The magazine of the
UK Faculty of Public Health
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Public Health Today

Let's talk about sex

All the good things and the bad things

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Welcome

IT IS a particular pleasure for me to welcome so many of our members, fellows and friends to Sage in Gateshead for this year's Faculty of Public Health conference. The response has been magnificent with a record number of delegates registered and a meaty and stimulating programme. We must be especially grateful to the conference planning team of Mag Connolly, Duni Vincent, Keith Carter and Chantel Sutherland-Singh, as well as our extended planning committee.

For myself it is an especially nostalgic trip back to my medical alma mater. It is exactly 50 years ago that a skinny,callow, wet-behind-the-ears youth from Liverpool arrived on the train at Newcastle Central Station and struggled to understand an accent, which I later came to know and love, and brave the harsh autumn fog on the Tyne to find my way up to the old medical school and a journey into adulthood and a life in medicine and public health. It was and is a remarkable place, and in the period of 1965-70, embracing as it did the summer of love of 1967 and the year of global youth cultural revolution in 1968, an amazing time to be a student in this special place. How it has changed from a grimy city languishing in a forgotten post-industrial cocoon. It could scarcely have anticipated the vibrant European metropolis that NewcastleGateshead and the rest of the Tyne and Wear region has become today. But beneath the sophisticated surface, the challenge of economic disadvantage and health inequality remains as stark as ever. There is much public health work to be done.

Fortunately, inspiration for those inclined to public health action has never been far away. John Snow came to Newcastle from York, where he was born, in 1827 at the age of 14 to be apprenticed to William Hardcastle, a surgeon-apothecary. This apprenticeship lasted six years during which he had his first encounter with cholera during the 1831-32 outbreak, and he also became an active member of the temperance movement. Then, as now, alcohol was clearly a major public health issue in the area. We will no doubt hear more of John Snow's Newcastle days while we are in Gateshead. He left the North East in 1836 and travelled home to York, then via Liverpool ,Wales and Bath to start his formal medical education in London at the Hunterian School of Medicine. The rest, as they say, is public health history.

The tradition of public health, social medicine and primary care runs deep in this area. Social obstetrics, paediatrics and psychiatry are in the genes of medicine here. Sir James Spence set the standard when it came to a medical school taking responsibility for the children of poverty at the gates of the teaching hospital. Domiciliary family planning and day care abortion services were pioneered here and the department of family medicine was fully integrated with public health in the new curriculum which I was fortunate to be exposed to in the 1960s. Newcastle boasted the first general practice training scheme in the country, the first director of children's services and much more. In our first week of study we walked the streets and the slums under the expert guidance of Professor Johnny Walker and saw the backside of the city from the river, from the Tyne bridge to the North Sea. It made an enduring impact on many of us who pursued careers in the unfashionable areas of public health and general practice. I hope this gives a flavour of the spirit of the place for us to savour while we are here.

This edition of *Public Health Today* appropriately focuses on some of the areas of sexual health and wellbeing which are so close to the interests alluded to above.

As we reach out in ever wider circles of public health engagement and influence and embrace more disciplines to create a truly multidisciplinary endeavour, what better place could there be? Let's enjoy a wonderful and successful conference.

John Ashton

How prevention could save the health service

AS THE Government embarks on its next five-year term, FPH welcomes the Prime Minister's recognition of the unsustainable "costs of obesity, smoking, alcohol and diabetes" – and his commitment to ensuring public health and preventable disease are at the "heart of the plan". That plan, given form through NHS England's *Five Year Forward View*, is, as Simon Stevens affirms, a "no brainer – pull out all the stops on prevention, or face the music".

In truly integrated care, people keep healthy and independent as long as possible, and cross-sectoral policies reduce health- and social-care demand. Doctors need to develop their role in preventing illness and enabling rehabilitation. We must improve mental resilience and family and social support to help people live rewarding lives and prevent crises.

Primary care is central to preventing illness but needs more support to deliver its true potential. Creating crisis-free emergency care requires prevention of alcohol-related harms, accidents and major causes of hospital admissions such as cardiovascular disease and self poisoning. It requires attention to capacity problems caused by healthcare-acquired infections and housing and social-care problems. Indeed, all aspects of the NHS need a population medicine overview. In the digital revolution, population-based risk stratification and primary-care data-extraction tools offer chances for systematic disease prevention and control of long-term conditions.

> **Primary care is central to preventing illness but needs more support to deliver its true potential**

Finally, we continue to make the case for the 12 priorities outlined in our manifesto, *Start Well, Live Better*, which we believe will improve health and wellbeing and save lives.

Mark Weiss

FPH launches major offensive against violence

"VIOLENCE is predictable and therefore preventable." This simple, powerful message underlines the World Health Organization's case for investment in violence prevention and is the bedrock of the Faculty of Public Health's (FPH's) developing work in this field.

The intentional use of physical force appears in many forms and has a major negative impact on a global level. It causes approximately 1.3m deaths annually (not including indirect deaths) and causes injury, psychological harm, maldevelopment and deprivation.

The direct and indirect costs on long-term physical, mental and sexual health and the strain on resources, make violence a major public health issue – and one that FPH's Board has identified as a priority area. Further to a successful workshop, FPH is soon to publish an evidence-based briefing paper on violence prevention.

The paper will provide up-to-date statistics, explore violence's different forms, outline the key risk factors and most vulnerable groups, and identify models of prevention that include early identification, multi-systems approaches, community development, fostering economic and social equality, and education and training for health professionals. Interventions across primary, secondary and tertiary settings will be explored.

Mark Weiss
Senior Policy Officer
Faculty of Public Health

News in brief

Fifth of teenagers trying e-cigs
Many teenagers, even those who have never smoked, are experimenting with e-cigarettes, researchers in north-west England say. A survey of more than 16,000 14-17 year-olds, published in *BMC Public Health*, showed one in five had tried or bought e-cigarettes. The researchers described e-cigarettes as the "alcopops of the nicotine world".

Beaches risk water-quality failure
A record number of England's beaches are at risk of failing to meet EU water quality standards this year, the Environment Agency has warned. It suggests new EU regulations will make it much harder for beaches to attain the top rating. The water of 25 beaches is forecast to be classed as 'poor'.

Dutch are getting thinner
Holland is the only country for which the World Health Organization (WHO) is predicting a decline in obesity rates. WHO's obesity report predicts 49% of Dutch men will be overweight, and 8% obese, in 2030 — compared to 54% and 10% in 2010. The overweight rates for women are expected to remain stable at about 43%, though obesity is set to drop from 13% to 9%.

School rugby plan 'too dangerous'
A government drive to boost participation in rugby in English schools risks children getting seriously hurt, public health doctors have warned. Prof Allyson Pollock and colleagues at Queen Mary University of London say the contact sport is too dangerous and needs to change.

Scientists artificially make heroin
Home-brewed heroin could become a reality, scientists have warned, following the creation of yeast strains designed to convert sugar into opiates. Tania Bubela, a public health professor at the University of Alberta, wrote in the journal *Nature*: "In principle, anyone with access to the yeast strain and basic skills in fermentation could grow morphine-producing yeast using a home-brew kit for beer making."

UK's unhealthiest high streets
A league table of the unhealthiest high streets has named Preston as the UK's worst. The Royal Society for Public Health assessed 70 areas according to the types of businesses found there. Bookmakers, loan shops, tanning salons and fast-food outlets were viewed as having a "negative impact" on public health, while leisure centres were deemed positive.

INTERVIEW

Clare Gerada is a London-based general practitioner and was Chair of the Council of the Royal College of General Practitioners for three years from November 2010. She was the college's first female Chair for 50 years. Here she tells *Public Health Today* why she sees herself as predominantly a public health doctor

'Public health should lead healthcare'

You can make a big difference, says Gerada

You've talked about medicine being an art as well as a science. How do you see public health supporting general practice, and vice versa?
Public health and general practice are probably two of the most similar specialties. I always consider as a GP that I am predominantly a public health doctor who looks at the social determinants of ill-health and how we address them. I have always felt that public health people should lead clinical commissioning groups and be at the centre of the NHS. If we don't take a public health perspective, what sort of perspective are we to take? That's why I'm so disappointed by these reforms and successive governments. By taking our eye off the ball, we spend money in the wrong place.

