Josie Gibson won TV reality show *Big Brother* in 2010. Following a series of comments and photographs in the media about her weight, she began to exercise more and eat sugar less

FOR readers who don't know who I am, I went on a TV show about three years ago and have been one of the lucky ones, as the show has given me a successful career in doing what I love: helping people to lose weight and get fit. I have struggled with my weight from the age of six, and it took me 20 years to find the answer.

My key problem was the sheer amount of sugar I was consuming without even knowing it. What I thought was healthy (white bread, tinned foods and low-fat ready meals) turned out, when I read the ingredients, to be full of sugar. By identifying sugar and processed ingredients in common foods and selecting healthy, natural ingredients instead, I was able to lose weight without dieting. I went from nearly 17 stone to my current size 10, and I feel better than ever.

This was one of the hardest and biggest achievements of my life, and now I've found the answer I want to make sure other people don't fall into the same sugar trap. A scary thought is that currently in the UK obesity rates have almost quadrupled in the past 25 years, and this rise has been accompanied by a rise in sugar intake. Recent reports have also shown that fizzy drinks can contain up to nine teaspoons of sugar, which is more than enough to spike a rise in blood glucose and consequently insulin. This can then lead to type 2 diabetes and other health concerns as well as excess storage of fat.

> **This was one of the hardest achievements of my life, and now I want to make sure other people don't fall into the same sugar trap**

Sugar was my addiction and the thing that set me free was educating myself on diet and exercise. I found that after about 21 days of eating natural foods and kicking the habit of sugar my mood swings and depression disappeared, and I had more energy than I had felt for a long time. I really feel sorry for people these days: it's nearly impossible to have a healthy diet with the amount of food products that we wrongly deem to be good for us stacked in our shopping aisles. I am so glad we are raising awareness of the growing sugar epidemic as I feel obesity has taken some of my best years away from me. I am now an advanced nutrition advisor and a personal trainer [Josie's latest DVD, *The 21 Day Fat Burn*, is out now] and my mission in life is to help other people beat their addiction to sugar.

Josie Gibson

Information

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The magazine of the
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March 2014

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Welcome

THE role of president of the Faculty of Public Health (FPH) is very much like a piece of string: it's as much as you want to make of it. Notionally two days a week has felt very much in excess of the European working time directive, but it is very satisfying. I have reported in the ebulletin on my first round of visits to all parts of the UK which is nearing its conclusion. The good news is that the troops still have an appetite for changing the world and that our registrars coming through are an inspiration. The bad news is that Andrew Lansley's reorganisation of the NHS has had a devastating effect on morale in some places and that a proportion of local authorities either don't 'get' public health or appear to be wilfully neglecting their duty of stewardship. There has been significant attrition of experienced staff, and there have also been casualties. At the recent meeting of the Academy of Medical Royal Colleges, Clare Gerada reported on the service she runs in London for sick and stressed doctors. She was clear that our specialty has not been exempt from the significant increase in those seeking help. We all have a duty of care towards each other, and I trust that following the "transition", the legacy of harm will not be overlooked by those with a responsibility for human resources.

On some of my regional visits I have been taken aback by the numbers of vacancies which seem to exist and the apparent dearth of timely information about them. Please keep me informed as to what is happening on the ground, so that we can ensure a good flow of information. Serious oddities and issues about terms and conditions continue to surface. They are a legitimate matter of concern for FPH and are not exclusively a trades union issue. Strong, effective teams depend on having the best people with the right complementary skill sets in each public health directorate. Postcode public health is unacceptable.

January saw some important meetings. Many of you will have come across the North of England European Union Health Partnership which has done good work over many years from its Brussels and England bases. Each time there is a reorganisation there has to be a new scramble for funding if the programme of Brussels visits and support for programme bids is to continue. Hopefully, arrangements will soon be in place to ensure that this resource continues to be available. For details contact Chris Birt at christopher.birt@liverpool.ac.uk. January saw the inauguration by the Royal College of Physicians (RCP) of London of a working party on the impact of air pollution. I am involved as a Council Adviser of the RCP. Many people still think that air pollution in the UK disappeared with the clean air acts of the 1950s, but this could not be further from the truth. This working party under Stephen Holgate should make a significant contribution to public health. For more information contact kateeisenstein@rcplondon.ac.uk

I assumed the chairmanship of the FPH International Committee in January and together with our Chief Executive, David Allen, am considering how best to put it on a strategic basis that is congruent with the overall FPH strategy. I will report on this further in due course. Meanwhile David and the staff at St Andrews Place have been running a series of strategy workshops which will give us a refreshed draft for consideration at our annual conference in Manchester in July.

David Allen and I had an excellent meeting with Ian Cumming, Chief Executive of Health Education England, and I am happy to report that Ian is a public health enthusiast. We used to work together at Mersey Regional Health Authority in the 1980s, so perhaps I can claim some early influence! He particularly wishes to see an improvement in public health careers awareness from age 13, including awareness of the different degree routes which can culminate in public health. This is, of course, essential for the ongoing development and support of multidisciplinary public health.

A lot of ground is covered in this issue of *Public Health Today*. There is growing concern about the state of the nation's children compared to other countries. The launching of the British Association for Child and Adolescent Public Health, which has grown out of a Special Interest Group, is most welcome. I would encourage those who feel passionately about this issue to join up and get involved. The case has to be made that the economic future of the UK depends on us not wasting our most precious assets.

John Ashton

Web drinking craze is 'tip of an iceberg'

THE Faculty of Public Health (FPH) has been prominent in warning about nekNominate, a web-based drinking challenge that has caused at least five deaths among young people as we went to press. FPH alcohol spokesman Mark Bellis was widely quoted and told BBC TV that the harm caused by the drinking 'game' was probably the tip of an iceberg. Professor Bellis was able to use the media interest to broadcast the public health message on the harm caused by UK alcohol consumption. Speaking on BBC Breakfast, he pointed out that around one in five of all deaths in adults under 45 was linked to alcohol.

NekNominate is a recent craze, thought to have originated in Australia. People video themselves drinking to extremes and challenge others, usually 'friends', to do the same. Some add other challenges or video themselves taking stupid risks. The *Daily Telegraph* reported a youth swallowing the head of a young chick and stubbing out a cigarette on his tongue in an online video, interspersed with heavy drinking. Another 19-year-old was reported to have downed three bottles of spirits before being found by his parents unconscious on the sofa covered in vomit.

It's the combination of heavy drinking and daring others to do the same on the internet that makes nekNominate especially dangerous. "This has created a very dangerous cultural environment," Professor Bellis told the *Telegraph*. "A few things come together here, with social media and a real risk of peer pressure, especially combined with a substance that makes people very susceptible." That gives public health professionals a platform to remind everyone – not just the very young – of the dangers of abusing alcohol.

> **"Social media and peer pressure are combined with a substance that makes people very susceptible"**

Protect children from smoke in cars, say MPs

A VOTE has been passed in Parliament in favour of banning smoking in cars when children are present. The vote on amending the Children and Families Bill was passed by 376 votes to 107. The amendment opens the way to a future change in the law, making it a criminal offence to fail to prevent smoking in a privately owned vehicle when children are present. The strength of support given to the motion makes a legal ban much more likely, and government sources have since said that legislation will follow.

John Middleton, FPH's Vice President for Policy, welcomed the result: "We owe our thanks to all those MPs who voted to protect children's health. Passive smoking results in around 400 sudden infant deaths a year. Adults can choose how they travel, but children can't. A single cigarette in a car, even if a window is half-open, creates two-thirds of the second-hand smoke a child would have inhaled in a smoky pub.

"We very much hope that public support will help this law to be enforced, just as the smoking ban in public places has been. We need more of this evidence-based approach to policy so that we protect and save lives."

Some attitudes take time to change, but a majority of legislators in the Commons have accepted the case for a ban. FPH will keep an eye on the parliamentary timetable to make sure the ban gets into law as soon as possible.

David Dickinson

News in brief

Significant drop in measles cases
There was a sharp fall in the number of cases of measles in England at the end of 2013, figures from Public Health England show. Twenty four people were infected between October and December, in contrast to the hundreds of cases each month at the beginning of the year. The fall was put down to efforts to get more children vaccinated with the MMR jab.

