Recipes for disaster
Coping with emergencies
Cuts will cost £1bn extra in the long-term

The Faculty of Public Health (FPH) has made unequivocal responses to both the Department of Health’s (DH’s) proposal, as part of wider government action on the deficit, to reduce by £200m the ring-fenced public health grant in the financial year 2015-16 (http://bit.ly/1U6BEC7O) and the Treasury’s Spending Review 2015 (http://bit.ly/1JaW6UQ).

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

FPH did not address the questions outlined within the consultation on how to mitigate the proposed cuts, on the grounds that they will:
• worsen significantly the health and wellbeing of local populations
• increase inequalities across the life course, including within hard-to-reach groups
• make harder the provision of population healthcare advice
• compromise the delegated health protection and health improvement functions.

And will consequently:

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

Read FPH’s response to the DH’s consultation at http://bit.ly/1U9J0hD and Spending Review Representation at http://bit.ly/1KcZlbU. FPH is working closely with its partners in calling on the DH and Treasury to reverse the proposed £200m cuts. If you are aware of any likely impacts from the cuts, please tell us in confidence, by emailing fph@fph.org.uk

Mark Weisz
Senior Policy Officer
Faculty of Public Health

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

Nigeria reaches polio milestone

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

Children’s health postcode lottery

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

‘Tax sugary drinks by 20%’

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

MMR vaccination rates falter

The proportion of two-year-olds in England having the MMR vaccine has fallen. In 2014-15, 92.3% of children had the vaccine, compared with 92.7% in the previous year. Some parts of the country had less than 80% of children immunised.

Hand-washing lessons to cut drug resistance

Schoolchildren should be taught how to wash their hands to tackle the threat of drug-resistant bacteria, according to a report written by the National Institute for Health and Care Excellence (NICE) guidelines for England. Teachers should also provide lessons on when antibiotic drugs are unnecessary, said NICE.

‘Paid-to-poo’ fights open defecation

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

Up Front

Welcome

From the President

Interview with Brian McCloskey

Special feature: Disasters and emergencies

Get our act together

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

The three pillars of public health are health protection, health improvement and population wellbeing of local populations.

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

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

John Ashton

News in brief

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Books and publications

Endnotes

Noticeboard

The Final Word

Cover image: Flooding in Toll Bar near Doncaster, June 2007
Preparation and communication are crucial

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

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

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

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

If you had a magic wand, what would you do to make it easier for public health specialists to improve health?
Get rid of tobacco companies. Not just because of the health impact of tobacco, but also because the way in which the tobacco industry works has gradually influenced other companies who might be doing things that are not particularly good for health. Secondly, give public health more money. Given the current climate, we understand that’s difficult. At a time when we are seriously looking to reduce health inequalities, there are plenty of opportunities to do that, but you can’t do it without funding.

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

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

I have a photograph of one of the rowing races in London 2012, when the British crew were expecting to win. They came second and they were so completely worn out that when the BBC ... that much to prepare for the Games, then the rest of the people involved need a similar commitment to make sure it works.

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

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

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

Is there anything that keeps you awake at night?
We need to learn to do things differently to manage the risk of the next emerging diseases, perhaps something like MERS. ... next infectious disease will be on top of us before we’ve learnt those lessons does keep me a little bit awake at night.

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

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

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

Few health impacts result directly from heatstroke, but rather it contributes to increasing mortality and morbidity due to other causes such as cardiovascular and respiratory disease. The elderly, the very young, and the already compromised. During the 2015 heatwave, three million chickens perished in one Indian state within a fortnight, causing the price of eggs and chicken to soar.

Perhaps the most ominous impact on public health is related to the increasing risks of water scarcity, crop failure and drought, food insecurity, and the reduction of agricultural productivity by 20% in at least 30 countries by 2050. By 2020, 60% of the world’s population could live in countries prone to drought. Moreover, climate change has already increased the frequency of extreme weather events, such as heatwaves, which are expected to increase in frequency and severity as global temperatures rise. The effects of climate change on public health are not just immediate, but also long-term, with impacts on agricultural productivity, food security, and human health.