How did you come to specialise in psychiatry?
I didn't go into general practice straight from qualifying because I don't think you should. It's the sort of profession, a bit like psychiatry, that you grow into as you mature as a doctor. I did nine months in A&E and then did a medical rotation for two years and went back to A&E. Psychiatry really drew me in. I loved every job I did at the Maudsley, from child psychiatry to care of the elderly, and I thought, I must be a generalist. So I went into general practice.

My last job in psychiatry was caring for drug users. I set up a barefoot service, for drug users who did not have access to a GP, and loved the work. Working with drug users epitomises what is so great about general practice. You can make an enormous difference from a tiny intervention – the same as public health, really.

How did you come to specialise in supporting GPs and all doctors with mental health needs?
I had an expertise in mental health, substance misuse, general practice, clinical governance and the regulatory framework. So, when the tender for running a new sick-doctor service was put out [in 2007] it cried out for me to apply. I got the contract and have been running it ever since.

If money were no object and you could do one thing tomorrow to help the GPs you support, what would it be?
The one thing I would do would be to establish a lead for mental health and wellbeing for all NHS staff, not just GPs. Under that I would put together a whole programme, with mindfulness and thematic reflection at one end, right through to a confidential mental health service for those who can't access more mainstream services. I would also tackle some of the toxic structures that are causing great ill-health in the NHS, such as the regulatory process, the Care Quality Commission and the name-shame-blame environment.

I would start to inspect around compassion. I'd triangulate it and use metrics to tap into the experience of staff in an organisation, sickness absence rates, records of bullying and whistleblowing and complaints. Those are hard measures of a service in distress. We know that where we have a compassionate organisation where staff feel attended to, you will get better patient outcomes and you could save millions of pounds because you wouldn't need the inspectorate process.

How would you like to see general practice shaping up in 10 years' time?
I don't think there's been another specialty where others have done [so much] to them without asking them what should be done. One thing that hasn't changed is people: they want a doctor who is there, they can trust and who knows what to do.

As a GP, I want to be able to work in my local community, have relationships with patients that are intergenerational, have fast access to specialists and have enough time in the consulting room. It's not very much to ask, is it? I went to do a home visit today with an elderly patient who I've known for 25 years. She's now blind. I can sit down in front of her and she recognises my voice because of our relationship. That's what general practice is about.

> **I would say to women: you can never do all the right things for your family. You will only ever be good enough. So just don't worry about it**

The absolute mark [of success] would be if I can name my GP. I might have to wait to see them if it's an emergency, but I would know who they are.

What's been your proudest moment, professionally, so far?
If I've had a bad day, what invariably helps is thinking about how I've helped a patient. Career-wise, I'm not one to dwell on successes. Even when I was Chair of the [Royal College of General Practitioners] Council, I couldn't believe that I was.

I'm pleased that if I died tomorrow people might remember who I am. Recently Professor Aidan Halligan died. He was an old boss of mine, and an amazing man. I would love it if, when I'm long gone, people remembered me as someone who stood up for what was right about our health service and the most deprived people in our communities.

Sexism is present in all professions. What advice would you give to women working in public health who are considering a more senior leadership role?
You come up against everyday sexism. It's not the groping, because that doesn't happen any more. Some of it was things like you'd have a meeting, but the real meeting would happen afterwards over a bottle of whisky. And you just couldn't be there, because you had family. Or discussions on the football terraces, which still happens to a certain extent.

I have experienced racism. I think more, though, I've just faced it and just marched onwards and upwards. I would say to women: don't feel guilty. You can never do all the right things for your family. Your home will never be clean enough. Your children will never see you enough. You will only ever be good enough. So just don't worry about it.

Your partner is Sir Simon Wessely, President of the Royal College of Psychiatrists. How do you avoid talking shop too often at home?
You'd have to ask my sons. I think they think we talk about it all the time. I think we are the first husband and wife couple to both be presidents of our colleges, and so I think we help each other. The funniest moment was when I demitted office and Simon was [Royal College of Psychiatrists] President. The story of the day was about war veterans and post-traumatic stress disorder [PTSD], Simon's absolute area of expertise. The *Today* programme rang, I picked up the phone, and they said, we want you to talk about this story. I said, you don't mean me, you mean my husband. They said, no, we want a GP view. I told Simon that they wanted me, not him, to talk about PTSD!

Interview by Liz Skinner

Sexual healing

The subject of sex is so elaborate and entangled that it can be hard to pick out the key issues. But it is central to the subject of wellbeing, says Alan Maryon-Davis

"I DON'T know what the question is, but sex is definitely the answer," declared Woody Allen.

If only it were that simple, which of course it never is. On the contrary, sex is so complex and multifaceted that, when the *Public Health Today* editorial board brainstormed the subject for this issue, we came up with more angles than the *Kama Sutra*. So we've had to pick out just a handful of topics which we hope you'll find particularly relevant to public health.

We start with a snapshot of what UK citizens think, feel and do about sex. Our most comprehensive understanding of these things – and we have arguably the best population-level information in the world – comes from a series of three national surveys of sexual attitudes and lifestyles (Natsal-1, -2 and -3) undertaken by the London School of Hygiene and Tropical Medicine over the past quarter-century. On page 7, researcher Wendy Macdowall takes us through the main trends and notes that, while the median age at first intercourse is edging younger, as a nation we are typically waiting longer before committing to a 'live-in' relationship – hence more exposure to multiple partners and sexual health problems. Natsal-3 (2010-12) has also revealed links between sexual wellbeing and mental and physical health, and the particular vulnerabilities of disabled and older people – all angles which we cover elsewhere in this issue.

> **There are 25 health benefits from a happy, fulfilled sex-life**

With about one young person in three having first sex before the current legal age of 16, our Big Debate asks the highly divisive question: should the age of consent be lowered to 15? There are compelling arguments for and against. On the Yes side we have Richard Wingfield of the Equal Rights Trust saying it is counterproductive to criminalise so many young people, and we should follow the example of many other developed countries. Against this view, Anne-Marie O'Leary of Netmums argues that it would cut short childhood and expose young people to more risks, including teenage pregnancy. Read the articles and decide for yourself.

We present many other facets to reflect upon: supporting well-taught PSHE in schools; child sexual abuse and how to prevent it; sexual abuse of vulnerable patients and people in care; stopping human trafficking for sex; respecting the rights of lesbian, gay, bisexual and trans people; extending HPV immunisation to boys; using TV to promote sexual health in Nigeria; safe sex messages for older people; supporting the sexual health needs of disabled people; and the importance of partnership in commissioning sexual health services.

According to the Planned Parenthood Federation of America there are 25 health benefits from a happy, fulfilled sex-life. That's more than you get from Nordic walking, a Mediterranean diet and transcendental meditation combined.

So, maybe sex really is the answer. If we can get it right.

Alan Maryon-Davis
Editor in Chief

Sexual health is not just about STIs and unplanned pregnancy

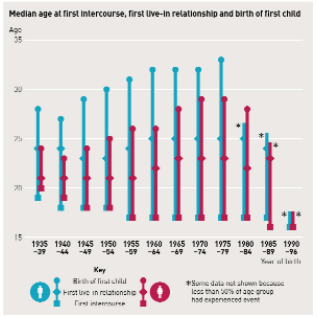
THE National Surveys of Sexual Attitudes and Lifestyles (Natsal) are large probability surveys of the British population undertaken approximately decennially since 1990. The advent of HIV/AIDS, and the urgent need for population data to inform prevention and prediction of HIV transmission, provided the impetus for the first survey (Natsal-1), conducted in 1990-91. In the second survey (Natsal-2), carried out in 2000-01, the focus was expanded to include broader aspects of sexual and reproductive health.

