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

September 2014

In this issue

Public Health Today

Loud and clear

The advocacy edition

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Welcome

'HE WAS responsible for the traditional environmental services of water supply, sewage disposal, food control and hygiene; for the public health aspects of housing; for the control and prevention of infectious disease; for the maternity and child welfare clinics and their attendant health visitors and midwives; he was responsible for the TB dispensary and the VD clinic; then... he was in charge of school health. Now to all this was added responsibility for the management of the local hospital. The Medical Officer of Health [MOH} was at the height of his power; this was the peak of his career." I quote here from Sidney Chave's seminal essay on *The Rise and Fall of the Medical Officer of Health*. I quoted it previously in a paper for the AGM of the Faculty of Community Medicine in 1988 entitled *Where have all the troublemakers gone?*. I lamented, with one of the fathers of the Faculty of Public Health, Huw Francis, the passing of the robust tradition of "the breadth and richness of classical public health" as articulated by Sir John Simon and quoted by Huw. The latter went on to eavesdrop on Sir John Simon reflecting in 1890 on his annual reports as MOH of the City of London from 1849 onwards: "After a lapse of so many years... I rejoice to remember that, even in those early days, I did my best to make clear to the commission, what sufferings and degradation were incurred by the masses of the labouring population through the conditions under which they were so generally housed in courts and alleys they inhabited: not only how unwholesome were those conditions, but how shamefully inconsistent with reasonable standards of civilisation; and how vain it must be to expect good social fruit from human life running its course under such conditions." Neither Sir John Simon, who became the country's first Chief Medical Officer, nor Edwin Chadwick, president of the Board of Health, were shrinking violets. They stood up for the poor, the dispossessed and those whose health was threatened. *The Times* famously stated that it would rather "take its chance with the cholera than be bullied into health by Mr Chadwick". Truly we stand on the shoulders of giants.

We have a choice of role models for the practice of public health, most notably Edwin Chadwick and John Snow at the national level and William Henry Duncan and his equivalents around the UK at the local. During my career, I have been privileged to sit at the feet of a succession of colleagues, friends and citizens who have made major contributions to public health and the human condition. Very few have made that contribution by remaining seated behind their desks. Perhaps most vivid has been the example of my friend Slobodan Lang, City Medical Officer for Zagreb, whose practice of public health extended to him standing between Serbian tanks and striking miners in Kryena and mediating. Slobodan is certainly out of the mould of 'classical public health'; there are many more from a wide range of backgrounds and not necessarily with public health in their job title. Somebody who had a profound effect on my personal approach to public health was the Governor of Visagapatnam in India. Every night at the end of the working day, he would go with his driver to the main station and scoop up all the newly arrived children and deposit them at the municipal orphanage. Clearly he was acting on an understanding of proactive public health.

So we must ask "will we prove worthy successors or are we to be reduced to petty clerks and bureaucratic commissioners? The wheel turns and we are once more having to define what we stand for and whether in future years our efforts will attract the approval or the approbation of our great grandchildren. Let us rise to the task!

John Ashton

'Health in every policy' dropped from Welsh white paper

THE Welsh Government's public health white paper, *Listening to you – your health matters*, sets out wide-ranging proposals, including action to reduce the harms caused by smoking, alcohol misuse and obesity, and strong practical actions that will have a positive impact on health and wellbeing.

The Faculty of Public Health's (FPH) key concern, responding to the plans, is to highlight part of the preceding green paper that didn't reach the white paper: proposals to ensure that health was built into all Welsh Government policies. FPH said that a framework for health in all policies should form a central pillar of an eventual Welsh public health bill, ensuring strong collaborative links across different sectors, and a strategic national approach supported by local initiatives.
Read FPH's response: http://bit.ly/1nQwVAX

Food poverty on the increase
There is known to be a gap in health circumstances and outcomes between rich and poor people in the UK. The reasons for inequalities are complex, but many working families are now living in poverty – and do not have enough income for a decent diet. That was the FPH's message to the All Party Parliamentary Inquiry into Hunger and Food Poverty, led by Frank Field MP. The submission focused on three problems:

- Increasing food poverty and increasing use of food banks – a marker of pressure for emergency food aid
- Volatile food prices which are proving increasingly hard for lower-income households to manage
- Stagnant incomes among the low paid – actually a fall in real terms, the first substantial decrease since the 1960s.