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

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

LESSON: The fire at Buncefield of Depot, Hertfordshire, December 2005

PUBLIC HEALTH TODAY
SEPTEMBER 2015

SPECIAL FEATURE: DISASTERS & EMERGENCIES

Get our act together

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

A LITTLE boy lies face-down on a Turkish beach, washed up, drowned. The unforgettable image of three-year-old Syrian Aylan Kurdi shone the global spotlight on the desperate plight of hundreds of thousands of children fleeing war, famine or dying in an attempt to escape from mayhem. But his image helped to sting reluctant governments into action.

Flashback 15 months, and it was pictures of corpses lying shunned in the streets and villages of Sierra Leone that seized the world’s attention. The Ebola epidemic was out of control. The public health role in emergency preparedness, resilience and response is crucial. But we may not be able to stop wars or prevent earthquakes, but our skills can certainly help reduce the toll of many another drowned boy on the beach.

Alan Maryon-Davis
Editor-in-Chief

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

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

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Perhaps the most ominous impact on public health is related to the increasing risks of water scarcity, crop failure and reduced food security, not only in countries heavily reliant on rain-fed agriculture but worldwide. Furthermore, heat stress has already reduced global labour capacity to 90 per cent and, in the worst-case climate scenario, may drop to as low as 40 per cent.

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

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Professor & Senior Clinical Fellow
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More disasters will mean more mental trauma

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

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

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

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

Anne Eyre
Director
Trauma Training
A crisis of humanitarian governance

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

Following institutional tensions among UN agencies, the Coordination Cluster System usually put in place during relief operations. Crises and disasters clearly have an impact on psychosocial wellbeing and mental health of the exposed... problems, alcohol abuse, relationship breakdown and years of hidden suffering within the humanitarian workforce.

THERE is a hidden cost of humanitarian work – the human cost. Research by the Antennae Foundation and the United Nations’ Office for the Coordination of Humanitarian Affairs (OCHA) has found alarming levels of anxiety, depression and burnout among humanitarian workers. Behind the statistics, we find stories of chronic health problems, alcohol abuse, relationship breakdown and years of hidden suffering within the humanitarian workforce.

Organisations and employees tend to view stressors, such as insecure employment status, security risks and variable funding, as an inevitable aspect of the work. However, the impact of this stress is often underestimated. Persistent and inevitable stress can lead to a high turnover of staff, health problems, loss of productivity and a lack of empathy towards affected populations, family and co-workers. However, research has also shown that organisational support, delivered by positive supervisory relationships and team cohesion, can help to diffuse the long-term negative outcomes of stress. Within the OCHA report, there was a clear correlation between organisational support and staff wellbeing. Many respondents specifically identified organisational support as a factor which could mitigate their stress levels. Factors such as psychological support, positive organisational culture, clear leadership, recognition and reward of effort, workload management, physical safety and work-life balance all help to promote long-term staff wellbeing.

There is a need for programmes and a culture that supports humanitarian staff. This means ensuring that policies are implemented through comprehensive and holistic actions that include the often neglected ‘heroes’ – locally recruited staff. Such investment in staff welfare can improve productivity and reduce burnout, making organisations far more effective. Within humanitarian organisations, there is a widespread macho culture that prevents those who are most in need of help from seeking support. Humanitarian organisations have a responsibility to promote a positive work environment and staff wellbeing. However, this can only be achieved with long-term investment in preventive practices and a cultural shift at all levels of an organisation. The stigma against seeking support must be addressed, organisational development management and leadership placing health and wellbeing as a priority on their agenda.

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

MOST people do not consider the fire service to be a health provider, yet we are contributing to a healthier community and working with the same cohort of people as public health specialists. West Midlands Fire Service (WMFS) incorporates into its wide-ranging work the so-called Marmot Principles – the six key policies for reducing health inequalities recommended by Michael Marmot in his 2008 report Fair Society Health Lives. We believe this has made the West Midlands a safer place, particularly for vulnerable residents and communities. At a conference hosted by WMFS at its headquarters in Birmingham, Sir Michael praised the brigade for “clearly recognising” the links between people’s risk from fire and the conditions in which they lived, and endorsed the work of WMFS in tackling health inequalities.

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

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

We realised that the best way to prevent people dying in fires was to look for the causes of health inequality and tackle them. For example, if you are male, aged 25 to 45, living alone in certain areas and unemployed for more than a year, you are more likely to have a fire in your home. As a prevention service, we have to understand the cross-overs and become an extension of the wider workforce that supports public health. We have worked with Coventry University to map out these links. The next step will be to work with a big enough cohort of people to produce the scientific proof that backs up our experience.