The most recent survey (Natsal-3), conducted in 2010-12, was the most ambitious to date. The age range was extended to 74 years and the scope was expanded yet further, a decision informed by the World Health Organization definition of sexual health. This moved away from thinking about sex solely in terms of the prevention of adverse health outcomes, and widened the remit to include "the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence".

Taken together, the three Natsal surveys provide rich data from more than 45,000 people, analysis of which has revealed changes in sexual behaviour over time and through the life course, and also advanced our understanding of the factors affecting sexual health and the interplay between them. Three big themes emerge from the data.

The first relates to major changes in the timing of sexual health events (see figure). There has been a progressive decrease in the median age at first sex from 19 years among women and 18 years among men aged 65-75 years, to 16 years among both men and women under 25 years at interview in Natsal-3. The age at first live-in relationship and first child, however, has increased especially among women. The widening of the interval between these events means that the period in which 'young people' may be at higher risk of adverse sexual health outcomes, and in greater need of services, has increased dramatically.

The second relates to the strong associations we have found between the different domains of sexual health, ie. sexually transmitted infections (STIs), unplanned pregnancy, sexual violence and sexual function, and between poor sexual health and poorer mental and physical health. The former challenges us to think of sexual health in a more holistic way rather than in 'silos', and the latter to think of sexual health alongside physical and mental health.



Third, our findings related to the life course. The stereotype of asexuality in older ages is not borne out in our data. Conversely, sexual problems, such as lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness, and problems getting or keeping an erection, are not exclusive to older people, but affect young people too.

Two common threads run through these examples. One is the need to adopt a broader concept of sexual health that includes outcomes relating to the quality and consensuality of sexual experience, not only as risk factors for adverse outcomes, such as STIs and unplanned pregnancy, but as important ends in themselves. The other relates to the need to challenge assumptions about sexuality and age. Both have important implications for how sexual health services and prevention activities are conceived and delivered.

Wendy Macdowall
Lecturer
Centre for Sexual and Reproductive Health
London School of Hygiene & Tropical Medicine
Member of Natsal study team

Where to go looking for human traffic

THE subject of human trafficking is vast and crosses many areas of work and circumstances. So, when Active Communities Against Trafficking (ACT) approached the Chichester District Joint Action Group (JAG) to raise the profile of human trafficking among organisations, the JAG set up a task-and-finish group to specifically look at the areas of labour and sexual exploitation. To ensure that it was focused and to raise its profile, it was felt that training for frontline staff was key and would be the initial drive for the campaign.

Officers from environmental health, housing and communities teams were trained on spotting signs of trafficking and how to report any suspicions. We also supported the "no smoking, no human trafficking in this vehicle" sticker campaign with taxis. We visited a large caravan park in the district and gave a presentation to managers about human trafficking, particularly focusing on grooming. It was felt that this type of location could be used by groomers or by people trying to hide trafficked people.

A project tackling the street community's vulnerability to labour exploitation was also undertaken. Key partners for this were ACT, a local homeless charity, Sussex Police, West Sussex Fire and Rescue Service and Crimestoppers. The charity received training in raising awareness of the signs of trafficking, supporting clients and referring them on. Before the training had even finished, one of the support staff had to leave to speak to one of their clients as they believed he was potentially at risk of being trafficked for work. We held a poster campaign in the day- and night-centres warning clients of the dangers of being trafficked and making them aware of the tactics traffickers use to engage with them. This project ran across Chichester and Arun districts.

The group was keen to work with the hospitality industry to prevent sexual exploitation, but hotels proved difficult to engage. However, the group has evolved into the Child Sexual Exploitation (CSE) group and, as part of the action plan, these locations will be revisited and their part in preventing CSE explored.

Pam Bushby
Communities Intervention Manager
Chichester District Council

DEBATE: Should the age of consent be lowered to 15? Richard Wingfield says the law criminalises a third of 15-year-olds, while Anne-Marie O'Leary fears sexualising children

This law leaves young people vulnerable

YES

CHILDREN'S rights, including their right to the "highest attainable standard of health" (as guaranteed by Article 24 of the UN Convention on the Rights of the Child), are not protected by criminalising them for having consensual sexual relations. Whilst, as a society, our motivation to protect children from abuse and exploitation is admirable, using the criminal law to set an age of consent for sexual relations at 16 does not achieve this aim. Instead of focusing on the exploitation of 15-year-olds by older persons, the current law criminalises both persons where sexual relations involving a 15-year-old take place, even where no abuse or exploitation takes place and even where both partners are aged 15.

A 2006 survey found that 30% of all 18- to 24-year-olds in the UK had had sexual relations under the age of 16. The vast majority of these experiences are likely to have been with partners around the same age. Few, if any, parents would want to see their child arrested, charged and punished by the law for this. Indeed, for the children concerned, knowing that they had broken the law might have made them reluctant to come forward when they felt that they had not fully given their consent, or where there were unintended consequences to their health such as pregnancy or sexually transmitted infections. Reducing the age of consent to 15 would also make it easier for the NHS, other health providers and teachers to provide important sex and relationship advice, including advice on sexual health, free from any fear that they were encouraging or condoning illegal behaviour.

I want to live in a country where young people have the confidence to wait until they are emotionally mature enough to have sex, free from any pressure or manipulation, and with excellent and age-appropriate sex education empowering young people to make the right choices. I also want to live in a country where young people are protected from sexual abuse and exploitation. But far from protecting children's rights and their health, our current age of consent leaves 15-year-olds vulnerable, criminalised and unwilling to come forward when something harmful happens to them. We should follow the examples of countries such as Denmark, France and Sweden and lower the age of consent to 15.

Richard Wingfield
Advocacy Officer
The Equal Rights Trust

It would send the message that it's OK

NO

CHOOSING to start having sex is a life-changing decision. Done well, it can set you on the path to a lifetime of mutually fulfilling and respectful relationships. Done badly, it can devalue sex and lead to poor relationships. and feelings of low self-worth.

Would you leave a hormonal teenager barely out of childhood to make such a huge decision? Probably not, but that's the view being put forward by some who are seeking to slash the age of consent to 15.

While few parents are comfortable with the thought of their child becoming sexually active, it's a debate that needs to be had.

Studies show around one in four UK teens currently lose their virginity before they hit 16. Worryingly, many of these are the most vulnerable in our society, with children in fractured, low-income homes or in care most likely to have underage sex. Tellingly, 40% go on to say they regret having sex so young.

Dropping the age of consent to 15 doesn't reflect the majority – and brings with it a myriad of problems. Firstly, it may well exacerbate the problem of underage sex. We could end up with the disturbing prospect of a society in which a quarter of 14-, 13- or even 12-year-olds are having sex.

Secondly, by insinuating that younger children are ready to have sex, we cut short childhood and increase the already prevalent problem of society sexualising children. Recent official reports, such as the *Bailey Review of the Commercialisation and Sexualisation of Childhood*, have shown that UK children are "being pressured to grow up too quickly". If the law told them that it is acceptable to have sex at 15, this pressure would only increase. Very few 15-year-olds are mature or emotionally strong enough to resist ongoing pressure from their peers, let alone an older adult wanting to have sex with them.

Thirdly, is it right to be telling 15-year-olds that it is fine for them to have sex and even a baby – the biggest responsibility of all – when they are years off being seen as responsible enough to vote, buy an alcoholic drink or drive a car?

As a society we need to work together to decide exactly why some teens are having sex early, and adopt strategies to help those who feel unhappy and pressured into it. People will always break the law, but let us retain laws that are designed to keep our children safe.