Read FPH's response :http://bit.ly/1pcVJT4

EU-US Trade agreement
Most FPH members believe that overwhelming international evidence points to a universal health service available to all, free at the point of need and funded through general taxation, as being the cheapest and most effective way to deliver healthcare. Most of us in public health believe in integrating health and social care; and in setting the best possible legal, regulatory and fiscal conditions to promote and protect the public's health.

That is why FPH sees the Transatlantic Trade and Investment Partnership (TTIP), a free-trade agreement under negotiation between the EU and USA, as a threat to the health and livelihoods of all the populations involved. FPH predicts several threats to public health from TTIP:

- It will reduce the sovereign ability of governments to legislate to protect health, safety and the working conditions of their people
- It will hinder the ability of governments to protect the environment and to prevent global warming, by limiting regulation of industry and commerce
- It will interfere with national policies on provision of health and social care.

Read FPH's response to the recent European Commission consultation on TTIP: http://bit.ly/1pWQMxG

Mark Weiss
Policy Officer
Faculty of Public Health

FOOD FOR THOUGHT: Many working families do not have enough income for a decent diet

News in brief

Double vaccines 'hasten the end of polio'
Using both types of polio vaccine could speed up efforts to free the world of the disease, research suggests. The oral vaccine is leading the fight to eradicate polio, but trials in India show an additional injection of inactivated virus boosts immunity, according to the journal *Science*.

'Sugar intake must be slashed further'
The target to reduce sugar consumption should be much more ambitious, health experts say. The latest official advice is that sugar should account for 5% of energy intake – down from 10%. But a study published in the *BMC Public Health* journal said the target should be no more than 3%.

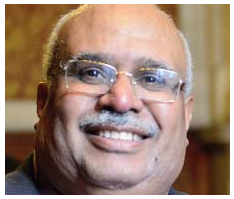
Guide dog owners 'fearful' of cyclists
A charity for blind people has said guide dog owners are scared of going out in London because of cyclists. The Guide Dogs for the Blind Association said it had seen more reports from guide dog owners who had been hit by a cyclist or come close to a collision. Rob Harris from the group said some visually impaired people were "fearful" about going out.

Children flock to hospital to have teeth out
The number one reason for children of primary school age being admitted to hospital is to have multiple teeth taken out. The number of children aged five to nine needing hospital treatment for dental problems has risen by more than 3,000 in the past three years, according to figures analysed by the Health and Social Care Information Centre.

Kerala plans to ban alcohol
Authorities in the southern Indian state of Kerala have outlined plans to ban the sale and consumption of alcohol to tackle the state's drink problem. The first phase of the ban would see more than 700 bars and some shops selling alcohol shut down, with more alcohol-free days introduced. The government aims to enforce total prohibition in 10 years.

Breast cancer test 'Angelina effect' found
Referrals to breast cancer clinics more than doubled in the UK after Angelina Jolie announced she had had a double mastectomy. The actress revealed in May last year she had had the surgery, after being told she had an 87% chance of the disease. The news encouraged women with concerns about their family history to get advice, a study by Manchester University found.

INTERVIEW



Georges Benjamin has been executive director of the American Public Health Association since 2002. He was secretary of the Maryland Department of Health and Mental Hygiene and earlier served in Washington DC in various roles including director of the ambulance service. Here he talks about the differences between US and UK public health

BE PREPARED: By 9/11 Georges and his team had already put in place systems to cope with large-scale terrorist attacks

‘I’ve learnt a lot about my span of control’

How HIV and violence shaped Georges’ career

Looking back over your long career in public health, what would you say were your proudest moments so far?
During my time in Washington DC we had two major problems. One was a lot of firearm violence in the city and the second was HIV and AIDS. At that time, AIDS was beginning to actively manifest itself in some of the poorest parts of town, and we were beginning to try to redistribute resources and find innovative ways to get into communities.

We had health workers working with everyone including the sex industry to try and get the message out that everybody was at risk. We made some substantial inroads, working with community outreach workers, beauticians and barbers, all sharing information about safe sex. We actively engaged school-age children and got recognition for our work from the city and community. That was very rewarding.

During my tenure with the state health department in Maryland, our department built the infrastructure to address biological terrorism and weapons of mass destruction. By 9/11 we had already put in place systems to address some of the tragedy that we’re now seeing around the world today.

