low birthweight, and death in the early weeks after birth.

Smoking is a major contributor to inequalities in health. People who live in disadvantaged circumstances are much more likely than better-off people to smoke and to suffer the health consequences. Moreover, while the prevalence of smoking fell by more than 50% in the most advantaged section of the population of Britain between 1973 and 1996, it remained unchanged in the most deprived group.

Findings from the Your Health and Wellbeing survey

How many people in Argyll and Clyde smoke?

<table>
<thead>
<tr>
<th>Figure from the survey</th>
<th>Adjusted figure (see page 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>35%</td>
</tr>
</tbody>
</table>

- 25% of respondents said that they smoke some days or every day.
- 26% said that they have given up smoking.
- 48% said that they have never smoked.

The figure of 25% for current smokers found in the survey is likely to be lower than the actual figure in the population overall. The issue of non-response bias is described on page 8, as is the thinking behind giving the ‘adjusted figure’ shown above. Reporting bias, also described on page 8, can also occur when people are asked in surveys whether they smoke or not.

A higher percentage of men (28%) than women (23%) said that they smoke. This differs from the pattern seen in younger people in Scotland – across the country as a whole,
a higher percentage of girls than boys smoke. This means that we may in time come to see a higher percentage of women than men smoking.

**What about links with life circumstances?**

As described on page 4, it was possible to compare survey findings between respondents from different communities within Argyll and Clyde, ranging from the 20% of the population who live in the most affluent areas (depquint 1) to the 20% in the most deprived (depquint 5). As can be seen from Figure 14, the percentage of smokers was found to be lowest in the respondents from depquint 1 and highest in those from depquint 5, with a fairly steady gradient in between.

![Figure 14: Percentage of respondents within each deprivation quintile who said they smoke some days or every day](image)

**How many smokers are thinking about stopping smoking?**

Table 9 shows that almost three-quarters (73%) of current smokers said they are either thinking about stopping smoking or are going to stop. (This compares with 60% in the 1996 Argyll and Clyde An Apple a Day survey who reported they would like to give up smoking.) Just over a quarter (27%) said they do not intend to stop smoking. A higher percentage of male smokers (33%) than female smokers (22%) said they do not intend to stop smoking.

<table>
<thead>
<tr>
<th></th>
<th>I do not intend to stop smoking</th>
<th>I am thinking about stopping smoking</th>
<th>I am going to stop smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>33%</td>
<td>49%</td>
<td>18%</td>
</tr>
<tr>
<td>Females</td>
<td>22%</td>
<td>57%</td>
<td>21%</td>
</tr>
<tr>
<td>Both sexes</td>
<td>27%</td>
<td>53%</td>
<td>20%</td>
</tr>
</tbody>
</table>

A higher percentage of smokers in the older age groups (aged 75+ and 55-74) than in younger age groups said that they do not intend to stop smoking.

**At what age did people start smoking?**

The survey asked current smokers and ex-smokers what age they were when they first started smoking. Figure 15 shows the percentage of respondents who started smoking at each age. The commonest reported ages for having started smoking were 16 and 15. 80% started smoking before they were 20.
What about passive smoking?

The survey asked how often people are exposed to other people’s tobacco smoke in various places. The findings from non-smokers are shown in Table 10. We are concentrating on the non-smokers here because they have chosen not to take in tobacco smoke directly and would otherwise not be exposed to it.

<table>
<thead>
<tr>
<th>Place</th>
<th>Rarely or never</th>
<th>A few days (1-2 days per wk)</th>
<th>Some days (3-5 days per wk)</th>
<th>All or most days (6-7 days per wk)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At home</td>
<td>81%</td>
<td>4%</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>At work</td>
<td>76%</td>
<td>7%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>On public transport</td>
<td>82%</td>
<td>10%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>In pubs/clubs</td>
<td>54%</td>
<td>36%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

The percentage exposed on one or more days per week ranged from 18% on public transport to 46% in pubs/clubs. The home was the place where the highest percentage of non-smokers (12%) reported exposure to other people’s tobacco smoke every day or nearly every day.

Action

Policy and strategy background

In 1998, the UK Government published the White Paper on Tobacco, Smoking Kills, which drew attention to the devastating impact of tobacco use on the public’s health, and set out a wide-ranging strategy and action plan to reduce smoking. The strategy includes measures affecting the whole population, but identifies as priorities action relating to:

- children and young people
- adults who smoke – especially the most disadvantaged, and pregnant women.

The action plan includes:
- a ban on tobacco advertising, promotion and sponsorship
- increases in tobacco tax
Section 2 - Lifestyle and action in Argyll and Clyde

- action against tobacco smuggling
- action on underage sales of tobacco
- new NHS services to help smokers to quit
- mass media campaigns
- voluntary controls on smoking in workplaces and public places.

Reducing the prevalence of smoking was also identified as a priority in the 1999 White Paper on Health, *Towards a Healthier Scotland*, which set the following targets:

- reduce smoking among 12-15 year-olds from 14% (in 1995) to 12% by 2005, and 11% by 2010
- reduce the proportion of women who smoke during pregnancy from 29% (in 1995) to 23% in 2005, and 20% by 2010
- reduce the proportion of 16-64 year-olds who smoke from an average of 35% (in 1995) to 33% by 2005, and 31% by 2010.

Helping smokers to stop smoking is a very important part of the strategy, and new NHS smoking cessation services have been developed through the Health Improvement Fund that was created from the income from tobacco taxation. Based on evidence from research into best practice, the *Smoking Cessation Guidelines for Scotland* report promotes a 'stepped care' approach whereby health professionals offer and provide advice and support that is tailored to the needs of the individual smoker. The report encourages health professionals to ask their patients about their smoking habits, give smokers advice and support to help them quit (including advice on smoking cessation aids such as nicotine replacement therapy – NRT), and refer them to more specialist cessation support where necessary.

The NHS is only one of many agencies with parts to play in tackling smoking. Action against tobacco involves all sectors of society – including local authorities, businesses, the voluntary sector and the media – working in partnership.

Most smokers start smoking in their teenage years, and almost one in four 15 year-olds in Scotland smoke. From the starting point of experimenting with cigarettes, a smoking pattern like that of an adult smoker can become established in less than a year. When they take up smoking, young people are often confident that they will be able to quit at some point in the future. However, nicotine is highly addictive, and most find that stopping smoking is not as easy as they had expected. In fact, four out of every five teenage smokers go on to smoke regularly in adult life. Action to help young people not to start smoking and to help young smokers to quit as early as possible are important parts of the overall tobacco strategy.

**Examples of action in Argyll and Clyde**

The Argyll and Clyde Tobacco Steering Group was formed to support local implementation of *Smoking Kills*. It has representatives from local government, social inclusion partnerships, community health projects and the NHS. The group helps join up a range of developments in tobacco control in Argyll and Clyde, encourages evaluation, and acts as a vehicle for exchanging and spreading information on good practice.

**Smoking cessation services** - Services to help people give up smoking are being developed in all areas in Argyll and Clyde, in line with national guidance. Primary care services are leading the way. Money from the Scottish Executive's Health Improvement Fund has been used to develop specialist services within each local health care co-operative (LHCC), and there are smoking cessation advisers in LHCCs to coordinate and develop local services and provide specialist support to smokers who find it particularly difficult to quit. A number of community pharmacies are providing support services for local people who are trying to stop smoking. Also, there are innovative...
projects to meet the particular needs of pregnant women, young people and low income groups.

Learning and development - In order to be confident and as effective as possible in helping smokers to quit, health workers need relevant knowledge and skills. Training on skills and strategies to help people stop smoking has been delivered throughout Argyll and Clyde. Following training, practitioners have developed smoking cessation services based in GP practices, local community centres and community pharmacies.

No Smoking Day - A number of local groups and organisations take part in the annual No Smoking Day campaign. The campaign raises awareness of the health issues related to tobacco use, encourages smokers to quit, and promotes locally-available smoking cessation services.

Local authorities - Councils have roles to play in promoting smoke-free environments for their staff, service users and the public at large. Councils in Argyll and Clyde are partners in a range of tobacco initiatives and are reviewing and updating their policies on smoking. There are a number of other ways in which local authorities can contribute to tobacco control, including:
- the involvement of environmental health officers in measures to reduce environmental tobacco smoke in public places such as restaurants and bars
- support for trading standards departments to develop interventions to tackle underage sales of tobacco products
- effective tobacco policies and strategies in schools and other education settings.

Social inclusion partnerships - Community health projects, established in most social inclusion partnership areas in Argyll and Clyde, are playing their parts. For instance:
- the Phoenix Health Project in Inverclyde helps smokers find alternative ways of dealing with stress
- Magic Wand has taken the lead in forming the TAR (Tobacco Awareness Raising) Group, an alliance of statutory and voluntary organisations in the Barrhead area
- Renfrewshire Community Health Initiative is involved in awareness raising, training and smoking cessation service delivery.

Workplaces - The Scotland's Health at Work award scheme is encouraging and helping workplaces to develop policies that restrict exposure to environmental tobacco smoke, and support employees who want to quit smoking.

Examples of local-level work

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Bute</td>
<td>• The Zone stop smoking programme in Bute</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>• TAR (Tobacco Awareness Raising) Group</td>
</tr>
<tr>
<td></td>
<td>• HEBS/ASH Scotland-supported project on smoking cessation for young pregnant women and their partners</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>• Inverclyde Tobacco Control Alliance</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>• Training needs assessment with youth workers</td>
</tr>
<tr>
<td></td>
<td>• Have a Heart Paisley tobacco projects</td>
</tr>
<tr>
<td></td>
<td>• Project on smoking cessation for young pregnant women and their partners (see under East Renfrewshire)</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>• Training in 'negotiating behaviour change'</td>
</tr>
</tbody>
</table>
Action priorities for Argyll and Clyde

Changing culture is vital if we are to achieve a lasting change for the better. Local media, NHS Argyll and Clyde, councils, local businesses, voluntary organisations and community groups can all challenge the image of smoking as acceptable or desirable. This needs to be combined with partnership action ‘on the ground’ to help young people not to start smoking, to help smokers quit, and to protect children and others from passive smoking in the home and elsewhere.

Key action points

- Overarching priority – tackle inequalities in smoking and smoking-related harm
- Help local communities have the motivation, confidence and skills that enable them to recognise the importance of tobacco as a health issue, and to take action against it
- Further develop local-level smoking cessation services, responsive to the needs of different smokers
- Find new ways of promoting and supporting smoking cessation among young people, and helping them not to start in the first place
- Help pregnant women and their partners to stop smoking – and stay stopped
- Reduce public exposure to environmental tobacco smoke
- Reduce accessibility of tobacco products to underage children

Diet

Introduction

It is important to point out that the term ‘diet’ here means the food we eat in our everyday lives, not the idea of ‘going on a diet’ to reduce weight. Eating for health, including controlling body weight, is about the diet we eat throughout our lifespans.

The Scottish diet is notoriously high in fat, salt and sugar, and low in fruit and vegetables. The White Paper on Health, Towards a Healthier Scotland, identified diet as the second most important cause of Scotland’s poor health, next to smoking. It has been linked to many different health problems, including coronary heart disease (CHD), cancer, stroke, high blood pressure and dental disease. Differences in diet between sections of the population contribute significantly to inequalities in health.

The link between diet and CHD is widely recognised, but it often comes as a surprise to people to hear that dietary factors may be responsible for up to 30% of cancers. The all-too-common Scottish diet pattern has long been linked to cancer of the bowel, and evidence has been building up of links between diet and other types of cancer. For example, diets high in green and ‘yellow’ vegetables, and citrus fruits, have been associated with lower rates of cancer of the lung, bowel, gullet and stomach.

Traditionally, healthy eating messages have been seen as meaning only that we should eat less of this, that and the next thing. Good news in recent years has been the more positive message that there are foods that we as a nation should be eating more of if we are to have a healthily balanced diet – fruit and vegetables, bread,
breakfast cereals, pasta, rice, potatoes and oil-rich fish. Acting on such advice gives sources of fibre and nutrients that promote well-being and help protect against heart disease and cancer, and naturally reduces the amount of fat and processed sugar in the diet.

A source of major concern in Scotland is the increasing number of people who are overweight or obese. Being overweight or obese increases the risk of high blood pressure, CHD, stroke, some cancers and an increasingly common type of diabetes ('type 2' diabetes). Low self-esteem, physical, mental and social discomfort, reduced mobility and a generally impaired quality of life are common experiences for many people who are obese. Also, obesity is associated with an increased mortality in people of all ages. Although some people are more genetically predisposed than others to put on weight, the modern 'epidemic' of overweight and obesity is considered to be due to a combination of unhealthy diet and physical inactivity.

Breastfeeding is good for health in infancy, and into childhood. There is growing evidence that health benefits even extend into adulthood. More generally, diet in the early years influences adult health. The diets of children and young people in Scotland tend to be worryingly high in sugary and fatty foods and low in fruit and vegetables. This, together with too little physical activity, is proving to be a recipe for overweight and obesity in these groups.

There are some encouraging trends in the Scottish diet. These include evidence of increases in consumption of fruit, vegetables, salads, pasta, rice and low fat milk among 11 year-olds in recent years. However, improving Scotland's diet across the lifespan is still a massive, complex and long-term task.

Findings from the Your Health and Wellbeing survey

How many people in Argyll and Clyde eat the recommended five or more portions of fruit and vegetables every day?

Figure from the survey: 39%
No adjusted figure available (see page 8)

The number of portions of fruit and vegetables we eat each day is a useful pointer to whether or not we are eating a healthy diet. The recommendation for promoting and protecting health is to have at least five portions daily. The Your Health and Wellbeing survey asked people on average how many pieces or portions of fruit they eat each day (including up to one glass of fruit juice), and how many portions of vegetables or salad (not counting potatoes) they eat each day. 39% of respondents reported eating five or more portions of fruit and vegetables each day. The actual figure in the population of
Argyll and Clyde may be lower than this. No adjustment is available for possible non-
response bias (see page 8). Also, there is a possibility of reporting bias (see page 8).
A higher percentage of women (46%) than men (29%) reported eating five or more
portions each day. The percentage of respondents eating five or more portions each
day increased with increased age among the under-15 year-olds, before falling slightly
in the 75+ age group.
Figure 16 shows that the percentage of respondents eating five or more portions each
day was lower in the more disadvantaged communities, with a downward gradient from
depquin 1 to depquin 5.

It can be seen from Figure 17 that a higher percentage of respondents in Argyll and
Bute council area said that they eat five or more portions each day than in the other
council areas.

Figure 17: Percentage of respondents within each council area
eating five or more portions of fruit and vegetables each day

A higher percentage of respondents in Argyll and Bute (45%) and Lomond (43%) LHCC
localities eat five or more portions each day than in the other LHCC localities (34% to
38%).

The average number of portions eaten daily, as reported by respondents, was 4.1. This
is higher than would be expected, and may reflect bias (see page 8).

What type of milk do people use?
Another useful indicator of the healthiness of our diet is what kind of milk we usually
drink, in terms of its fat content. Semi-skimmed milk contains less fat than full cream
milk, and skimmed milk is almost fat-free.
Almost three-quarters of respondents (73%) usually use semi-skimmed milk (63%) or
skimmed milk (10%), and just under a quarter (23%) whole milk. The actual figures for
semi-skimmed and skimmed milk in the whole population of Argyll and Clyde may be
lower, again due to the possibility of bias.

Reported use of whole milk was higher among: men (26%) than women (22%); the 75+
age group; and those from the more disadvantaged depquins.

How often do people eat breakfast?
Eating breakfast is an important start to the day. It boosts metabolism after overnight
sleep, and promotes a feeling of being full and so reduces mid-morning cravings for
fatty snacks. Both of these benefits are factors in weight management.