Anne-Marie O'Leary
Editor in Chief
Netmums

Like other people

It is everyone's right to be able to enjoy a fulfilling sex life, but the sexual needs of the disabled are being ignored, says Tuppy Owens

AFTER survival, sex is the strongest human drive, so it is inhumane for health and social care professionals to ignore the sexual needs of clients. It's especially inhumane to ignore the sexuality of disabled people because sex might be one of the few pleasures they can enjoy – as they may be unable to see, hear, walk, talk, taste, move, feel or fully understand. In any case history, care plan, policy or service provision, it is important to address *all* of an individual's needs, including their sexual needs.

There are 25 health benefits of a happy, fulfilling sex life, according to the American white paper the *Health Benefits of Sexual Expression*. This makes it even more important, when services are commissioned, that they should address sexual needs.

Because many professionals may avoid the subject due to shyness or prudishness, contracts must require them to ask disabled clients routinely if they are experiencing personal problems of a sexual nature, and then point them in the direction of an expert sex therapist, counsellor or sex worker. Our Sexual Respect Toolkit offers advice on how to do this and provides a hand-out for timid professionals to use.

Disabled people may be lacking in confidence sexually because their sex education was worse than useless. As gay students said in the past, it wasn't relevant to them.

Rather than assume that all disabled people are asexual, professionals should consider their sex lives when placing them in care, allowing, for example, marital/partner sexual activity in a double bed. Don't assume they are heterosexual or straight; they may be gay, queer, bisexual, pansexual and may be kinky and/or into polyamory – just like anyone else.

Many disabled people struggle to find partners and some cannot even masturbate. They may need sexual services – our TLC website provides responsible escorts, Tantric practitioners and sexological bodyworkers who specialise in disabled clients. Our Outsiders Club provides peer support and opportunities for people with physical and social impairments to find a partner. Other clubs provide dating opportunities for those with learning difficulties.

> **Disabled people may be lacking in confidence because their sex education was worse than useless**

Financial provision for sex is not an extravagance or a risk for scandal but is as necessary as food, housing and transport. Public opinion is positive about it. Disabled people may need a rail to steady themselves on the bed, a sex toy, condoms or a sexual service. This is their right. It will be your right and my right too, sooner or later.

You may like to join our group, the Sexual Health and Disability Alliance for health and social care professionals. We are a self-help and pressure group and are currently conducting a freedom of information request to determine what local Health and Wellbeing Boards are doing to address the sexual needs of their disabled residents. Improvements will not happen unless public health identifies them as major determinants of the mental wellbeing of disabled people and promotes action to facilitate their implementation to stop disabled people being disadvantaged.

It is actually illegal *not* to support disabled people in enjoying the same pleasures as other people in the privacy of their own homes – so, legally, you have no choice.

Tuppy Owens
Founder and coordinator
The Outsiders Club, the Sex & Disability Helpline, the Sexual Health & Disability Alliance and the TLC Trust

NSPCC Schools Service workshop. © Jon Osborne. Pictured are models and volunteers

Collaboration needed on child sexual abuse

DESPITE the fact that child sexual abuse has increasingly been seen as a public health problem, relatively little progress has been made in any country in dealing with the issue using a public health approach.

We can stop child sexual abuse before it occurs (primary prevention) using a public health approach, but it will require effort from all areas of society. Those responsible for forming public opinion must urgently spread the message that all sexual abuse is wrong, and promote the importance of healthy, equal and consensual relationships.

In our report, *Preventing Child Sexual Abuse: Towards a National Strategy for England*, we outline a wealth of knowledge about effective programmes and primary prevention interventions. Based on this evidence, we want to start an active discussion about what a strategy for child sexual abuse (CSA) prevention in England should look like. Actions, across all levels of society, could include:

Government

- Including sex and relationships education (SRE) as part of a statutory entitlement to personal, social, health and economic (PSHE) education.
- Funding a national CSA prevention resource centre similar to the National Sexual Violence Resource Centre in the US.

Schools

- Regularly teaching CSA prevention classes throughout primary and secondary education as part of the curriculum.

Parents

- Discussing keeping safe with children eg. the National Society for the Prevention of Cruelty to Children (NSPCC) underwear rule.

> **We can stop child sexual abuse before it occurs using a public health approach**

Professionals (including health professionals, legal professionals, social workers, teachers)

- Training and learning in dealing with potential CSA.

Voluntary sector

- Providing services for young people and adults at risk of committing abuse.

Community

- Community members, eg. trained NSPCC School Service volunteers, helping to raise awareness about CSA and CSE (child sexual exploitation) in the community.

Media

- Signing up to and following a code of conduct when writing about CSA.

Agreeing and implementing a national strategy will require significant collaborative working across organisations. This will be challenging, but with such an important goal, it is vital that we start now, building on some great work by a number of organisations and individuals.

Jon Brown
Head of Strategy and Development (Sexual Abuse)
NSPCC

Savile-style abuse just thin end of wedge

THERE has been a recent string of high profile cases of sexual abuse against patients within the NHS, covered in the national press. Most people respond to such stories with horror and disbelief. Healthcare organisations, by their very nature, have a duty to protect their patients from harm.

Cases involving famous people or unusual circumstances are at one end of a spectrum of sexual abuse against patients. Sadly, the spectrum is populated by many more cases that are not newsworthy but nevertheless cause considerable physical and psychological damage to the victims. Despite many inquiries and policy changes, some fundamental lessons have not been learned.

Those responsible for healthcare need to move away from seeing sexual violence against patients as a freak event to seeing it as the consequence of poor governance, poor supervision and a lack of power held by vulnerable patients. Despite a common belief that abuse is always conducted by sexual predators, evidence is emerging that situations and environments can generate abusive tendencies in people who did not set out to abuse. Creating healthcare systems where power is culturally and structurally concentrated and unchallenged in a small number of individuals can precipitate sexual violence and other abuses.

Lessons learned from previous cases show that perpetrators will abuse victims precisely because they are less likely to be believed or defended by others. Risk factors making a person more vulnerable to abuse include having a mental health problem, having a learning difficulty or disability, having a speech difficulty, being dependent on others for care, being elderly or being outside mainstream society. It seems that society has yet to learn how to believe and defend those reporting sexual violence regardless of their social circumstances.

The Department of Health is currently working with other sectors, such as those working in criminal justice and education, to change the perception of sexual violence against those receiving health and care, and to develop a better understanding of how health systems can be strengthened to prevent its occurrence.

Stella Botchway
Public Health Speciality Registrar
Health Education Thames Valley

Time for class action

The voices who want sex and relationships education to become a statutory requirement for schools are growing. We must heed them, says Joe Hayman

THE Education Act 2002 says that every state-funded school must offer a balanced and broadly-based curriculum which promotes the spiritual, moral, cultural, mental and physical development of pupils and prepares them for the opportunities, responsibilities and experiences of life.

Personal, social, health and economic (PSHE) education, the subject through which sex and relationships education (SRE) is taught, seeks to achieve this objective, by providing a broad curriculum focused on pupils' health and wellbeing. In a changing world, where young people have huge opportunities but many anxieties too, it provides a safe classroom context for pupils to explore concepts such as healthy relationships and consent.

Yet the potential is not always realised. Ofsted's 2013 review of PSHE provision in England labelled it "not yet good enough", raising concerns that lack of age-appropriate PSHE education may leave young people vulnerable to inappropriate sexual behaviours and exploitation. We know from international evidence that young people who get good education of this kind are better able to report abuse, but our ultimate aim should be to prevent abusive behaviours, not simply ensure reporting when consent is not respected.

In response, the PSHE Association and its partners have worked hard to provide advice and support to schools. With Brook and the Sex Education Forum, we produced our *SRE for the 21st Century* guidance, which supplements statutory guidance on SRE published in 2000. The association has also produced guidance for schools on teaching about consent, emphasising the responsibility on the seeker of consent rather than simply teaching pupils to say no'.