Hair straighteners top child burns list
Hot mugs and hair straighteners are the leading causes of childhood scalds and burns, and one-year-olds are at greatest risk, data reveals. Professor Alison Mary Kemp from Cardiff University and colleagues looked at admissions to three leading burns units and five emergency departments in the UK.

Obese people in Wales 'told to gain weight'
Life-saving treatments are being denied to obese people in Wales, a leading group of surgeons has said. The British Obesity and Metabolic Surgery Society said morbidly obese people had been told to gain weight to qualify for bariatric surgery. It voiced its concerns to the Welsh Government's Health and Social Care Committee.

'Pocket optician' trialled in Kenyan schools
A modified smartphone is to be used by teachers in Kenya as part of trial to catch pupils' eye disease. The same kit used on older people had had promising results and led to more than 1,000 people receiving treatment, according to the team behind the project at the London School of Hygiene and Tropical Medicine.

Ban on 'no helmet' advert under review
A ruling against a safe-cycling advert which showed a rider without a helmet has been withdrawn while authorities review their decision. The advert is part of a campaign by Cycling Scotland. The Advertising Standards Authority objected on "health and safety" grounds but has now withdrawn its "potentially flawed" ruling while an independent review takes place.

WHO: Daily sugar intake should be halved
People will be advised to halve the amount of sugar in their diet under World Health Organization (WHO) guidance. The recommended sugar intake will stay at below 10% of total calorie intake a day, but with 5% the target. UK campaigners said it was a "tragedy" that WHO had taken 10 years to think about changing its advice.

INTERVIEW

Camila Batmanghelidjh is the founder and director of Kids Company and has been a psychotherapist for more than 20 years. In her early twenties she founded her first charity, Place2Be. She told *Public Health Today* that we have to rethink how we provide physical and mental healthcare to children with behaviour problems.

`Futility is our biggest enemy'

Deliver emotional contact, says Batmanghelidjh

What aspects of your work do you enjoy most?
Spending time with the children and young people. I have such a deep love for them. There is an immediate intimacy from getting to the point. I love those conversations. I put structures in place because I wanted workers to have meaningful conversations and then problem solve every aspect of a child's life, there and then. The child deserves that help, and we apologise if the resources are not there. It's so important to deliver the solution and apology simultaneously.

The children we work with have complex problems. A third of our kids under 14 don't have a bed. One in four don't have any chairs or tables. Just under 20% don't have underpants, and 85% rely on us for their evening meal. They are usually sexually and physically abused by their immediate carers.

University College London carried out research with us which showed that one in five of the children they had assessed had been shot at or stabbed, and 50% had witnessed shootings and stabbings in the previous year. The research found that the neuronal pathways of these children were mimicking war veterans with post-traumatic stress disorder. The kids tell me they are soldiers. Their war is growing up in Britain.

There isn't enough help because society has ended up passing moral judgement. Decision-makers attribute moral flaws to kids and young people who are said to have chosen to be criminals or join gangs. This notion of choice means that often politicians don't create a care infrastructure to protect these kids. Health delivery is determined by a political narrative.

Health providers are not providing reparative programmes for children and young people who are, in effect, as traumatised as soldiers. These kids are heroic. I believe their courage and heroism are not acknowledged enough. To be that traumatised and violated and to get up every morning is an incredible act of courage. That's why I like working with them.

What are the common misconceptions about the children Kids Company works with?
Generally people don't get close to these kids to find out what's happened to them. Our job is to bridge that divide. That's why we've brought in scientists and researchers to look at what was happening to these children's brains. Results are showing significant structural and functional changes that result in poor social behaviours.

Is that something that can be reversed?
This model of intensive re-parenting works. A medical paper is about to be published which shows that after nine months of intensive care by Kids Company, there were dramatic, positive, functional changes in the most criminally disturbed group of 11-17 year olds.

We have to rethink how we provide physical and mental healthcare to these kids. At the moment, the model is based around appointments. The assumption is that an adult will take the child to the appointment. Yet 80% of these children are being abused by their immediate family who won't want the psychiatrist to find out what's going on.

A good drop-in model is better, where you almost recreate a family home, but parental figures are the doctor, nurse or artist. Some of our centres are open from 9am to 10pm. So the psychiatrist plays basketball with the children and gets to know them better. That makes it much more likely that the psychiatrist [can] do a formal assessment. The child will be much more honest. It's so much more efficient.

Because it is a solution-focused approach, rooted in the community, the children have a sense of security. You can no longer divide physical and emotional health. We have to change our public health models to create more resilience against practical and emotional environmental adversity. Robust care is about the delivery of emotional contact backed up by systems.

> These kids are heroic. To be that traumatised and violated and to get up every morning is an incredible act of courage

There's something ingrained in the British psyche where emotionality equals chaos. Emotions are logical: you just have to work out what the logic is. You need to operate as a caregiver or clinician through your emotions to function as a healer. You need to back that up with robust and systemic narratives. We've ended up with a culture of delivering care through systems. That's where we are going wrong. It ends up burning out workers.

Our London School of Economics research into our front-line staff came with 92-97% wellbeing rates. Our staff stress levels came out within a normal range. Regulating and nurturing our staff, and making sure they have the right resources, is very important.

What's the best way for public health professionals to tackle the social determinants of health?
The clients and the community hold the expertise. It's a question of being curious and extracting the philosophy of practice from the clients themselves. Do we have the guts to rewrite services in the way our patients are telling us are needed? I think the time has come to make philosophy of care top of the list of political priorities. Politicians rarely talk about their agenda for child protection. It's because Britain does care under the carpet.

Care is the wellbeing of a human being, and it's not divided between social care and healthcare. How do you want to do public health? At its source or at an after-event that has suppressed the symptoms of poor care?

How can FPH's members support this model of care?
Come and visit us, and we'll show you how it works. We help 3,600 children, people and vulnerable adults through a tiered system of intervention. Also, you could run a pilot, assess the outcomes and do a comparative study. I'm all for rigorous research. Futility is our biggest enemy and justifies people to do nothing.

Where do you want to see the care of vulnerable children and young people in 10 years' time?
Top of the agenda, and for politicians to stop passing judgements and take responsibility. Parents are responsible for coming up with solutions. If they are not functioning, the state needs to step in, provide loving care and honour the childhood contract so that it is responsible for the wellbeing of a child. If you break that contract, be prepared as a society to pay the price for it.

Is there anything that keeps you awake at night?
The one thing I obsess about is fundraising. I have to raise £23 million a year. I'm very focused when I need to be – but my head is very empty and peaceful. I love swimming. I love compassion for compassion's sake.

Interview by Liz Skinner

Playing politics

Improvements in child health through legislation and industry practice are being undermined by cuts in services, says Alan Maryon-Davis

AS YOU might expect, in the world of children's public health, it's all snakes and ladders.

First the ladders. Westminster MPs voted by a thumping 3:1 majority to bring in a ban on smoking in cars with a child on board, and No 10 said it would be law before the 2015 election. The stalled issue of standardised packaging of cigarettes, an important deterrent for young people, has been revived with a strong indication that it too will soon be mandated. A unified traffic-light food-labelling scheme, crucial in the battle against child obesity, has been grudgingly accepted on a voluntary basis by most of the food industry.

But now the snakes. The Government's austerity programme is doing real damage to the support system for children and young people in need. Dozens of children's centres have had to cut back their activities or close altogether. Child and Adolescent Mental Health Services are similarly under threat across the country. GP services are stretched to breaking point, and A&E departments are packed with the overspill. The benefits system is in turmoil and the number of young families facing real hardship has soared. Food banks are in huge demand. Pawn shops, discount stores and pay-day lenders are booming. It's a grim picture getting grimmer by the day.

> **The Government's austerity programme is doing real damage to the support system for needy children**

Against this broad backdrop we have invited a selection of contributors to focus on a range of specific public health challenges in the sphere of children's and young people's wellbeing.

Our Big Debate is on breastfeeding, and in particular whether providing financial incentives for mums to breastfeed is a good or bad idea. Clare Relton of Sheffield University, who is doing a study on this hot issue, says yes, maybe. Suzanne Barston, Californian author of *Bottled Up: How the Way We Feed Babies Has Come to Define Motherhood, and Why It Shouldn't*, says no.