Almost two-thirds (63%) of respondents said that they eat breakfast every day, while
13% replied that they rarely or never eat breakfast.

A higher percentage of women (66%) than men (60%) said they eat breakfast every day. The percentage of respondents eating breakfast every day increased with increased age, while the percentage who rarely or never eat breakfast decreased with increased age. In the 16-34 age group, 46% of respondents eat breakfast every day, and 19% rarely or never eat breakfast. In the 75+ age group, 85% of respondents eat breakfast every day, while 7% do so rarely or never.

The percentage of respondents who eat breakfast every day was lower in the more disadvantaged communities. 57% of respondents from depquin 5 (most deprived) said they eat breakfast every day, compared with 69% of those from depquin 1 (most affluent).

**Healthy eating score**

In order to paint an overall picture of how healthy our diets are, the survey asked people how often they eat a range of different foods. Twelve food groups were chosen:

- six ‘healthy’ – fruit; vegetables; pulses; potatoes (not chips); fish (not fried); and bread, rice, pasta or other grains
- six ‘less healthy’ – meat products such as pies and burgers; chips, crisps and savoury snacks; cakes, pastries or biscuits; chocolate or sweets; and soft fizzy drinks (regular or diet).

A scoring system was used such that the more often a respondent eats a ‘healthy’ food, and the less often they eat a ‘less healthy’ food, the higher the overall score for that person. The respondents were then categorised into one of three groups (‘least healthy’, ‘intermediate’ and ‘most healthy’) on the basis of their overall score, with roughly a third of the total number of respondents in each group.

A higher percentage of men (36%) than women (28%) were in the least healthy category, and a higher percentage of women (34%) than men (25%) were in the most healthy category.

As shown in Table 11, the youngest respondents were more likely than other age groups to be in the least healthy category.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Least Healthy</th>
<th>Intermediate</th>
<th>Most Healthy</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16 to 34</td>
<td>54%</td>
<td>32%</td>
<td>13%</td>
<td>100%</td>
</tr>
<tr>
<td>35 to 54</td>
<td>36%</td>
<td>37%</td>
<td>27%</td>
<td>100%</td>
</tr>
<tr>
<td>55 to 74</td>
<td>15%</td>
<td>42%</td>
<td>43%</td>
<td>100%</td>
</tr>
<tr>
<td>75+</td>
<td>18%</td>
<td>45%</td>
<td>38%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: the figures within a row of the table do not necessarily add up to 100%, due to rounding.

The percentage of respondents in the least healthy category was highest, and the percentage in the most healthy category lowest, in the more disadvantaged communities. 29% of respondents in depquin 1 (most affluent) were in the least healthy category and 34% in the most healthy category, compared with 38% and 24% respectively for depquin 5 (most deprived).

A higher percentage of respondents in Argyll and Bute council area (41%) were in the most healthy category than in the other council areas (27% to 29%). Similarly, a higher percentage of respondents in Argyll and Bute LHCC locality (41%) were in the most healthy category than in the other LHCC localities (25% to 32%).
How many people are overweight?

Whether a person is considered to be of normal weight, or above or below it, depends on both their weight and their height. A person’s body mass index (BMI) is calculated by taking their weight in kilograms and dividing it by the square of their height in metres (kg/m²). The calculated BMI is then used to classify the person as underweight, normal weight, overweight, obese, or very obese.

The survey asked people to give their weight and height, and BMIs were calculated from the figures they provided. Respondents were then classified as in Table 12.

Table 12: Classification of respondents by body mass index (BMI)

<table>
<thead>
<tr>
<th>BMI</th>
<th>Description</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 18.5</td>
<td>Underweight</td>
<td>3%</td>
</tr>
<tr>
<td>18.5 to 24.9</td>
<td>Normal weight</td>
<td>48%</td>
</tr>
<tr>
<td>25.0 to 29.9</td>
<td>Overweight</td>
<td>35%</td>
</tr>
<tr>
<td>30.0 to 39.9</td>
<td>Obese</td>
<td>14%</td>
</tr>
<tr>
<td>40.0 and over</td>
<td>Very obese</td>
<td>1%</td>
</tr>
</tbody>
</table>

50% of respondents were classified as overweight, obese or very obese. This is a lower percentage than would be expected from national figures, and there is a possibility of bias (see page 8).

A higher percentage of men (56%) than women (45%) were found to be overweight, obese or very obese. This difference between the sexes is consistent with the picture in Scotland as a whole. The figures can be compared with the findings from the 1996 Argyll and Clyde An Apple a Day survey - 45% of respondents in that survey (51% of the men and 42% of the women) were classed as overweight, obese or very obese.

The percentage of respondents of normal weight decreased with increased age among under-75 year-olds and was then higher in the 75+ age group. The percentage of overweight or obese respondents increased with increased age among the under-75s and then decreased in the 75+ age group.

Obesity was found to be commoner among the respondents from the more disadvantaged communities. 16% of those from depquin 5 (most deprived) respondents were classed as obese and 45% as being of normal weight, compared with 11% and 50% respectively for depquin 1 (most affluent).

Links with life circumstances

In summary, compared to respondents from the more affluent communities in Argyll and Clyde, those from the more deprived areas were found to be:

- less likely to eat the recommended daily number of portions of fruit and vegetables
- less likely to eat breakfast
- less likely to use semi-skimmed or skimmed milk
- more likely to have an overall healthy eating score in the 'least healthy' category
- more likely to be obese

Action

Policy and strategy background

The strategy on improving Scotland’s diet is set out in the diet action plan for Scotland, *Eating for Health*, published in 1996. Stimulating and meeting demands for healthier foods are central themes. The plan describes key steps under three headings.
Section 2 - Lifestyle and action in Argyll and Clyde

- shaping consumer tastes and making them count
- supplying food for a healthier diet
- understanding food better.

The diet action plan sets out action points relating to food producers, manufacturers, processors and retailers, and to communities, preschool and school settings, caterers, the NHS and local authorities.

The plan includes targets for improving the Scottish diet by the year 2005 (see Table 13).

**Table 13: Target areas in the diet action plan for Scotland**

<table>
<thead>
<tr>
<th>Increases in:</th>
<th>Decreases in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• fruit and vegetables intake</td>
<td>• intake of fats – total and saturated</td>
</tr>
<tr>
<td>• intake of bread, mainly wholemeal and brown</td>
<td>• salt intake</td>
</tr>
<tr>
<td>• intake of breakfast cereals</td>
<td>• intake of NME sugars* in children</td>
</tr>
<tr>
<td>• intake of non-sugar carbohydrates (through the above, plus increased intake of rice, pasta and potatoes)</td>
<td></td>
</tr>
<tr>
<td>• intake of oily fish</td>
<td></td>
</tr>
<tr>
<td>• breastfeeding</td>
<td></td>
</tr>
</tbody>
</table>

*Note: NME (non-milk extrinsic) sugars are sugars other than those that are naturally present in milk and within the plant cells of fruits and vegetables – e.g. sugar added in the manufacture of fizzy drinks or processed foods.

These targets include:

- doubling the average intake of fruit and vegetables
- reducing the average intake of total fat from 40.7% of food energy consumed to no more than 35%
- doubling the consumption of oily fish.

A healthier diet was identified as one of the national priorities in *Towards a Healthier Scotland*, which endorsed the targets set out in the diet action plan.

Tackling inequalities is an important part of the strategy on eating for health, and this raises issues of access to quality food at affordable prices. The Scottish Community Diet Project, set up as a result of the diet action plan, is taking forward work in that area. Another specific development from the plan is the Scottish Healthy Choices Award Scheme, which encourages caterers in a wide range of establishments to provide healthy eating choices. The award also involves meeting standards in terms of food safety and hygiene, support for breastfeeding mothers, and no-smoking areas. A national food and health coordinator has recently been appointed by the Scottish Executive to drive forward progress in implementing the diet action plan.

**Examples of action in Argyll and Clyde**

There is a wide range of healthy eating initiatives underway across Argyll and Clyde, involving local authorities, community health projects, local groups and the NHS. NHS Argyll and Clyde has appointed a diet action plan coordinator to help drive forward implementation of the Scottish diet action plan in the area. The postholder will promote coordination of local effort and partnership working, and will link in with the work of the national food and health coordinator.

**Nurseries and schools** - Money from the Health Improvement Fund has been used by each of the local authorities in Argyll and Clyde to provide fresh fruit for nursery and primary school children.
The councils are involved in a number of other healthy eating initiatives. Examples include:

- nutritional guidelines for pre-5 establishments
- school nutrition action groups (SNAGs)
- improving oral health and feeding practices in schools and pre-5 establishments in Inverclyde through a multiagency approach
- Vale of Leven Academy health promoting school – healthy eating project
- healthy vending project in West Dunbartonshire
- nutritional assessment of school meals provision in Argyll and Bute.

Four new nutrition and dietetic specialists have been appointed to support and develop school nutrition activities, particularly within the related concepts of the health promoting school and new community school.

**Workplaces** - The Scotland’s Health at Work and Scottish Healthy Choices award schemes are providing incentives and help to workplaces in Argyll and Clyde towards ensuring that healthy food choices are available to employees.

**Breastfeeding** - Many factors influence breastfeeding, including cultural acceptance, public awareness and education. NHS Argyll and Clyde has a breastfeeding strategy and action plan that outlines the route to be taken, in collaboration and partnership with others, to make it more likely that mothers in the area will commence, and continue, breastfeeding. Key activities include implementing the UNICEF UK Baby Friendly Initiative in maternity units and the community healthcare setting, and developing community-based initiatives to encourage and support local mothers.

**Learning and development** - A key part of the work on diet and nutrition is training for a range of health professionals, people involved in community food initiatives, and others. This is focused not only on knowledge of nutrition and food but also on understanding barriers that make choosing healthier foods more difficult, such as difficulty in accessing fresh fruit and vegetables. In addition, cooking and shopping skills are essential to support healthy eating messages.

**Examples of local-level work**

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Bute</td>
<td>• Food and health strategy group, developing action plan on schools nutrition</td>
</tr>
<tr>
<td></td>
<td>• Training for health professionals</td>
</tr>
<tr>
<td></td>
<td>• Food access work as part of healthy living centre project, eg Islay community garden</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>• Arther Group, working on nutrition in education settings</td>
</tr>
<tr>
<td></td>
<td>• Levern Valley needs assessment, addressing food poverty and access</td>
</tr>
<tr>
<td></td>
<td>• Healthy Learning Project, encouraging consumption of fruit and water in primary schools</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>• Infant feeding guidelines</td>
</tr>
<tr>
<td></td>
<td>• Pre-5 nursery training, including oral health</td>
</tr>
<tr>
<td></td>
<td>• SNAG work, including curriculum support and working with parents</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>• Renfrewshire Food Federation – community food projects</td>
</tr>
<tr>
<td></td>
<td>• Have a Heart Paisley community projects</td>
</tr>
<tr>
<td></td>
<td>• Royal Alexandra Hospital fruit stall</td>
</tr>
<tr>
<td></td>
<td>• Healthy eating for community care clients</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>• Food Action Network on food in schools</td>
</tr>
<tr>
<td></td>
<td>• Healthy Vending Initiative – a healthy modern approach to providing food in school</td>
</tr>
<tr>
<td></td>
<td>• Food poverty work within healthy living initiative</td>
</tr>
</tbody>
</table>
Action priorities

Diet is a wide and complex issue. The promotion of healthy choices and healthier eating in Argyll and Clyde needs action across a broad front, involving local authorities, social inclusion partnerships, local food producers, retailers and caterers, community groups, voluntary organisations, workplaces and private sector nurseries, as well as the NHS. The NHS and local authorities have important roles both as agents of public health - working in partnership with one another, with other agencies and with communities - and as providers of food for many people, in schools, nurseries, hospitals and other care settings. As with other health and lifestyle issues, setting a good example is very important.

Key action points

- Overarching priority - tackle inequalities in diet and diet-related harm
- Implement breastfeeding strategy and action plan
- Further develop positive influences in nurseries and schools, promoting healthy eating through meals provided and through education
- Increase access to affordable healthier food choices in communities, with particular attention to fresh fruit and vegetables
- Encourage and support food initiatives in disadvantaged communities, focusing on accessibility as well as knowledge and skills (eg in selecting and preparing foods for a healthily balanced diet)
- Promote healthy eating through NHS catering, and contacts with patients
- Promote healthy eating in other care settings
- Link in with new national initiatives through the national food and health coordinator

Physical activity

Introduction

Being physically active in our everyday lives has many benefits for health. Physical activity helps protect against coronary heart disease (CHD), high blood pressure, cancer of the colon (the longest part of the large bowel), overweight and obesity, type 2 diabetes, osteoporosis (thinness and brittleness of the bones), and falls among elderly people. Through its effects on body weight and blood pressure, it also helps prevent strokes. It promotes well-being and can help reduce symptoms of anxiety and depression. Regular activity throughout life is also important for developing and maintaining the body and its everyday functioning.

According to the Physical Activity Task Force, nearly 2,500 people in Scotland die prematurely each year due to physical inactivity. This calculation is based on evidence that physical inactivity accounts for:

- 42% of deaths from CHD
- 25% of deaths from stroke
- 25% of deaths from colon cancer

The improvements in population health that could be achieved by becoming a more active nation are made all the greater by the fact that so many people take little or no exercise of a level that will promote and protect health.

One of the best pieces of public health news in recent years has been that we do not have to be marathon runners, sports champions or even regular joggers to gain
worthwhile health benefits through exercise. Even regular moderate physical activity, such as brisk walking, can have significant beneficial effects, and there is strong evidence that the greatest benefits happen when the least active people become moderately active. These points, together with the levels of inactivity in the population, mean that promoting regular moderate physical activity is not only the most feasible route to a more active population, but also the one that will yield the greatest overall health gain for Scotland and Argyll and Clyde.

The health messages for moderate physical activity are:

- adults should accumulate (build up) at least 30 minutes of moderate activity on most days of the week (meaning five or more days a week)
- children should accumulate at least 1 hour of moderate activity on most days of the week.

**Findings from the Your Health and Wellbeing survey**

*How many people in Argyll and Clyde do not take any significant exercise in an average week?*

<table>
<thead>
<tr>
<th></th>
<th>From the survey</th>
<th>Adjusted figure (see page 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure</td>
<td>15%</td>
<td>20%</td>
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</tbody>
</table>

The survey asked people on how many days in an average week they take at least 30 minutes (not necessarily all at once) of moderate physical exercise such as brisk walking. It also asked on how many days in an average week they spend at least 20 minutes doing vigorous exercise (enough to make them sweaty and out of breath).

15% of those who answered both these questions indicated that they do not take either level of exercise at all in an average week. This is likely to be lower than the actual figure in the population overall due to non-response bias (see page 8), hence the higher adjusted figure shown above.

The answers to the above questions were used to calculate the percentage of respondents who reach either or both of the following recommended levels of activity:

- at least 30 minutes of moderate physical activity (not necessarily all at once) on five or more days each week
- at least 20 minutes of continuous vigorous exercise on three or more days each week. This second level reflects the fact that additional benefit to health can be gained by stepping up from regular moderate activity to more vigorous exercise.

The findings are summarised in Figures 18 and 19.

*How many people reach the recommended levels of moderate or vigorous physical activity, or both?*

**Moderate physical activity**

<table>
<thead>
<tr>
<th></th>
<th>From the survey</th>
<th>No adjusted figure available (see page 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure</td>
<td>42%</td>
<td></td>
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</tbody>
</table>

**Vigorous exercise**

<table>
<thead>
<tr>
<th></th>
<th>From the survey</th>
<th>No adjusted figure available (see page 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure</td>
<td>27%</td>
<td></td>
</tr>
</tbody>
</table>

**Either or both**

<table>
<thead>
<tr>
<th></th>
<th>From the survey</th>
<th>No adjusted figure available (see page 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure</td>
<td>52%</td>
<td></td>
</tr>
</tbody>
</table>
**Section 2 - Lifestyle and action in Argyll and Clyde**

**Moderate physical activity** - It can be seen from Figure 18 that 42% of respondents (the total of the three right-hand columns) reach the recommended level of moderate activity. Put another way, over half (58%) do not. Given the possibility of bias (see page 8), it may be that an even higher percentage of people in the overall population of Argyll and Clyde do not reach the recommended level.