What kind of scenarios do you plan for when you don’t know what the threat is yet?
There are a lot of simple things such as making sure that people know one another. The worst thing in the world is to be exchanging business cards in the middle of a disaster. We asked ourselves: what would happen if we could not operate out of our major headquarters? We worked on communication so that we could tell people about the level of threat without scaring them. We worked on lab infrastructure and training in a very broad way. At that time, no-one would have thought that airplanes or the mail system would be used as weapons of mass assault. A lot of work was done with our colleagues in the region to build biosurveillance systems. It was good we had built a regional response system because our first case of anthrax was a Maryland resident who was exposed to anthrax in Washington DC and hospitalised in the state of Virginia. This was a regional event that was picked up, not by a fancy surveillance system, but by an astute clinician. Over the years, tragically, we’ve all learnt a lot about terrorism.

Which experience do you think you learned most from?
We all make mistakes, and I’ve made a few. And I’ve learnt from them. They’ve taught me to be better prepared in communications and to be more thoughtful about the ramifications of what I say. I’ve also learnt a lot about my span of control and how to focus on what I can actually do something about. Sometimes that means waiting a few days until you get the facts so you can solve a problem: there are no permanent friends and no permanent enemies. If you do what’s in the best interests of the public’s health, regardless of how difficult it is, you are probably going to do well.

What have you found to be the main hurdles in translating evidence into public health practice in the US?
While we may be comfortable with the evidence we have, others may not be. We have to spend a lot of time convincing others that the evidence is correct. We have to be lot more critical of the evidence. The biggest hurdle is that we often take something that is in line with our own beliefs and run with it, versus questioning it to see if it’s truly correct. I’m not talking about changing our values, but the evidence may mean we have to be open-minded about the solution.

> “The worst thing in the world is to be exchanging business cards in the middle of a disaster”

What do you think ordinary Americans would make of our NHS?
The average American doesn’t have a clue about the accomplishments of your health system. The more we begin to move into a broader system that provides care for all, there will be a greater appreciation of what your universal healthcare system has accomplished.

What are your hopes and fears for ‘Obamacare’ in 10 years’ time?
Hopefully to achieve our goals, which were to improve on the cost-quality equation. We spend twice as much as the other industrialised nations of the world, and we get poorer results overall. We are not as healthy as we could be. It’s a challenge: I’m overweight and struggling with my weight all the time. As a nation we have too much of that, and we also have over 100,000 people who die prematurely because of medical errors. We are also trying to get rid of the variability in quality in our healthcare. My biggest hope is that we move from a system that is designed to fix things when they break, to a system that is predominantly designed to prevent things from happening in the first place. Prevention is a central tenet of our health reform and is persuasive throughout the law. I’m hoping we don’t become complacent to the cost-value equation. Covering people with insurance is the beginning, not the end, of our quest.

What do you regard as the real priorities in tackling health inequalities in the US?
We are beginning to see progress, most recently with infant mortality through insurance coverage, particularly children who are born with congenital malformations. Social determinants of health make an enormous difference, and we hope to address more of those. For example, many of our low-income children are fed foods in nurseries and schools that contribute to obesity. Our task will be getting everybody on board with tackling these issues.

What’s your perspective on how public health issues differ here in the UK?
In the US, we are talking about a very distinct entity from clinical care in most cases. In the UK, you have a much more integrated system. For many people in the United States, public health is only for people on low incomes. Public health is seen as either government related [for people on low incomes], or the clinical preventive services provided by the private sector.

How do you relax and find some work-life balance?
My journey to work is about an hour each way, and I listen to books on tape or the radio. There was a time when my idea of a vacation was going to a medical meeting and dragging my family along with me. I now realise there’s a value in resetting your brain and going on vacation and leaving everything behind. Nobody is indispensable, and I have an amazing staff.

Interview by Liz Skinner

Make yourself clear

Advocacy can be problematic, but it remains one of our key activities and should evolve with the changing landscape, says Alan Maryon-Davis

WHAT a pickle we public health people are in when it comes to advocacy.