We have Thara Raj on the perennial effort to improve immunisation coverage and the challenges in introducing a universal flu vaccine for children. There's also Laura Chu exposing some of the wicked tricks the food industry uses to market its not-so-healthy products to the nation's youth. Plus Martin Schweiger on trafficked children and the failures of the system to offer child-friendly support, Emma-Jane Cross on the insidious dangers of 'cyberbullying', Rachel Hodkin on the many harms from corporal punishment and Campbell Bell on safeguarding in sport.

Professor Dame Sally Davies, England's Chief Medical Officer, dedicated her latest annual report to the health and wellbeing of children. Laura Weil, Jason Strelitz and Claire Lemer look back at *Our Children Deserve Better: Prevention Pays* and highlight some of the ways in which its 24 key recommendations are being taken forward.

And finally, Ingrid Wolfe tells us about the rationale for the recent launch of the British Association for Child and Adolescent Public Health and invites us all to join the cause.

Alan Maryon-Davis
Editor in Chief

Government is failing to protect children from food advertising

THIS month, the British Heart Foundation is working with a group of concerned charities and health experts, including the Faculty of Public Health, to call on the Government to take action on junk food marketing to children.

The Government is failing to protect children from advertising of processed foods and drinks high in fat, salt and sugar (HFSS). Children are a vulnerable group and should not be directly targeted by advertising for unhealthy food and drink products. This practice is compromising parents' efforts to keep their kids healthy in the context of a looming obesity crisis where around one in three children in the UK are already overweight or obese.

Children are constantly exposed to junk food marketing: on TV, on radio, on the internet, in emails, social media and text messages, at the cinema, in comics and magazines, in supermarkets, on food packaging, and, for some, even at school.

Research shows that food promotions can influence children's behaviour in a number of ways including their preferences, purchase behaviour and consumption. Children as young as 18 months can recognise brands, and children as young as three have been shown to prefer branded, over identical unbranded food. Marketing therefore plays a significant role in influencing children's dietary choices.

Internationally, there are a handful of examples of governments using legislation to try and tackle this issue. In Canada, the province of Quebec has banned all broadcast advertising targeted at children under the age of 13, preventing any messaging designed to promote goods, services or an organisation. In Sweden, all broadcast advertising aimed at children under 12 has been banned since 1991. The rationale behind this is based on the principle that advertising should be easily distinguishable from other media content and that the audience must be able to understand its purpose.

The case for restricting advertising for unhealthy foods and drinks to children has already been accepted by the UK government. There are rules in place banning unhealthy food and drink advertisements on television during children's programming which are intended to reduce the number of these adverts that children see. However, this is a small measure that has not had the desired impact – children's peak TV viewing time is now 8pm-9pm and children are spending more time online.

The Government needs go further to protect children: UK rules need to be brought up to date so that they apply to where and when children are actually watching and consuming media. This is clearly a public health issue that needs attention. You can support our campaign calling for a ban on adverts for unhealthy food and drink products before 9pm on TV and for stricter rules to apply to online advertising to children by signing the petition at www.bhf.org.uk/junkfood.

More can also be done locally to ensure that environments where children gather or go to get active are free of advertising for HFSS products. Health specialists working locally can help by supporting local schools, youth and leisure centres, and sporting or cultural events to ensure that these settings aren't marketing HFSS food and drinks to children.

If you would like to be involved in the campaign, please get in touch with us by emailing campaigns@bhf.org.uk.

Laura Chu
Advocacy Officer
British Heart Foundation

Healthy children will mean a healthy future

WE SHOULD be profoundly ashamed of our child mortality rates, says England's Chief Medical Officer, Dame Sally Davies. Child poverty is rising, and inequalities are growing ever wider. Universal child benefit has been abolished, and the lives of thousands of young people are being blighted by lack of education, training and employment. Little wonder that UNICEF ranks the UK low in many measures of health and wellbeing.

At the British Association for Child and Adolescent Public Health (BACAPH) launch in October, Sir Michael Marmot set a challenge: we are failing children on a grand scale. What are we going to do about it?

There is unprecedented turmoil in the NHS and local authorities, with reorganisations and privatisation. Action is more urgent than ever. We need our combined expertise and voices to improve the health and wellbeing of children and young people.

BACAPH has an ambitious aim: to create a blueprint to meet the health and wellbeing needs of children and young people – now and in the future.

BACAPH will work through three themes:

- Policy: promoting the development and implementation of evidence- and rights-based child public health programmes.
- Advocacy: encouraging participation of children and young people speaking on important issues that matter to UK children and families.
- Knowledge: promoting learning that brings new science to long-standing questions and providing training to gain the skills, competencies and insights to meet the diverse and growing challenges we face in child and adolescent public health.

Please join us! We need you – whatever your professional background. We hope to offer you an indispensable resource.

Our website (www.bacaph.org.uk) provides a doorway to a wide selection of resources from all four nations of the UK and beyond: policy documents, papers, reports, data sources, training events and conferences, and soon a members-only forum where we can share ideas, insights experience and advice.

We can work together to make the UK the best place in the world in which to grow up.

Ingrid Wolfe
Co-Chair
British Association for Child and Adolescent Public Health

DEBATE: Is breast necessarily best? Mothers in Sheffield are being offered £200 to breastfeed. Clare Relton defends the scheme, while Suzanne Barston says it won't work

UK rates are among lowest in the world

BREASTFEEDING is a powerful tool in the prevention of disease and the promotion of health in both mums and babies. The World Health Organization and all four UK departments of health recommend that all babies are breastfed exclusively up to the age of six months, yet only 2% of babies are. Despite a wide range of evidence-based policies being implemented, breastfeeding rates in the UK remain stubbornly low and are among the lowest worldwide.

Financial disincentives are widely and effectively applied in taxes on harmful products, such as alcohol and tobacco. Mums on benefits are incentivised to eat fruit and veg with Healthy Start vouchers. Though incentives to stop smoking during pregnancy are being tested, the impact of offering financial incentives to breastfeed is an unexplored area.

In our NOurishing Start for Health (NOSH) study, we are working closely with local stakeholders in infant feeding (mums, partners, midwives, health visitors and breastfeeding support workers and commissioners) in developing and testing the feasibility of the NOSH scheme. While designing the scheme, we also looked closely at what was offered by other health behaviour-change schemes. We found only

YES

one breastfeeding financial-incentive scheme, in Quebec, Canada, where mums were given $55 per month to breastfeed until their baby was one year old.

So far we have found that, locally, there is broad acceptance of the idea of financial incentives for breastfeeding from healthcare providers and women in neighbourhoods with low breastfeeding rates. We are now testing the acceptability and deliverability of the NOSH scheme in three local areas. If this goes well, we will test its cost effectiveness by comparing neighbourhoods which offer the NOSH scheme with those where the scheme is not offered.

We are aware of the controversial nature of the intervention, the sensitivities surrounding breastfeeding and the taboo nature of breastfeeding in some areas, often reinforced by infant formula advertising.

Other countries have taken more radical steps to improve their breastfeeding rates. For example, in some Nordic countries infant formula is only available on GP prescription. Earlier this year, the United Arab Emirates passed a law that all babies had to be breastfed until the age of two.

New methods are needed if the UK is to improve its breastfeeding rates. We are studying one potential method. The results of our feasibility stage will be out this summer.

Dr Clare Relton
Senior Research Fellow
University of Sheffield

Not all babies are born to be breastfed...

SOME are born tongue-tied, early, sick or jaundiced and need extra help learning to eat. And that's not factoring in maternal difficulties such as insufficient glandular tissue, medications contraindicated for breastfeeding or postpartum depression.

Policymakers and advocates cling stubbornly to the belief that if women were convinced more fully of breastfeeding's value – whether the value is intrinsic (the promise of better health outcomes) or extrinsic (status or financial reward) – they would be more likely to meet breastfeeding recommendations. The Sheffield scheme is reportedly an attempt to counteract societal forces in a low-income area where breasts are overly sexualized and bottle-feeding is the norm – but then why not reward husbands, grandparents and employers for supporting breastfeeding, instead of putting a price on a woman's individual biological capabilities?

