The magazine of the
UK Faculty of Public Health
www.fph.org.uk

September 2015

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Public Health Today

Recipes for disaster

Coping with emergencies

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Cover image: Flooding in Toll Bar near Doncaster, June 2007

Welcome

THE three pillars of public health are health protection, health improvement and population health and social care. The first of these represents the very foundations of public health especially with its environmental focus on the external threats to health whether they be biological, physical or chemical. The work of the Faculty of Public Health over the past 30 years has reinstated a focus on this vital area and the succession of public health emergencies during this time has reinforced the need for the relevant competences to be acquired by all those who claim to be fully formed public health generalists.

In this issue of *Public Health Today* we offer a strong menu that touches on many aspects of public health emergencies. It is a rich and stimulating set of contributions. It is conventional to categorise such emergencies as 'big bang', 'rising tide' or 'slow burn' and aspects of all these are to be found in this issue. A sound knowledge-base, preparedness and experience are essential if we are to play our part as full partners when called upon to rise to the challenge. I speak as a generalist with the benefit of having been involved with more public health emergencies than I could ever have imagined when I set out on my career over 40 years ago. We have all had to acquaint ourselves with the plethora of new infectious disease in recent times, but, in addition, I have found myself in the middle of a range of situations, including the Hillsborough disaster, two IRA bombs, the death of Chinese cocklers in Morecambe Bay, the third largest Legionella outbreak in Barrow, a rail crash, fatal school bus crash, several major flooding incidents and a mass shooting. I was deployed to Macedonia with colleagues during the Kosovo emergency and played a peripheral role in the recent Ebola crisis. Specialist colleagues, some of whom have written here, can claim much more extensive experience than myself. My point is that we need to be ready whether as generalist or specialist and one message I would give to those embarking on a career in public health is seek out opportunities for experience. Senior colleagues I would encourage to involve registrars and junior colleagues in incidents that come your way. There are invaluable experiences to be had and each in its own way is unique.

Whether we are talking about a heatwave, a flood, an earthquake or an outbreak of an exotic disease, some of the skills needed are generic. The ability to learn quickly and think on your feet, partnership and team-working and a knowledge of the limitations of your own skills are but a few worth thinking about. Nor is our focus restricted to the immediate, blue-light phase of an emergency. Public health has a great deal to offer in the recovery period and in building resilience against future incidents. Colleagues' current work in the latest phase of the Ebola emergency illustrates as much. Humanitarian work may be short-, middle- or long-term. For those interested in developing their careers in this direction there are increasing opportunities to acquire the necessary expertise. Courses are available at Manchester University, the Liverpool School of Tropical Medicine and the London School of Hygiene and Tropical Medicine among others, and the Society of Apothecaries also offers a qualification. For those interested in making themselves available for regular deployment in humanitarian situations, the Department of Health now supports a register maintained by UK-Med under Professor Tony Redmond at Manchester University.

This area of public health is very challenging but also very rewarding. I would like to thank the contributors to this issue of *Public Health Today* for sharing their experiences with us.

John Ashton

Cuts will cost £1bn extra in the long-term

THE Faculty of Public Health (FPH) has made unequivocal responses to both the Department of Health's (DH's) proposal, as part of wider government action on the deficit, to reduce by £200m the ring-fenced public health grant in the financial year 2015-16 (http://bit.ly/1UbECTG) and the Treasury's Spending Review 2015 (http://bit.ly/1IaMsUQ).

FPH has called for the proposed cuts to be reversed, for the ring-fence to remain in place and for no further cuts to be made in future years. The cuts will increase inequalities in health, worsen population health outcomes and increase pressure on our overburdened NHS. It is both a false distinction and a false economy to consider NHS and public health funding as separate – and it is contrary to NHS England's Five Year Forward View.

FPH did not address the questions outlined within the consultation on how to apportion the proposed cuts, on the grounds that they will:

- worsen significantly the health and wellbeing of local populations
- increase inequalities across the life course, including within hard-to-reach groups
- make harder the provision of population healthcare advice
- compromise the delegated health protection and health improvement functions.

And will consequently:

- increase the burden of preventable non-communicable disease and pressure on the NHS (which already spends 70% of its budget managing long-term conditions)
- contradict the key premise of the consultation in that it will increase the overall deficit and generate at least £1billion additional costs in health and social care.

> **It is a false distinction and a false economy to consider NHS and public health funding as separate**

Read FPH's response to the DH's consultation at http://bit.ly/1hulx0H and Spending Review Representation at http://bit.ly/1KCs2dB.

FPH is working closely with its partners in calling on the DH and Treasury to reverse the proposed £200m cuts. If you are aware of any likely impacts from the cuts, please tell us in confidence, by emailing lizskinner@fph.org.uk

Mark Weiss
Senior Policy Officer
Faculty of Public Health

Is EU keeping its promise to protect health?

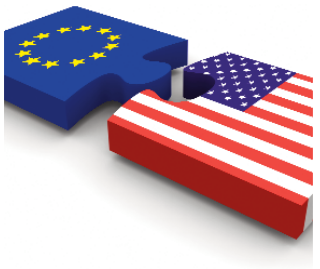
ARTICLES about the risks posed by the Transatlantic Trade and Investment Partnership (TTIP) agreement co-authored by the Faculty of Public Health (FPH) have been published in the *Journal of Public Health* and *European Journal of Public Health*.

In *Warning: TTIP could be hazardous to your health* (http://bit.ly/1Jsw9GJ), we identify how the numerous risks presented will seriously undermine the policies FPH has called for in its recent manifesto (http://bit.ly/1wDfDv0).

In *The Europe we want – a Transatlantic Health and Wellbeing Partnership* (http://bit.ly/1U9nrlu), we ask whether the European Commission is abiding by its own legal commitment to protect health in all its policies and activities.

In July, the International Health Coordination Centre and Public Health Wales facilitated an event, Understanding TTIP and Europe. Read more at http://bit.ly/1N27rBa and watch a talk by FPH's Senior Policy Officer, Mark Weiss, at http://bit.ly/1JpcGEV

Mark Weiss



News in brief

Nigeria reaches polio milestone
Nigeria has been removed from the list of polio-endemic countries. It follows Nigeria going more than a year without a case of wild – naturally occurring – polio. Three years without cases are required before a country can be declared polio-free. The decision means there are now just two endemic countries – Pakistan and Afghanistan.

Children's health postcode lottery
Some local authorities in England are not doing enough to prevent ill health in children under five, a report by the National Children's Bureau said. It found wide variations in levels of obesity and tooth decay, even in areas of similar deprivation. 51% of five-year-olds in Leicester had tooth decay compared with 9.5% in West Sussex.

'Tax sugary drinks by 20%'
An extra 20% tax on sugary drinks should be introduced to tackle the obesity crisis, the British Medical Association said. It estimated that poor diets were causing around 70,000 premature deaths each year. The body called for the extra money raised to be used to subsidise fresh fruit and vegetables.

MMR vaccination rates falter
The proportion of two-year-old children in England having the MMR vaccine has fallen. In 2014-15, 92.3% of children had the jab to protect them from measles, mumps and rubella. The Health and Social Care Information Centre said the figure was 92.7% in the previous year. Some parts of the country had less than 80% of children immunised.

Hand-washing lessons to cut drug resistance
Schoolchildren should be taught how to wash their hands to tackle the threat of drug-resistant bacteria, according to draft National Institute for Clinical Excellence (NICE) guidelines for England. Teachers should also provide lessons on when antibiotic drugs are unnecessary, said NICE.

'Paid-to-poo' fights open defecation
A scheme in Ahmedabad, India, is aiming to instil better toilet habits in children by paying them one rupee to use public loos. In India, nearly half of the population relieve themselves in the open, many even when public facilities are available. Hundreds of thousands of children die every year because of diseases transmitted through human waste.

INTERVIEW

Brian McCloskey is Director of Global Health at Public Health England. He was involved in the Health Protection Agency's response to the 2005 London bombings, the Buncefield Oil Depot fire in 2005, the 2007 floods and pandemic flu in 2009. He tells *Public Health Today* what it takes to handle high-profile health protection situations

Olympic-sized achievement

Preparation and communication are crucial

GOOD MOMENT: London 2012 Olympic Park showing the Olympic Stadium

What was it that first interested you about public health?
I was training to be a consultant in cardiology. I took a couple of years out to do my research degree and decided I'd enjoyed the epidemiology more than the cardiology, because it was more intellectually challenging.