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

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

Steve Vincent
Area Commander
West Midlands Fire Service
After the earthquake, prepare for epidemics

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

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

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

A large trial reported in the Lancet in July 2015 about the effectiveness of cholera vaccine in Bangladesh found that behavioural interventions to improve hygiene and sanitation are clearly key in preventing this debilitating and potentially fatal disease. The Nepali Ministry of Health and Population, in collaboration with many non-governmental organisations, is trying to provide proper sanitation and clean water in the temporary shelters and camps, but prevention of these illnesses is a daunting task during the monsoon rains of the summer months. "A case could be made for stockpiling vaccines effective against typhoid, hepatitis E and cholera."

There is insufficient evidence on successful integration of past waves of migration and through our membership reaching out to tell the stories of migrants that we become effective advocates for addressing and responding to the tragedy unfolding in the Mediterranean.

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

We must guard against prejudice undermining our sense of common humanity and eroding the solidarity at the heart of community is a threat to public health. So what is it that the membership of FPH can offer? The FPH Global Health Strategy, launched in June at the FPH annual conference in Gateshead, identified four key functions of our international work:

- Global Health Strategy,
- Advocacy
- Standards
- Workforce

The strategy is a call to action for all those interested in international health work.

It is these resources we need to draw upon Knowledge, evidence and research.

Our workforce

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The strategy is a call to action for all those interested in international health work.

It is these resources we need to draw upon Knowledge, evidence and research.

Our workforce

Standards

Advocacy

Global Health Strategy,

Advocacy

Standards

Workforce

launched in June at the FPH annual conference in Gateshead, identified four key functions of our international work:

- Global Health Strategy,
- Advocacy
- Standards
- Workforce

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Advocacy

Global Health Strategy,
Public health community in the UK have played a greater role in ensuring a timely and effective response? Certainly, they should be in a better position than most to identify and communicate the threat posed by situations such as the Ebola outbreak and to make the case for early intervention on humanitarian, health protection and economic grounds.

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

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

Aliko Ahmed, Victor Joseph, Matthew Neilson
Public Health Africa

MERS: a reminder that we need to be vigilant

ONE AGAIN the world has had a wake-up call about the risks of emerging infections and the need for a transparent global response. On 26 July 2015 the Prime Minister of South Korea declared the end of the outbreak of Middle Eastern Respiratory Syndrome (MERS). The preceding months had been an anxious time.

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

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

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

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

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

Siân Griffiths
Emeritus Professor
Chinese University of Hong Kong

Combating war with primary prevention

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

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

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

Bayad Abdalrahman and Daniel Flecknoe
Specialty Registrars in Public Health
Derby Hospitals NHS Foundation Trust
When opium was the opium of the people

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

Berridge is also keen to debunk some of the prejudice against drugs, offering an intellectually rigorous and dispassionate insight into the internal machinations of the government as it confronted the emergent epidemic – and of some of the most important issues facing nations today.

Ten areas requiring focus are identified:
- Investment in prevention
- Public education to increase testing
- Sex and relationship education
- Offering ART to all people with HIV
- Development of a vaccine
- Confronting the corruption
- Encouraging the expansion of sex work
- Global drug harm-reduction policies
- A new dialogue with faith leaders

Berridge also argues that the strongest argument for policy change is compassionate and urgent call to fight the biggest threat to HIV/AIDS prevention.

Dispassionate figures reveal the scale of the epidemic:
- In 1981, the United States had 2,920 cases
- In 1990, the United States had 130,000 cases
- In 2000, the United States had 1.1 million cases
- In 2009, the United States had 1.1 million cases

And few other numbers are so stark:
- The epidemic now claims 1.2 million lives each year
- 95 per cent of all new HIV infections occur in sub-Saharan Africa
- Women in sub-Saharan Africa are three times more likely to be infected with HIV than men

Solutions are complex, but so much simpler for every battle:
- The solution is evident for anyone who has seen what simple clean water and sanitation can achieve in a refugee camp or a small village.
- The solution is also evident for anyone who has seen what a knowledge and skills base can achieve in a classroom, village meeting or community health event.
- The solution is also evident for anyone who has seen simple clean water and sanitation work in the field in any situation where they are needed.