In producing guidance, we always seek to start from where pupils are, assessing their needs and tailoring lessons for them. The learning acknowledges the reality of the world children live in, which means we don't shy away from addressing issues such as the widespread availability of pornography to young people. And our aim is always to encourage dialogue with young people, moving beyond the model of a film shown at the front of the class. This approach has also helped us to work with over 10 local authorities across the country to deliver support to their schools in improving their PSHE provision, including SRE.

> **As a non-statutory subject, there is virtually no coverage of PSHE in teacher training**

Yet guidance can only do so much, and action from the government is needed to drive real change. As a non-statutory subject, there is virtually no coverage of PSHE in teacher training, while in school PSHE teachers are not given the curriculum time or professional development they need. Too often, PSHE falls off the agenda in schools; this needs to change.

In February this year, the Commons Education Committee completed an inquiry into the status of PSHE education, including SRE. The committee, having received 431 written pieces of evidence and heard from 25 experts, recommended that PSHE, including SRE, should be made statutory. Statutory status is also backed by more than 100 expert organisations, including six medical royal colleges, two royal societies and the Faculty of Public Health. The Chief Medical Officer called the subject "a bridge between education and public health". The vast majority (88%) of parents support a move to statutory status and hundreds of thousands of young people have been involved in the UK Youth Parliament's curriculum for life campaign. It is time for these voices to be heard.

Joe Hayman
Chief Executive
PSHE Association

Let's get together

It is crucial that local councils, CCGs and NHS England recognise their shared duty to provide sexual and reproductive health services, says Paul Sheehan

THE commissioning of sexual and reproductive health services has been dramatically affected by the impact of the Health and Social Care Act 2012. These services span both population and individual health and are often interlinked with criminal justice and education. The act mandated local authorities to commission confidential, open-access services for sexually transmitted infections (STIs) in addition to "reasonable access" to all methods of contraception. Sexual health promotion and preventive services, a core part of most sexual health programmes, were not explicitly mandated.

Local authorities are not the sole commissioners of sexual and reproductive health services. Clinical commissioning groups (CCGs) are responsible for services such as abortion, female sterilisation and vasectomy. NHS England (NHSE) is responsible for HIV treatment and care and sexual-assault referral centres.

These parameters have created two significant risks. First, some definitions of commissioning responsibilities are unclear; for example, what is "reasonable" access? Second, there is potential fragmentation of care pathways where different commissioning responsibilities lie across preventive, treatment and care provision. For example, genitourinary medicine (GUM) services undertake the majority of STI testing and treatment, including HIV treatment and care. Traditionally there has been no separation of these elements at the point of service-user contact. What happens when a local authority has to re-procure GUM provision? Should it separate mainstream STI provision and HIV treatment and care, since it is the responsible commissioner for one of these elements? What would be the impact on providers in terms of stability and service viability? How would it affect service users? Would there be missed opportunities for HIV testing and diagnosis for wider population health?

Key to overcoming such challenges is the establishment of a collaborative approach to commissioning from all partners. A simple start can be a strategic commissioning group that involves all key players. Such a group should recognise the shared public health agenda in sexual health and how working together to improve sexual and health outcomes benefits all involved. As an example, reducing the rate of under-18 conceptions and ensuring young people have appropriate access to contraception can improve individual health through increased control over fertility and improved self-esteem. Benefits at a population level can be fewer unwanted pregnancies and better educational attainment. For the commissioning bodies involved, there is potential for decreases in the number of abortions, reduced usage of social and mental health services and correspondingly lower financial costs across health and social care.

A collaborative approach to commissioning takes time and commitment. It requires a clear understanding of local market conditions – you cannot always assume a large number of providers can engage in the procurement process in a niche area such as sexual health. Working with existing and potential providers to encourage their involvement and understand their perspective is a worthwhile investment. Collaborative commissioners also need to be proactive in attaining meaningful engagement with service users. The stigma associated with a STI or teenage conception remains deeply rooted and commissioners need to understand and learn from their service-user experiences.

With finances increasingly limited, it is vital that local authorities, CCGs and NHSE recognise their collective responsibilities and actively cooperate in commissioning. Getting the basics right at the outset really can enable holistic commissioning to improve sexual and reproductive health outcomes at both individual and population levels.

Paul Sheehan
Public Health Development and Commissioning Manager
Bath & North East Somerset Council

You're never too old for safe-sex messages

BACK in 2001, the Department of Health (DH) published the National Strategy for Sexual Health and HIV with a central theme of providing clear information so that people could take informed decisions about preventing sexually transmitted infections (STIs). What was conspicuous by its absence was any mention of older people. Since then the DH has released the Framework for Sexual Health Improvement in England (2013), within which only a single page was devoted to the sexual health needs of the over 50s.

So why the ongoing absence of sexual health messages aimed at older men and women? An increasing amount of academic research has focused on later-life sexual activities and lifestyles over the past decade, and, while such studies have done much to debunk societal stereotypes and myths about older people being 'asexual', little attention has been paid to delivering safe-sex advice to this age group. Messages about safe sex and avoidance of STIs have primarily focused on younger people, and, although this remains the highest risk group, an unintended consequence is the perpetuation of the myth that they are of little relevance to older people.

National statistics describing the trends in STIs in the UK are mainly compiled using data from genitourinary medicine (GUM) clinic attendances. While STI rates in the over-50s accounted for less than 5% of all STIs diagnosed in GUM clinics in 2011, they rose by 20% between 2009 and 2011. However, there is compelling evidence that these data may underestimate the true burden of the problem, as older people may be either unwilling to seek treatment or seek treatment options elsewhere to avoid the stigma of attending GUM clinics.

An ageing population and changing social and behavioural patterns may have contributed to the increase in STIs seen among older people. The so-called 'silver splitters' – divorcing and re-partnering baby boomers – are at increased risk of STIs. There is good evidence that they are less likely to use condoms consistently because they equate their use with preventing unwanted pregnancy rather than STIs.

As long as campaigns about safe sexual practices remain almost exclusively focused on teenagers and younger adults, opportunities continue to be missed to engage with older people. Research among older people continues to show that this age group does not feel they have received much advice or information about STIs. Although healthcare professionals recognise that older people are at risk of STIs, there remains an unwillingness among clinicians to discuss sexual health with this age group. Interestingly, ageist assumptions seem to be working in both directions here with health professionals fearing offending their older patients if they raise issues of sexual health, and older people themselves believing that sexual problems aren't important 'at their age' or waiting to see if problems get better on their own.

Ultimately, messages advocating safe sex and sexual health should target all sexually active people. Age-appropriate educational materials, delivered via general media, GPs or GUM professionals, shouldn't continue to overlook older men and women.

David Lee
Age UK Research Fellow
Cathie Marsh Institute for Social Research
University of Manchester

Sex lives and videotape – TV as health forum

SOPHIE looks to the ceiling, her lips begin to tremble, tears start to flow down her cheeks. In her hand she holds a life-changing piece of paper – the results of her HIV test. Her tears are of joy; thankfully, her test results are negative.

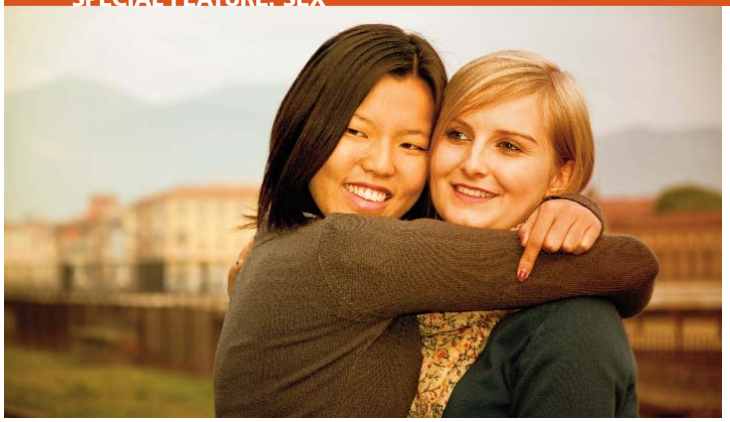
Sophie Dorcas Shola Fapson is a lead character in the hit TV show *MTV Shuga*, about the lives of young Nigerian characters as they navigate the trials and tribulations of love, life and lust.