![Figure 18: In an average week, on how many days do you take at least 30 minutes of moderate physical exercise?](image)

A slightly higher percentage of men (44%) than women (40%) reach the recommended level. People in the older age groups were found to be less likely than younger people to reach the recommended level. The percentage reaching the recommended level was lower in the respondents from the more disadvantaged depopulsions than in those from the more affluent.

Taking council areas and LHCC localities separately, the percentages reaching the recommended level were highest for Argyll and Bute Council area (49% as compared with 38% to 41% for the other council areas) and Argyll and Bute LHCC locality (50% as compared with 37% to 43% for the others).

**Vigorous exercise** - From Figure 19, we can see that 27% of respondents (the total of the five right-hand columns) reach the recommended level for vigorous activity. In other words, nearly three-quarters (73%) do not. Again we need to consider the possible impact of bias.

![Figure 19: In an average week, on how many days do you spend at least 20 continuous minutes doing vigorous physical exercise?](image)
A higher percentage of men (31%) than women (24%) reach the recommended vigorous exercise level. The percentage of people reaching the level decreased with increased age.

Compared with the respondents from other council areas (25% to 26%), higher percentages of those from Argyll and Bute (31%) and West Dunbartonshire (29%) reach the recommended level for vigorous activity. Correspondingly, so do a higher percentage of respondents from Argyll and Bute (32%) and Lomond (29%) LHCC localities than from other LHCC localities (25% to 26%).

Either or both levels of activity - Considering the recommended levels for moderate and vigorous physical activity together, 52% of respondents reach one or other, or both. In other words, nearly half of respondents do not reach either level. Once again we need to consider the possibility of bias.

How active do people see themselves as being, and how many people are interested in being more active?

The survey then asked people to pick which one of the categories shown in Figure 20 describes them best.

Figure 20: Which category best describes how physically active you have been over the last 6 months?

- Physically active and have been for longer than 6 months (43%)
- Physically active but only began in the last 6 months (6%)
- Not physically active but intend to be in the next 6 months (19%)
- Not physically active and do not intend to be in the next 6 months (15%)
- Not physically active but am thinking about starting to be in the next 6 months (17%)

About half (49%) of the respondents said they were physically active for at least some of the preceding six months. Nearly two-thirds (63%) of those who said they were not physically active indicated that they were either thinking about or intending to be physically active in the next six months.

Do people feel that they take enough exercise?

People were asked whether or not they feel that they take enough exercise. Two-thirds (67%) of respondents said no, and the other third answered yes.

A slightly higher percentage of women (69%) than men (65%) feel that they do not take enough exercise. The percentage decreased with increased age. It was lower in Argyll and Bute Council area (62%) than in the other council areas (67% to 70%), and likewise in Argyll and Bute LHCC locality (60%) as compared with the other LHCC localities (66% to 71%).

Why would people consider being more active?

Those who feel that they do not take enough exercise were also asked if they would consider being more physically active for any of the reasons in Table 14. The respondents could select all of the reasons that they felt applied to them, and that is why the percentages do not add up to 100.
Table 14: Would you consider being more physically active for any of the following reasons?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>To feel healthier/fitter</td>
<td>83%</td>
</tr>
<tr>
<td>To lose weight</td>
<td>63%</td>
</tr>
<tr>
<td>To prevent disease or ill-health</td>
<td>60%</td>
</tr>
<tr>
<td>To help me relax</td>
<td>47%</td>
</tr>
<tr>
<td>To look better</td>
<td>44%</td>
</tr>
<tr>
<td>To enjoy myself</td>
<td>40%</td>
</tr>
</tbody>
</table>

What do people see as preventing them from being more active?

Survey respondents who said they feel that they do not take enough exercise were asked which of the reasons shown in Table 15 prevent them from being more physically active. Again the respondents could select as many reasons as they wanted to, and so the percentages do not add up to 100.

Table 15: Which of the following reasons prevent you from being more physically active?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of time</td>
<td>49%</td>
</tr>
<tr>
<td>Lack of interest</td>
<td>21%</td>
</tr>
<tr>
<td>Lack of easily available facilities in the community</td>
<td>17%</td>
</tr>
<tr>
<td>Lack of money</td>
<td>17%</td>
</tr>
<tr>
<td>Lack of easily available facilities at work</td>
<td>14%</td>
</tr>
<tr>
<td>Lack of interesting or relevant activities</td>
<td>11%</td>
</tr>
<tr>
<td>Lack of transport</td>
<td>6%</td>
</tr>
</tbody>
</table>

Action

Policy and strategy background

More physical activity is one of the priorities identified in *Towards a Healthier Scotland*. That White Paper set targets for moderate activity among adults and vigorous exercise among 11-15 year-olds, and announced the intention to set up a task force on physical activity.

In June 2002, the Physical Activity Task Force published a strategic consultation document, *Let’s Make Scotland More Active*. It concentrates firmly on moderate activity (for reasons that will be clear from page 41 of this report), and proposes the following new targets for moderate activity in adults and children aged 16 and under, for achievement by the year 2022:

- 50% of people aged over 16 to meet the minimum recommended level of physical activity for adults – ie build up at least 30 minutes of moderate activity on most days of the week (meaning five or more days a week)
- 80% of those aged 16 and under to meet the minimum recommended level of physical activity for children – ie build up at least 1 hour of moderate activity on most days of the week.
The Task Force document calls for changes in both policy and culture, and identifies four strategic objectives to help reverse the falling trend in activity levels and bring about gradual improvements in the overall levels of physical activity across the population:

- to develop and maintain long-lasting, high-quality physical and social environments to support inactive people to become active
- to provide accurate and evidence-based advice to staff who are involved in government policy and service delivery and who work in the voluntary and private sectors
- to raise awareness and develop knowledge and understanding about the benefits of physical activity, and provide access to information
- to carry out research, monitoring and evaluation.

Strategic priorities are identified in terms of lifestyle groups (children and young people; adults of working age; adults in later life) and settings in which they can be supported (respectively: the home, nursery, primary and secondary schools, further and higher education institutions; primary care, the workplace; communities, the home, residential care). The document suggests that there should be action plans for each of these areas, and strategic coordination frameworks, at both national and local levels. Community planning partnerships are seen as the focus for local-level coordination.

The Task Force's document draws attention to the importance of tackling inequalities in physical activity. The situation is complicated. The percentage of men in Scotland who undertake a high level of moderate activity (at least 30 minutes, on five days or more each week) is actually higher in the lower socioeconomic groups, largely due to manual work and lack of access to private cars. However, the percentage of adults in the lowest socioeconomic group who are sedentary (undertake 30 minutes or less of physical activity on one day a week or not at all) is double that in the highest group.

The Scottish Executive has recently appointed a national physical activity coordinator, as recommended by the Task Force.

**Examples of action in Argyll and Clyde**

**Exercise on Referral** - Exercise on Referral schemes are up and running in all five council areas in Argyll and Clyde. Through these, health professionals can refer patients to exercise facilities. During a ten-week programme they learn about healthy lifestyles, safe and healthy exercise, and how to manage stress and anxiety through exercise and relaxation. A wider than ever range of health professionals can now refer people on to the schemes – including health visitors, practice nurses, physiotherapists, occupational therapists and dietitians as well as GPs.

**Cardiac rehabilitation** - For people who have already suffered symptoms of CHD, physical activity has important parts to play in promoting physical recovery and fitness, rebuilding self-confidence, and reducing the chances of worsening or recurrence of the condition. Community cardiac rehabilitation classes are available in Renfrewshire, West Dunbartonshire (Argyll and Clyde part) and Inverclyde, and are going to become available in Argyll and Bute. (See also Have a Heart Paisley, page 72.)

**Schools** - It is important to establish physical activity as a way of life from childhood, and schools-based physical activity initiatives are examples of partnership working between councils and NHS Argyll and Clyde.

The Quality Of Life (QOL) programme in six Renfrewshire high schools uses physical education as a vehicle for health education and a route to enhanced wellbeing and general learning.

Travelling Green was a pilot project involving West Dunbartonshire Council, NHS Greater Glasgow and N-HS Argyll and Clyde. Its aim was to assess whether or not the use of interactive materials could increase active commuting (walking) to school.
The results were positive, and the project will be rolled out over the whole of West Dunbartonshire in the next two years.

The Class Moves! programme aims to encourage primary schoolchildren to take part in various types of physical activity on a daily basis, and to promote ‘the joy of moving’.

Local authorities are currently developing proposals for the New Opportunities for PE and Sport programme funded through the New Opportunities Fund.

Learning and development - Many people within and outwith the NHS are in good positions to promote physical activity, but they need the knowledge, skills and confidence to play their part, and to keep pace with developments in the field. *A Little Physical Activity Means A Lot* is a training pack designed to meet this need and is open to a wide range of professionals.

Specific initiatives on physical activity often give rise to particular training needs. A nationally recognised certificated course, run jointly by Argyll & Clyde NHS Board and Reid Kerr College, provides training for leisure centre staff in the five Argyll and Clyde councils to be involved in Exercise on Referral.

**Examples of local-level work**

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll &amp; Bute</td>
<td>• Argyllactive outreach pilot – expanding Exercise on Referral into small communities</td>
</tr>
<tr>
<td></td>
<td>• Soroba children’s health programme – widening access to, and increasing participation in, structured exercise</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>• East Renfrewshire Outdoor Access Forum – reviewing, and improving, access for walking, cycling and horseriding</td>
</tr>
<tr>
<td></td>
<td>• Paths to Health – encouraging people to use paths</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>• Routes to Regeneration, Inverclyde pilot access study – mapping relationships of path networks to local people’s movements to work, facilities and services, and for recreation</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>• Quality of Life high schools programme – using physical education as a vehicle for health education</td>
</tr>
<tr>
<td></td>
<td>• Renfrewshire Healthy Living Network – pilot project with young people, addressing transport and cost of leisure facilities within West Johnstone and Johnstone Castle</td>
</tr>
<tr>
<td></td>
<td>• Paths to Health</td>
</tr>
<tr>
<td></td>
<td>• Safe routes to schools</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>• Travelling Green – project aimed at getting children to walk to school</td>
</tr>
</tbody>
</table>

**Action priorities**

Many different factors influence how active we are throughout our lives. Helping Argyll and Clyde to be more active therefore needs action involving partnership between councils, the NHS, community groups and communities more widely, voluntary organisations, and the private sector. The following key action points take account of the recommendations in the Physical Activity Task Force’s strategic consultation document. They can be adjusted as necessary should the proposed national strategy be amended in the light of consultation feedback.
**Key action points**

- **Overarching priority – tackle inequalities in physical activity and inactivity-related harm**
- **Concentrate on promoting moderate physical activity, and place the highest priority on encouraging and enabling the least active people to become more active**
- **Through community planning, promote physical activity across a broad front, joining up policies, plans and initiatives across sectors, settings and life-stage groups, and linking in with national developments**
- **In each community planning area, develop a plan for increasing physical activity in children and young people, through action in the home, in nursery, primary and secondary schools, and in further and higher education**
- **In each community planning area, develop a plan for increasing physical activity in adults of working age, through action in primary care, workplaces and communities**
- **In each community planning area, develop a plan for increasing physical activity in later life, through action in communities, in the home and in residential care**
- **Further develop tailored physical activity promotion and rehabilitation services and resources for people with established cardiovascular and other diseases**
- **Link in with new national initiatives through the national physical activity coordinator**

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**Alcohol**

**Introduction**

Alcohol misuse has for too long been the public health problem that is swept under the carpet. The huge range and amount of harm it causes – physical, mental and social – is commonly underestimated or overlooked.

Acceptance and embarrassment often get in the way of recognising hazardous or harmful drinking in others and encouraging them to confront the possibility that their drinking might damage themselves or those around them. This helps drinkers to exist in a state of denial.

Most people in our society drink alcohol, enjoy it, and value it as a ‘social lubricant’. Drinking is thus embedded in our culture. However, a feature of that culture is a tendency to turn a blind eye to alcohol problems, laugh them off, or see them as an inevitable and even acceptable flipside of the pleasures of drinking. Thus, drinking to excess becomes a joke even when it is really far from funny. People are praised and admired for having a large capacity for alcohol rather than being able to control and moderate their drinking. Adverse effects of drinking on people’s temper and behaviour are tolerated or excused, especially within their families.

The harsh reality is that alcohol problems in Scotland are wide-ranging, major, enormously costly, and getting worse. A number of conditions are specifically caused by drinking too much alcohol. These include alcohol poisoning, alcohol dependence, alcoholic cirrhosis, particular types of mental illness, and some forms of heart disease and nerve damage. Alcohol misuse also contributes to a wide range of...
other health and social problems. An illustration of the health impact comes from the USA, where it was estimated in the late 1980s that alcohol drunk to excess, or in inappropriate circumstances, accounted for almost 5% of total deaths, including:

- 7% of the large number of deaths from cerebrovascular disease (essentially stroke) in the 35+ age group
- 75% of deaths from cancer of the gullet (in the 35+ age group)
- 40-50% of deaths from cancer of the lip, mouth and throat (in the 35+ age group)
- 20% of deaths from stomach cancer (in the 35+ age group)
- 45% of deaths from fires
- 42% of deaths from motor vehicle accidents
- 35% of deaths from accidental falls (in the 15+ age group)
- 46% of homicides (in the 15+ age group)
- 25% of suicides (in the 15+ age group)

In addition, drinking too much alcohol has been linked to breast cancer, and drinking alcohol to excess in pregnancy can harm the unborn baby. Alcohol misuse can be a factor in domestic abuse (see page 76), family break-up, and job loss.

Recent publications have given the following examples of the scale of alcohol problems in Scotland.

- 15% of psychiatric hospital admissions have an alcohol-related diagnosis.
- 10% of hospital accident and emergency attendances have been attributed to alcohol misuse.
- There were over 1,400 emergency admissions of 10-19 year-olds to hospital for acute intoxication in Scotland in the year 2000.
- It has been estimated that over 73,000 GP consultations in Scotland in 1999 were due to an alcohol-specific diagnosis, while alcohol misuse also contributed to an even larger number of GP consultations for other conditions.
- 20% of road accident deaths have been attributed to drink driving.
- Of victims of violent crime who could tell anything about their attacker, 72% reported that the assailant was under the influence of alcohol.
- 25% of people arrested by the police have been found to test positive for alcohol.
- Alcohol problems are costing Scotland at least £1 billion each year.

The relationship between socioeconomic circumstances and drinking in Scotland is complicated. Among women, drinking above the sensible weekly level is commonest in social classes I and II (professional, managerial and technical). There is no clear social class pattern for men exceeding weekly sensible levels. On the other hand, men and women in the manual social classes are more likely than their non-manual counterparts to drink a high number of units on their heaviest drinking day in a given week. Also, men living in the most deprived areas of Scotland are seven times more likely to die an alcohol-related death than those in the least deprived areas.