Supply, demand and distribution:
- Supply: The problem is that there is a lot of supply and demand, but little distribution.
- Demand: The problem is that there is a lot of demand, but little supply.
- Distribution: The problem is that there is a lot of supply and demand, but little distribution.

The big threat to HIV/AIDS prevention

Almost 30 years have passed since a leaflet dropped onto the doorsteps of every household in the country. It relates the facts about a new virus – how it was spread, how serious a threat it was and how it could be prevented. With neither a vaccine nor a cure on the horizon, its bleak message – “Don’t die of ignorance” – offered the public protection in modern language and prevented its spreading: information.

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

Norman Fowler was Secretary of State for Health and Social Security in the Thatcher government and architect of that first national HIV/AIDS public awareness campaign. He offers a unique and

Everyone gets to benefit from global response

Framework for Disaster Risk Reduction 2015-2030, to help countries prepare for disasters. On their return from assisting the public health response to international disasters, the overwhelming majority of PHE staff describe their experience as positive. And foremost is the opportunity to help reduce avoidable mortality, morbidity and disability. But many find they also gain professionally and personally.

And it’s not just individuals who benefit from a response. Public health organisations are becoming increasingly aware of the value that international assistance can bring. New networks often lead to ongoing partnerships and successful international collaborations. Individuals return with transferable skills having been first-hand how organisations such as WHO operate during an emergency. They also benefit from exposure to infectious-disease threats no longer common in the UK, building their capacity to respond to risks emerging from an increasingly interconnected world.

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

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

Katie Carmichael
International Emergency Preparedness Coordinator
Public Health England

Bring water to people, not water to people

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

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

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

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

Sophie Mack Smith
Knowledge Management Advisor in Emergencies
Oxfam

Water point, South Sudan ©Kieran Doherty/Oxfam

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- A new dialogue with faith leaders

But how is it, during Fowler’s travels across four continents, that an 11th factor is identified? Experience and the changing environment within which HIV can thrive and through which efforts to address the critical areas identified are failing: prejudice.

The rights of minority groups, in particular Lesbian, Gay, Bisexual and Transgender (LGBT) people, are, in many countries, equivalent to the position of ‘being black under apartheid in South Africa, or being a low income urban dweller in Germany’. The solutions are complex, but, as a starting point, Fowler calls for an international mechanism to protect the rights of those most at risk: not only LGBT people, but also drug users, sex workers and, more generally, women. We know what works. We understand the evidence-based. AIDS: Don’t Die of Prejudice offers a compassionate and urgent call to fight the biggest threat to HIV/AIDS prevention.

Mark Weiss

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

Given the scale of the disaster, the team remained in-country with WHO to continue supporting recovery. They focused on logistical support, team leadership, training and public health priorities leading to a phased recovery plan. They worked closely with the health cluster, the co-ordinating mechanism for disaster response, led the WHO response team, developed infectious disease outbreak control plans, identified rehabilitation priorities for health facilities and developed a wide range of public health development and movement strategies. These also had skills in environmental health and dead-body management which were required during the recovery.

Key to the success of this work, as in any response, was the strong working relationships built-up between the team and the Philippine Department of Health, existing

New networks often lead to ongoing partnerships and international collaborations

PHOTOGRAPHS

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

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

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In memoriam

Shakeel Bhatti 1973 – 2014

SHAKEEL qualified from University College London in 2003 and began training in Southwark public health department in 2006, initially as senior house officer and then on the specialty public health training programme. He contributed significantly to the department over the ensuing years in various positions in and out of CDC including as a spell as Associate Director for Global Health in the National Center for HIV, STD, and TB prevention and treatment programmes. For further information and past trainee reports visit: http://www.bradfordresearch.nhs.uk/our-research/international-public-health

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

Dick’s career in epidemiology began in 1976, initially as an officer in the Epidemic Intelligence Service carrying out research on a variety of infectious and non-infectious diseases. He was very much involved in the chronic disease research studies that formed the basis of the renowned SECUmac Community Health Project and the Seven Sisters Project.

In 1978 Victor took up the chair in Epidemiology at the University of Michigan. He was very much involved in the chronic disease research studies that formed the basis of the renowned SECUmac Community Health Project and the Seven Sisters Project.