I was doing outpatient appointments in cardiology and would see the same people come back every month with their angina – mostly still overweight, smoking and with high cholesterol. I thought: "There must be a better way of solving this problem." Public health seemed to be it.

What kind of qualities do public health people need in high-profile health protection situations?
You need to be logical and analytical. You need to go into a meeting with a clear view about what is possible and acceptable and what is not, and the limits to what you can compromise on. You need to be fairly flexible, and good communication skills are one of the essential requirements, both in terms of working your way through complicated meetings, but also explaining it all to the public afterwards. Miscommunication or failure to communicate well is probably one of the most common reasons why incident responses go wrong – or are perceived to.

What do you think is the most high-profile health protection situation you have had to face?
In pure health protection terms, one of the most challenging was the Litvinenko poisoning with polonium. That was the first time that we systematically applied epidemiology skills from infectious diseases to a radiation hazard and realised that a lot of the same principles, expertise and training worked. That was a complex and high-profile, politically-charged event. Explaining difficult concepts about radiation, which I had only learned an hour before, to politicians was a challenging time.

What advice would you give to public health specialists about how to communicate in a political environment?
Remember that the politicians were elected to run the country and you weren't. They are coming at the problem with a different perspective. While we would like all of our decisions to be made on the basis of science and evidence, the reality is that politicians have, quite legitimately, other factors to consider. We have to fight for the science to the very end, but science is not the only thing that will influence a decision.

If you had a magic wand, what would you do to make it easier for public health specialists to improve health?
Get rid of tobacco companies. Not just because of the health impact of tobacco, but also because the way in which the tobacco industry works has gradually influenced other companies who might be doing things that are not particularly good for health.

Secondly, give public health more money. Given the current climate, we understand that's difficult. At a time when we are seriously looking to reduce health inequalities, there are plenty of opportunities to do that, but you can't do it without funding.

Which have been the high points in your career so far?
The obvious one is getting my CBE from Princess Anne. The other is that I was invited to the opening ceremony of the Paralympic Games, and sitting in that stadium and seeing – for the first time ever – a completely full stadium for the Paralympic Games, not just the Olympic Games, brought home just how good the London Organising Committee had been. Watching the amount of community engagement for the Paralympics and realising that it had made quite a substantial difference to people's attitudes to disability was a good moment.

> **Miscommunication is probably one of the most common reasons why incident responses go wrong – or are perceived to**

Our preparations over seven years worked. Not a lot happened during the Games, but when things did happen, such as rumours about measles or food poisoning, the surveillance systems that we had in place meant that those rumours could be tackled very quickly.

I have a photograph of one of the rowing races in London 2012, when the British crew were expecting to win. They came second and they were so completely worn out that when the BBC was interviewing them, Steve Redgrave had to lift them out of the boat. I think it's 0.02 seconds between them and the Gold medallists. Eight years of work comes down to 0.02 seconds. If the athletes are doing that much to prepare for the Games, then the rest of the people involved need a similar commitment to make sure it works.

Which have been some of the more challenging times?
I was in Bosnia during the civil war, and the job was mainly around trying to identify the health needs of the population and how the international community could provide them. It was important to keep in touch with reality and family, which was difficult in the days before mobile phones.

We had to think about how to create a better health system for people after the war and keep the focus on the longer-term. One of the earliest pieces of advice I got in my public health career was: everything takes a long time to happen, and by the time it happens, someone else is taking the credit for it!

The other serious challenge over the past 12 months has been Ebola. It was probably the most complex public health event I've been involved in. We had to focus on a strategy that would get us through it and resist the temptation to change the strategy every time there was a blip in the epidemiology. The range of people involved in the response made focusing on a single strategy a challenge, but, if we had started responding to every blip, we would have ended up getting lost. A combination of factors made Ebola more scary than it should have been.

Is there anything that keeps you awake at night?
We need to learn to do things differently to manage the risk of the next emerging diseases, perhaps something like MERS. We've said so many times that we need to learn the lessons, but globally we haven't. The idea that the next infectious disease will be on top of us before we've learnt those lessons does keep me a little bit awake at night.

How do you relax?
I took up rowing after I moved to England. It's a relaxing thing to be out on the river on a sunny Saturday morning. A bit of exercise and some good food and wine is my public health balance.

Interview by Liz Skinner

Get our act together

The message that consistently emerges from emergencies is that coordination is the key to effective response, says Alan Maryon-Davis

LESSONS: The fire at Buncefield oil depot, Hertfordshire, December 2005

A LITTLE boy lies face-down on a Turkish beach, washed up, drowned. The unforgettable image of three-year-old Syrian Aylan Kurdi shone the global spotlight on a humanitarian crisis that had been unfolding for months. Aylan was just one of thousands drowning or dying in an attempt to escape from mayhem. But his image helped to sting reluctant governments into action.

Flashback 15 months, and it was pictures of corpses lying shunned in the streets and villages of Sierra Leone that seized the world's attention. The Ebola epidemic in West Africa had been running out of control for months. Despite the mounting concern of non-governmental organisations on the ground and many experts, including the co-discoverer of the Ebola virus Professor Peter Piot, the international community was agonisingly slow to respond. Denial was rife at all levels. It wasn't until August 2014, a full five months after the first cases, that the World Health Organization belatedly declared the outbreak an international public health emergency, and the full-response machinery at last swung into action.

Every major emergency or disaster teaches us lessons, from Haiti to New Orleans, from Fukushima to Nepal, or closer to home, from Buncefield to the 7/7 London bombings. One persistent failing seems to run through them all to a greater or lesser degree. Lack of coordination. The effectiveness of every response stands or falls on how well its many elements are orchestrated. Human resources, supplies, expertise, intelligence, logistics, infrastructure, liaison, negotiation – all have to be brought into play in the right place at the right time in the right quantity and working in the right direction. And it requires a clarity of purpose and fleetness of foot that the international community continues to lack.

> **The effectiveness of every response stands or falls on how well its many elements are orchestrated**

Not surprisingly it's also a common thread that emerges in the articles we've gathered for you in this edition of *Public Health Today*. We've tried to look at disasters and emergencies from a variety of public health angles. So we've got pieces on topics ranging from the prevention of public health crises in war zones to rebuilding the health and wellbeing of Mediterranean migrants, and from coping with the aftermath of the earthquakes in Nepal to restoring public health capacity in Sierra Leone. Plus we have thought pieces on the importance of cultural sensitivity in humanitarian responses and the hidden psychological burden borne by those working in disaster relief on the ground.

The public health role in emergency preparedness, resilience and response is crucial. But we have an even greater role in helping to build or rebuild health systems in countries where the set-up is inadequate and coordination lacking. We may not be able to stop wars or prevent earthquakes, but our skills can certainly help reduce the toll of many another drowned boy on the beach.

Alan Maryon-Davis
Editor-in-Chief

It's getting hotter and hotter and there is only one solution

ONE of the worst heatwaves India had ever experienced struck the country in May this year. While heatwaves are a feature of many summers, the 2015 event was significant because of the rapid rise in recorded deaths totalling approximately 2,500 and reported to be the highest toll since 1979. The temperatures increased to levels as high as 48 degrees Celsius in some places. Roads melted and hospitals were inundated with patients suffering from dehydration and heatstroke.

The heatwave occurred in India's dry season which generally lasts from March until June when the monsoons are expected to bring rain and relief from the searing heat. This year, however, the monsoon arrived late and the rainfall was sparser than usual, contributing not only to the heatwave but also to fears that the country was facing its first drought in several years. The government struggled to minimise the health impacts. Relief efforts included ensuring that drinking water and oral rehydration salts were freely available in public places and raising awareness of the need to wear hats and light-coloured cotton clothes and to avoid being outdoors during the hottest time of day. But what is the future likely to bring both to India and the world, as climate change progresses, global mean temperatures continue to rise and heatwaves become more intense and frequent?