A higher percentage of men than women in Scotland are drinking too much, but the figure for men seems to have levelled out whereas the proportion of women drinking above their recommended sensible level has continued to rise. Also, children and young people are drinking more than ever before. We have seen from Section 1 that Argyll and Clyde has more than its fair share of alcohol problems, and that there is evidence that they are increasing even faster than in the country as a whole.
Reference was made above to sensible drinking. Until 1995, the health guidance to adults on sensible drinking was consistently expressed in terms of weekly consumption levels, with men being advised to drink no more than 21 ‘units’ of alcohol a week and women no more than 14. In the UK, a unit is 10 millilitres (ml) of pure alcohol. The units content of drinks can be calculated from the strength of the drink (percentage alcohol by volume - ABV) and the volume of the drink. For example, a lager that is 5% alcohol by volume (ABV) contains 50 ml (5 units) of alcohol per litre, and a 500 ml can of the same lager contains 2.5 units of alcohol. A 750 ml bottle of 13.5% ABV wine contains over 10 units, and a 125 ml glass of that wine contains 1.7 units.

In 1995, the main advice on sensible drinking was revised to ‘daily benchmarks’ for men and women. The guidance for men is that it is not advisable to drink 4 or more units of alcohol a day consistently, and the corresponding figure for women is 3 or more units. If people drink heavily on an occasion, they are advised not to take any alcohol for 48 hours to let the body recover. It is important to recognise that the daily benchmarks, like the weekly limits, are intended for adults and not for younger people whose physical development puts them more at risk from alcohol. To keep down the risk of damage to the unborn baby, pregnant women and women who are trying to become pregnant should not drink more than 1 or 2 units of alcohol once or twice a week, and should avoid intoxication.

There is evidence that, in men over the age of 40 and women after the menopause, light to moderate drinking can help protect against coronary heart disease and have some other health benefits. The maximum health advantage lies at drinking levels of 1-2 units a day, and any health benefit may be lost if people drink heavily at times.

In practice it is common to use the weekly levels guidance and daily benchmarks together, since steady excessive drinking and bouts of binge drinking can both damage health.

In recent years there has been a tendency towards increased ABV strength of lagers, other beers and wines, and towards larger cans, bottles and glasses. This means that it is easy for people to underestimate their intake of units if they think of the traditional guidance that half a pint of normal strength lager or a small glass of table wine contain 1 unit each. The fact that home measures of drinks tend to be larger than standard pub measures can also lead to people underestimating their alcohol intake.

The guidance on sensible drinking also draws attention to situations where people should not drink alcohol at all, such as: before or during driving; before swimming; before or during active sport; before using machinery, electrical equipment, ladders etc; before working, or in the workplace; and when taking certain medications.

Findings from the Your Health and Wellbeing survey

How many people drink alcohol?

Figure from the survey 79%  No adjusted figure available (see page 8)

Almost four out of five respondents (79%) said they drink alcohol. This figure is similar to that found in the 1996 Argyll and Clyde An Apple a Day survey, and it may or may not be lower than in the whole population (see discussion of possible sources of bias, page 8). No clear evidence on non-response bias has been found from experience elsewhere, and so no adjusted figure is available.

A higher percentage of male respondents (83%) than female (76%) said they drink alcohol. The percentage of drinkers decreased with increased age (86% among those aged 16-34, compared with 55% of those aged 75+). A lower percentage of respondents from the more deprived communities said they drink (75% in depquin 5 compared with 82% in depquin 1).
How often do drinkers drink alcohol?

Those who said they drink alcohol were then asked how often they do so. Figure 21 shows that nearly two-thirds (63%) of drinkers said they drink on one or more days per week, with 9% drinking on 6 or 7 days per week. A higher percentage of male drinkers (74%) than female drinkers (55%) consume alcohol on one or more days per week, while 13% of male drinkers and 6% of female drinkers drink on 6 or 7 days per week.

Figure 21: How often do you drink alcohol at present?
(Drinkers only)

It can be seen from Figure 22 that the percentage of drinkers who said they drink on 1 or 2 days per week decreased with increased age, while the percentage who said they drink on 6 or 7 days per week increased with increased age. In short, older drinkers appear to consume alcohol on more days each week than younger drinkers.

Figure 22: How often do you drink alcohol at present?
(Responses within age groups - drinkers only)

A higher percentage of drinkers from the more affluent depuqins than from the less affluent ones said they drink alcohol on 3 or more days per week.
How much do people drink?

The survey asked drinkers whether they had an alcoholic drink in the preceding seven days. Over three-quarters (78%) of respondents said they did. They were then asked to fill in a grid indicating how much of what sorts of drinks they consumed on each of the seven days. From the answers given, the number of units of alcohol consumed on each individual day, and during the week as a whole, were calculated. For the sake of accuracy in converting recorded drinks to units of alcohol, the grid was very detailed in terms of types of alcohol products, beers etc of different strengths, and sizes of drinks. Nevertheless, there is a possibility that amounts drunk will have been underestimated. Also, it could well be that heavier drinking is commoner in non-respondents, but no adjustment for possible non-response bias is available (see page 8).

Weekly alcohol consumption

Figure from the survey: 29% of respondents who drank alcohol in the preceding week consumed over their recommended weekly sensible limit.

This represents 17% of all survey respondents (including non-drinkers).

Those drinkers who gave information on their drinking in the preceding seven days were placed in one of four categories according to the total units of alcohol they consumed in that week. The categories are shown in Table 16. The descriptions 'low risk', 'intermediate risk' etc only truly apply if the level of drinking in the week in question is typical of the regular drinking pattern over time. This is not necessarily the case—respondents perhaps drank more or less than usual in the week concerned or on individual days in that week. However, 81% of the respondents concerned indicated either that the week in question was typical, or that they usually drink more than they did that week.

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Units of alcohol per week</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
</tr>
<tr>
<td>Low risk</td>
<td>1-21</td>
</tr>
<tr>
<td>Intermediate risk</td>
<td>22-35</td>
</tr>
<tr>
<td>High risk</td>
<td>36-50</td>
</tr>
<tr>
<td>Very high risk</td>
<td>51+</td>
</tr>
</tbody>
</table>

It should be noted that even the 'low risk' levels of consumption could cause harm, eg if consumed during only one or two sessions in a week rather than being spread across the whole week.

Table 17 shows the percentage of those respondents who drank alcohol in the preceding week who fell into each category.

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Percentage of drinkers in the preceding week who fell into each category</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low risk</td>
</tr>
<tr>
<td>Males</td>
<td>62%</td>
</tr>
<tr>
<td>Females</td>
<td>79%</td>
</tr>
<tr>
<td>Both sexes</td>
<td>71%</td>
</tr>
</tbody>
</table>
Taking the sexes together, 29% of those who drank in the preceding week consumed over 21 (for males) or 14 (for females) units of alcohol in that week. The figure for the male respondents was 38% (over 21 units), compared with 21% (over 14 units) for the females. Men who drank alcohol in the preceding week consumed an average of 22.1 units of alcohol in that week (this being above the sensible limit), women 10.5 units.

Figure 23 shows that a higher percentage of preceding-week drinkers in the younger age groups exceeded the relevant weekly guideline on sensible drinking. Taken together with the finding that younger drinkers drank alcohol on fewer days per week than older drinkers (see Figure 22), this is evidence that binge drinking is a particular issue amongst the younger people.

Figure 23: Percentage of drinkers in preceding week, within each age group, who exceeded relevant weekly sensible drinking guideline

![Figure 23](image)

**Daily alcohol consumption**

Table 18 shows the reported daily pattern of alcohol consumption among those who drank in the week preceding the survey.

<table>
<thead>
<tr>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drank alcohol</td>
<td>30%</td>
<td>30%</td>
<td>33%</td>
<td>33%</td>
<td>59%</td>
<td>74%</td>
</tr>
<tr>
<td>of whom: drank within relevant daily benchmark</td>
<td>58%</td>
<td>55%</td>
<td>57%</td>
<td>49%</td>
<td>34%</td>
<td>28%</td>
</tr>
<tr>
<td>exceeded relevant daily benchmark</td>
<td>42%</td>
<td>45%</td>
<td>43%</td>
<td>51%</td>
<td>66%</td>
<td>72%</td>
</tr>
</tbody>
</table>

The pattern of alcohol consumption was fairly constant from Monday to Thursday, with around a third of drinkers during the preceding week drinking on any of these particular days. In any given day, Monday to Thursday, between 42% and 51% exceeded the relevant daily benchmark for sensible drinking (under 4 units for men, under 3 for women).
Peak drinking days were at the weekend. 59% of those who drank alcohol at some point during the preceding seven days drank on the Friday, 74% on the Saturday, and 47% on the Sunday. Of those who drank on the Friday, two-thirds exceeded the relevant daily benchmark. Of Saturday drinkers, nearly three-quarters (72%) exceeded their daily benchmark.

Table 19 shows that for every single day of the preceding week, the average (mean) alcohol consumption of those men who drank on that particular day was above the relevant daily benchmark. On average, the women who drank at some point during the preceding week exceeded their daily benchmark on four days out of seven (Thursday to Sunday). For both men and women, peak drinking days in terms of average number of units consumed were Friday and Saturday.

Table 19: Average units of alcohol consumed by those who drank on any given day in the preceding week

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>4.8</td>
<td>4.8</td>
<td>4.7</td>
<td>5.6</td>
<td>7.8</td>
<td>8.4</td>
<td>6.1</td>
</tr>
<tr>
<td>Females</td>
<td>2.9</td>
<td>2.8</td>
<td>2.8</td>
<td>3.3</td>
<td>4.6</td>
<td>4.8</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Given that the daily sensible drinking guidance refers to not drinking consistently above the relevant daily benchmark, it is useful to look at how often people exceed their daily benchmark. Figure 20 shows how often those who drank in the preceding week exceeded their daily benchmark.

Table 20: Percentage of drinkers in the preceding week who exceeded their daily benchmark on any given number of days in that week

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>25%</td>
<td>22%</td>
<td>24%</td>
<td>12%</td>
<td>6%</td>
<td>3%</td>
<td>2%</td>
<td>6%</td>
</tr>
<tr>
<td>Females</td>
<td>25%</td>
<td>32%</td>
<td>25%</td>
<td>10%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Both sexes</td>
<td>25%</td>
<td>27%</td>
<td>25%</td>
<td>11%</td>
<td>5%</td>
<td>2%</td>
<td>1%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Do people think their drinking affects their health?

Of those who drank more than the weekly guidelines on sensible drinking in the preceding week, only 17% thought their present level of drinking harms their health, and 26% even thought their current level of drinking benefits their health. A lower percentage of women (9%) than men (22%) who in the preceding week drank above the relevant sensible drinking level thought their present level of drinking harms their health. This may reflect lack of awareness of the lower sensible drinking limit that applies to women as compared to men.

Experiences of effects of drinking

The survey asked those who said they drink alcohol which of the consequences of drinking shown in Table 21 had applied to them in the preceding year.
Section 2 - Lifestyle and action in Argyll and Clyde

Table 21: In the past year, as a result of drinking, have you...

<table>
<thead>
<tr>
<th>Event</th>
<th>% of Drinkers</th>
</tr>
</thead>
<tbody>
<tr>
<td>done something you later regretted?</td>
<td>14%</td>
</tr>
<tr>
<td>had an argument or fight?</td>
<td>12%</td>
</tr>
<tr>
<td>performed less well at work?</td>
<td>8%</td>
</tr>
<tr>
<td>stayed off work?</td>
<td>5%</td>
</tr>
<tr>
<td>had an accident?</td>
<td>2%</td>
</tr>
</tbody>
</table>

Over one-fifth (21%) indicated that one or more of the above consequences applied to them. The percentage was significantly higher for men (26%) than women (20%).

Action

Policy and strategy background

Alcohol misuse was identified as a priority topic in the Health White Paper Towards a Healthier Scotland, published in 1999. That document set the following targets:

- reduce the proportion of men exceeding their weekly sensible drinking limit (21 units), from 33% (in 1995) to 31% by 2005, and 29% by 2010
- reduce the proportion of women exceeding their weekly sensible drinking limit (14 units), from 13% (in 1995) to 12% by 2005, and 11% by 2010
- reduce the frequency and level of drinking among 12-15 year-olds.

In January 2002 the Scottish Executive published the Plan for Action on Alcohol Problems. The plan gives an overview of the harm caused by alcohol misuse, and the estimated costs of alcohol problems to Scottish society. It identifies the key priorities as:

- to reduce binge drinking, because of the harmful social and individual consequences
- to reduce harmful drinking by children and young people, because of the particular health and social risks.

The plan defines binge drinking as drinking an excessive amount on any one occasion. There is no standard definition of what quantity of alcohol amounts to a binge, but the plan for action refers to the Scottish Health Survey’s criterion of drinking more than twice the recommended daily benchmark (ie more than 8 units for men and more than 6 units for women) on any given day. It is important that people who drink heavily on a steady basis do not see themselves as ‘let off the hook’ by the focus on binge drinking in the above priorities. Binge drinking does not just mean drinking heavily now and again – if you drink heavily on a frequent or daily basis, then you are a frequent or daily binge drinker.

The plan states that the priorities will require change on the part of individuals, families, communities and society as a whole, as well as action by relevant organisations and agencies. It sets out action under the following areas:

- culture change, with early action on a national communications strategy
- prevention and education, with early action on drink driving, occupational health and school-based education
- providing support and treatment services, with early action to develop a framework for services
Section 2 - Lifestyle and action in Argyll and Clyde

- protection and controls for individuals and the wider community, with early action to strengthen community safety
- delivery, with early action to strengthen local alcohol misuse coordinating committees (since renamed as alcohol action teams) and provide training, information and research to support implementation.

The plan for action was accompanied by detailed background documents on: alcohol misuse trends and costs; alcohol misuse information; attitudes towards alcohol; consultation with children and young people; international alcohol policies; effective and cost-effective measures; perceptions of factors that promote and protect against alcohol misuse; evidence informing the plan; and response to the plan’s written consultation process.

Alcohol action teams are seen as the vehicle for delivering the plan locally, with a remit to bring together local delivery agencies and voluntary sector, industry, community and service user interests, to draw up local strategies to address alcohol problems, and to implement these strategies. In many areas in Scotland, including Argyll and Clyde, alcohol action teams are combined with drug action teams.

Examples of action in Argyll and Clyde

Alcohol and Drug Action Team (ADAT) - The Argyll and Clyde Alcohol and Drug Action Team (ADAT) has a leading role in developing, implementing and overseeing strategy on tackling alcohol and drug misuse in the area. It has a strategic group and an implementation group, and links to a forum in each of the five local authority areas that fall wholly or partly within Argyll and Clyde.

The ADAT brings together representatives from NHS Argyll and Clyde, the five local authorities, Strathclyde Police, the Scottish Prison Service, Alcohol Focus Scotland and Scottish Drugs Forum. The ADAT chair is seconded from a community health initiative.

The ADAT is currently developing a plan to inform and assist local communities in implementing wide-ranging action on alcohol problems. There will be widespread consultation towards finalising the plan for action by the end of March 2003.

The following are examples of recent and current work supported by the ADAT and carried out by a range of individuals and agencies:

- the setting up of an area-wide Coordinated Addiction Network, bringing together specialist services to enhance accessibility and integrate delivery
- further development and support of the local fora
- continuing development and delivery of the Drinkwise campaign across the five local authority areas
- production of an addiction services handbook in paper and electronic formats, with sections on strategy and parliamentary constituency health profiles as well as a directory of services.

Partnerships - Partnership is a central principle of the national plan for action on alcohol problems, and of the ADAT. Community planning, including the production of joint health improvement plans, is important in this regard. Social inclusion partnerships, community safety partnerships and community learning partnerships all have important contributions to make. An important task for the ADAT is to encourage and enable all of the relevant partnerships to play their parts in a coordinated way.