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

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

Dick was widely regarded as a charming, witty and endearing person who made countless friends across the world.

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News in brief

FPH governance review
We are very pleased to announce that the Faculty of Public Health (FPH) membership approved the proposed changes to the FPH governance structures in the recent membership ballot, and we will therefore be proceeding to incorporation as a company limited by guarantee. The Memorandum and Articles of Association and Regulations for the new company were approved by 96.2%. The preferred choice of name was ‘Faculty of Public Health’ (53.4%). Applications are being prepared for submission to Companies House and the Charity Commission to register FPH as a company limited by guarantee by 31 December 2015 if possible. The full results of the ballot are available in the FPH online members’ area or from carolinewren@fph.org.uk

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

FPH courses in 2015
Getting the Most Out of Your Professional Appraisal – London, 9 October
How the appraisal system works, and how to enhance the process so that it can maintain your practice. More information from garethcooke@fph.org.uk

Mental Wellbeing in Population Health: An Introduction – London, 16-17 November
Provides an understanding of the principles of mental wellbeing, the effect on the individual and community and how to address these issues. More information from garethcooke@fph.org.uk

Develops skills in appraising research on different study types and refreshes understanding of research methodologies. Reviews a randomised controlled trial, a systematic review and a case-control study. Further information at http://tinyurl.com/ofg98r6

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

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

HONOURARY FELLOWS
Amanda Amos
Michael Bannon
Ibora Finlay of Llandaff
Trevor Hancock
Janet Hemmingsway
David Heymann
Ronald Laborite

FELLOWS THROUGH DISTINCTION
Robin Ireland
Christopher Lewis
Tom Loney
Che Chung Luk
Helen McAvoy
Anna Pronyszyn-Hughes
Colin Sibbald
Mary Tooley

MEMBERS
Amina Aitsi-Selmi
Dominique Allwood
Behrooz Behbod
Jane Bray
Kathryn Cobain
Anna Donaldson
Doruka Dourgali
Gemma Dunn
Ashley Goodfellow
Katy Harker
Metala Kakad
Stuart Keeble
Abigail Knight
Fatimah Lakha
Catherine Mibenna
Gerardo Javier Melendez-Torres
Matthew Pearce
Sarah Rayfield
Colin Sibbald
Angeline Walker

DIPLOMATE MEMBERS
Balsam Ahmad
Shaiza Ahmed
Suzanne Barton
David Dickinson
Sheila Duffy
Simon Ellis
Anders Freiberg
Philipp Insall
Sally James
Alhussein Khaled
Monika Kosinska
Bennett Lee
John Masham
Daniel Pope
Bayard Roberts
Edmond Rooney
Cathy Roth
Anthony Rudd
Catherine Swann
Timothy Crocker-Busque
Andrew Dalton
Daniel Recknagel
Rebecca Ramsay
Ruth Mallory
Emily-Rose Phipps
Robin Poole
Darryl Quantz
Zainab Shather
Paul Southworth
Matthew Tyer
Emmeline Watkins
Stuart Keeble
Abigail Knight
Fatimah Lakha
Catherine Mibenna
Gerardo Javier Melendez-Torres
Matthew Pearce
Sarah Rayfield
Colin Sibbald
Angeline Walker

NEW PUBLIC HEALTH SPECIALISTS
Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER
Duncan Cooper
Helene Denness
Louise Gulliford
Victoria Spencer-Huges
Kirsten Watters
Glen Wilson

DEFINED SPECIALIST PORTFOLIO ROUTE
Lyddie Lawrence

NEW PUBLIC HEALTH SPECIALISTS
Amina Aitsi-Selmi
Elspeth Anvar
Catherine Coyle
Jane Fowles
Srinivasa Katikireddi
Fatimah Lakha
Bruce McKenzie
Richard Forder
Charlotte Simpson
Charlotte Stevenson
 Rhinoar Stiff
Jamine Thompson
Nicholas Young

PUBLIC HEALTH TODAY
SEPTEMBER 2015
HAVING had mental health issues from a very young age, it was part of my life. I was resigned to the fact that I would be on medication and have this illness forever. Even the ‘experts’ told me I would, so it must be true, right? Wrong.

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

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

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

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

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

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