Few health impacts result directly from heatstroke, but rather it contributes to increasing mortality and morbidity due to other causes such as cardiovascular and respiratory disease. The elderly are particularly vulnerable, a risk likely to be magnified as the population ages in many parts of the world. Government exhortations to remain indoors are meaningless for outdoor workers, the group at greatest risk, as they face a stark choice between a livelihood or protection from the blistering heat. Gender inequalities are especially amplified among outdoor workers. Women make up the majority of agricultural workers globally and in construction work in India where they do the most physically exhausting jobs. Animal health too, may be compromised. During the 2015 heatwave, three million chickens perished in one Indian state within a fortnight, causing the price of eggs and chicken to soar. Perhaps the most ominous impact on public health is related to the increasing risks of water scarcity, crop failure and reduced food security, not only in countries heavily reliant on rain-fed agriculture but worldwide. Furthermore, heat stress has already reduced global labour capacity to 90 per cent and, in the worst-case climate scenario, may drop to as low as 40 per cent.

Air-conditioned tractors may improve the lot of the American farmer, but such adaptations are out of reach in many countries. And everywhere, the poor face the worst risks. Life-threatening power outages and the consequent rise in demand for energy are reported even in developed countries during heatwaves, highlighting that technology is unlikely to offer long-term solutions. Similarly, policies to improve occupational standards to protect workforce health may offer short-term benefit to some workforces. There is increasing realisation that the only sustainable solution is to reduce global warming. Let us hope that our leaders can agree a deal to achieve this at the upcoming climate summit in Paris in November.

Mala Rao OBE
Professor & Senior Clinical Fellow
Department of Primary Care and Public Health
Imperial College London

More disasters will mean more mental trauma

LAST year, I asked a director of public health (DPH) about the provision of psychological trauma support services for people in the event of a major emergency in her area and was so shocked by her response. She replied, somewhat curtly, that she did not know: it was neither her responsibility nor her budget. I posted about it on the Faculty of Public Health blog. I was told I obviously hadn't read the Health and Social Care Act, 2012. "Confusion reigns as to who does what" on emergency preparedness and health protection, as one person put it, in response to my blog.

Since then Public Health England has helped develop the National Flood Emergency Framework for England, a strategic reference point for all those involved in flood planning and response. It acknowledges that the mental health impact as well as other health effects of living through flooding of a home or a loss of livelihood can have a profound effect on a person's wellbeing. In response to the challenge of assessing, monitoring and protecting against the long-term health impacts of flooding it has produced a protocol for establishing a health register after a flood. It emphasises the role public health has to play in major incident preparedness, planning, response and recovery.

The role of local authorities, via their DPH, is to provide leadership for the public health system within their area. In the event of flooding events, the role of public health includes actively contributing to multi-agency humanitarian assistance working groups and longer-term recovery strategies, working closely with those directly affected in ensuring access to psychological and other support services.

Public health must address the psycho-social needs of people before, during and after any disaster. There will always be human consequences and measurable health effects from any potentially devastating, large-scale life-and-death experience. With experts anticipating more rather than fewer disasters in future, being clear about the role of public health professionals is more important than ever.

Anne Eyre
Director
Trauma Training

DEBATE: Is the humanitarian community fit for purpose? Karl Blanchet criticises the Ebola response, while Jorge Sierralta is concerned about aid workers' mental wellbeing

A crisis of humanitarian governance

THE Ebola outbreak has revealed the weaknesses of the international humanitarian system to respond quickly and efficiently to a regional public health outbreak. It took the World Health Organization (WHO) too long to declare it an international health emergency. By September 2014 there were 1,800 fatalities confirmed but still no clear sign on the ground of a structured and coherent international response. A handful of international non-governmental organisations (NGOs) had not waited for the United Nations (UN) to be operational (eg. Medecins Sans Frontieres, International Medical Corps). But the major international donors had no clear strategy in place at the moment of the WHO declaration.

Following institutional tensions among UN agencies, the Coordination Cluster System usually put in place during relief interventions was not chosen. WHO decided to take the lead and in September 2014 put in place the UN Mission for Ebola Emergency Response (UNMEER). The strategy was focused on case management, case finding, contact tracing, safe and dignified burials and social mobilisation. All other humanitarian matters such as education, access to food and water, protection of civilians and security were outside their scope of work. As a result, many NGOs, and more specifically the ones with no medical mandate, did not feel recognised as legitimate operational actors and decided not to sit down at the table of UNMEER.

> **All other sectors of the health system were neglected**

All other sectors of the health system were neglected. No comprehensive package of care was delivered to respond to the other needs of the population, such as malaria, measles, malnutrition, HIV/Aids or obstetrics, although most patients in Ebola treatment centres systematically received malaria prophylaxis. In Guinea-Conakry it was estimated that 74,000 malaria cases did not get access to anti–malaria treatment during the outbreak, which suggests that fatalities attributed to malaria might have been higher than the number of deaths related to Ebola. Based on the Ministry of Health and Sanitation's recent Facility Improvement Team (FIT) assessment, the pressure of Ebola on the healthcare system led to the closure of health facilities and a drop in those that were able to provide emergency obstetric and neonatal care.

This regional crisis must help us reshape our humanitarian system to better respond to major public health outbreaks, not only to avoid governance issues but also to revisit the content of our interventions.

Karl Blanchet
Co-founder
Public Health in Humanitarian Crises Group
London School of Hygiene & Tropical Medicine

Humanitarian work – the human cost

THERE is a hidden cost of humanitarian operations. Crises and disasters clearly have an impact on psychosocial wellbeing and mental health of the exposed population, but studies have shown that humanitarian workers and organisations are also affected. Research by the Antares Foundation and the United Nations' Office for the Coordination of Humanitarian Affairs (OCHA) has found alarming levels of anxiety, depression and burnout among humanitarian workers. Behind the statistics, we find stories of chronic health problems, alcohol abuse, relationship breakdown and years of hidden suffering within the humanitarian workforce.

Organisations and employees tend to view stressors, such as insecure employment status, security risks and variable funding, as an inevitable aspect of the work. However, the impact of this stress is often underestimated. Persistent and inevitable stress can lead to a high turnover of staff, health problems, loss of productivity and a lack of empathy towards affected populations, family and co-workers.

However, research has also shown that organisational support, delivered by positive supervisory relationships and team cohesion, can help to diffuse the long-term negative outcomes of stress. Within the OCHA report, there was a clear correlation between organisational support and staff wellbeing. Many respondents specifically identified organisational support as a factor which could mitigate their stress levels. Factors such as psychological support, positive organisational culture, clear leadership, recognition and reward of effort, workload management, physical safety and work-life balance all help to promote long-term staff wellbeing.

> **The impact of this stress is often underestimated**

There is a need for programmes and a culture that supports humanitarian staff. This means ensuring that policies are implemented through comprehensive and holistic actions that include the often neglected 'heroes' – locally recruited staff. Such investment in staff welfare can improve productivity and reduce burnout, making organisations far more effective.

Within many organisations, there is a widespread macho culture that prevents those who are most in need of help from seeking support. Humanitarian organisations have a responsibility to promote a positive work environment and staff wellness. However, this can only be achieved with long-term investment in preventive practices and a cultural shift at all levels of an organisation. The stigma against seeking support must be addressed, beginning with management and leadership placing health and wellbeing as a priority on their agenda.

Jorge Sierralta
Clinical Psychologist
UN Office for the Coordination of Humanitarian Affairs

Burning questions

The best way to prevent fires is to tackle inequalities, and this places the fire service at the heart of public health, says Steve Vincent

MOST people do not consider the fire service to be a health provider, yet we are contributing to a healthier community and working with the same cohort of people as public health specialists.

West Midlands Fire Service (WMFS) incorporates into its wide-ranging work the so-called Marmot Principles – the six key policies for reducing health inequalities recommended by Michael Marmot in his 2008 report *Fair Society Health Lives*. We believe this has made the West Midlands a safer place, particularly for vulnerable residents and communities. At a conference hosted by WMFS at its headquarters in Birmingham, Sir Michael praised the brigade for "clearly recognising" the links between people's risk from fire and the conditions in which they lived, and endorsed the work of WMFS in tackling health inequalities.