Schools - Children and young people are identified as priority groups in the national plan for action on alcohol problems, and schools are important settings for alcohol education. NHS Argyll and Clyde, in partnership with other agencies, supports schools through, for instance, teacher training on alcohol and drug education, resources such as Exploring Alcohol, and interactive education (eg drama workshops with PACE Theatre). Other action in schools has included the devising of curriculum policies for alcohol and drug education, and the development of alcohol incident protocols.
Learning and development

Learning and development is an important focus for work on alcohol in Argyll and Clyde. In addition to the above teacher training, examples of this include:

- STRADA (Scottish Training on Drugs and Alcohol) training for health and social work professionals
- Training in other community settings, including workplaces and community education centres.

Examples of local-level work

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Argyll & Bute       | • Training for people who serve alcohol  
                      • Drinkwise-funded local media initiative on responsible drinking  
                      • Development of multiagency licensing action plan |
| East Renfrewshire   | • Alcohol awareness training for social work and community education staff, using *Cuts Both Ways* package                              |
| Inverclyde          | • Alcohol work in new community schools                                                                                               |
| Renfrewshire        | • Social work and community education training  
                      • Alcohol and drugs policy training for managers at the Benefits Agency in Paisley                                             |
| West Dunbartonshire | • Alcohol awareness in Secondary 1, through health promoting schools                                                                   |

Action priorities

The biggest and most important challenge facing Argyll and Clyde is to change cultural attitudes towards alcohol and alcohol problems, directly tackling the issues raised on page 48. Everyone has a part to play in this – including local media, councils, the NHS, the licensed trade, other businesses and workplaces, voluntary organisations, communities, families and individuals. Changing culture does not happen overnight, but we need to start now, building on the encouraging precedent of hardened attitudes against drink driving. In addition, all concerned need to take forward action under the other headings of the national plan of action on alcohol problems, with the ADAT and the community planning process enabling coordination of effort.

Key action points

- Overarching priority – tackle inequalities in alcohol misuse and alcohol problems
- Specific priorities – reduce binge drinking in the population, and reduce harmful drinking by children and young people
- Through the ADAT and with wide consultation, develop a comprehensive, multiagency Argyll and Clyde plan for action on alcohol problems, within the framework of the national plan for action
- Within the context of the Argyll and Clyde plan for action, develop and implement a communications strategy to raise awareness of the scale of alcohol problems in the area, and challenge aspects of culture that do not help
- Help the public and all agencies to have a clear understanding of sensible drinking and binge drinking
- Promote consistent and high-quality alcohol education in rolling out the new community schools concept, and through community education
Section 2 - Lifestyle and action in Argyll and Clyde

- With the involvement of the local fora and social inclusion partnerships, work with communities to promote acknowledgment of problems arising from alcohol in local populations, promote alternatives to alcohol misuse, and encourage and support community initiatives
- Encourage early recognition of problem drinking, and early interventions in primary care, acute healthcare services and other settings
- With service user involvement, redesign health and social services to enhance coordination, improve the recognition of problem drinking, and meet the changing nature and growing scale of alcohol problems

Drugs

Introduction

For the purposes of this report, ‘drug misuse’ can be taken to mean use of illicit drugs and the misuse of prescribable and over-the-counter medications and other substances (but excluding tobacco and alcohol, which are dealt with in their own right).

Drug misuse has become more common and commanded increasing attention over the past decade, and the use of illicit drugs is now widespread. For instance, in various parts of Scotland half or more of young people responding to surveys have reported that they have taken one or more such drugs at some point in their lives. The blunt fact is that drug taking has become part of many people’s way of life, with no section of society or part of the country, urban or rural, immune.

The drugs most commonly associated with dependent or problem drug misuse have been opiates (the family of addictive drugs that includes heroin, morphine and methadone) and the benzodiazepine group of tranquillisers. The impact of problem drug misuse is considerable and far-reaching. For users, in addition to physical and mental ill-health and premature death, it can lead to chaotic and wasted lives. For those close to them, it can bring disruption, worry and much suffering. It can break down trust and relationships between users and their families and friends. Society more widely is affected by crimes that fund drug misuse, and by other antisocial behaviour. Research in Glasgow suggested that 8,500 heroin injectors in the city committed 2.6 million offences a year, mostly involving shoplifting, other theft and drug dealing, with theft amounting to around £200m. It has been estimated that a third of all recorded crime is related to drugs. Hospital statistics show a higher rate of admissions for drug misuse among people living in deprived areas compared with people from more affluent areas.

Concerns have been fuelled by the numbers of deaths arising directly from drug misuse in recent times, most commonly entailing overdosage with opiates and often involving a ‘cocktail’ of drugs with or without alcohol. Death soon after taking drugs can also result from choking, or inhaling vomit.

Deaths after taking Ecstasy have attracted a high profile in the media, not least because they often occur in dramatic circumstances and can involve young people who are very different from the stereotype of the addicted drug misuser. There have been concerns that young people have come to underestimite the dangers of heroin relative to Ecstasy. Like Ecstasy, misuse of volatile substances or solvents (including ‘glue-sniffing’) can lead to sudden death, even on first use.
A common complicating factor in problem drug misuse is the taking of the drugs by injection. Not only does this increase the risk of death by overdose, it can lead to a number of severe infections, including blood poisoning (septicaemia), and to blockage of arteries with the risk of losing a limb. Also, sharing of needles and other 'works' can lead to infection with blood-borne viruses (BBVs) such as HIV (human immunodeficiency virus, the cause of AIDS), hepatitis B and hepatitis C.

Hepatitis C virus (HCV) infection has been likened to a timebomb in terms of its potential effects on infected individuals, on population health, and on the NHS. This is because:

- the virus has been spreading among injecting drug misusers in Scotland
- most people who become infected are unaware of it at the time
- around 80% of those who become infected remain so for a very long time, are at high risk of liver damage, and can spread the virus through shared drug injecting works, through other blood contact, and sometimes through sexual contact
- untreated, about 20% of those who remain infected will develop cirrhosis of the liver within 20 years; as many as 50% may develop cirrhosis within 30 years; and a proportion of those with cirrhosis will go on to develop liver failure or liver cancer
- although medical treatment for hepatitis C is improving, at present it is only effective in clearing the virus in about half of those treated, is unsuitable for many patients, and is expensive
- liver failure due to HCV is expected to increase the demand for liver transplantation.

Alcohol consumption is strongly associated with increased likelihood of severe liver complications in HCV infection.

HCV has been found not only in syringes but also in swabs, filters, spoons and water used by drug injectors. A study in Glasgow found that injecting drug misusers reported sharing accessories such as spoons and filters more than needles or syringes.

Infection with BBVs can occur on the first occasion that someone injects drugs, especially since first-time injectors are likely to use shared works.

Drug misuse in Argyll and Clyde

After careful consideration, it was decided not to include in the Your Health and Wellbeing survey 2001 any questions about taking drugs. People might not have been willing to disclose information about drug-taking, even with confidentiality and anonymity guaranteed. Also, the survey team was concerned that the inclusion of questions about illicit behaviour in a general health survey might have put people off completing and returning the questionnaire at all.

Information on aspects of drug taking in Argyll and Clyde are available from two recently published reports.

The Oban Youth Health & Lifestyle Survey, commissioned by the Argyll and Clyde Alcohol and Drug Action Team (ADAT), used peer researchers to carry out face-to-face interviews with 12-18 year-olds in a high school, local youth clubs and street settings in the town, in the year 2000. 20% of the 12-18 year-olds living in the Oban area were interviewed. Nearly half (49%) of the respondents said that they had ever been offered drugs (excluding alcohol and tobacco), most commonly cannabis. 37% of respondents said they had used cannabis, 10% solvents, 9% Ecstasy, 7% magic mushrooms, 7% amphetamine, and 4% LSD. For heroin, crack, methadone and cocaine, the percentages ranged from 1 to 2%. There was a marked association between cigarette smoking and illicit drug use.

Another study reported to the Argyll and Clyde ADAT, concentrating on opiates and benzodiazepines, estimated that in the year 2000 there were between 4,183 and
Section 2 - Lifestyle and action in Argyll and Clyde

7,431 problem drug misusers in Argyll and Clyde, amounting to 1.8% to 3.2% of the population aged 15 to 54 (as compared to an estimate of between 1.5% and 2.7% for Scotland). The study also estimated that there were between 1,601 and 2,990 drug injectors in Argyll and Clyde, and that between 368 and 1,052 of them were infected with the hepatitis C virus.

Action

Policy and strategy background

Drug misuse was identified as a priority topic in the 1999 White Paper on Health, Towards a Healthier Scotland. In the same year, The Scottish Office published Scotland’s drugs strategy, Tackling Drugs in Scotland: Action in Partnership. This was set within the four aims set out in the UK 10-year strategy produced the previous year, Tackling Drugs to Build a Better Britain:

- **Aim 1**: Young people - to help young people resist drug misuse in order to achieve their full potential in society
- **Aim 2**: Communities - to protect our communities from drug-related antisocial and criminal behaviour
- **Aim 3**: Treatment - to enable people with drug problems to overcome them and live healthy and crime-free lives
- **Aim 4**: Availability - to stifle the availability of illegal drugs on our streets.

The Scottish strategy lays out action across a broad front, in the areas of law and enforcement, education and social action. It is underpinned by four key principles:

- **Inclusion** - integrating action on drug misuse with tackling social exclusion
- **Partnership** - coordinated and collective work, with partnership between agencies and with parents, young people, business and users
- **Understanding** - basing work on well-targeted and accurate research and information
- **Accountability** - clarity over what results are required and who should achieve them, with drug action teams leading and coordinating local action throughout Scotland.

In 2000, the Scottish Executive issued its drugs action plan, Protecting our Future. This built on the drugs strategy by presenting a 10-year programme of action, including creation of the Scottish Drug Enforcement Agency, funding for social inclusion partnerships (SIPs) to work with drug action teams, and additional resources for Scotland Against Drugs community and business projects.

In December 2000, the Scottish Executive announced a set of nine national targets relating to drug-related harm, to various aspects of the misuse and availability of drugs, and to contact with treatment and care services. These include:

- reverse the upward trend in drug-related deaths, and reduce the total number by at least 25% between 1999 and 2005
- reduce the proportion of drug misusers who inject, by one-fifth between 1999 and 2005
- reduce the proportion of injecting drug users sharing needles and syringes, by 20% between 1999 and 2005
- substantially reduce the proportion of people under 25 reporting use of illegal drugs in the last month and previous year, with a 25% reduction (between 1999 and 2005) in the proportion using heroin.
Examples of action in Argyll and Clyde

Alcohol and Drug Action Team - As described on page 56, Argyll and Clyde Alcohol and Drug Action Team (ADAT) has a combined remit for strategy and action on alcohol and drugs. With regard to drug misuse, the ADAT:

- leads and coordinates sustained action for local delivery of the national strategy
- brings together local agencies in partnership
- reflects local community views on tackling drug misuse
- assesses local needs and priorities
- assesses local progress and performance to ensure value for money
- (since 2001) has authority from the Scottish Executive to 'sign off' a range of funding channelled through NHS, local authorities and social inclusion partnerships.

The ADAT has a strategy which is structured along the lines of the Scottish drugs strategy (see page 60). Recent and current work on drugs, carried out by a range of individuals and agencies and supported by ADAT, includes:

- the setting up of the area-wide Coordinated Addiction Network (see page 56)
- further development and support of the local fora
- the addiction services handbook (see page 56)
- engagement with user groups to influence the planning and delivery of services
- continuing support for local family support groups.

Learning and development - As with alcohol, learning and development is an important focus for action on drugs. Examples of this include:

- training and support for schoolteachers
- STRADA training for health and social work professionals
- training for a range of other services and organisations
- specific training on blood-borne viruses (BBVs) and harm minimisation
- needle exchange training

Workplaces - Support for the Scotland’s Health at Work award scheme (SHAW) includes training and advice for businesses and other organisations on developing workplace drug policies.

Examples of local-level work

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Bute</td>
<td>- Development of a health promoting school’s drug policy and teacher training</td>
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<tr>
<td></td>
<td>- Work through the healthy living centre on Islay</td>
</tr>
<tr>
<td></td>
<td>- Expansion of needle exchange services in Helensburgh and Oban</td>
</tr>
<tr>
<td></td>
<td>- New rehabilitation services in Oban and Lorn, Helensburgh, and Cowal areas</td>
</tr>
<tr>
<td></td>
<td>- progress2work in Oban and Lorn, Helensburgh, Cowal, and Bute areas</td>
</tr>
<tr>
<td></td>
<td>- Oban Youth Health &amp; Lifestyle Survey (see page 59)</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>- Expansion of rehabilitation services</td>
</tr>
<tr>
<td></td>
<td>- Social inclusion partnership rehabilitation project</td>
</tr>
</tbody>
</table>
Inverclyde
- Education and resources for prisoners
- New rehabilitation groups
- Development of family support groups
- Launch of new Moving On project

Renfrewshire
- Review of local authority policy on tackling drugs, by Renfrewshire Substance Misuse Forum young persons subgroup
- Community involvement through community health initiative

West Dunbartonshire
- New needle exchange programme
- Ongoing work through youth drop-in centre
- progress2work
- New rehabilitation services
- Drug Awareness Group

**Action priorities**

As with alcohol misuse, the ADAT and the community planning process are important in ensuring coordination of effort to tackle drug misuse. Local action should reflect the four headings of the national drugs strategy and action plan: young people, communities, treatment, and availability — with different agencies playing greater or lesser roles in these in accordance with their remits.

**Key action points**

- Overarching priority – tackle inequalities in drug misuse and drug-related harm
- Specific priorities — help young people to resist drugs, promote harm reduction among drug misusers, and strengthen community action against problem drug misuse
- Through the ADAT and wide consultation, develop a comprehensive, multiagency Argyll and Clyde plan for action on drug misuse, within the framework of the national strategy and action plan
- Raise awareness of the scale of drug problems in Argyll and Clyde, and challenge aspects of culture that might play these down
- Promote consistent and high-quality drugs education in rolling out the new community schools concept, and through community education
- With the involvement of social inclusion partnerships, work with communities to promote acknowledgment of problems arising from drugs in local populations, promote alternatives to drug misuse, and encourage and support community initiatives
- Redesign health and social services to meet the changing nature and growing scale of problem drug misuse
- Finalise and implement NHS Argyll and Clyde strategy on BBVs, including hepatitis C
Sexual lifestyle

Introduction

The emergence of AIDS in the 1980s refocused the attention of public health on preventing the transmission of infection through sexual contact and through exposure to blood. Like HIV, hepatitis B and hepatitis C can be spread in these ways. Further urgency to the challenge of influencing sexual behaviour in Scotland has been added by growing recognition that chlamydia is a serious and common sexually transmitted infection (STI), by rising numbers of cases of gonorrhoea, syphilis and other long-established STIs, and by continuing high rates of teenage pregnancy.

The main messages for prevention are:

- STIs are common and between them bring a range of threats to life, health, wellbeing and fertility
- the more people you have sex with, the more likely it is that you will have sex with a partner who has an STI and thus be put at risk of infection yourself
- using condoms properly greatly reduces (but does not completely cut out) the risk of developing an STI or having an unwanted pregnancy
- to prevent pregnancy, it is best not to rely only on a barrier contraceptive (condom or cap) but also to use the oral contraceptive pill or other reliable method.

Findings from the Your Health and Wellbeing survey

How many people have changed their sexual behaviour?

Figure from the survey 13%

The survey asked people whether they have changed their sexual lifestyle in any way because of concerns about becoming infected with a sexually transmitted infection. 13% of those who responded answered yes, 87% no. There were no significant differences between the percentages for males and females.

The percentage of respondents answering yes decreased with increased age among those aged under 75, and was then higher again in the 75+ age group (percentage answering yes for each age group: 16-34 year-olds 24%, 35-54s 11%, 55-74s 8%, 75+ age group 16%). The higher figure for those aged 75+ may reflect some misunderstanding of the question and reporting of changed sexual behaviour for other reasons. For example, comments written on some questionnaires suggested that changes in sexual lifestyle at that stage of life were due to age rather than concerns about sexually transmitted infections.