The show is the brainchild of Georgia Arnold, Executive Director of the MTV Staying Alive Foundation, who said: "The impact TV has on people's behaviour and its ability to introduce new ideas into society is undeniable, so it made sense to harness this power to try to create a positive change in the sexual and reproductive health of young people. TV is a particularly powerful medium in societies where literacy levels are low and social norms create barriers to the introduction of new ideas."

To amplify the messaging of the latest series of *Shuga*, a comic book has been published which expands on the storyline of gender-based violence. Viewers can also call the characters on Skype to listen to their 'confessions', and social and digital media is used to stimulate public debate.

To assess the impact *MTV Shuga* is having on the sexual and reproductive health of young people in Nigeria, the World Bank's Development Impact Evaluation (DIME) is running a cluster randomised study, the results of which will be available later in 2015.

Mario Christodoulou
Partnerships and Communications Manager
MTV Staying Alive



Services must be fully inclusive of sexuality

ESTIMATES for the size of the lesbian, gay or bisexual (LGB) population in the UK vary from 1.6% to 7%. However, the number of people engaging in same-sex sexual activity is higher than those reporting LGB identity; the most recent National Survey of Sexual Attitudes and Lifestyles (Natsal) survey found that 5% of men and 8% of women had ever had a same-sex experience with genital contact.

Prevalence of HIV remains high among men who have sex with men, who continue to be the group most affected by HIV infection. What is less well known is that 40% of women attending genitourinary medicine clinics who had exclusively female partners received a sexually transmitted infection or other diagnosis, compared to 18.5% of women who had sex with men.

A lack of comprehensive and consistent sexual-orientation monitoring in healthcare services means that the specific needs and experiences of LGB people often remain unrecognised and unaddressed. Even in sexual health provision, women who have sex with women can go under the radar. The figures cited above only represent women who had recently had exclusively female partners and who disclosed this information to the clinic staff. Furthermore, there is a lack of knowledge in services about trans people's sexual health needs, and little understanding of the interplay between gender identity and sexual orientation.

The National Lesbian, Gay, Bisexual and Transgender (LGBT) Partnership, with the support of Public Health England, published a companion document to the Public Health Outcomes Framework, bringing together evidence of inequalities impacting on the health of LGBT people and their experiences of the healthcare system. It makes recommendations across four key areas:

- recognition of LGBT needs in health strategies, including Joint Strategic Needs Assessments
- engagement with LGBT communities
- monitoring sexual orientation and gender identity
- service provision to LGBT patients, including specialist services to address specific needs locally.

The LGBT voluntary and community sector can support public health professionals to implement these recommendations, for example by consulting with the local LGBT community, providing staff training on communicating effectively with patients about sexual orientation and behaviours, and co-designing and delivering specialist services.

Independent cost-benefit analysis has shown that specialist services provided to the LGBT community can provide value for money. For instance, every £1 invested in the LGBT Foundation's sexual health service produces £6 of potential savings in the budgets of public agencies as a result of fewer HIV and STI infections. In these challenging economic times, this adds further weight to the argument that public health, and sexual health services, should be fully inclusive of people's sexuality and expressions of sexual identity.

Heather Williams
Policy & Research Manager
LGBT Foundation

HPV is not a women-only problem

THE inclusion of boys in the national human papilloma virus (HPV) vaccination programme has become a live issue in the UK. While the government's vaccination advisory body considers this, 36 patient and professional organisations (including the Faculty of Public Health) have joined together as HPV Action to make the case for gender-neutral vaccination.

HPV causes disease in both sexes. HPV Action estimates that the virus caused almost 5,000 cancer cases in women (cervical, vaginal, vulval, oral and anal) and over 2,000 cases in men (oral, anal and penile) in the UK in 2011. HPV additionally causes 39,000 new cases of genital warts in women and 48,000 cases in men.

Immunising girls against HPV will not protect all men. They can still acquire the virus if they have sexual contact with someone outside the vaccinated 'herd'. The group most obviously at risk is men who have sex with men (MSM). The solution to this cannot be to try only to vaccinate MSM – there is no way of ensuring that enough of the MSM population will be reached.

Heterosexual males also remain at risk from a girls-only programme: not all girls will be vaccinated and many men will have sex with women from countries where there is no HPV vaccination programme for girls or where uptake is relatively low.

It would cost an estimated £22 million a year to add boys to the UK's HPV vaccination programme. The cost of treating genital warts alone was over £52 million in the UK in 2010. The government's decision on vaccinating boys is expected in 2017.

Peter Baker
Campaign Director
HPV Action

The drugs don't work – but they do make money

BY THE time you've read the title of Peter Gøtzsche's book, you won't be in any doubt about where he stands on big pharma. However, he is well placed to comment on some of its morally questionable techniques of marketing and research having worked in the industry in the late 1970s and early '80s. He left to train in medicine and went on to co-found the Cochrane Collaboration, making him the ultimate poacher turned gamekeeper.

Gøtzsche is admirably candid about his time in the drugs industry and the nature of some of his own contributions. He admits to co-authoring a paper which used 'fishing expedition' analysis to support claims for a drug's anti-inflammatory effect on sports injuries, when the reality of the study data appeared to be that it was no better than aspirin.

In fact, what Gøtzsche says about NSAIDs is one of the more startling revelations. Despite anti-inflammatory being a defining characteristic of such drugs, Gøtzsche describes this as an elaborate hoax, created through manipulative marketing. It might be a reflection of how ingrained this belief has become, but I still haven't decided whether to believe Gøtzsche on this one. This might also be because of the style of writing; despite the thoroughness of the referencing, it is at times difficult to disentangle evidenced findings from personal assertion.

The issues dealt with are highly relevant to public health. Gøtzsche writes that prescription drugs are the third leading cause of death in the USA and Europe after heart disease and cancer. He draws a direct comparison with the tobacco industry, saying that drug companies are successful because "they sell lies about drugs". In this respect, he seems to be on strong ground when he discusses psychiatry, which he terms "the drug industry's paradise", with its vague, shifting thresholds of diagnosis.

There is no doubt that this is an important book, thoroughly researched and bravely, earnestly and candidly delivered. The central message is of such consequence that it deserves to be widely read by healthcare professionals and politicians alike. The impact is at times undermined by awkward sentence structure, haphazard arrangement of paragraphs and excessive use of hyperbole, but it is difficult not to share the author's moral outrage and support his call for revolution.

Alex Hawley

Deadly Medicines and Organised Crime: How Big Pharma has Corrupted Healthcare
Peter C Gøtzsche

Published by Radcliffe
ISBN 9781846198847
RRP: £24.99

Meticulous tour of researching health services

THIS latest book by former Faculty of Public Health president Walter Holland is an invaluable historical record of how health services research (HSR) has evolved over the past 50 years in the UK.

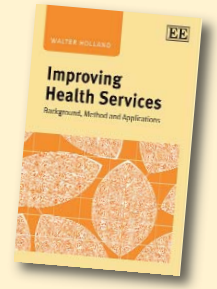
Beginning with a brief overview of the many uses and methodologies of HSR, Prof Holland quickly immerses us in the story of its early days in the United States, when it was initiated in the 1920s and '30s by the huge US healthcare organisations, and its later development in post-war Britain by the then Ministry of Health. We learn that the original HSR techniques in the UK evolved from operational research and logistics to plan the welfare state and local government services. Only later were such insights as epidemiology and randomised controlled trials applied to the assessment of need and effectiveness.

Much of the early history centres on the struggle to have HSR valued by research funders and policymakers. The core of the book is a lengthy chapter in which Holland details his own experiences in setting up and running a health services research unit at St Thomas' Hospital Medical School in London beginning in the 1960s. A great deal of time and effort was spent in trying to overcome the obstacles to funding, particularly the intransigence of government officials.