Our first step towards this endorsement was beginning to understand what was creating fires and why people were getting hurt. We knew fires were created by factors such as careless disposal, arson or the inappropriate use of electrical appliances. We wanted to target our resources to deliver 'upstream firefighting', and we focused on three basic themes: behaviour, environment and support.

When we started to consider how to prevent fires, we developed a home safety check. The behaviours and issues we were identifying – such as mental health issues, drug dependency and type-2 diabetes – are all part of social inequalities. Some of the measures we use to prevent slips, trips and falls when someone needs to get out of a building quickly can also reduce health inequalities. Replacing an elderly person's worn-out slippers helps them escape their home in the event of fire and also reduces the possibility of them falling in their home, breaking a femur and needing hospital treatment.

> **Some of the measures we use to prevent slips, trips and falls can also reduce health inequalities**

We realised that the best way to prevent people dying in fires was to look for the causes of health inequality and tackle them. For example, if you are male, aged 25 to 45, living alone in certain areas and unemployed for more than a year, you are more likely to have a fire in your home.

As a prevention service, we have to understand the cross-overs and become an extension of the wider workforce that supports public health. We have worked with Coventry University to map out these links. The next step will be to work with a big enough cohort of people to produce the scientific proof that backs up our experience.

My advice to public health specialists would be to work with their fire service colleagues and gain an understanding of how they can support each other. Health professionals have the data and the intelligence. The fire service has a group of professionals who are respected and welcomed into the community. Yet, until these conversations take place, it can be difficult for public health professionals to see beyond the firefighting kit and see how our work can bring about wider health benefits.

We have worked with public health professionals to help tackle child obesity by devising a programme conveying both fire safety and health messages to children in Year Six over a sustained period; this was designed to empower them to make decisions for themselves. We are not social workers; we are a practical health support in the community that increases people's livability in their homes.

Steve Vincent
Area Commander
West Midlands Fire Service

After the earthquake, prepare for epidemics

ON 25 April 2015 Nepal suffered a calamitous earthquake (7.8 on the Richter scale). As though this were not enough, on 12 May a strong aftershock (7.2 in intensity) hit the same area. The combined destruction led to the deaths of around 9,000 people and displaced thousands more, many of whom are still living in temporary shelters.

Many infectious diseases are endemic in Nepal, including enteric fever and rickettsial illnesses such as murine typhus, hepatitis E and cholera. Post earthquake, with deteriorating hygiene and sanitation especially in the temporary shelters, there is a high risk of outbreaks of such diseases, perhaps even epidemics, in the ensuing monsoon months. Preparation is vital.

The government of Nepal says it is doing its best to provide clean water and sanitation to keep these diseases at bay. But it may be important to go one step beyond these usual measures. A case could be made for stockpiling vaccines effective against typhoid, hepatitis E and cholera.

A large trial reported in the *Lancet* in July 2015 about the effectiveness of cholera vaccine in Bangladesh found that behavioural interventions to improve water quality and personal hygiene afforded little additional protection beyond that provided by the vaccine. This was a disappointing finding but clearly shows the importance of vaccination against cholera. Because typhoid fever and hepatitis E, like cholera, are transmitted by the fecal-oral route, it may be important to keep this finding in mind.

Clearly, proper sanitation and hygiene are very important in the prevention of diseases spread by fecal-oral transmission – but it may be necessary to deploy vaccines, at least in the short term, to deal with these life-threatening illnesses.

> **A case could be made for stockpiling vaccines effective against typhoid, hepatitis E and cholera**

Little known to people outside the research community in Nepal, murine typhus is transmitted by rat fleas and is the second most common cause of undifferentiated febrile illness in this part of the world. Since no vaccination is available, pest control and improving sanitation are clearly key in preventing this debilitating and potentially fatal disease.

The Nepali Ministry of Health and Population, in collaboration with many non-governmental organisations, is trying to provide proper sanitation and clean water in the temporary shelters and camps, but prevention of these illnesses is a daunting task during the monsoon rains of the summer months.

Buddha Basnyat
Director
Oxford University Clinical Research Unit – Nepal
Patan Hospital
Kathmandu

Giving power back to affected populations

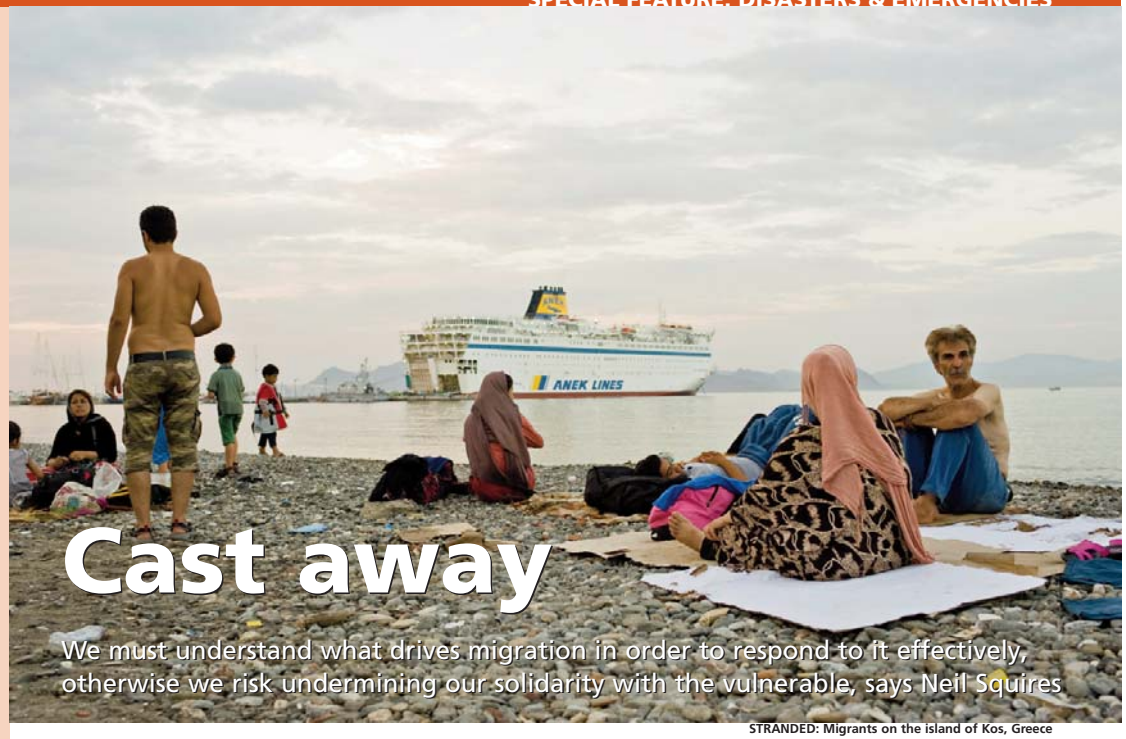
THE power balance between the affected population (often in developing countries and nearly always in areas of deprivation) and the organisations who fly in to help out in their hour of need (predominantly based and funded in developed countries) is particularly pertinent in public health disasters. When survival depends on external help, would any of us say thanks, but no thanks? However, the argument becomes more nuanced if, for the requisite resources to be effective, culturally specific values and practices need to be suspended.

Long-term development work has evolved because time taken to work slowly, alongside people (particularly leaders and influencers in a community) often brings the greatest benefits for a community. There is mutual learning and respect for both development worker and community, and the population claims knowledge as their own to best serve their needs.

Is this possible in a disaster where every second is of the essence? Perhaps not to the extent of a 15-year development project, but it is necessary to adapt this approach to ensure that communities feel involved in the response. This can be undertaken through couching the intervention in culturally understandable ways, using collaborative approaches and allowing the community to take ownership of the intervention process whenever possible. These approaches are now adopted with far more frequency as lessons have been learned from major disaster-relief operations, including the tsunami in south-east Asia in 2004 and Hurricane Katrina in New Orleans in 2005. These approaches also allow development to continue in a community long after the relief teams have moved to the next headline disaster.

It is always worth bearing in mind that the clash between cultural values and effective interventions (ie. saved lives) does not and will not always default in favour of saving lives. This is perhaps one of the most difficult issues in public health ethics – your own perspective on the right thing to do does not always correspond with other people's reality. For this reason, public health ethics must continue to be debated in all areas of the profession.