Critics call this pilot study "bribery"; its defenders allude to similar programmes for encouraging weight loss and smoking cessation. But unlike ridding oneself of unwanted pounds or nicotine addiction, successful breastfeeding requires the physical and emotional cooperation of two individuals – the baby and the mother. In a recent study of 2,946 women by Wagner *et al*, the main reasons for quitting breastfeeding

NO

included breast pain, latching issues and fears about insufficient milk supply. Very few mentioned societal pressures to bottle feed and not one complained that she would have succeeded if someone had only awarded her a grocery gift card for her hard work.

Breastfeeding problems are often fixable, given the right combination of expert care and a mother's ability to commit time and energy. But success is also reliant on a flawed system that mistakes ominous health warnings with practical support, and, when things don't work out, families are often left floundering with a dearth of information on safe formula feeding. Improper preparation and sanitisation can cause serious illness; overfeeding has been correlated with future obesity. Ignoring the reality of formula feeding is the public health equivalent of handing someone an umbrella in the midst of a hurricane. Denying the physiological and emotional impediments to breastfeeding is like taking away the umbrella altogether.

Rewarding nursing mums with 200 quid won't create a 'breastfeeding culture', it won't fix a bad latch, and it won't help babies be fed safely when breastfeeding isn't possible. What it will do is create a culture that celebrates those blessed with cooperative biology and better circumstances and abandons those without.

Suzanne Barston
Journalist, author and maternal health advocate

Stairway to haven

Even when child asylum seekers manage to avoid the clutches of traffickers, the system in the UK is not child friendly, says Martin Schweiger

THERE is a lot we don't know about child asylum seekers entering the United Kingdom in 2014. The number of people arriving who are, or claim to be, under 16 is somewhere between 1,000 and 3,000 per year. The limited data available is based on those who have claimed asylum, but many never do so. Some arrive with other family members, but many vulnerable young people arrive alone. It is thought that an increasing proportion of those who apparently arrive alone are being trafficked to work as cheap labour or in the sex industry.

Traffickers are becoming very sophisticated in their techniques. Not surprisingly, there is no good data because traffickers do not submit reports on their criminal activities. It is probable that a child newly arrived in the UK with a mobile phone, no papers or simply a telephone number committed to memory is being trafficked. These children are very vulnerable to exploitation.

Even when children are brought to the attention of local authorities, the asylum system is not child friendly. Barriers of language and culture are compounded by the lack of resources to respond to the needs of child asylum seekers. It can be extremely difficult for traumatised young people who find themselves alone in a strange culture to navigate its complexities and deal with professionals including lawyers, Home Office officials and social workers. Children damaged today will be tomorrow's damaged adults.

The distribution of asylum seekers is not even across the UK. Ports of entry, particularly Dover, are associated with higher asylum entry levels than other areas. Areas in which particular nationalities have previously arrived are also those areas that attract the next set of arrivals. There are

> **An increasing proportion of those who arrive alone are being trafficked to work as cheap labour or in the sex industry**

complex arrangements between local authorities, the Home Office and some housing providers that can mean isolated people becoming more isolated as they are moved to accommodation remote from those with common background or language.

The issue of child asylum seekers is topical. The imminent arrival of vulnerable people displaced by the war in Syria will inevitably include children. With barely a year to go before the next General Election it is likely that all aspects of immigration and asylum seeking will be contentious and used for political point scoring.

Public health objectives need to be reaffirmed in relation to child asylum seekers, preferably as part of ongoing discussion among all who practise public health. Reductions in morbidity and mortality need to be mirrored by positive gains in physical, mental and social health.

Approaches that can be taken include:

- Seeking and sharing relevant data
- Active advocacy
- Speaking up when wrong messages are pushed out
- Identifying, supporting and sharing models of good practice.

The Scottish Guardianship Service, for example, allocates guardians to child asylum seekers to provide support and guidance during the immigration and welfare process. This scheme is resource-intensive but, if the current three-year pilot project is successful, could point the way to partially mitigating the human cost of children fleeing their homes for a new life in the UK.

Martin Schweiger
Consultant in Communicable Disease Control
Public Health England

Third of young people suffer online abuse

IN THE past six months, several cases of cyberbullying that have resulted in suicide have hit the headlines. Sadly, cyberbullying is not a new problem. When BeatBullying launched its online support service in 2009, we found that more than one in three young people had been victims of online abuse. We also analysed data from 2000-2008 and found that as many as 44% of suicides committed by young people in the UK are linked at least in part to bullying.

Bullying not only makes daily life intolerable for many children, but also affects how they develop in the longer term. In the past five years, we've supported hundreds of thousands of children and teenagers with the help of our community of online volunteers (both young people and adults) and qualified counsellors. Being bullied can have a devastating impact on young people's lives. For many it can result in anxiety, eating disorders, depression, self-harm and, in severe cases, suicide. What quickly became clear was that many of the young people who came to us for help had broader mental health issues, which were often exacerbated or even caused by the bullying that they were experiencing.

To meet this demand, we launched MindFull, a children's mental health charity. Based on a similar model of flexible, online support, in just six months we have already provided more than 1,000 counselling hours to vulnerable young people, significantly increasing the capacity of mental health care in the UK. Using the Warwick-Edinburgh Mental Wellbeing Scale, we have also seen significant improvements in clients' wellbeing. Young people tell us that accessing support online is less intimidating than doing so face-to-face, and they also like the fact that the service is accessible outside normal working hours.

> **Many of the young people who came to us for help had broader mental health issues**

Perhaps, most importantly, we believe in the importance of early intervention. Our model eases the pressure on local authorities, saving much-needed money and resources. We are currently establishing the service with clinical commissioning groups, public health commissioners, schools and communities as a cost-effective and reliable way to reach vulnerable young people. As cuts to child and adolescent mental health services make waiting lists for traditional face-to-face counselling longer, we anticipate that demand for this innovative service can only grow.

Emma-Jane Cross
CEO and founder
BeatBullying and MindFull

www.mindfull.org/get-mindfull/

By sparing the rod you can save the child

OFFICIAL inquiries are regularly held into child protection, early years intervention and antisocial behaviour. There is much hand-wringing about dysfunctional parenting and our 'broken society'. Evidence-led measures of prevention are always identified as crucial.

But there is one measure of prevention that is never mentioned: ending the physical punishment of children. The silence on the topic is extraordinary given the mountain of evidence showing clear links between 'ordinary' physical punishment (as distinguished from 'abusive' punishment) and negative outcomes such as aggressive behaviour, impaired cognitive development, damaged family relationships, domestic violence, child abuse, criminality and poor mental and physical health in adult life.

In 2002 a meta-analysis was published in the US of 88 studies which examined lawful corporal punishment by parents. This found significant associations with 10 undesirable "behaviours or experiences" (the eleventh, "immediate compliance", had mixed results and its desirability was seen as questionable).

A handful of academics challenged the meta-analysis. They alleged that factors such as socioeconomic status, parental warmth, minority cultural norms or the child's individual pathology might explain the results. More studies were conducted to address these points, and a number of large-scale international and longitudinal studies included physical punishment in their remit. Over and over again the same conclusion was reached: smacking was both an ineffective form of discipline and posed risks to children's wellbeing and development.

Meanwhile research conducted in countries that had outlawed smacking found no adverse consequences (such as increased prosecutions of parents) and also that violence to children at all levels of severity decreased more rapidly in banning countries.

So why doesn't the Government leap at such an evidence-led and low-cost preventive measure? The short answer is politics. A majority of the general public do not support a ban, and the victims themselves do not have the vote. The anti-smacking campaign focuses on children's human rights and the impact smacking has on child protection. It is time for the public health case to be strongly advocated too.

Rachel Hodkin
Policy Officer
Children are Unbeatable Alliance

Breaking the cycle

Multisystemic therapy tries to engage all the systems in which young people displaying antisocial behaviour are embedded, writes Jennifer McAuslane

CONDUCT disorder is a public health issue, and the social costs of conduct and behaviour problems cannot be overstated. Poor educational outcomes and an increased likelihood of becoming involved in the criminal justice system at a young age are the tip of the iceberg. Clear links have been identified between severe childhood behavioural disorders, adult psychiatric disorders and violent behaviour in later life.