A whole string of the unit's many groundbreaking studies are described in minute detail. One of the earliest was to investigate the need and likely demand for a number of different services to be provided by a planned new hospital – so many imponderables. Another was a randomised controlled trial of multi-phasic screening in general practice – "very dubious" value (and still a divisive issue today: witness NHS Health Check).

There is a wealth of experience here. In telling his story, Holland exposes and examines key issues in HSR – the importance of precisely defining the research questions, the challenges involved in coordination and working to realistic timescales, and the difficulties with publication and confidentiality. He decries the perennial problem of obtaining government backing for any research that might undermine government policy. He also deplores policymakers' profligate use of management consultants, calling for the money to be spent on proper HSR – more rigorous and robust, just as timely and much cheaper.

This book is a meticulous tour through Prof Holland's unrivalled experience as a health service researcher and government adviser. It deserves a place in any library serious about supporting the study of health services from a population perspective.



Alan Maryon-Davis

Improving Health Services: Background, Method and Applications
Walter Holland

Published by Edward Elgar Publishing
ISBN 9781783470181
RRP: £83.00

From the CEO

I RECENTLY spent my first of two weeks on the Duke of Edinburgh's Commonwealth Study Conferences rushing around Oxford, London and Surrey with 100 Commonwealth leaders from 23 countries, challenged by the topic 'What makes a smart city?'

I interviewed five public health leaders in advance to get their ideas: an ICT approach, sustainability, connectivity, education, leadership and governance, culture and history, environmental sustainability. But of course there was as much to gain from the cultural and professional diversity of my fellow participants. I worked with a representative from the Tanzanian prime minister's office, a British Army colonel, a former child soldier from Uganda, a social enterprise leader from Kenya, a lawyer from Canada and a South African mining company executive.

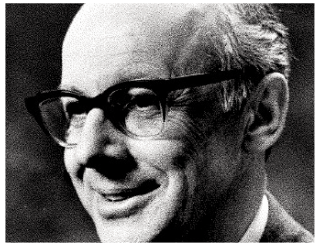
The week was a mix of research, visits, masterclasses, panel discussions and interviews. We met schoolchildren in Tottenham, NGOs in Tower Hamlets, industry leaders (CEO of Unilever), academics, members of the royal family, developers of the Francis Crick Institute behind the British Library and a wonderful sustainability centre in Greenwich.

At the end we downloaded our learning and ideas and developed prototype solutions to improve the 'smartness' of cities – to present to a distinguished panel by Saturday lunchtime. It was hugely encouraging that all the projects centred on public health and improved public engagement, such as free mobile-phone charging and wifi points for countries with little infrastructure, and a commonwealth currency scheme that values socially responsible employers and individuals – reminiscent of time-banking but developed as a full-blown currency! My own team's project focused on developing a product-labelling system using an over-arching 'sustainability' traffic-light system, pulling together the various existing badges (Fairtrade, organic, low-emission, low-fat).

Lots of great ideas – some of which will get worked up more fully. But it was the journeys that colleagues went on that surprised me: an engineer offering to mentor an illegal immigrant towards her employment dream, a mining developer deciding to engage in community projects in his neighbourhood, a senior public servant vowing to support those born without the advantages they took for granted. And perhaps that is another strength of the public health message: the chance to use evidence to change people's minds and create a healthier future for all.

David Allen

In memoriam



Michael Warren Hon FFPH
1923 – 2015

A man of quiet and unassuming demeanour, Michael made an exceptional contribution in the early years of FPH by his work on the training programme curriculum, a monumental task. He was the founding Academic Registrar, a post to which he was appointed on the basis of his record in the development of the master's degree at the London School of Hygiene and Tropical Medicine where he was Reader in Public Health.

Previously, he held appointments on the Council of the Society of Medical Officers of Health and as Chairman of the Society for Social Medicine and was ideally placed to integrate the academic and practising components of the larger public health discipline. He also served as editor of the *British Journal of Preventive and Social Medicine*.

In 1971 he went to the University of Kent as Professor of Social Medicine and the first Director of the Health Services Research Unit. It was a brave move, as he joined the social science faculty of a new university and was the first medically qualified member of staff. He continued to play a vital part in the consortia of academic departments which helped develop FPH's training programme. He acted as external examiner to the master's degree courses in the various universities developing them, often from pre-existing courses of the formerly statutory Diploma of Public Health. He used this opportunity to assist and inspire those providing these programmes to ensure that they met and also helped develop FPH's requirements for specialty training.

After retiring in 1983 Michael spent a long period reflecting and writing on the history and future of public health both as an academic discipline and as a professional practice. Two major publications for FPH were a thorough and scholarly history of its founding and early development, and a historical bibliography of major publications relating to state medicine, public health and social services development from 1066 to 1999.

Michael was an immensely civilised and scholarly man who was always ready to respond generously to a request to undertake tasks and duties relating to public service. Whatever he took on, he worked thoroughly and creatively. Although many of those who knew him best have long pre-deceased him, those who remain will all attest that he was not only a much admired but a very well-liked man.

Alwyn Smith

Anthony Hedley FFPH
1941 – 2014

Tony's postgraduate (Aberdeen University) travels, often under World Health Organization (WHO) auspices, cultivated passions for public health and photography. He held the Henry Mechan Chair of Public Health in Glasgow from 1984 following a senior lectureship at Nottingham and helped establish the Faculty of Medicine at Khon Kaen University, Thailand, receiving an honorary degree from King Bhumibol in 1983. From 1988, he led the Department of Community Medicine at the University of Hong Kong, staying until his retirement in 2010. He was for many years an examiner for FPH and a passionate go-between, pushing FPH to develop its first international links. He ran weekly tutorials ensuring a generation of Hong Kong trainees passed their FPH exams.

Tony's interest in respiratory health was seen in dogged work on tobacco control. Concurrently, he established a world-class air pollution research team, creating the Hedley Environmental Index of real-time air pollution costs in Hong Kong. He received the WHO Medal and the Hong Kong Bronze Bauhinia Medal. He was awarded Emeritus Professor in 2014 and 10 days before his death flew 8,000 miles from his beloved Isle of Man to Hong Kong for a sold-out forum in his honour.

Richard Fielding

Marko Petrovic MFPH
1963 – 2015

Marko was born in the UK to Serbian refugees and was immensely proud of his Balkan heritage. After graduation he worked in surgery then trained in public health in Wales where he made a significant contribution to the national MMR scare response. As Consultant in Communicable Disease Control in Greater Manchester, his great passion was TB, and he developed a deep and expert knowledge on all aspects of the disease. He worked tirelessly with clinicians, nurses and epidemiologists across the country to reduce the incidence of TB, improve patient care and control outbreaks. In recent years he undertook research for an MD into the immunology of TB. Although ill health meant he was unable to complete his thesis, he published several papers which have advanced understanding of the disease. He was diagnosed with an aggressive prostate cancer in the summer of 2013. Despite significant discomfort, he continued with his MD and worked part time, dialling into a TB strategy meeting only 10 days before he died. He was so committed and prolific that many colleagues outside the Health Protection Team were unaware how ill he was.

He was supported in his illness by his family, his faith and his colleagues. He leaves his wife, Danica, a son and a daughter.

Lorraine Lighton
Diane Fiefield
Barbara Isalska

Deceased members

The following members have also passed away:

Gregory Dilliway FFPH
Victor Hawthorne FFPH
Mabel Mills MFPH
Elizabeth Timothy FFPH

Letters

CHRIS Boardman (The Final Word, *Public Health Today* December 2014) performs a valuable service in emphasising the most powerful ways of increasing the prevalence and safety of cycling and the potential counter-productive effect of focusing solely on helmets and high-visibility clothing.