Rebecca Cooper
Public Health Consultant
Solutions4Health



Cast away

We must understand what drives migration in order to respond to it effectively, otherwise we risk undermining our solidarity with the vulnerable, says Neil Squires

STRANDED: Migrants on the island of Kos, Greece

MEDIA coverage of overcrowded boats in which migrants risk everything to cross the Mediterranean has graphically illustrated the horror of a journey that has already claimed the lives of more than 1,500 people this year. These perilous voyages are likely to kill more than 2,500 children in 2015.

What we hear less of, and what is probably harder for many ordinary people to really comprehend, are the back stories of those individuals forced into the hands of ruthless traffickers as they head for an uncertain future. Maintaining a focus on the drivers of migration is essential to understand and respond effectively.

On 14 May this year, the Faculty of Public Health (FPH), the Royal College of Paediatrics and the British Association of Child and Adolescent Health wrote to the *Times* offering the expertise of their memberships to help address the complex determinants of the tragic and often fatal flow of migrants.

The *Times* letter drew attention to the stigma often placed on migrants in a political context in which we regularly see images of UK borders apparently under siege. At a safe distance from the harsh reality of the refugee camps of Greece and Italy, we can perhaps be forgiven for struggling to reconcile the images of dehydrated people rescued from the sea with images of gangs of fit young migrants climbing into lorries in search of economic security. These contrasting images of migrants and a media-fuelled fear of economic migration in a context of austerity are the real threat to public health, threatening our solidarity with vulnerable and traumatised people. We must guard against prejudice undermining our sense of common humanity and diminishing our care. The public's health is built upon a foundation of community,

> **We must guard against prejudice undermining our sense of common humanity**

and eroding the solidarity at the heart of community is a threat to public health.

So what is it that the membership of FPH can offer? The FPH *Global Health Strategy*, launched in June at the FPH annual conference in Gateshead, identified four key functions of our international work:

- Advocacy
- Standards
- Our workforce
- Knowledge, evidence and research.

It is these resources we need to draw upon to support action.

The UK has a long tradition of accepting and integrating people from other countries. Past international crises have led to other waves of migration which, although often challenging, have been managed. Documenting the evidence of how systems have coped and using this knowledge to highlight the system's resilience is necessary to reduce the fear and stigma generated by the current crisis.

Direct contact with people in need can help overcome the sense of difference that underpins 'us' and 'them' attitudes. When directly confronted by a humanitarian crisis, our inclination is to help. The public health community (our membership and workforce) can help bridge the distance between 'us' and 'them' by using personal stories to focus in on individual lives and help strengthen that sense of common humanity.

It will be through our collection of evidence on successful integration of past waves of migration and through our membership reaching out to tell the stories of the current wave of migrants that we become effective advocates for addressing and responding to the tragedy unfolding in the Mediterranean.

Neil Squires
Chair
FPH International Committee

Build capacity now

Urgent action is needed to improve the health systems of countries likely to suffer outbreaks of diseases such as Ebola, says Public Health Africa

ILL-PREPARED: Small village near Makeni, Sierra Leone

HUMAN trials of a new vaccine against Ebola infection have been exceptionally successful, in what is widely seen as a breakthrough both in control of this deadly disease, and in rapid vaccine development and inter-agency collaboration. This has been one of the few highlights in a global response that otherwise lacked the required urgency in its early stages and suffered a damaging lack of insight and coordination. While an Ebola vaccine will play an important role in the prevention of the disease, we must not forget the contexts in which people first contracted Ebola, and how it rapidly spread to several West African countries. Public education, vigilance and a shift in traditional cultural practice are needed to protect people's health in the long run.

The UK government responded to the Ebola crisis by supporting disease-control efforts in the affected region, screening at major ports of entry to the UK and ensuring local services were prepared should suspected cases arise. Public health professionals have provided support, technical expertise and local and national leadership in each of these areas. However, the UK's early efforts did not have the necessary urgency or importance.The first UK-funded treatment facility opened in November 2014, when weekly cases were already in the hundreds. Should the public health community in the UK have played a greater role in ensuring a timely and effective response? Certainly, they should be in a better position than most to identify and communicate the threat posed by situations such as the Ebola outbreak and to make the case for early intervention on humanitarian, health protection and economic grounds.

Questions are being asked at all levels about what can be done to prevent future outbreaks like this. Much has been written about the need for a dedicated international emergency response unit and the need to encourage countries to declare outbreaks and seek help, but public health leaders must strengthen their calls for more fundamental action. There needs to be urgent, coordinated activity by the international community to improve and support the health systems of the countries most likely to suffer widespread outbreaks of diseases like Ebola. Before the Ebola outbreak, Sierra Leone had only 120 doctors, including only one virologist, who then became an early victim of the disease. The health system was ill-prepared to deal with a small outbreak of highly infectious disease, yet was faced with thousands of cases in a period of only a few months. Without an immediate and long-term commitment to change this, we cannot fully address the risk of another Ebola. The recent vaccine development has demonstrated that, with a strong, coordinated international effort, changes that usually take years can be brought about much more quickly. This approach must be taken to build the capacity of public health and health services in the countries most at risk.

> **Public education, vigilance and a shift in traditional cultural practice are needed**

Public Health Africa, an FPH special interest group, aims to support the building of public health capacity within African nations. The tragedy of Ebola has created a platform for Public Health Africa to make the case that global health is the business of all public health professionals. We urge our colleagues across the public health system to do the same and to advocate for the change required to prevent – rather than belatedly cure – the next big outbreak.

Aliko Ahmed, Victor Joseph, Matthew Neilson
Public Health Africa

MERS: a reminder that we need to be vigilant

ONCE again the world has had a wake-up call about the risks of emerging infections and the need for a transparent global response. On 28 July 2015 the Prime Minister of South Korea declared the end of the outbreak of Middle Eastern Respiratory Syndrome (MERS). The preceding months had been an anxious time.

MERS is caused by a coronavirus, a type from the family that includes SARS as well as the common cold. Much remains unknown about the disease and how it may behave in the future.The first cases of MERS emerged in 2012 in the Middle East and the first confirmed death in Saudi Arabia that year. Researchers believe its origins are animal-to-man transmission from dromedary camels. It does not pass easily between humans and in most cases there has been close contact between affected individuals. Globally the total number of reported cases from 26 countries as of 7 July 2015 stands at 1,368 with 487 deaths.

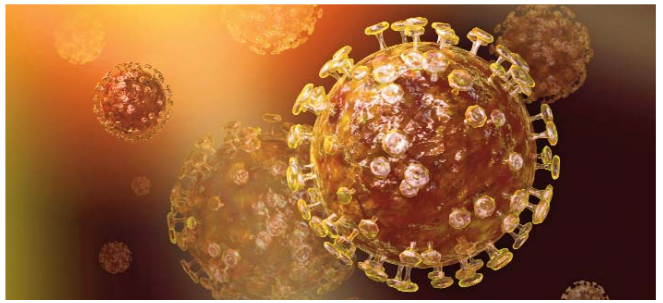
The MERS outbreak in South Korea started in May when a patient returned from visiting the Middle East with respiratory symptoms. He visited four hospitals; 186 patients were infected and 36 died. Questions about the speed of response became a matter of global concern, leading to the Prime Minister's apology on 28 July. Since MERS is probably spread by droplets, good prevention and control of infection practice and appropriate standard isolation facilities in hospital would be expected to control its spread. There is no vaccine, but reports from Hong Kong suggest that there are useful drugs on the horizon.

MERS can be difficult to diagnose and needs to be in the differential diagnosis of patients presenting with respiratory symptoms, including fever, cough, sore throat and muscle pain, particularly if there is a history of travel. Once suspected, isolation to prevent spread is essential as hospitals present a high-risk environment, not only because of close contact, but also because immunocompromised and elderly patients are at higher risk. Contact tracing of suspected cases is critical, as is information for the public on good hand hygiene and general health. This is particularly important for people who have close proximity to animals.