Taking all age groups together, the percentage of respondents answering yes was higher in the more disadvantaged communities. It was 19% in depquin 5 (most deprived) as compared with 10% in depquin 1 (most affluent).

There were no significant differences between the percentages answering yes in the various council areas, but the figure was higher in the Paisley (17%), Renfrew (16%) and Inverclyde (15%) LHCC localities than in the others (10% to 13%).

How has people's behaviour changed?

Those who answered yes when asked whether they have changed their sexual lifestyle were asked to select which of the options in Table 22 apply to them. Respondents could select as many options as they wanted to, so the percentages do not add up to 100.
Table 22: Reported changes in sexual lifestyle

<table>
<thead>
<tr>
<th>Reported change</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have only one partner</td>
<td>53%</td>
</tr>
<tr>
<td>Always use a condom with a new partner</td>
<td>36%</td>
</tr>
<tr>
<td>Find out more about a person before having sex</td>
<td>23%</td>
</tr>
<tr>
<td>Stopped having sex</td>
<td>21%</td>
</tr>
<tr>
<td>Avoid some sexual practices</td>
<td>10%</td>
</tr>
<tr>
<td>Have fewer sexual practices</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Action**

**Policy and strategy background**

Sexual health, including teenage pregnancies and sexually transmitted diseases, was identified as a national priority in the White Paper on Health, *Towards a Healthier Scotland*.

In 2001, the national HIV Health Promotion Strategy Review Group published recommendations for future work against HIV and other STIs. The Group's report acknowledged some success over the previous decade in controlling the spread of HIV infection, but drew attention to the still-significant numbers of new HIV infections in Scotland, and highlighted those occurring among young heterosexually active people travelling abroad on holiday. Identified areas for action include availability of condoms, training in HIV and other blood-borne viruses (BBVs), production of appropriate materials for all age groups, and development of services for young people together with policies for sex education in schools.

Sex education through schools is generally held to be an important part of any sexual health strategy. A research project in Scotland, involving a specially designed school-based sex education programme for adolescents, recently reported no evidence of reduction in sexual activity or sexual risk taking compared with conventional sex education. However, pupils evaluated the programme more positively, and their knowledge of sexual health improved. The study can be looked on as raising fundamental issues as to the prime purpose of sex education: to inform choice or directly influence behaviour? There can surely be no doubt that informed choices are preferable to uninformed ones. In any case, it may be that conventional sex education is already fulfilling the potential for teacher-delivered class-based sex education to influence behaviour.

Other age groups also need help and support to look after their sexual health. This needs the right combination of the right services, in the right places and provided by the right mix of staff. NHS Argyll and Clyde is currently working to develop these services across the area. Also, the Scottish Executive is currently working towards a national strategy for sexual health in Scotland.

**Examples of action in Argyll and Clyde**

**Sexual Health Strategy Group** - The Argyll and Clyde Sexual Health Strategy Group was formed to develop and support a strategy to improve sexual health throughout the area. It has representation from all relevant clinical disciplines, geographical localities across Argyll and Clyde, patients, and ethical interests. The group joins up a range of developments in sexual health, and will take forward action from the national strategy once it is published.

**Sexual health services in general** - Services for sexual health have been greatly enhanced within Argyll and Clyde in recent times. In 2001, sexual health services in Inverclyde and Paisley were both expanded to provide a full service, including clinics for
Inverclyde

- SHIFTT (Sexual Health Information for Teens and Twenties), offering a drop-in service to young people for sexual health information, advice and counselling
- Launch and distribution of CD resource mainly for 18-30 year-olds going to clubbing holiday destinations (see under East Renfrewshire/Renfrewshire, above)
- Time for Change Network (see under East Renfrewshire/Renfrewshire)

West Dunbartonshire

- Youth 2 Youth health drop-in service in Dumbarton

Action priorities

Future action on sexual health in Argyll and Clyde will need to take account of the anticipated national strategy. In the meantime, the following key action points have been identified.

Key action points

- Overarching priority – tackle inequalities in sexual lifestyle and sexual health
- Develop an integrated approach to sexual health, incorporating sexual health promotion and all relevant clinical services
- Ensure equitable access to sexual health services across Argyll and Clyde, including services that meet the needs of young people, and ethnic and other minority groups
- Develop and implement sex education policies and recommended resources for use in schools throughout the area, in line with national policy, as well as appropriate training for those involved in the delivery of sex education in schools
- Develop appropriate and accessible information on HIV and other BBVs in prisons, hospitals, schools and communities
- Learn from the experiences of the national health demonstration project Healthy Respect, based in Lothian
- Implement the national sexual health strategy once produced

Lifestyle: what helps, and what gets in the way?

Introduction

As described on page 9, focus group sessions were held to find out more about what people feel helps them to take up and maintain healthier lifestyles, and what gets in their way. The sessions were such that the discussions mostly flowed from points raised by the group members themselves. The NHS staff running the sessions concentrated mainly on encouraging exploration and clarification of the issues that came up, rather than suggesting possible issues for the groups to consider.

The influences on lifestyle that came to light can mostly be grouped under the following overlapping headings:

- internal or personal factors
- family, friends and groups
- community and wider environmental influences
the diagnosis, management and investigation of STIs, counselling, and blood-borne virus screening programmes in both these areas. Specialist family planning services have been concentrated in the Inverclyde and Renfrewshire areas but, with the creation of a consultant-led area-wide service, provision is now developing across the entire NHS Board area. Improvements are also underway as regards to services for assessment, counselling and management in relation to unwanted pregnancy.

As part of the work on strategy development for a 'holistic' sexual health service across Argyll and Clyde, the Sexual Health Strategy Group has sent a questionnaire to every GP surgery in the area to find out more about services currently provided for their patients, and to seek views on the future shape of this important aspect of health services.

Health services for young people - In 2000, the Scottish Executive published the Walk the Talk resource to support the development of health services for young people, including services of relevance to sexual health. Additional funding was made available to support such developments at local levels. In Argyll and Clyde, comprehensive needs assessments were carried out by the NHS in partnership with young people and other agencies, to establish a baseline for the planning of services. New services have been launched in local areas across Argyll and Clyde, and others are being developed. Young people have an active say in the shaping and delivery of these services, through membership of local management groups. The developments in the area of sexual health reflect the recommendations of the national HIV health promotion strategy.

School sex education policies - A steering group has been established in each council area to develop a sex education policy for local schools, taking account of national guidance.

Learning and development - Locality groups have been established to support professionals in their work on sexual health, through training and policy development. The support provided includes training in relevant subject areas such as working with young people, blood-borne viruses, and lesbian, gay, bisexual and transgender issues.

Examples of local-level work

<table>
<thead>
<tr>
<th>Local area</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argyll and Bute</td>
<td>Establishment of confidential drop-in services for young people, including access to information on sexual health issues in Rothesay (The Zone), Lochgilphead (Pitstop), Dunoon (CHAT), Campbeltown (Teenwise), Oban (Teen Aid), Tarbert and Islay</td>
</tr>
<tr>
<td></td>
<td>Multiagency Argyll and Bute Sexual Health Strategy Group has supported development of Education Department sex education policy, and is supporting development of future services and training</td>
</tr>
<tr>
<td></td>
<td>Multiagency Lesbian, Gay, Bisexual and Transgender (LGBT) Issues Group, addressing service development and access, and issues of diversity</td>
</tr>
<tr>
<td>East Renfrewshire/Renfrewshire</td>
<td>Multiagency group addressing sexual health education issues for young people, including access to information, condoms and contraception services</td>
</tr>
<tr>
<td></td>
<td>Launch and distribution of a CD resource via Glasgow Airport, travel agents, youth groups, colleges, Paisley University and primary care, providing information on STIs including HIV and designed mainly for 18-30 year-olds going to clubbing holiday destinations</td>
</tr>
<tr>
<td></td>
<td>Time for Change Network, addressing issues relating to services for LGBT people</td>
</tr>
<tr>
<td></td>
<td>Health drop-in service for young people in Barrhead and Neilston</td>
</tr>
</tbody>
</table>
The following summary of the focus group discussions uses these headings, illustrating some of the points with quotes from individual participants.

**Internal or personal factors**

**Motivation**

"You've got to want to do it" sums up a view held by most of the focus group members, regardless of the particular lifestyle behaviour in question. Motivation and willpower, or the lack of these, were seen as important. Having fun was brought up as a motivating factor, especially in relation to exercise.

"I used to play netball and that was fun, there was a point to it. We weren’t there to lose weight, but to have a game and have fun."

Gyms came in for some criticism for being "too work-like", "a chore", and "boring".

**Finding time**

For some people, finding time and motivation go hand-in-hand with each other.

"I’d like to get motivated to exercise and find time to do it."

Some acknowledged that lack of time is sometimes just an excuse – "It’s just sheer laziness." One person had found a way of slotting in some physical activity by walking to the next train station instead of waiting for 20 minutes on the platform for a train to arrive. That same person did not like to exercise if it took time away from doing something they enjoyed more.

**Knowledge about healthy and unhealthy behaviours**

Knowledge about the health impact of lifestyle behaviours motivated some people to make changes, but knowing that something might cause harm was not necessarily enough in itself.

"I knew it [being overweight] had a bad effect on my life, knew I had to change. One day I realised there was a good chance I would not be there for the children when they were older."

"I worried the plane would go down because of my weight, and I wouldn’t fit the chair. Next time I go on holiday I want to feel comfortable….. Even when I went to hospital I worried whether they could lift me onto the trolley."

"You know what you’re doing [smoking] is wrong, you know it’s doing you harm, but something inside you makes you do it anyway."

The groups were asked whether they thought they had enough knowledge about what healthy eating was. Most people felt knowledgeable, but some considered that they only had a broad knowledge and would like to know more. Some participants felt confused by information and advertising from food companies. Healthy eating was frequently equated with dieting, although this view was challenged by some people in some of the groups. One of the groups felt strongly that knowledge about healthy and unhealthy eating had little influence on what they ate.

**Embarrassment**

For a number of people, fear of embarrassment gets in the way of lifestyle change.

"I... too embarrassed. I’ve not exercised for years, and when you go there’s these ones with their hair perfect and they’ve been doing it for years."
For a number of women, concerns about their size are a barrier to going swimming. Women-only events were seen as helpful, but problems were raised regarding childcare arrangements and classes being at inconvenient times.

On the other hand, feelings of embarrassment have for some people been a trigger for action. For example, one woman reported that she had felt that her children were becoming embarrassed by her size and did not want her around, and that had prompted her to make some changes to her lifestyle.

**Past experience**

Well-established habits and routines, often from childhood, were agreed by most participants as having a strong and enduring influence on what people eat – eg "I've been brought up on chips and fry-ups".

One group member described eating more healthily when staying with a family who had a healthier diet. Unfortunately, on returning home the old unhealthy behaviours crept back and she was unable to sustain the changes.

**Other factors**

Other internal or personal factors mentioned included lack of confidence, the need to pluck up courage, loneliness, feeling down, and health problems.

"I've not got a lot of self-confidence and that puts me off – I think they're laughing at me."

"It took me weeks and weeks to go, and when I went it wasn't that bad."

"When I get lonely or fed-up I want to eat."

**Family, friends and groups**

**Family**

The discussions suggest having children in the family can have a bearing on the lifestyle behaviour of other family members, particularly their mothers. This can encourage or discourage healthy changes.

There were experiences of children prompting healthier eating in families.

"My oldest is 10. He's asking for salads instead of chips all the time, because they're getting healthy food in school and he likes it."

In some cases, having children around encouraged or helped mothers to take more exercise. Wanting to play with her children and finding herself out of breath after a couple of steps encouraged one woman to try and take more exercise and become a bit fitter. One mother had joined in with a boxercise class with her children to encourage them to get active, thereby taking exercise herself. Another enjoyed "going to keep-fit because it gets me away from the kids".

One woman trying to give up smoking reported, "My wee boy says my hair smells nicer."

On the less helpful side, some participants unable to persuade other family members to eat more healthily found themselves struggling to eat healthily, even if they did all the cooking. Also, having children was sometimes felt to sap energy and reduce time for exercise.

"By the time he gets to nursery….I sit and moan, but just can’t get up to doing it."

"I run after the weans, then you’re down here doing classes."
Some comments by family members can have either encouraging or discouraging effects, depending on a complex tangle of individual, family and other circumstances.

"The wean turns and says, 'Look at you – you’re fat'."

Comments such as the above sometimes prompted participants to eat more healthily, but were felt more to contribute to feelings of guilt and other negative thoughts that were seen as leading to unhealthy eating behaviour.

**Friends**

Having friends around was seen as mostly supportive. For example, most group members agreed that doing some exercise with someone else is helpful. Having someone to ask for advice and give encouragement was found to be very helpful. Knowledge that people you care about are proud of you for making changes was seen as a powerful motivator. Friends were considered to be less likely than family members to make comments that were discouraging.

**Groups**

Involvement in groups was highlighted both as helpful and as unhelpful.

"Being around other people who are healthy can be an inspiration."

One such group consisted of people who shared a common goal – to take part in a 10 kilometres event. This seemed to help motivate them, even though they did not all exercise as a group.

"In January we started walking, me and my flatmates. Now six or seven of us are going out at different times... at different levels and walk at different speeds."

In one focus group, the social benefits of going to a class together were highlighted. On the other hand, some focus group participants viewed trying to make changes as part of a group as "too much pressure" or "too scary", particularly for those who feel they are not progressing as fast as everyone else appears to be.

**Community and wider environmental influences**

**Access to facilities and healthy options**

Lack of access to facilities was highlighted as a barrier to exercise.

"There’s nothing – no swimming pool, the gym’s closed."

"...no dance classes... you have to have very strong willpower."

Mention was made of easy access to ‘junk food’ and ‘fast food’ and difficulty in finding healthy alternatives.

"Fast food is everywhere."

"If the café here just sold healthy food, everybody would eat healthy stuff. They'd soon get used to it."

On the other hand, access to healthier options does not necessarily lead to healthier eating. One of the focus groups attended a community centre where healthy eating options are offered. This was felt to have no effect on those who were finding it difficult to eat more healthily. The members of that focus group all agreed that they would always, or nearly always, choose an unhealthier option. Similarly, during a discussion about healthier alternatives, one woman said she buys oven chips but fries them;
"Oven chips are rotten - I hate them - but they're okay because I fry them".
Healthier alternatives tended to be perceived as more expensive, although one person found it cheaper to eat more healthily.

"I spend a lot on fruit... it's costing more to be healthier."
"I can't buy a salad for the price of a bag of chips."

Support from professionals or other paid workers
Discussion on this aspect resulted from prompting by the staff running the focus groups. It may not have been seen as an important consideration by the participants, or they may have been hesitant to raise it without an 'invitation' to do so.

Many of the focus group members had at one time or other tried to obtain help from a healthcare professional. Types of help mentioned as having been offered included: diet sheets, information leaflets, referral to others for specialist advice (eg dietitian, practice nurse, a weight control clinic, smoking alliance, telephone helplines). Participants in one of the focus groups had a support group for stopping smoking, which they highlighted as helpful. The majority of the focus group members felt that more could be done to support them.

A number of participants had negative views of their experiences of approaching GPs for help.

"They don't give you enough time."
"They're sitting criticising you."
"You'll seldom get a doctor willing to sit with you, to talk to you."

On the other hand, a participant said that she had found support, encouragement and monitoring from her doctor to be very important and helpful. Another recalled the efforts of a health visitor who had run a weight management group, which she had found helpful.