It seems inconsiderate of him, however, not even to mention the effect of high-visibility clothing on motorists. All drivers, even the most cycle-friendly, know the difference between following a grey-clad cyclist on a grey day and one in high-visibility clothing. The difference in confidence and stress is real.

Doesn't Chris consider motorists merit any consideration, except as potential cyclists-slayers? I should be interested if you have the opportunity to put the question to him: I'm sure he will find the right balance.

Paul Snell OBE

SHOULD not your item 'Cut music to an hour a day' [News in brief, *Public Health Today* March 2015] have said: "People should not listen to music for more than one hour a day *on headphones*"? I can see some people running off like they have with umpteen other *Daily Mail* headlines and making some of us feel guilty. Sloppy journalism in my humble opinion.

Irene Stratton
(after 5.5 hours of music at Oxford Folk weekend including an hour of 18th Century dance music on fiddles, viola and piano)
Honorary Associate Professor
University of Warwick Clinical Sciences Research Institute

Editor: *Yes, the one-hour limit in the WHO report did indeed refer to "personal audio devices". Apologies. NB: The BBC made the same mistake!*

FPH in brief

Global Health Strategy
This strategy sets out FPH's aims for its global health and international work for the next five years and will be launched at this year's FPH conference on 23 and 24 June. The work will build on FPH's many existing international partnerships, as well as challenge it to work harder and with greater impact towards improved global health outcomes.

Support us
If you have a passion for public health and the significance of its contribution to the human condition, you may feel moved to donate to the further development of FPH as it embarks on the next stage of its journey. FPH's ambitions include extending its reach and influence locally and globally, extending its membership base and moving towards college status. You can donate to FPH using a debit or credit card by visiting the FPH online donation page at http://www.fph.org.uk/support_us

Welcome to new FPH members

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

Fellows
Ian Ashworth
Michael Caley
Daniel Carter
Ying Yang Emily Chan
Mariana Dyakova
Paul Fisher
Elizabeth Green
Katherine Harvey
Jorg Hoffmann
Richard Holmes
Soo Lim
Elizabeth Lingard
Yeung Wong
Emily Youngman

Members
Arun Ahluwalia
Simona Baracaia
Nicholas Bundle
Andrea Clement
Ian Diley
Clare Ebberson
James Elston
Louise Flanagan
Suzanne Gilman
Ruth Goldstein
Mary Hall
Catherine John
Peter MacPherson
Robert Marr
Matthew Neilson
Charlotte Pavitt
Ellen Pringle
Allan Reid
Melanie Roche
Caroline Rumble
Ashley Sharp
Louise Sigfrid
Katie Smith
Emily Stevenson
Hayley Teshome Tesfaye
Taavi Tillmann
Gerald Tompkins
Kirsten Watters
Helen Webster
Nicholas Young

Diplomate members
Kathryn Cobain
Lucie Collinson
Kathryn Faulkner
Matthew Fung
Andrew Graham
Ali Hasan
Alexander Hawley
Emma Kain
Janice Lo
Orsolina Martino
Gerardo Javier Melendez-Torres
Helen Skirrow
Judith Stonebridge
Sam Williamson

Specialty Registrar members
Suzanne Bartington
Julia Bates
Lucy Devapal
Yannish Naik
Saran Shantikumar

The great British care contest

DARLINGTON Borough Council was the winner of the Health and Social Care Award at the *Local Government Chronicle* (LGC) Awards 2015, hosted by TV presenter Sue Perkins.

The award, which was sponsored by the Faculty of Public Health (FPH) and the Public Health Action Support Team (PHAST) CIC, was in recognition of Darlington's innovative Good Friends scheme. This involves a network of people who keep an eye on their older and vulnerable neighbours. The scheme, which builds on an innovative alliance between Age UK Darlington, the police and Neighbourhood Watch, was launched in October 2013. By June 2014 there were 645 Good Friends recruited, helping 238 neighbours.

Pictured (left to right) are Catherine Brogan, Chief Executive of PHAST, FPH President John Ashton, Seth Pearson, Partnership Director at Darlington Borough Council, Gillian Peel, Chief Executive of Age UK Darlington, and Sue Perkins.

Highly commended was North East Lincolnshire Council for Beyond Buzzwords.

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Samantha Bennett
Mandy Clarkson
Sarah Crouch
Rose Dunlop
Paul Fisher
Katharine Harvey
Clare Humphreys
Elizabeth Lingard
Helen McAuslane
Joseph McDonnell
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FPH annual general meeting

THE 43rd annual general meeting of the Faculty of Public Health (FPH) will be held on Tuesday 23 June 2015 from 4.45pm to 6pm in Hall 1, Level 1, Sage Gateshead, St Mary's Square, Gateshead Quays, Gateshead, NE8 2JR. The agenda papers can be found on the FPH online members' area or are available from carolinewren@fph.org.uk, tel. 020 3696 1464.

Doctors used to be the masters of the NHS universe with their medical gobbledegook. Then along came managers who spoke of 'workstreams' and 'business solutions'. Here, **Phil Hammond** gives his prescription for the next stage of reform: the bidet revolution

WHAT do doctors really think? Humans have evolved to lie to other people, all the better to lie to ourselves, but doctors are still just about trusted to tell the truth. However, there's plenty we still hide from public view, particularly when it comes to how we feel about our jobs or working for the NHS. Doctors may look cool and composed on the outside, but we're often as anxious as patients during consultations. We're worried about missing an important diagnosis, not being able to give people the time they need and not being able to cope safely with the demands placed on us. Just as we shouldn't blame people for being ill, old or overweight, we shouldn't blame NHS staff for not being able to always provide the highest standards of care in a chaotic system that's creaking at the seams.

Doctors once held all the aces in the NHS with our secret language. We used to be able to baffle the masses with silly Greek words: we spoke of menorrhagia, rather than heavy periods, or dysmenorrhoea, instead of painful periods. And let's not forget oligomenorrhoea (infrequent periods), amenorrhoea (absent periods) and – wait for it – polymenometrorrhagia (frequent, heavy, irregular periods). Travel an inch or so upwards and you can have dysuria (painful wee), haematuria (bloody wee) and polyuria (lots of wee).

But, thanks to mobile phones, anyone can have instant access to a medical dictionary to demystify their doctor. The power has shifted to managers who may speak in ways that no dictionary can help you understand. Of all the examples of NHS 'wonk' I've collected over the years, my favourite is this advertisement: "Applications are invited to become a Blue Sky Practitioner reporting to the Blue Sky Lead in the New NHS Modernisation Agency. The workstreams will work to a generic cycle based on a hypothesis driven, creative problem-solving process to create improvement products... You will undertake horizon scanning and futures research… creating curve leverage systems for rapid diffusion… helping customers articulate and understand mess." How have we evolved to speak such drivel?

> **The power has shifted to managers who may speak in ways that no dictionary can help you understand**

Doctors hate this new corporate language in the NHS but are generally too fearful to shout it out loudly. Turning healthcare into a market puts targets and profits above patients. A friend of mine resigned as clinical director of a mental health service when he was told that the "core purpose of your role is to drive the business development strategy, in line with the Business Proposition, scanning the mental health environment for new opportunities and identifying and stimulating new business solutions that fit with the corporate vision". He said, rather wearily: "All I want to do is help the mentally ill."

The NHS is facing a £30 billion black hole in its finances in the next five years, and keeping it on the rails won't be easy. I've had enough top-down reform. We need a bidet revolution, from the bottom up, with patients and carers leading the charge. What they need is the confidence, courage, tips and tactics to stay well outside the NHS and thrive inside it. I've written a book to kick it all off. Let me know what you think (@drphilhammond).

Phil Hammond
Doctor, journalist, broadcaster and comedian

Phil Hammond's latest book, 'Staying alive – how to get the best from the NHS', is published by Quercus. Public Health Today readers can get a discounted copy for £10 with free P&P (UK only) by calling 01235 827702 and quoting reference 'BOOKPOINT'.

Information

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