The need for system-wide control of infection was a lesson learned from the SARS epidemic in 2003. SARS was more highly infective and spread more rapidly than MERS, but both viruses impacted not only on hospital systems but on the socioeconomic environment. As the disease began to spread in Korea, 209 schools were closed as a precautionary measure. In Hong Kong, when a South Korean man who transited in Hong Kong en route to China fell ill with MERS, other passengers sitting within two rows of him on the flight to Hong Kong were quarantined at a holiday camp for two weeks. This action reminded the community of the importance of air travel as a vector of spread and of the need for airport information and controls.

As in Hong Kong post-SARS, the impact of the coronavirus outbreak has contributed to falling GDP in South Korea and the need to rebuild confidence in health protection systems. For now, the threat of MERS in South Korea has abated, but recent events underline the need for good surveillance and communication and the importance of the World Health Organization in a globally coordinated response.

Siân Griffiths
Emeritus Professor
Chinese University of Hong Kong



Combating war with primary prevention

A BILLION children live in areas affected by armed conflict and will consequently experience a range of preventable health outcomes including psychological trauma, malnutrition, forced displacement, disease, physical injury and death. However, public health professionals often feel that the diplomatic and political determinants of modern warfare are not within their remit to address. On the contrary, we would argue that a robust public health approach to this grievous international health and human rights issue is urgently needed.

Both authors have spent time working in armed-conflict zones trying to ameliorate the malnutrition, lack of medical care and psychological distress they generate, as well as treating the injuries that those conflicts directly cause. Although neither of us thought of it in precisely these terms at the time, we might now classify those activities as secondary and tertiary prevention strategies for the negative health impacts of war. It seems to us that the real challenge is to promote greater public health engagement with the primary prevention of armed conflict.

International laws governing the rules of war are the product of many self-interested compromises and are ultimately only as good as their enforcement – a test of credibility which the international community is currently failing, most notably in Syria. We are keen to be involved in forming a special interest group of the Faculty of Public Health (FPH) to explore the positive contribution that public health professionals can make to this issue.

See the FPH blog at betterhealthforall.org for a full version of this article.

Bayad Abdalrahman and Daniel Flecknoe
Specialty Registrars in Public Health
Derby Hospitals NHS Foundation Trust

Everyone gets to benefit from global response

IN NOVEMBER 2013, Typhoon Yolanda, otherwise known as Haiyan, caused widespread destruction to the Philippines resulting in an estimated 6,300 deaths and 28,689 injuries. It was the deadliest Philippine typhoon recorded in modern history. An international humanitarian response was swiftly mobilised.

Experienced Public Health England (PHE) field epidemiologists, microbiologists and infectious disease surveillance and control experts were deployed as part of the World Health Organization (WHO) country team to assist in the emergency response. Two experts arrived in the WHO country office within 48 hours of the disaster. The PHE team worked within the WHO structure to support the Philippines Department of Health under the WHO response framework. They were involved with drafting the immediate response plans and public health priorities leading to a phased recovery plan. They worked closely with the health cluster, the co-ordinating mechanism for disaster response, led the WHO response team, developed infectious disease outbreak control plans, identified rehabilitation priorities for health facilities and developed a wide range of public health development strategies. They also had skills in environmental health and dead-body management which were required during the response.

Key to the success of this work, as in any response, was the strong working relationships between PHE and the Philippines Department of Health, existing

> **New networks often lead to ongoing partnerships and international collaborations**

WHO country office staff and numerous local, national and international non-governmental organisations.

Given the scale of the disaster, the team remained in-country with WHO to continue supporting recovery. They focused on logistical support, team leadership, public health recovery and rehabilitation planning. PHE experts in disaster risk reduction continue to support the development of policies, such as the United Nations' *Sendai Framework for Disaster Risk Reduction 2015-2030*, to help countries prepare for disasters.

On their return from assisting the public health response to international disasters, the overwhelming majority of PHE staff describe their experience as positive. First and foremost is the opportunity to help reduce avoidable mortality, morbidity and disability. But many find they also gain professionally and personally.

And it's not just individuals who benefit from a response. Public health organisations are becoming increasingly aware of the value that international assistance can bring. New networks often lead to ongoing partnerships and successful international collaborations. Individuals return with transferable skills having seen first-hand how organisations such as WHO operate during an emergency. They also benefit from

exposure to infectious-disease threats no longer common in the UK, building their capacity to respond to risks emerging from an increasingly interconnected world.

The broad training received by public health specialists in the UK is considered invaluable in preparing them for the flexibility, adaptability and knowledge required for the early phase of a disaster response. Sudden onset and often unexpected challenges can mean that those deployed need to quickly turn their hand to any aspect of public health. PHE recognises this and aims to complement the existing knowledge base of staff by ensuring that each person deployed has adequate technical and practical pre-deployment training.

Globally, there are a significant number of emergencies with public health implications. The need for the international community to work together to develop rapid and effective responses is clear, and PHE is committed to playing its part.

Katie Carmichael
International Emergency Preparedness Coordinator
Public Health England

Bring water to people, not people to water

OXFAM is well known for providing clean water in emergencies, and this is vital for preventing a range of waterborne and hygiene-related diseases. For decades, our technical experts have been designing and adapting equipment for use in difficult conditions across the world, from huge tanks holding 90,000 litres of water to portable filtration devices for individuals.

However, we know that facilities will only be used if they are culturally appropriate, easy for children or disabled people to access, and placed where people feel safe to go. Listening to communities through group discussions, interviews and observation is crucial to understanding local norms, customs and tastes. Our principle is to 'bring water to people rather than make people go to water'. This saves the women and girls who usually fetch it many hours' walking time, often in dangerous conditions.

Innovation has always been central to Oxfam's approach; staff are asked to propose technical solutions to hard-to-crack problems. These can then be worked up with universities or companies. In 1985, Oxfam and Surrey University collaborated to design the Delagua water-testing kit – a portable 'lab in a box' allowing instant testing of water potability in isolated rural settings. It is now used all over the world.

Sometimes what's needed is a new way of providing information. Unable to get into Somalia during a recent cholera epidemic, Oxfam sent interactive text messages in the local language on cholera prevention which helped mobilise the community to understand the risks and stay healthy.

Sophie Mack Smith
Knowledge Management Advisor in Emergencies
Oxfam

Water point, South Sudan ©Kieran Doherty/Oxfam

The big threat to HIV/AIDS prevention

ALMOST 30 years have passed since a leaflet dropped onto the doormats of every household in the country. It explained the facts about a new virus – how it was spread, how serious a threat it was and how it could be avoided. With neither a vaccine nor a cure on the horizon, its bleak message – "Don't die of ignorance" – offered the public a vital means of protecting themselves and preventing its spread: information.

In the intervening years, much scientific and medical progress has been made in understanding Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS). Standard Antiretroviral Therapy (ART) is now very effective, enabling people with HIV to live long and healthy lives. Yet today UNAIDS estimates that half of the 35 million people living with HIV are undiagnosed.

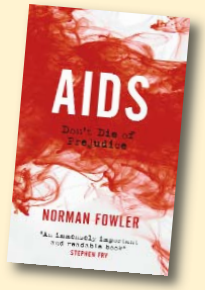
Norman Fowler was Secretary of State for Health and Social Security in the Thatcher government and architect of that first national HIV/AIDS public awareness campaign. He offers a unique and dispassionate insight into the internal machinations of the government as it confronted the emergent epidemic – and of some of the most important issues facing nations today.

Ten areas requiring focus are identified:

- Investment in prevention
- Public education to increase testing
- Sex and relationship education
- Offering ART to all people with HIV
- Development of a vaccine
- Confronting the corruption
- Ending criminalisation of sex work
- Global drug harm-reduction policies
- A new dialogue with faith leaders
- Political leadership.

However, it is during Fowler's travels across four continents, that an 11th factor is identified. It creates an optimal environment within which HIV can thrive and through which efforts to address the critical areas identified are failing: prejudice. The rights of minority groups, in particular Lesbian, Gay, Bisexual and Transgender (LGBT) people, are, in many countries, comparable to the position "of being black under apartheid in South Africa, or being a Jew living under the Nazis in Germany".

The solutions are complex, but, as a starting point, Fowler calls for an international convention to protect the rights of those most at risk: not only LGBT



people, but also drug users, sex workers and, more generally, women. We know what works. We understand the evidence-base. *AIDS: Don't Die of Prejudice* offers a compassionate and urgent call to fight the biggest threat to HIV/AIDS prevention.