Working predominantly in the family home, multisystemic (MST) therapists establish a rapport with family members to encourage them to be open about their child's problem behaviours. These might include:

- Truancy and academic problems
- Aggressive behaviour (violence, fighting, property destruction)
- Criminal behaviour
- Drug and alcohol problems
- Running away.

These reflections from parents about how they felt at the start of their treatment with a MST team are typical of what a therapist might hear: "I was scared that if I put in sanctions, [my son] would be violent toward me" or "It was really bad. Every minute it's phone calls and at police stations."

A primary assumption of the MST theory of change is that adolescent antisocial behaviour is driven by the interplay of risk factors associated with multiple systems in which young people are embedded (family, school, peer and neighbourhood). Thus therapists work hard to engage all of these systems and involve them in the treatment process.

Therapists see families for several hours each week and are available to them 24 hours a day, seven days a week. Treatment typically lasts three to five months. MST uses research-based techniques such as behavioural parenting interventions, cognitive behavioural therapy and structural and strategic family therapy to inform interventions that are tailored to each family.

> **I think it was change in me that brought about changes in him, and he hasn't offended since**

The effectiveness of MST has been demonstrated repeatedly over more than 30 years of research involving more than 7,000 families. In the UK, MST is part of a large-scale randomised controlled trial following 682 families co-ordinated by University College London, the outcomes of which will be published in May 2014.

The financial savings that can be made by intervening on these issues in adolescence are significant. Estimates suggest that a quarter to a half of mental health problems in adults could be averted with timely and effective interventions in childhood and adolescence. Additionally, the cost of violence to health services in emergency admissions and medical care has been estimated at £2.5 billion per year which could be substantially reduced by intervening early in life.

The National Institute for Health and Care Excellence guidelines on conduct disorder published in 2013 point to MST as an effective intervention for this population. Many of our families agree:

"I think it was the change in me that brought about changes in him, and he hasn't offended since. So, instead of having an angry mum who pushed him out of the house, because I've changed it has given him the space to think about what he wants." (Parent)

"I listen to my mum more. I'm closer. We talk a lot more. My mum's more happy when I speak to her because she used to be grumpy. We go out a lot more to places together. MST actually helps you build up families." (Young person)

Jennifer McAuslane
Multisystemic Therapy Supervisor
Sheffield City Council

They matter to us all

Five months on from the England CMO's report on child health, Leonora Weil, Jason Strelitz and Claire Lemer examine some responses and outcomes

CHIEF Medical Officer (CMO) for England Dame Sally Davies published her second Annual Report (Advocacy Volume) on 24 October 2013. *Our Children Deserve Better: Prevention Pays* outlines 24 recommendations to improve the health and wellbeing of children and young people, including the initiation of an annual National Children's Week and an emphasis on the importance of school nurses. The message underlying the whole report is that "improving health and wellbeing in early life benefits us all – not just through improved health gains but also economically".

The media focussed on recommendation six, that the National Institute for Health and Care Excellence (NICE) "examines the cost-effectiveness of moving the Healthy Start vitamin programme from a targeted to a universal offering". The BBC, for example, framed an article around the headline "Call for free vitamins for children". The headline in the *Daily Mail* was "Babies and young children should be given free vitamins to ward off rickets as lack of time outdoors increases risk of disease". Medical organisations addressed other recommendations. The British Medical Association centred on recommendation 10, that children with long-term health conditions should have a named GP to coordinate their care.

There has already been progress in several areas. These include the need:

- To assess the progress on early intervention and prevention and to disseminate the evidence for why this matters (recommendation 2)
- To undertake a Healthy Child Programme evidence-refresh (recommendation 4); working with local authorities, schools and other relevant agencies to increase participation in physical activity (recommendation 5)

> **There has already been progress in several areas**

- To identify how the health needs of families are met through the Troubled Families Programme (recommendation 8)
- To aim to include paediatrics and child health as part of the core component of GP training (recommendation 11)
- For Public Health England to develop an adolescent health and wellbeing framework (recommendation 16)
- For the National Institute for Health Research to work towards an evidence base to improve health outcomes for long-term conditions in childhood (recommendation 22).

The CMO concludes her summary: "Perhaps more than the effect of any one single recommendation, I believe that the benefit of this report will be to remind us all of how much the health and wellbeing of children matters to us all." It is still too early to assess the full impact of this year's annual report. However, the reaction to it and other recent publications on child health has set a backdrop against which the medical community are now ready to change the health and wellbeing of young people. The way to achieve this is through a coordinated response by key players. Local authorities have new responsibilities that provide great potential to embed the report's core messages, such as early intervention. The recent Local Government Association publication *Bright futures: local children, local approaches* shows what can be achieved. Now is the time to remember "how much the health and wellbeing of children matters to us all".

Leonora Weil
Speciality Registrar in Public Health
London Deanery
Jason Strelitz
Acting Assistant Director of Public Health
London boroughs of Camden and Islington
Claire Lemer
Consultant in General Paediatrics
Evelina London Children's Hospital

Going for gold with sport safeguarding

WITH the 2014 Commonwealth Games around the corner, it's hoped that a new generation will be inspired to get involved in sport. Scottish children's charity CHILDREN 1ST runs more than 50 services aimed at giving children a safe, secure and happy childhood.

Twelve years ago there was no national body in Scotland for ensuring children's wellbeing in sport. Although good work was being carried out within individual sports governing bodies (SGBs) and local clubs, child protection lacked a consistent and coordinated approach.

CHILDREN 1ST and Scotland's national agency for sport, sportscotland, joined forces in 2002 to create the Safeguarding in Sport service. It provides case-specific advice, training and resources to sports groups. It is an expert child protection resource and produces guidance via newsletters, meetings and a website.

Safeguarding in Sport trains more than 400 Club Child Protection Officers every year and takes around 150 calls a day on subjects as diverse as training, poor practice and child abuse. Hundreds of coaches and people working with children and young people in sport participate in basic child protection awareness courses.

The aim is to ensure that children and young people can participate fully in sport, free from the risk of harm. More recently the service has begun to embed the 'Getting It Right For Every Child' principles in its materials using the SHANARRI assessment, so a child is safe, healthy, achieving, nurtured, active, respected, responsible and included. This keeps the world of sport in line with our partners in health and local authorities in dealing with children and young people in the community.

Sport has physical benefits for children and also provides opportunities for them to develop self-esteem, confidence, leadership and teamwork skills. It can have a very powerful and positive influence if activities are led by adults who put the wellbeing of children first and adopt practices that support, protect and empower them.

One of the service's biggest achievements over the years has been in prompting all SGBs to adopt minimum standards in child protection. Scotland's *National Guidance for Child Protection* mentions Safeguarding in Sport as a 'go to' for help and advice. The team regularly contributes to the Scottish Government's Cross-Party Group on Sport.

Most SGBs in Scotland have used the service's resource *10 Steps to Safeguard Children in Sport* as a basis for their own policies and procedures. But the biggest demand on the service is in relation to training and children's welfare within sport.

Often children will choose to tell a trusted adult, such as their sports coach, about problems in their life. It is important, therefore, that adults know how to respond appropriately and how to share information with those who can help the child. It is equally essential that sports organisations ensure that children are protected from abuse or poor practice within sport. Our training for coaches includes information on recognising child abuse, responding to concerns and passing on this information to the appropriate statutory service.

Campbell Bell
Service Manager
CHILDREN 1ST

Putting the D back into child development

TO TARGET inequalities and improve health and wellbeing of children and families, we focus on reducing vitamin D deficiency in pregnant women and young children. We have a significant number of children and adults with vitamin D deficiency, the majority of whom are South Asian. From 2007 to 2010, 17 cases a year of rickets were diagnosed in Bradford children. Nearly 2,000 women of childbearing age were diagnosed with severe vitamin D deficiency in Bradford between 2008 and 2010.

We promote the effective treatment of people diagnosed with a vitamin D deficiency and the use of supplements in those at risk. We have developed a vitamin D pathway in partnership with GPs, paediatricians, early years staff, dietitians, midwives and the voluntary sector.

We also promote vitamin and sunshine messages via leaflets and DVDs and have developed early years settings training to promote safe and consistent sunshine messages. We have trained more than 40 local 'vitamin D champions' to target hard-to-reach communities. Our clinical commissioning groups support increasing Healthy Start vitamin uptake. All pregnant women, babies aged up to six months and at-risk children aged up to two years are offered free Healthy Start vitamins.