Social acceptability
The social acceptability and unacceptability of different lifestyle behaviours were brought up in one of the groups. For example, one group member contrasted social acceptance of eating chips with social pressure against smoking.

Finding the right formula
Finding a 'formula' that is right for you as an individual was a recurring general theme. Discovering a successful way of weaving healthy behaviours into everyday life was viewed as a very individual thing. The lack of one or more of these elements personally important to an individual was seen as making healthy changes more problematic.

Initiating and maintaining lifestyle changes
All four focus groups felt strongly that initiating a change in any given lifestyle behaviour was easier than maintaining that change. Participants felt that the stage of maintaining change is when they need the most encouragement and support. However, most had experience of receiving the most help to get started. When, for example, time-limited classes come to an end, people feel left to struggle to maintain changes.

Noticing the effects of making a lifestyle change emerged as an influencing factor, mostly in terms of encouraging continuation of the healthier behaviour. For some, the benefits of weight loss (eg trousers fitting) were motivating, although one person described reverting to old eating habits once weight loss had been achieved. One of the focus group members mentioned disliking the taste of fat since switching to skimmed milk.
Differences between and within the focus groups

On the whole, little variation was found between the different groups. In particular, rural and urban groups highlighted a similar range of factors that help or hinder change.

Although the intention was to recruit people into two types of groups according to their success or otherwise in making lifestyle changes, all groups included participants with a mixed degree of success in relation to different lifestyle changes. Participants who felt they had achieved change(s) tended to come over as having more positive, 'can do' attitudes than those who felt they were struggling to make any changes. The latter tended to attribute their difficulties to external factors such as lack of access to facilities.

Have a Heart Paisley

Introduction

Have a Heart Paisley (HaHP) is a major project which pulls together action on the lifestyle factors that affect a person’s risk of suffering from coronary heart disease (CHD) – and in so doing pays attention to people’s life circumstances.

HaHP is one of a set of national health demonstration projects created as a result of the White Paper on Health, Towards a Healthier Scotland, each focusing on a different health priority area. The idea is that locally based, specially funded projects can act as testbeds to help the whole of Scotland to find the best way forward. Detailed information on the projects is available through a national website (www.show.scot.nhs.uk/demonstrationprojects), and HaHP has its own website at www.haveaheart.org.uk.

HaHP was selected as the CHD demonstration project through an open national bidding process, and has a budget of £8m over 3 years from the Scottish Executive. It is a partnership initiative involving NHS Argyll and Clyde, Renfrewshire Council, Red Kerr College, and a number of community organisations and groups. It aims to make sure that wherever and whenever people live, work, go to school, enjoy a meal out in the town, go about their communities, visit the doctor, or even read a local newspaper, they know something is happening to tackle heart disease.

The project has five intertwined strands of work:

- Call to action
- Building community capacity
- Opportunities, environments and lifestyles
- Developments in health care and health information
- Learning and development.

HaHP was launched in October 2000. What has it done – and learned – so far?

Call to action

HaHP is trying to capture the imagination of all the people of Paisley, and promote self-belief among individuals, families, agencies and the town as a whole – belief that everyone can play a part in weaving a new Paisley pattern of better health. This has involved a whole host of publicity campaigns and other communication activities. The project has gained widespread recognition among the people of the town, and has helped place improving health high up the agendas of its partners. The call to action strand promotes and supports the essential community-based and service-based elements of HaHP, and these in turn contribute to the call to action. An ability to capture communities’ imagination has been shown by the number and variety of ideas that have been suggested for community projects as part of HaHP – more than 80 since HaHP began.
Building community capacity

Promoting and supporting community involvement is central to HaHP, as is paying particular attention to the needs of Paisley’s more disadvantaged communities. The project has four locality networks, each with a HaHP coordinator who encourages the development of community initiatives and helps link community groups with Paisley-wide HaHP activities and various agencies. As well as working in partnership with existing initiatives that are tackling inequalities, HaHP is stimulating new ideas. A key part of building community capacity is the funding of community projects, and over 80 have been supported so far. HaHP has already learned a great deal about engaging communities in action to prevent CHD, and about remaining challenges – not least winning the attention of men and enhancing the enthusiasm of communities for projects dealing with tobacco.

Opportunities, environments and lifestyles

HaHP action on lifestyle involves encouraging, informing and giving practical help to the people of Paisley in the areas of non-smoking, eating for health and living more actively. Crucially, the project recognises the importance of life circumstances, environments and real opportunities in helping people to take up and maintain healthier lifestyles. An early success in this area is a project that encourages participation in dance-related classes for all ages – toddlers to older people – and is involving males and females in all parts of the town. It is often difficult to get men involved in health activities, but teenage boys have been joining street dance routines and men taking part in salsa classes.

Developments in health care and health information

Early intervention and assistance for people who already have CHD, or are at risk of it, is another vital part of the HaHP approach. A ground-breaking computerised CHD register means that more patients with CHD or at risk of the disease receive the best up-to-date treatment whether in a GP surgery or hospital clinic. Good links have been made between primary and secondary care, and an innovative programme and facility at the Royal Alexandra Hospital has greatly increased the numbers of heart disease patients being offered tailor-made cardiac rehabilitation.

Learning and development

People need learning and personal development opportunities to help them play their parts in the overall CHD prevention effort. This applies to various professionals and workers, community organisations, groups and representatives, and members of the public alike. HaHP learning and development work helps identify and meet the various needs of these different groups. A particularly important part of this is helping community members, organisations, groups and representatives to develop the self-confidence, knowledge and skills they need to participate effectively and as equal partners in the overall project. An early success has been the Paisley Heart Award, a unique new scheme that raises awareness of heart disease, offers the chance to learn about related issues, and acknowledges the determination and achievements of the people of Paisley in learning about heart disease. Over 250 people have won awards so far, and the awards ceremonies have been a resounding success.
Section 3

Some other health issues in Argyll and Clyde
Section 3 - Some other health issues in Argyll and Clyde

Carers issues

Background and national guidance

Carers are people who look after family, partners, or friends in need of help because they are ill or frail, or have a disability. The care they provide is unpaid. There are an estimated 626,000 carers in Scotland.

The hidden costs of caring can be exhaustion, stress, social disruption, and physical illness or injury among the carers. Ignored and Invisible, published by the Carers National Association in 1998, reported that just over half of carers who responded to a UK-wide survey had been physically injured as a result of caring, and a similar proportion had been treated for stress-related illness since becoming carers.

It has increasingly been recognised that carers themselves need help and support, and should be seen as partners in service delivery. This is evident in a number of official documents in recent times, including the Strategy for Carers in Scotland, published by the Scottish Executive in 1999.

Argyll and Clyde profile

Argyll and Clyde's mix of urban, rural and island populations brings with it a range of different issues affecting carers, with access to transport being of particular importance to the rural and island communities. Voluntary sector carers organisations exist in all five council areas in Argyll and Clyde. They provide a range of help for carers, such as emotional and practical support, befriending schemes, advice on available benefits, and counselling. They also promote the needs of carers at local and national levels, helping to ensure that they have a voice. Carers issues are an important part of the Joint Future agenda which promotes joint working between the NHS and local authorities.

The Your Health and Wellbeing survey 2001 in Argyll and Clyde asked people whether they are responsible (other than in their jobs) for caring for someone on a day-to-day basis.

- 11% of respondents answered yes (12% of women, 10% of men).
- The percentage increased with increased age in the under-75s, then fell in the 75+ age group (16-34 age group 6%; 35-54 12%; 55-74 14%; 75+ 12%).
- The percentage was higher among respondents from the more deprived communities (14% in deprivation 5; 10% in deprivation 1).

Those who answered yes (referred to below as 'the carers') were asked for some more information about their caring roles.

- 13% of the carers said they provided continuous care, ie 24 hours a day, 7 days a week.
- On average, the carers reported spending 48 hours a week caring.
- The average age of the person cared for was 63.
- The majority of the carers (57%) said they cared for their father or mother (32%), or their husband or wife (25%).
- 57% said that one or more of the people that they cared for lived with them.
The carers were asked what support they need with their caring that they do not receive. About 10% of the carers responded. The most common responses were help with lifting, respite care, general help/support, help with bathing/washing, and help with shopping. Other responses included financial help, help with transport, help with housework, help with meals/cooking, help with dressing, and information on support groups.

As described on page 13, the survey asked respondents to rate their own health over the preceding 12 months on a scale from 1 ("excellent") to 5 ("poor"). Ratings 1 and 2 were taken together as representing "good" health, 3 was classed as "fair", and 4 and 5 together as "poor". Table 23 shows that more than half (55%) of carers came into the "good" health category, while other respondents were more likely to do so.

Table 23: Self-reported health (over the preceding 12 months) – carers compared with other respondents (‘non-carers’)

<table>
<thead>
<tr>
<th>Percentage of respondents, by self-reported health rating</th>
<th>Carers</th>
<th>Non-carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>55%</td>
<td>61%</td>
</tr>
<tr>
<td>Fair</td>
<td>29%</td>
<td>25%</td>
</tr>
<tr>
<td>Poor</td>
<td>16%</td>
<td>14%</td>
</tr>
</tbody>
</table>

The differences shown in Table 23 are not necessarily directly related, or wholly related, to the caring role. The percentage of carers was found to be higher among respondents from the more deprived communities, and there are links between deprivation and poorer health. Also, the age profile of the carers may have had a bearing on the findings. Whatever the explanation, it has to be a matter of concern that as many as 16% of the carers in the survey are caring day-to-day for others in the face of poor self-reported health.

Argyll and Clyde action

The following are priorities for action by NHS Argyll and Clyde:

- Develop a carer information strategy
- Within the NHS, jointly with local authority partners, and through supporting carers organisations, enhance the support available to carers, with a focus on preventing harmful consequences of caring
- Work closely with carers groups and representatives to find out whether and how NHS developments are improving their quality of life
- Monitor and annually report the levels of illness caused to carers by fulfilling their caring role

Domestic abuse

Background and national guidance

Domestic abuse has a major impact on families. It affects the health of those who experience it, whether mental, physical or both. It causes trauma to children who witness it. People who experience domestic abuse may have low self-esteem, be lacking in confidence, and find it difficult to speak about their problems. Many feel trapped in a desperate situation. Alcohol is often, but not always, implicated in domestic abuse.
The Scottish Partnership on Domestic Abuse describes domestic abuse as follows.

Domestic abuse can be perpetrated by partners or ex-partners, and can include physical abuse (assault and physical attack involving a range of behaviours), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental/emotional abuse (such as threats, verbal abuse, withholding money and other types of controlling behaviour such as isolation from family and friends). Children are witness to and subjected to much of this abuse; there is a correlation between domestic abuse and the mental, physical and sexual abuse of children.

It is recognised that domestic abuse can include abuse of men by women, abuse within same-sex relationships and intergenerational abuse. However, currently available statistics imply that domestic abuse is overwhelmingly inflicted on women by men.

Awareness of the issues around domestic abuse has been growing, and there has been a great deal of activity on the subject at a national level. The Scottish Partnership for Domestic Abuse produced its workplan in 1999, and this was followed in 2000 by a national strategy. Implementation of the strategy has included the 'No Excuses' mass media campaign first aired in December 2001. Monies have been made available to local domestic abuse fora from a central Domestic Abuse Service Development Fund, with the aim of increasing services on the ground for people who are fleeing from domestic abuse.

**Scottish profile**

Since domestic abuse is often hidden and unreported, there is no complete record of the number of people involved. It has been estimated from various research studies that between 260,000 and 700,000 Scottish women may be experiencing domestic abuse. Work is underway to obtain a clearer picture.

Statistics on domestic abuse are now produced nationally from details provided by the eight Scottish police forces. These relate to incidents involving physical, non-physical or sexual abuse involving partners (married, cohabiting or otherwise) or ex-partners, occurring in the home or elsewhere. In 2000 (the latest year for which figures are available), there were 36,000 reported incidents. Of those incidents where the gender of the victim and perpetrator were both recorded, 92% involved a female victim and male perpetrator.

The NHS is often the first port of call for people experiencing domestic abuse. It has been estimated that in a year in Scotland, domestic abuse inflicted on women is responsible for:

- 87,000-136,000 GP consultations
- 55,000-145,000 accident and emergency out-patient attendances
- 28,000-69,000 gynaecology out-patient attendances
- 16,000-40,000 gynaecology in-patient bed-days
- 26,000-53,000 psychiatry out-patient attendances
- 120,000-239,000 psychiatry in-patient bed days.

**Argyll and Clyde action**

The health consequences of domestic abuse and the enormous financial cost to the NHS give good reason for the NHS to be a partner in multiagency action to tackle domestic abuse. There is a domestic abuse forum for each of the five council areas that fall wholly or partly within Argyll and Clyde. These fora are mostly council-led, but all are multiagency. Representatives from the legal system, the police, Women's Aid, education, social work and the NHS are usually key members. The fora liaise closely with others, including homelessness coordinators, welfare rights staff and drugs...
agencies. They are involved in the full spectrum of domestic abuse issues, from culture change (challenging acceptance of domestic abuse) to the provision of shelter.

As well as contributing to the work of the fora, NHS Argyll and Clyde has a group focusing on the NHS response to domestic abuse. The NHS provides front-line services for those experiencing domestic abuse, and needs to be able to respond well to those seeking help.

- Domestic abuse fora activities include awareness-raising, education programmes for young people, training and development for staff in a range of agencies, and service provision for people needing help to escape from domestic abuse
- The NHS Argyll and Clyde group on domestic abuse is devising protocols for a range of service areas and will develop a rolling programme of awareness-raising and training for NHS staff
- The four employing organisations in NHS Argyll and Clyde are considering their policies as employers and how they can best support employees experiencing domestic abuse
- NHS Argyll and Clyde is involved in research on the local prevalence of domestic abuse and on how services can be better designed to meet needs

Health and homelessness

Background and national guidance

Homeless people are among the most vulnerable and disadvantaged members of society, and have a large and complex range of needs, including health needs. It is important that local authorities and the NHS work together with other key partners to identify and meet these needs. Health problems that are commoner in homeless people include mental health problems, misuse of alcohol and drugs, foot and skin care problems, respiratory infections, and poor dental health. This is due to a combination and accumulation of circumstances, often including a relative lack of access to health services. Unmet health needs can lead to people becoming trapped in homelessness.

The Scottish Health Plan, *Our National Health: A plan for action, a plan for change*, highlighted tackling homelessness as a priority for NHS Scotland, within the wide priority of reducing health inequalities. Subsequent guidance from the Scottish Executive (in September 2001) required NHS boards to develop three-year health and homelessness action plans with local stakeholders, by the end of February 2002. These plans are to align with local authorities’ homelessness strategies (due to be completed by the end of March 2003) and be included in local health plans.

Argyll and Clyde profile

Between April 1999 and March 2000 (the latest year for which figures are available), there were over 2,500 housing applications from homeless people to local authorities within or overlapping with the NHS Argyll and Clyde area. That figure relates to whole council areas, including the non-Argyll and Clyde parts of East Renfrewshire and West Dunbartonshire. It is recognised that not all people who are covered by the comprehensive definition of homelessness set out by the Homelessness Task Force present to local authority housing departments as homeless. NHS Argyll and Clyde and its partners will seek to find ways of uncovering this group of ‘hidden homeless’ people and addressing their needs.
A vital part of building up the picture of homelessness and health in Argyll and Clyde is to learn more about the health needs of homeless people in the area. As part of the health and homelessness action plan referred to below, NHS Argyll and Clyde and its partners are undertaking a health needs assessment. This includes: a survey of homeless people to ask them about their health and their healthcare needs and about their access to health services; interviews with service providers; and a ‘mapping exercise’ to describe the health services available for homeless people. The report of the health needs assessment will be available by the end of December 2002 and will guide future strategy to improve the health of homeless people within Argyll and Clyde.