Mark Weiss

AIDS: Don't Die of Prejudice
Norman Fowler

Published by Biteback
ISBN 9781849547048
RRP: £14.99

When opium was the opium of the people

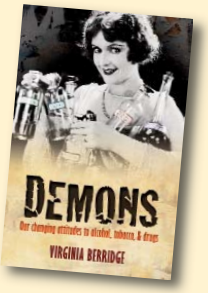
HOW did opiates, once regarded as kind of wonder drugs, become an international scourge and a multi-billion-pound criminal industry? And conversely, why is alcohol, once the target of the massively popular grass-roots temperance movement, now as embedded in our culture as ever?

These are questions that are answered by Virginia Berridge's fascinating history of the public and private attitudes to these drugs and others. She takes us step by step through the scientific research, international conventions, parliamentary reports, media stories and cultural shifts which have brought us to this point – a point at which, after 200 years of public panic, drug wars and burgeoning subcultures, there exists a similar kind of 'normalisation' of drug use to that which existed right at the beginning of the period.

However, if you are looking for an opinionated voice on one side or other of the legalisation argument, you will not find it here. Professor Berridge, Director of the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine, is refreshingly unpolemical in her treatment of the subject, casting a meticulous and dispassionate eye over the facts. What she is more interested in doing is seeing patterns and movements over the course of the many decades she examines. The point is to read the book and draw your own conclusions.

Berridge is also keen to debunk some of the myths and over-simplifications of the drugs debate when it tries to use history to support its arguments. The often stated 'fact' that Queen Victoria used cannabis (one repeated in this magazine's review of David Nutt's book *Drugs Without the Hot Air*) has, it turns out, little foundation in truth. (Instead, judging by Berridge's startling depiction of opium use in every stratum of 19th Century society to treat almost every ailment in existence, it would seem much more likely that Her Majesty was a regular user of the latter drug.) And, when it comes to the mantra that alcohol prohibition did not work in 1920s America, having discussed the problems of enforcement and the rise in organised crime, she demonstrates that, all in all, Americans drank less and alcohol-related disease fell.

Berridge identifies several key influences, such as trade, tax receipts, technology, war, xenophobia and gender politics, which have shaped the history of drugs



policy far more than medical research. Policy-makers, who are often over concerned with short-term trends, might do well to read this book and take fresh lessons from history.

Richard Allen

Demons: Our changing attitudes to alcohol, tobacco and drugs
Virginia Berridge

Published by Oxford University Press
ISBN 9780199604982
RRP: £16.99

From the CEO

A GREAT number of column inches have been devoted to the refugee crisis in Europe. Sections of the media have referred to a 'flood' of 'migrants' 'swarming' towards Europe, while the publication on 2 September of a photo of the body of three-year-old Aylan Kurdi on a Turkish beach seemed to shift public attitudes. The debate remains polarised. There has been public outcry – mainly in favour of improving the UK's response. There continues to be significant discussion about migration, immigration, domestic and foreign policy and what constitutes 'humanity'.

At the heart of it, thousands of people are fleeing their countries and taking huge risks in the hope of a safer, better life. We have heard of people being drowned, suffocated in lorries, electrocuted on rail lines, beaten by smugglers and fatally injured after clashes with authorities.

In the continuing absence of a consensus for action from across the European Union, refugees and individual countries are taking matters into their own hands. We have seen Germany beginning to deal with the consequences of its generous pragmatism towards refugees, Hungary using water cannons and tear gas and closing its borders, and Croatia shipping people into Hungary for onward transport to Austria. Here in the UK, the Prime Minister has announced a doubling of the numbers of refugees Britain will take in over a five-year period.

Some of the world's religious leaders have not only called on their communities to house people seeking help, they have opened their own houses. And Europeans have marched with banners welcoming refugees and taken to social media to pressurise their politicians into action.

And what are the practical solutions to this centuries-old issue? It seems to me it's as complicated or as simple as we want to make it. Europe has a population of 740 million and some of the wealthiest economies in the world. We should be able to do more, faster, than we have to date – both in handling the crisis and its causes.

It's good to see the public health community responding in partnership to the issues with the evidence and with compassion. The Faculty of Public Health and the Association of Directors of Public Health have issued a joint call for action (http://www.fph.org.uk/joint_adph_and_fph_press_statement), and we are inviting support from our partners across the public health community and from the Academy of Medical Royal Colleges. Together we can make a difference.

David Allen

In memoriam

Shakeel Bhatti
1979 – 2014

SHAKEEL qualified from University College London in 2003 and began training in Southwark public health department in 2006, initially as senior house officer and then on the specialty public health training programme. He contributed significantly to the department's output over the years – most recently by drafting the departmental training policy and working with Transport for London on a comparative review of London versus other European cities in terms of access for disabled people on public transport – a subject close to his heart.

As a teenager, Shakeel was a keen sportsman, excelling in football, cricket, and table tennis, with a broad spectrum of interests, including debating and chess. He won a scholarship to Dulwich College. It was in his third year at medical school that he developed symptoms of a neurodegenerative disease, spinocerebellar ataxia, which led to his increasing and severe disability. Many will remember the standing ovation he received at his medical school degree ceremony, when he walked slowly, unaided, to receive his final degree, an act that defined the determination with which he approached the challenges he faced daily as his disease progressed.

The spinocerebellar ataxias are a group of rare, inherited neurological disorders. Shakeel's father died from the same condition. However, Shakeel was affected earlier and more severely than his father, which is characteristic of this type of genetic disorder. The condition remains poorly understood and at present there is no cure.

Shakeel was an inspiration to us all in his life and work and in the dignity and fortitude with which he accepted his condition and the future that lay ahead of him. We remember his resolve to maintain his independence, his dry humour, his daily Café Nero cappuccino, his passion for football – he was a keen supporter of Tottenham Hotspur Football Club – and his avid interest in all new technologies and how they might be applied to enable him in his work and activities of daily life.

Gillian Holdsworth

Richard (Dick) Keenlyside FFCM
1944 – 2014

DICK qualified from Westminster Medical School before gaining a Diploma in Tropical Medicine and Hygiene at the London School of Hygiene & Tropical Medicine and a Masters in Epidemiology at Harvard.

He first joined the Centers for Disease Control (CDC) in Atlanta in 1976, initially as an officer in the Epidemic Intelligence Service carrying out research on a variety of infectious and non-infectious diseases.

Over the ensuing years he held various positions in and out of CDC including a spell as Associate Director for Global Health in the National Center for HIV, STD, and TB prevention in 1999-2000. Prior to his retirement in 2012 he was Country Manager for CDC's HIV/AIDS programmes in China, Russia, Ukraine, Central Asia and India.

Dick's career in epidemiology also took in a period as a lecturer at the London School, as a consultant to the Pan-American Health Organization's Caribbean Epidemiology Center and as State Epidemiologist to the Rhode Island Department of Health. In his later years, he became closely involved in Buddhism, studying at the Drepung Loseling Monastery, a Tibetan Buddhist learning centre affiliated to Emory University, Atlanta.

Well known for his ability to bring mindfulness, calmness, humour and joy to any situation, Dick was widely regarded as a charming, witty and endearing person who made countless friends across the world.

Victor Hawthorne FFCM
1921 – 2014

GRADUATING from Glasgow in 1951 and deeply affected by the toll of tuberculosis in the poorer parts of that city, Victor was soon drawn to epidemiology. After studies comparing the burden of respiratory disease and hypertension in the west of Scotland, he was offered a senior lectureship at the new department of epidemiology and preventive medicine at Glasgow in 1966.

There he pioneered the MIDSPAN prospective cohort studies, including the famous Renfrew/Paisley Study following the cardio-respiratory health of 15,000 men and women aged 45-64. Unusually at the time, this study involved 4,000 married couples and in 1996 spawned the MIDSPAN Family Study including sons and daughters, which continues to this day.

In 1978 Victor took up the chair in epidemiology at the University of Michigan. He was very much involved in the chronic disease research studies that formed the basis of the renowned Tecumseh Community Health Project and the Seven State Hypertension Control and Demonstration Project, as well as a range of studies looking at the quality of local healthcare provision.