Evidence from August 2011 indicates that 91% of the sample of pregnant women were taking a vitamin D supplement more than once a week and 81% daily. We aim to reduce vitamin D deficiency rates significantly across our population over the next few years.

Shirley Brierley
Consultant in Public Health
Ruksana Sardar-Akram
Senior Public Health Manager
Bradford Metropolitan District Council

How to make herd immunity herd mentality

EVEN the Marmot review noted that childhood immunisations were among the most cost-effective public health interventions. So why are there still significant variations in uptake of vaccines and vulnerability to disease, particularly in areas of socio-economic deprivation? And what can we do about it?

Vaccination demands absolute equality in access for it to be fully effective. Without equity we cannot achieve the holy grail of 'herd immunity' (if a population has vaccination above a certain threshold then non-vaccinated individuals are also protected). This must be the focus of all immunisation efforts. To do this, we need to actively target 'passive defaulters', implement the National Institute for Health and Care Excellence guidance fully and make sure that no-one falls through the net. Simply shrugging when 95% Cover of Vaccination Evaluated Rapidly (COVER) targets remain unmet is unacceptable – not just from a disease-prevention perspective but also from a safeguarding one.

Immunisation is a key plank of the healthy child programme and every healthcare professional who comes into contact with children who consistently miss immunisations should be asking why and whether it should give cause for concern.

In England, commissioning responsibility for immunisation services falls to NHS England with expert advice from Public Health England. But realistically these agencies do not have the local levers to mobilise and reach communities, and need strong leadership support from local authorities and the community and voluntary sectors.

> **Newham's uptake was affected by community concerns about the vaccine containing gelatin**

Professor David Salisbury, who retired in December as Director of the Department of Health's immunisation programme, devoted his career to reducing inequalities in vaccine uptake. He announced the introduction of the largest childhood flu immunisation programme that we have ever seen. The programme aims to offer the highly effective intra-nasal live vaccine to all children aged 2-16 years. According to Dr Mary Ramsay, Head of Immunisation at Public Health England: "Even with relatively modest coverage, this programme has the potential to interrupt transmission of influenza, thus providing protection to all of those at risk. This will include those in communities who are under-served by vaccination service and those who cannot mount an adequate response to the vaccination."

Early indications show that this year alone, almost 40% of two and three year-olds – the first age group to be eligible for vaccination – have received the nasal spray. Seven national early implementation sites offered flu vaccines to primary-school-aged children. Two of the London early implementation sites, Newham and Havering, have achieved very different

uptake. Havering, one of the least deprived boroughs in London achieved high uptake of 65-70%. Newham,one of the most deprived local authority areas in England, achieved close to 40%.

Nearly half of the parents in Newham did not return consent forms, despite repeated chasing. Newham's uptake was affected by community concerns about the vaccine containing gelatin products of porcine origin. Although the gelatin used in vaccines had previously been declared transformed (and therefore not prohibited) by many religious scholars, use of the new vaccine uncovered a wider diversity of opinion within the Muslim community.

Over the next few years we will see the full roll-out of the children's flu programme to all two to 16-year-olds. The programme needs to be underpinned by a clear focus on tackling health inequalities so that the benefits are experienced across all communities.

Thara Raj
Public Health Specialist and Acting Public Health Consultant
NHS England and Public Health England

Can of worms

WELCOME to our live online advisory panel where our three resident experts tackle your real-life public health problems. This week:

'My director of public health reeks of alcohol. At yesterday's Health and Wellbeing Board he giggled, burped in the face of the Borough Commander and told the Council Leader she was his best friend. Can you suggest anything?'

Over to you panel:

Councillor Roberts: What exactly is the problem here?
Helene Healthwatch: He's probably stressed.
Roberts: Sounds like my sort of man
Healthwatch: Absolutely. Do you think he's single?
Dr Chadwick-Snow: Hello? Is this working? Could I direct our conversation to the fact that drinking at work must clearly be tackled as part of a wider strategic approach to alcohol in the workplace?
Roberts: Alcohol in the workplace? Couldn't agree more. Am in the Nag's Head right now, actually.
Healthwatch: 🙂🙂🙂
Roberts: Do all my work from here. There's a 2 for 1 at lunchtime. Can't afford not to!!!!
Chadwick-Snow: Ah, now I do hope you're drinking sensibly.
Roberts: Absolutely. And taking my responsibility to be social very seriously.
Chadwick-Snow: Not more than 21 units a week?
Roberts: A week! My a***! I drink that at lunchtimes. Fancy a quick one Helene?
Healthwatch: 🙂 I'll get my coat
Chadwick-Snow: And that's if you're a man. Less for you Helene... And obviously not more than 3 or 4 units in one sitting... Hello?… Councillor?… Helene?… Anyone there?

Got a problem? Tell cow@fph.org.uk....
…
Column written by Jenny Hacker, Thara Raj and Dawn Reeves

Learning from our friends in HIA places

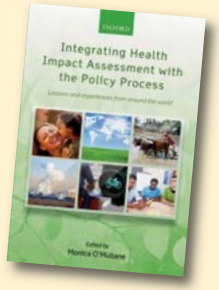
READERS of *Public Health Today* will need no convincing about the impact of public policy on the health of the population. Health impact assessment (HIA) is a key aspect of efforts to pursue healthy public policy, but how well is HIA actually integrated with the policy process, and what lessons can be learned from experiences around the world? In this edited volume, Monica O'Mullane addresses these important questions.

The first three chapters set the scene with a detailed exposition of the HIA literature. This section is very well referenced, so much so that the author's own voice gets a little lost at times, but it is nonetheless a concise and comprehensive account.

The main body of the book comprises 14 country case studies, mainly dealing with national-level policy in developed countries, with a few glances at local policy, and the developing world. All chapters provide specific examples of HIA in use, and some present the results of local research into HIA. Each concludes with a set of learning points for public health practitioners, policymakers and researchers. Notable chapters include: Denmark and Slovakia, Australia, New Zealand, Thailand, and Scotland. Every country has a different story to tell, but there are striking similarities between them, such as the challenges of limited resources and capacity, the jostling for position among the different impact assessments, and the difficulties encountered when it comes to implementing recommendations from HIAs.

In the final chapter, the editor concludes with a recapitulation of the now familiar themes, and a summary of the lessons learned. This chapter feels somewhat brief, given the magnitude of the territory that has just been covered, and it would have benefited from more detailed commentary about the countries visited. The case studies are somewhat left to speak for themselves, and with only around ten pages each, there isn't much room to do that, though the key messages do come through.

Really, it is the breadth of countries included that is this book's most interesting feature. Like a round-the-world tour, there perhaps isn't time to get to know any one country in depth, but we certainly learn a lot from taking the trip. It is



enlightening to take a truly global view of a topic that is of great importance for global health.

Ashley Sharp

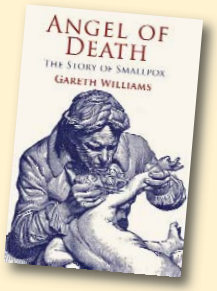
Integrating Health Impact Assessment with the Policy Process: Lessons from around the world
Edited by Monica O'Mullane

Published by Oxford University Press
ISBN 9780199639960
RRP: £29.99

A tale of a big disease with a little name

THIS fascinating book has something for everyone. It is an enjoyable read with clear explanations of the virology and immunology of the disease for the non-expert. There are detailed biographies of the major players in variolation and vaccination. There is a history of smallpox. I was surprised to learn that the severe disease described in textbooks only really became a problem over most the world after AD1000, with curiously little mention in ancient texts before this time. Gareth Williams describes the impact of the disease on whole populations and its use as a biological weapon, particularly during the conquest of the Americas. The book will strike a chord with scientists in its description, not only of the trials and tribulations of recognising a major discovery, but also the importance of publishing findings, gaining support from the rich and powerful and monitoring outcomes. Chapters 11-13 include a thorough examination of the mistakes made by all sides in the vaccination debate. Governments made vaccination compulsory, then realised the futility of this approach. Pro-vaccination campaigners ignored inconvenient truths such as the need for revaccination and side effects such as transmission of syphilis in arm-to-arm procedures. There is a detailed description of the behaviour and motivation of the first anti-vaccine campaigners. The strategies they used can be identified in the campaigns against MMR and other modern vaccines.