Argyll and Clyde action

The coordinating focal point for action on health and homelessness in Argyll and Clyde is the action plan produced by a short-life working group with representation from the NHS and other agencies, approved by the Scottish Executive during 2002. The plan is aimed at improving the health of homeless people through a partnership of all agencies involved. It sets out implementation plans for each of the three local authority areas that fall wholly within Argyll and Clyde (Argyll and Bute, Inverclyde and Renfrewshire), and for the Argyll and Clyde parts of the other two council areas (East Renfrewshire and West Dunbartonshire).

The health and homelessness action plan stresses the importance of:

♦ joining up working across agencies (for example joint training, jointly agreed assessment and support procedures, jointly agreed referral and discharge protocols, and sharing of information)

♦ involving service users and the wider community in the planning of services

♦ promoting the use of key support workers for homeless people

♦ helping homeless people to have access to mainstream healthcare provision

♦ ensuring that the needs of homeless people are recognised within other relevant strategies and developments (such as domestic abuse strategies, drug and alcohol strategies, children's services plans, and hospital discharge protocols)

Protecting health

This final part of the report focuses on topical issues regarding protection of the population against a number of important communicable diseases.

Meningitis C vaccination programme

The Group C conjugate meningococcal vaccine (MenC) protects against a particular group of the meningococcal bacteria that can cause meningitis and septicaemia (blood poisoning). MenC was added to the childhood immunisation programme in 1999. Table 2.1 shows that a high percentage (94.8%) of young children in Argyll and Clyde are being protected by the vaccine. In addition, there has been a ‘catch up’ programme for all other children and young people up to the age of 17. The vaccination has been a great success – there has been a substantial fall in meningococcal disease in children and young people.

In January 2002, the Scottish Executive Health Department decided that MenC should be offered to 20-24 year-olds. Those aged 18 and 19 would have been covered by
Section 3 - Some other health issues in Argyll and Clyde

the previous catch-up programme, and the overall risk of meningococcal infection in the 20-24 age group is more than twice as high as the rate in the population aged 25 and over.

Table 24: Percentage uptake of primary vaccination in children aged 24 months
Scotland, Argyll and Clyde and its four old local government districts
2000 and 2001

<table>
<thead>
<tr>
<th>Vaccination Type</th>
<th>2000  Scotland</th>
<th>Argyll and Clyde</th>
<th>Argyll and Bute</th>
<th>Renfrew</th>
<th>Dumbarton</th>
<th>Inverclyde</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pertussis (whooping cough)</td>
<td>97.0%</td>
<td>97.0%</td>
<td>97.4%</td>
<td>96.7%</td>
<td>96.9%</td>
<td>97.9%</td>
</tr>
<tr>
<td>2001 Jan - Mar</td>
<td>96.5%</td>
<td>97.0%</td>
<td>95.1%</td>
<td>97.0%</td>
<td>97.2%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Apr - June</td>
<td>96.4%</td>
<td>95.8%</td>
<td>89.9%</td>
<td>96.9%</td>
<td>96.1%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Jul - Sept</td>
<td>96.5%</td>
<td>96.9%</td>
<td>99.3%</td>
<td>96.3%</td>
<td>98.4%</td>
<td>96.0%</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>96.6%</td>
<td>97.3%</td>
<td>94.8%</td>
<td>97.5%</td>
<td>96.6%</td>
<td>98.8%</td>
</tr>
<tr>
<td>Total 2001</td>
<td>96.7%</td>
<td>97.1%</td>
<td>96.1%</td>
<td>97.4%</td>
<td>96.9%</td>
<td>97.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diphtheria</th>
<th>2000  Scotland</th>
<th>Argyll and Clyde</th>
<th>Argyll and Bute</th>
<th>Renfrew</th>
<th>Dumbarton</th>
<th>Inverclyde</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 Jan - Mar</td>
<td>97.6%</td>
<td>97.6%</td>
<td>97.8%</td>
<td>97.6%</td>
<td>97.8%</td>
<td>97.9%</td>
</tr>
<tr>
<td>Apr - June</td>
<td>97.2%</td>
<td>96.6%</td>
<td>91.5%</td>
<td>97.4%</td>
<td>97.0%</td>
<td>97.8%</td>
</tr>
<tr>
<td>Jul - Sept</td>
<td>97.3%</td>
<td>97.4%</td>
<td>100.0%</td>
<td>96.7%</td>
<td>98.9%</td>
<td>96.9%</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>97.3%</td>
<td>97.7%</td>
<td>94.8%</td>
<td>98.7%</td>
<td>97.7%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Total 2001</td>
<td>97.5%</td>
<td>97.7%</td>
<td>97.0%</td>
<td>97.8%</td>
<td>98.1%</td>
<td>97.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MMR (measles, mumps and rubella)</th>
<th>2000  Scotland</th>
<th>Argyll and Clyde</th>
<th>Argyll and Bute</th>
<th>Renfrew</th>
<th>Dumbarton</th>
<th>Inverclyde</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 Jan - Mar</td>
<td>93.2%</td>
<td>92.7%</td>
<td>92.3%</td>
<td>92.0%</td>
<td>94.2%</td>
<td>94.0%</td>
</tr>
<tr>
<td>Apr - June</td>
<td>90.7%</td>
<td>91.0%</td>
<td>89.2%</td>
<td>90.7%</td>
<td>93.7%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Jul - Sept</td>
<td>87.8%</td>
<td>86.7%</td>
<td>79.8%</td>
<td>86.2%</td>
<td>91.0%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>86.6%</td>
<td>87.8%</td>
<td>83.1%</td>
<td>87.6%</td>
<td>91.0%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Total 2001</td>
<td>86.4%</td>
<td>88.4%</td>
<td>84.2%</td>
<td>87.8%</td>
<td>91.1%</td>
<td>90.3%</td>
</tr>
</tbody>
</table>

NATIONAL TARGET FOR EACH OF ABOVE TYPES OF VACCINATION 95.0%

<table>
<thead>
<tr>
<th>Meningococcus group C</th>
<th>2000  Scotland</th>
<th>Argyll and Clyde</th>
<th>Argyll and Bute</th>
<th>Renfrew</th>
<th>Dumbarton</th>
<th>Inverclyde</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000 Jan - Mar</td>
<td>92.3%</td>
<td>93.7%</td>
<td>92.4%</td>
<td>93.2%</td>
<td>95.5%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Apr - June</td>
<td>92.2%</td>
<td>94.0%</td>
<td>87.6%</td>
<td>94.4%</td>
<td>97.1%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Jul - Sept</td>
<td>94.3%</td>
<td>94.6%</td>
<td>93.8%</td>
<td>94.2%</td>
<td>97.3%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Oct - Dec</td>
<td>96.0%</td>
<td>97.6%</td>
<td>94.9%</td>
<td>98.5%</td>
<td>97.7%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Total 2001</td>
<td>93.7%</td>
<td>94.8%</td>
<td>92.6%</td>
<td>95.0%</td>
<td>95.9%</td>
<td>95.0%</td>
</tr>
</tbody>
</table>

1. Primary vaccination refers to the completion of the first 3-dose course of vaccination for polio, diphtheria, tetanus, pertussis and Hib (Haemophilus influenzae type b), or receipt of a single dose of MMR, or a completed course of meningococcus group C vaccine.
2. The schedule for primary vaccination starts at 2 months of age. MMR is given at around 13 months.
3. Annual figures may differ from the average of the 4 quarters due to the migration of children into and out of an area.
4. Figures given for diphtheria vaccination; those for Hib, tetanus and polio closely reflect these (within 0.1%).
5. Target commonly agreed to be necessary for herd immunity.

Source: Standard Immunisation Recall System (SIRS) and ISD(S)13/2.

Childhood immunisation programme

Table 24 also shows that the childhood immunisation programme is achieving high levels of protection for children against whooping cough (pertussis) and diphtheria. During 2001, over 97% of children in Argyll and Clyde had a full 3-dose course of 'primary' vaccination against both of these serious diseases. This matches the levels of protection achieved across Scotland as a whole. Similarly high levels were achieved for polio, tetanus and Hib (Haemophilus influenzae type b).
However, following some concerns in the news media about the combined MMR immunisation, there has been a fall in uptake of immunisation against measles, mumps and rubella in Argyll and Clyde and Scotland as a whole. As can be seen from Table 24, in 2000, 92.7% of children in Argyll and Clyde received a first dose of MMR vaccine. This fell to 88.4% in 2001.

This reduction in the uptake of MMR is a matter of serious concern. It is especially worrying when the percentage in the population who are immunised against a particular disease falls below the 95% level recommended to achieve ‘herd immunity’. Herd immunity describes the situation where the uptake of immunisation against a particular virus or bacterium is high enough to keep the level of circulating infection so low that even unimmunised people gain benefit from the immunisation programme. Measles, mumps and rubella are not trivial illnesses. A recent epidemic in a region of Italy has served as a tragic reminder of the complications and deaths that can result from measles infection. There were no confirmed cases of measles in Scotland in 2001, but early in 2002 there was an outbreak in Fife. This brings home the importance of increasing the uptake of MMR in Argyll and Clyde.

Blood-borne viruses

Blood-borne viruses, and the NHS Argyll and Clyde blood-borne viruses strategy, were mentioned on pages 24, 59 and 62. A major aim of the strategy is to ensure equity of access to services, particularly for people infected with hepatitis C virus (HCV). There is a need to offer more HCV testing services, so that people can have the opportunity to receive treatment as soon as possible.

Argyll and Clyde NHS Board has appointed two trainers to provide training and education for people working in the NHS and in other sectors. Needle exchange schemes for intravenous drug misusers are being expanded, and a new fixed site was opened in January 2002 by Lomond and Argyll Primary Care NHS Trust.

Partnership working with voluntary organisations is important. Projects developed for 2002 include an internet outreach scheme in partnership with PHACE Scotland, peer education with C-Level, and access to treatment and services with Body Positive.

Infection control

Recent developments include:

- a programme of communicable diseases training for care homes and infection control link nurses within these
- updating of manuals, including the manual for infection control for care homes and day centres and Health Advice for Children in Schools and Pre-5 Establishments, in collaboration with local authority staff
- a policy on headlice control, prepared in partnership with Primary Care Trust community nurses, and education staff within a new community school in Inverclyde.

Tuberculosis

Levels of tuberculosis (TB) within Argyll and Clyde are fairly steady at around 40 cases per year. However, the numbers of people requiring contact tracing as a result reached 296 in 2001. These large numbers were, in part, due to some large screening exercises. To help maintain follow-up procedures for all contacts of TB cases within Argyll and Clyde, a TB database has been created. This is based on a contact tracing protocol that has been further developed within Argyll and Clyde NHS Board.
An NHS Argyll and Clyde multidisciplinary TB steering group has been formed. It will develop protocols and procedures for the control of TB throughout the area, raise TB awareness, and produce an annual TB report.

Alcohol problems can be associated with increased vulnerability to TB. The NHS Board is working in partnership with other agencies that help people who have alcohol problems. In particular, public health staff are providing information on TB for staff in local authorities, hostels and the NHS.

Other recent and current action in TB control includes:

- restarting of the school BCG immunisation programme from autumn 2001
- screening of students from countries with a high prevalence of TB, who are attending further and higher education establishments in Argyll and Clyde.
Glossary and references
Glossary of terms used

Bias - Any trend in the collection, analysis, interpretation, publication or review of data that can lead to conclusions which differ systematically from the actual situation in the population (e.g. underestimation of the percentage of smokers). See page 8 for more details.

Cancer registrations - A database of new cancers diagnosed in Scotland, which is maintained by the Scottish Cancer Registry in Edinburgh. Used to produce numbers, rates and rankings for the different sorts of cancer.

Community health index (CHI) - A database of people registered with GPs, which has many clinical uses and is also used to derive populations for residents of Argyll and Clyde and its various geographical groupings.

Council areas - Three council (local authority) areas lie completely within the NHS Argyll and Clyde area (Argyll and Bute, Renfrewshire and Inverclyde) and two partly within it (East Renfrewshire and West Dunbartonshire).

Death registrations - A database of all deaths registered in Scotland, collated by the General Register Office for Scotland (GROS) based in Edinburgh. Used in this report for analyses for 'Argyll and Clyde residents' - based on residents of Argyll and Clyde dying anywhere in Scotland (but not outwith Scotland) plus any non-residents of Scotland who die in Argyll and Clyde (e.g. on holiday). Similarly, analyses of 'Scottish residents' will exclude those Scottish residents dying outwith Scotland, and include any non-residents of Scotland who die in Scotland.

The database includes information on cause of death, based primarily on the death certificate completed by a doctor. In this report, all analyses are restricted to the primary or underlying cause of death, and are based on year in which the death was registered. Apparent time trends may be affected by the change to ICD10 from ICD9 in 2000 (see definitions below), and other changes in the coding of cause of death introduced in 1996.

Deprivation quintiles (depquins) - Within Argyll and Clyde, the population of each postcode sector has been assigned to one of five deprivation quintiles (depquins), according to its Carstairs deprivation score derived from the 1991 Census. Each deprivation quintile contains approximately 20% of the population of Argyll and Clyde. The deprivation quintiles range from depquin 1, the most affluent, to depquin 5, the most deprived.

GROS - General Register Office for Scotland, based in Edinburgh.

Incidence (rate) - The rate at which new events (e.g. cases of a disease) occur in a defined population. Calculated by dividing the number of new events in a given time period by the population at risk of experiencing the event.


Glossary of terms used

**ISD** – Information and Statistics Division of the Common Services Agency of NHSScotland, based in Edinburgh.

**Local health care co-operative (LHCC) localities** – LHCCs are groupings of general practices and other healthcare professionals, established to help enhance the planning, development and delivery of primary care services, and improve health, in local populations. There are seven LHCCs in Argyll and Clyde (Argyll and Bute, Inverclyde, Levern Valley, Lomond, Paisley, Renfrew, and West Renfrewshire). An **LHCC locality** is an aggregate of postcode sectors where the majority of residents are registered with a practice belonging to a particular LHCC.

**Prevalence** – The proportion of people in a defined population who have a particular characteristic (eg disease or risk factor) at a given point in time, or at any time during a given time period.

**Risk factor** – An aspect of an individual (eg lifestyle behaviour or genetic make-up) or the environment that has been identified as being associated with a particular disease or condition.

**Social inclusion partnership (SIP)** – A partnership of community representatives and local agencies, including the council, NHS, Scottish Homes, Scottish Enterprise and others. It aims to improve conditions for people living in particular places which were identified from the 1991 Census as being deprived or socially excluded.

**Standardised mortality ratio (SMR)** – A measure which compares the mortality (death) level in the local population with that in Scotland as a whole, making allowance for differences in the age/sex structures of the two populations. The SMR is calculated by dividing the observed (actual) number of deaths in the local population by the number that would be expected if the Scottish mortality rates applied, and then multiplying by 100. Scotland's SMR equals 100. An SMR of 115 in the local population would indicate that mortality was 15% higher than Scotland overall. Similarly, an SMR of 90 would suggest that mortality was 10% lower than Scotland overall. Statistical tests indicate whether or not such differences are significant.
Key references

**General**
- Scottish Executive (2001). *Nursing for health – a review of the contributions of nurses, midwives and health visitors to improving the public’s health in Scotland.* Scottish Executive, Edinburgh.

**Health and lifestyle in Scotland**

**Cancer, coronary heart disease and stroke**

**Oral health**

**Sexual health**

**Alcohol problems**
Key references

Drugs and drug-related harm


Smoking

  See also www.ashscotland.org.uk and www.ash.org.uk

Diet


Physical activity


Carers issues

Key references


Domestic abuse


Health and homelessness


Blood-borne viruses

See under ‘Sexual health’ and ‘Drugs and drug-related harm’