Victor retired in 1986, although he remained active in research and practice, his last journal article appearing as recently as 2009.

Deceased members

The following members have also passed away:

Mohamed Ashraff FFPHM
William Barton MBE FFPH
Hastings Carson FFPH
Aidan Halligan FFPH
Thomas Plumley MFPH
George Ritchie MFPH
Peter Roads FFPH
Walter Wigfield MFPH

News in brief

FPH governance review
We are very pleased to announce that the Faculty of Public Health (FPH) membership approved the proposed changes to the FPH governance structures in the recent membership ballot, and we will therefore be proceeding to incorporation as a company limited by guarantee. The Memorandum and Articles of Association and Regulations for the new company were approved by 86.2%. The preferred choice of name was 'Faculty of Public Health' (53.4%). Applications are being prepared for submission to Companies House and the Charity Commission to register FPH as a company limited by guarantee by 31 December 2015 if possible. The full results of the ballot are available in the FPH online members' area or from carolinewren@fph.org.uk

Election of FPH President
Nominations opened on 21 September 2015 for the election of a President to take office at the FPH annual general meeting in June 2016. The post is open to all FPH Fellows and Honorary Fellows in good standing. Nomination papers are available on the FPH online members' area or from carolinewren@fph.org.uk. The deadline for nominations is midday on 19 October 2015.

There will also be elections during the course of 2015/2016 for a Treasurer, Academic Registrar, Assistant Registrar and local council members. A full elections timetable can be found in the FPH online members' area.

FPH courses in 2015
Getting the Most Out of Your Professional Appraisal – London, 9 October
How the appraisal system works, and how to enhance the process so that it can maintain your practice. More information from garethcooke@fph.org.uk
Mental Wellbeing in Population Health: An Introduction – London, 16-17 November
Provides an understanding of the principles of mental wellbeing, the effect on the individual and community and how to address these issues. More information from garethcooke@fph.org.uk

PHAST courses in 2015
FPH is hosting the following courses in London in partnership with the Public Health Action Support Team (PHAST). More information from marion.deacon@phast.org.uk

Transformational Leadership Workshop – 23 October 2015
Covers all the key elements of transformational leadership for public health professionals working in a complex, multi-agency environment. Further information at http://tinyurl.com/obdltcr
Social Media with Confidence Workshop – 30 October 2015
Explores the uses, opportunities and risks of social media, offering real-time demonstrations and hands-on experience. Describes the most popular channels, explains their uses, differences and limitations. Further information at http://tinyurl.com/qxujdpo
Critical Appraisal: Making Sense of Research Evidence – 6 November 2015
Develops skills in appraising research on different study types and refreshes understanding of research methodologies. Reviews a randomised controlled trial, a systematic review and a case-control study. Further information at http://tinyurl.com/ofg98r6

Correction
In *Public Health Today* June 2015 we incorrectly quoted Clare Gerada in the pull-out quote in the Big Interview. That has been corrected in the online version. Apologies.

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between April 2015 and September 2015

Honorary Fellows
Amanda Amos
Michael Bannon
Ilora Finlay of Llandaff
Trevor Hancock
Janet Hemmingway
David Heymann
Ronald Labonte

Fellows through distinction
Karin Denton
Akram Eltom Mohamed
Sarah Hawkes
Muhammad Khan
Ha Yun Lee
Anna Miller
Edward O'Dwyer
Ikushi Onozaki
Rosalind Parkes-Ratanshi
Neil Pearce
Joseph Peiris
Jem Rashbass
Jacqueline Reilly
John Rumunu
Aziz Sheikh
Hong-Bing Shen
Jane South
Alistair Story
Ammar Suliman-Abbas
Peter Wright
Joseph Tsk Kei Wu

Fellows
Marta Busana
Sin Chor
Bethan Davies
Helene Denness
Jane Fowles
Rachel Isba
Jillian Johnston
Srinivasa Katikireddi
Rabia Khan
Ben Leaman
Bruce McKenzie
Gillian O'Neill
Maha Saeed
Ruksana Sardar-Akram
Louise Sigfrid
Samit Shah
Sarah Smith
Jason Strelitz
Celia Watt
Kirsten Watters

Honorary Members
Rhys Blake
Alex Bottle
Rosamund Bryar
Ben Cave
Carmel Clancy
Sarah Jane Cunningham-Burley
David Dickinson
Sheila Duffy
Simon Ellis
Anders Freiberg
Philip Insall
Sally James
Alhussein Khaled
Monika Kosinska
Bennett Lee
John Moxham
DanielPope
Bayard Roberts
Edmond Rooney
Cathy Roth
Anthony Rudd
Catherine Swann
Ian Trimble
Karen Wheeler
Sandra Whiles
Patti White
David Wilkinson
William C W Wong
Geoff Wykurz

Members through distinction
Robin Ireland
Christopher Lewis
Tom Loney
Che Chung Luk
Helen McAvoy
Anna Pronyszyn-Hughes
Colin Sibbald
Mary Tooley

Members
Amina Aitsi-Selmi
Dominique Allwood
Behrooz Behbod
Jane Bray
Kathryn Cobain
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New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

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Louise Sigfrid
Victoria Spencer-Hughes
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Generalist portfolio route
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Defined specialist portfolio route
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GENERAL MEDICAL COUNCIL REGISTER

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Fatim Lakha
Bruce McKenzie
Richard Pinder
Charlotte Simpson
Charlotte Stevenson
Rhianwen Stiff
Janine Thoulass
Nicholas Young

Bed-bound and taking 21 tablets a day, **Debs Taylor** was resigned to a life of debilitating mental ill health. Then one day she picked up a paintbrush and everything changed...

HAVING had mental health issues from a very young age, it was part of my life. I was resigned to the fact that I would be on medication and have this illness forever. Even the 'experts' told me I would, so it must be true, right? Wrong.

Three-and-a-half years ago I embarked on an 'art-for-wellbeing' course with Creative Minds, part of the South West Yorkshire NHS Trust. I went along to a taster session, having been ridiculed about the appalling state of my drawing when playing picture games with my children. Although I was not expecting miracles, that day was the start of the most incredible journey that I could ever imagine.

I was heavily medicated (21 tablets a day), bed bound most of the time and, as my girls were my carers, life didn't hold out much hope. After the initial taster, I began going regularly to the group. As my paintings improved my mind did too. I started to reduce medication and my confidence was growing along with my collection of work. I started doing talks to inspire service users that they too could have hope of getting better. Professionals started listening and started asking me questions on how they could help people like me. I felt I was contributing to life. I was making a difference to the world of mental illness.

Three-and-a-half years later, I do talks all over the country about mental illness and how it affects people. I have many pieces of my work adorning people's walls. I went to the Garden Party at Buckingham Palace last year after someone heard my story and was so inspired that they nominated me. I have had an art exhibition at Canary Wharf in London. Not bad for someone who was just a statistic in a failing system.

> **I went along to a taster session, having been ridiculed about the appalling state of my drawing when playing picture games with my children**

I want people to see that mental illness can be improved. If I can make such a huge difference with my life then I have no doubt others can too. I feel like I am finally living life. I am finally a part of what many take for granted. I once felt jealous of a terminal patient in hospital; her life was coming to an end, and mine was being forced to carry on with this illness that was consuming my whole body. The obstacles I used to see are now challenges. I will continue in my quest to change people's attitudes to mental illness. I want people to see that there are millions living with this illness. I don't want people to think only of that one person who has done something horrific and presume we are all like that.

Not only did my art therapy save the NHS essential funding (Social Return On Investment has been done on my treatment before and after the course), but the impact on my family and myself has been priceless. Art has changed my life. Something as simple as painting has given me a totally different outlook. I am no longer reliant on medication – I am now down to zero tablets. I have found skills that have equipped me to live my life. I never dreamed I would ever feel 'normal', let alone be an active campaigner in changing attitudes towards mental illness. The sky has no limit.

Debs Taylor

http://www.thedebseffect.co.uk
http://www.southwestyorkshire.nhs.uk/quality-innovation/creative-minds/

Information

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Liz Skinner

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Faculty of Public Health
4 St Andrews Place
London NW1 4LB
www.fph.org.uk

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