The remaining sections of the book are devoted to the response to outbreaks in the last 100 years of smallpox, the political and practical difficulties faced by those running the final WHO eradication campaign and a rather dark chapter on the potential for re-emergence as a biological weapon. Williams points out that we have repeatedly failed to learn lessons on prompt identification, isolation and vaccination of contacts.



I thoroughly recommend this book to anyone interested in outbreak control and immunisation campaigns, as it has many lessons for today's practitioners.

Sally Millership

Angel of Death: The Story of Smallpox
Gareth Williams

Published by Palgrave Macmillan
ISBN 9780230302310
RRP: £10.99

Book brief

STUDENTS and overseas visitors are being offered a free copy of *Disability With Dignity: Experience, potential and aspirations of persons with disabilities in developing countries* by Tom Fryers FFPH. It was published two years ago by the charity Action for Disability in collaboration with a community-based rehabilitation programme in Andhra Pradesh, India. The book contains 48 colour pictures. Qualified doctors pay £5 and all receipts go to Action for Disability. Contact Dr Fryers at yanyak@doctors.org.uk

From the CEO

Dear friends,

It has been a whirlwind first three months in post – perhaps understandably given the steepness of my learning curve! I am grateful to all members, staff and colleagues from partner organisations for their support, encouragement and willingness to share knowledge and experience so freely. It has reinforced the breadth and scale of 'public health' in my mind and helped distill some of the key issues we face as a body and as a community of interest.

Much of my time has been spent meeting agencies and individuals active in the world of public health and thinking about FPH's position and role in this world – as well as getting to understand the organisation itself: membership, employees, finance, history, relationships and pressing issues of the day.

Although it's early, it is already clear to me that some refreshment is required in our thinking and approach to the work of FPH. Clarifying the strategic opportunities and developing ambitious but effective implementation – based on as consensual a strategy as we can muster – will take some time; but we cannot allow it to take too long. There is too much to do, too many wrongs to right, too many threats to the public's health and wellbeing for complacency.

The enthusiasm and capability of our community has become clear – as has the need to harness this to greatest effect in an increasingly noisy environment. Outside our membership – indeed, often as an extension of it – there is broad recognition of the value of a collaborative approach across the wider public health community which could tap vital resources, capacity and funding sources.

Ideas and plans are developing – both for this coming year and for future years. As I write, an outline strategy is under review by the FPH Board, and it is my intention to bring this draft to members and stakeholders for wide consultation in the coming months.

Our 20 staff continue to impress me with their commitment, expertise and enthusiasm - and are keen to work in new ways with our membership. Overriding all and any other insights I may have had in these early days is the realisation that FPH is nothing without active engagement from our members. I look forward to talking with you about how we best achieve our shared ambitions for the future - for it is in our hands.

David Allen
Chief Executive Officer

Public Health Africa

THE public health challenges facing Africa are significantly greater than anywhere else in the world. With just over 10% of the world's population, the continent carries a quarter of the global burden of disease. Overpopulation and infrastructural and financial constraints contribute to the overall problem, as does limited capacity and capability in the public health system including the scarcity of an adequately trained and skilled workforce. The latter is exacerbated by a significant 'brain-drain' from the continent.

Britain has one of the largest concentrations of Africans from various health professional backgrounds, including public health. It also has an historically strong commitment to the improvement of the health status of Africa, largely through its aid and development programmes. These are, however, carried out mainly through bilateral and multi-lateral arrangements with governments and related organisations. Meaningful engagement with those in diaspora who are willing to contribute to the desired outcomes has been almost non-existent.

The availability of these African diaspora groups, coupled with the UK government's current commitment to Africa, offers a unique opportunity for an asset-based approach that will complement and strengthen the implementation of sustaining solutions in the continent.

Assets for a common and collective solution

Public Health Africa (PHA) is a volunteer-driven initiative by public health professionals. Its overall goal is to support the development of adequate capacity and capability of the African public health system to bring about sustainable improvement in the health and wellbeing of Africans.

PHA is a special interest group of the Faculty of Public Health and specifically aims to identify, mobilise and harness all public health professionals with interest in Africa (not restricted to Africans in diaspora) to offer their skills and expertise.

The pan-African and asset-based intentions of PHA represent the desire of the African public health volunteers to contribute to and complement initiatives for providing comprehensive, large-scale and sustainable solutions to the intractable problems of capacity and capability within the African public health system.

PHA priority actions:

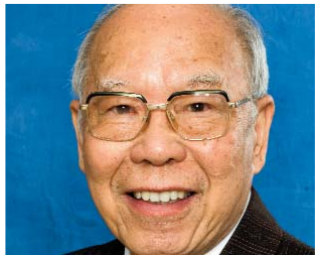
- Advocacy for health-focused public policies across Africa and beyond
- Sharing and exchange programmes, eg. education and training
- Maximising the efficiency and effectiveness of existing resources by offering charitable consultancy services to bilateral and multi-lateral public health programmes in Africa.

PHA and partnerships

The core assets of PHA lie in the dedication and commitment of its volunteer members, and its success depends largely on the strength of its partnerships. PHA strives to build and promote a culture of strong collaborations and coalitions for improving the public's health in Africa. Target partners include African governments, NGOs, donor government and its agencies, such as Public Health England and public health educational institutions.

For more details, contact Aliko Ahmed at aliko.ahmed@staffordshire.gov.uk or Victor Joseph at vuni.joseph@tinyworld.co.uk

In memoriam



Shui Hung 'SH' Lee FFPH
1933 – 2014

PROFESSOR SH Lee was a giant of public health, not just in Hong Kong, but across the global community. He travelled the world in his tireless pursuit of promoting health, energising us with his boundless enthusiasm for the idea that it was possible to achieve Health for All – be it through Healthy Cities, better primary care, community services or student ambassadors.

As Director of Health for Hong Kong he led initiatives to build up community health services across the colony. He would often talk of the times when he visited fishing communities in the New Territories, reached only by boat, and of the challenges of the influx of Vietnamese refugees which threatened to swamp the Hong Kong health services.

SH always emphasised the importance of working with local communities and local government and was active in Healthy Cities as well as in Healthy Schools. Hong Kong's success at reducing tobacco smoking rates to the lowest in the world is in no mean part due to his efforts and unceasing support. He held a deep conviction that better primary care would improve the health of all populations, reflected in his call for a Primary Care Authority in Hong Kong which he championed for more than 20 years.

Not only was SH the founding President of the Hong Kong College of Community Medicine but also the founder of the School of Public Health and Primary Care at the Chinese University of Hong Kong where he remained active to the last. Students at all levels enjoyed his lectures, especially his stories of how Hong Kong had developed over the timespan of his long and illustrious career. He was always there to provide advice, give guidance and support and his smiling presence lit up many ceremonial occasions. At a personal level he was a good friend. One of his last activities was to sign off the proofs for his chapter in the forthcoming book on global health in Asia. We will all miss him, but his spirit will remain with us and future generations.

Sian Griffiths

John Ashton writes:
I arrived in Hong Kong to join the launch of the World Health Organization (WHO) Healthy Cities project a few days after the momentous decision had been taken to slaughter the city's entire poultry flock to contain the spread of SARS. SH was an active advocate for this policy, believing that the root cause of the 1997 epidemic of H5N1 had been the wet markets for live fish and poultry. With H5N1 he had networked across government to make his views clear and to propose establishing more robust systems for environmental health control, just as he did years later at the time of SARS when he joined the inquiry team into the epidemic.

In addition to being a consummate political operator, SH was no less brilliant a teacher and mentor. It is testament to this that his protege, Margaret Chan, current Director General of WHO, recently visited him in Hong Kong. The UK Faculty of Public Health is proud that he was one of its Fellows. I will miss him and so will the world of public health.

Andrew Semple FFPH
1912 – 2013

DR ANDREW Semple was the Medical Officer of Health (MOH) for Liverpool City Council for the two decades leading up to 1974 when 'community physicians' were transferred into the NHS.

Andrew, a Scot, qualified in medicine at Glasgow in 1934 and took up a series of assistant MOH posts in Paisley, Portsmouth and Blackburn. During the war he joined the Royal Navy, achieving the rank of surgeon-commander in the submarine service. Returning to public health he was appointed MOH for Liverpool in 1953 and, enjoying newfound power and influence, immediately set about tackling some of the huge health inequalities across the city.

He had a particular interest in the effects of poor housing and rundown environments on health and was struck by the high levels of TB and emphysema being picked up by the mass X-ray unit in the poorest areas. He was one of the first to introduce smokeless zones following the 1956 Clean Air Act, and he spearheaded efforts to clear the dockside slums and re-house people in new estates on the city outskirts.

Andrew also championed public health approaches to inequalities in child and adolescent health, introducing immunisation for whooping cough and polio and setting up one of the first health education units in the country. He was a shrewd political operator, as demonstrated by his ability to push through a free council-funded family-planning service despite strong opposition at the time from Liverpool's sizeable Catholic minority.

A skilled negotiator with a wicked sense of humour, Andrew rounded off his career as a board member of the Royal College of Physicians' Faculty of Public Health Medicine (now the Faculty of Public Health) and Chairman of the Royal Society of Health (now the Royal Society for Public Health).

Kulsum Winship FFPH
1930 – 2013

BORN in Kenya, Dr Kulsum Winship was educated in Africa, Switzerland, India and the UK. Joining the Department of Health, where she was one of the first Asian women appointed to a senior post, she was part of a team that developed policies for the management of disabled and abused children and intensive care of newborns. She later moved into regulation of medicines and she reviewed the use of drugs containing oestrogens, metals and herbal substances.

As a council member of Breast Cancer Care, Kulsum worked on improving access, especially for women of ethnic minority communities. She was also a patron of Cherry Lodge Cancer Care in Barnet, Hertfordshire, and a published children's author.

Deceased members

The following members have also passed away:

Samuel Noel Donaldson
George Fyfe
Christina Moody

Policy update: smoking

MPs AND health campaigners celebrated a major parliamentary victory in February, after the House of Commons backed new legislation to help prevent children from starting to smoke.

The House of Commons agreed a raft of Lords amendments to the Children and Families Bill, to give the Health Secretary the power to bring in regulations:

- Requiring cigarettes and other tobacco products to be sold in standardised packaging
- Making it an offence to smoke in cars where children under 18 are present
- Age of sale of 18 for e-cigarettes
- The bill also includes an amendment prohibiting proxy purchasing of tobacco.

Smoking in cars

The amendment was passed by 376 votes to 107 in the House of Commons with cross-party support, after the House of Lords had voted in favour at the end of January.

Toxic second-hand smoke is especially dangerous to children's health due to their smaller lungs and faster breathing. The risks are increased in the small confines of the car. Every year, second-hand smoke in children results in around 300,000 GP visits and nearly 10,000 hospital admissions.

With more than 430,000 children being exposed on a weekly basis to second-hand smoke in their family car, this vote is a defining moment in the protection of children's health. There has been incredible support throughout from the public, medical professions and politicians from across parties.

Parliament has spoken in favour of a ban by giving the Government the ability to outlaw smoking in cars carrying children. We now look to the Government to introduce this ban at the earliest opportunity and build on the other welcome tobacco control measures it has backed.

You can find out more at: http://bit.ly/1gkgxrl

Standardised packaging

Standardised packaging of cigarettes and other tobacco products is intended to make starting to smoke less attractive to children and young people.

FPH congratulates parliament for supporting the inclusion of enabling legislation in the Children and Families Bill. In the Lords, this happened without a vote; the vote in the Commons was overwhelmingly in support of standardised packaging as well as proxy purchasing and an age of sale for e-cigarettes of 18, with 453 in favour and only 24 against.

A systematic review of peer reviewed studies carried out for the Department of Health found that plain standardised packaging was less attractive, especially to young people, improves the effectiveness of health warnings, reduces mistaken beliefs that some brands are 'safer' than others and is therefore likely to reduce smoking uptake among children and young people.

Among existing adult smokers, two thirds report that they began to smoke before the age of 18, and almost two fifths before the age of 16. The younger the age at which smokers start, the greater the harm is likely to be, because early uptake is associated with subsequent heavier smoking, higher dependency levels, lower chances of quitting and higher death rates.

You can find out more at http://bit.ly/1fTpObi

Mark Weiss

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between December 2013 and February 2014

Fellows
Craig Blundred
Sophie Coronini-Cronberg
Wendy Hatrick
Sally Hogg
Robert Howard
Sheena Ramsay
Jonathan Roberts
Ian Scale
Martin Smith
Alexandra Stirling
Philip Veal
Michael Wade

Members
Kathryn Blackburn
Carol Chatt
Helen Cruickshank
Claire Currie
Timothy Elwell-Sutton
Amanda Fletcher
Lynn Gibbons Martin
Catherine Johnson
Claire King
Heather Lewis
Catherine Lowndes
Kelly Mackenzie
William Maimaris
David McConalogue
Mark McGivern
Giles Ratcliffe
Donald Read
Caroline Tomes
Emily van de Venter

Specialty Registrars
Timothy Crocker-Buque
Judith Eling
Charlotte Flynn
Holly Jenkins
Orsolina Martino
Elizabeth Parry
Darryl Quantz
Susan Roberts
Ruramayi Rukuni
Anna Schwappach

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Craig Blundred
Sophie Coronini-Cronberg
Anjan Ghosh
Robert Howard
Sheena Ramsay
Martin Smith

Generalist portfolio route
Kate Lees
Anthony McGinty
Jonathan Roberts

Defined specialist portfolio route
Mike Roberts

Correction: In the last edition of *Public Health Today* the following names were placed in the wrong UKPHR route category. We apologise for any inconvenience. Here are the correct categories:

Training and examination route
Rachel Cloke
Lucy Denvir
Christopher Littlejohn
Rebecca Reynolds

Generalist portfolio route
Colin Thompson
Michael Wade

Defined specialist portfolio route
Morag Armer
Terry Blair-Stevens
Sharon Stoltz

GENERAL MEDICAL COUNCIL REGISTER

Rachel Beanland
Marie Casey
Kakoli Choudhury
Ishani Kar-Purkayastha
Samia Latif
Annette Luker
Susanna Roughton
Mohit Sharma
David Taylor-Robinson
Sucharita Yarlagadda

FPH in brief

FPH Annual General Meeting

The 42nd Annual General Meeting of the Faculty of Public Health will be held on 3 July 2014 at 12.40pm at Manchester University. The agenda papers will be available in the FPH online members' area from 6 June 2014. Hard copies will be available on request from Caroline Wren at carolinewren@fph.org.uk, tel. 020 3696 1464.

FPH elections

We are very pleased to advise the results of the following elections:

- Vice President for Standards – Meradin Peachey
- Academic Registrar – Premila Webster (re-elected unopposed)
- Treasurer – David Williams (re-elected unopposed)
- Local Board Member, North East – Toks Sangowawa (elected unopposed)
- Local Board Member, South West – Sally Pearson (elected unopposed)
- Local Board Member, East of England – Alistair Lipp (re-elected unopposed)
- Local Board Member, Wales – Hugo van Woerden (elected unopposed).

All those elected will take up office immediately after the close of the AGM on 3 July 2014. Full details can be found in the FPH online members' area or are available on request from Caroline Wren at carolinewren@fph.org.uk, tel. 020 3696 1464

Appointment of new *JPH* editors

We are delighted to announce the appointment of Ted Schrecker and Eugene Milne as the new editors of the *Journal of Public Health*. Ted is Professor of Global Health Policy at the School of Medicine, Pharmacy and Health at Durham University. He moved to the UK from Canada in 2013 and has extensive editorial and manuscript-review experience. Eugene was formerly Deputy Regional Director of Public Health for the North East Strategic Health Authority and is now Director of Public Health in Newcastle. He is also an honorary professor at Durham University.

Ted and Eugene will be working alongside Gabriel Leung until June, when Gabriel will formally step down as editor. We would like to record our sincere thanks to both Gabriel and Selena Gray, who stood down as editor in 2013, for all the time, energy and commitment they gave to this role. The journal enjoyed considerable success under the leadership and we very much look forward to working with Ted and Eugene on its future development.