On the one hand, we regard it as our lifeblood – fundamental to our role as champions for the people's health. Whether we work in health improvement, health protection or health service development, we see advocacy as core. It's our job to speak out, to put the case for translating evidence into policy and practice. The Faculty of Public Health (FPH) has advocacy up there as one of its three strategic pillars, along with knowledge and professional standards.

But, as participants in the media workshop at this year's FPH annual conference made very clear, many of us work for organisations that restrict our freedom to speak out publicly on matters concerning our populations' health. One of the consequences of moving into local government in England has been that, in many if not most cases, politics trumps public health.

This is most acute with media advocacy – talking to the local press, reacting to a hot news topic, running a campaign. Without strict adherence to the party line, speaking out can all too easily prove to be a career-limiting move.

But advocacy can take many forms. It doesn't have to be by loudhailer. It can be more subtle, behind-the-scenes, influencing and negotiating with partners and stakeholders in an effort to make good things happen. As someone outlined at the media workshop, this is how many of those working in local government, Public Health England or other politically sensitive organisations will have to do advocacy now. It's a different way of being heard, understood and acted upon. It's about relationships, trust and respect. It's also more challenging and certainly requires a different set of skills.

> **Without strict adherence to the party line, speaking out can all too easily prove to be a career-limiting move**

This edition of *Public Health Today* looks at many different facets of advocacy. Peter Rice outlines the bruising battle to get minimum unit pricing for alcohol actually happening in Scotland, and we hear about the British Lung Foundation's work in pushing for implementation of a ban on smoking in cars with a child on board. There's a piece on the plain packs saga in Australia, another on using personal stories to influence policy and a third on gender equality in the world of toys. We also have Roy Head talking about a study to evaluate the effectiveness of health education via community radio in Burkina Faso."

Our Big Debate considers whether advocacy organisations should accept funding from vested interests, such as pharmaceutical companies or the food industry. And we have articles on the Living Wage Campaign and the innovative use of social media and film as advocacy tools.

All in all, a piquant mix – a pickle no less. But in a nice way.

Alan Maryon-Davis
Editor in Chief

Scotland's battle to lead the world in banning cheap alcohol

THE story of minimum unit price (MUP) for alcohol in Scotland has been one of success in highlighting a problem and building professional, political and public support for a health policy. It is also one of frustration at the prolonged process of implementation, due to the opportunities afforded to well-funded litigants to delay legislation through legal action.

Early progress was rapid. Scottish Health Action on Alcohol Problems (SHAAP) was founded in November 2006 and first recommended MUP in a report in September 2007. The Scottish Government supported the policy in a consultation in May 2008. Further discussion built political support, and MUP legislation was passed in May 2012 without opposition.

The measure, with MUP set at 50p per unit with a commitment to evaluate rigorously, would have come into force in May 2013 but for legal action by the Scotch Whisky Association, and some European trade bodies. The legal findings have favoured the health and government case so far. The options for appeal and pace of the legal process is such that the introduction of the measure is unlikely to be before the end of 2015.

Aside from the need to be patient, what are the other lessons from the Scottish experience of minimum unit price? A case built on sound data is essential. An otherwise disappointing national alcohol strategy in 2002 established a group of epidemiologists then known as the National Alcohol Information Resource (NAIR). NAIR undertook the 'old school' public health role of data analysis, and this provided the basis for campaigners such as SHAAP to make the case that rates of alcohol harm were rapidly rising and action was needed. Information on mortality rates, hospital admission rates, consumption and inequalities provided regular press stories. The media likes alcohol stories and a steady momentum was built.

The role of the medical profession is important. Doctors are well placed to deliver messages that are initially unpalatable and present solutions that are beneficial in the long run. Doctors are also popular with the public, trusted by the media and politicians and hard for opponents to attack. There was a deliberate approach of using frontline staff to highlight the range and extent of alcohol problems, and SHAAP worked closely with national and local alcohol charities to coordinate our messages.

There are also parts of the alcohol industry which support price regulation. These tend to be independent publicans who see that the sustainable future for their business is one which limits harm, and small brewers who struggle in a supermarket-dominated market. Health advocates need to find ways to work with these supporters.

Outside support was important. While the key role of price and availability has been well recognised among public health specialists for decades, there are few international examples of this approach being systematically implemented. Recognition that MUP was a logical approach and that Scotland was being innovative were strong reinforcers for the Government. MUP was part of a number of evidence-based measures, in line with World Health Organization 'best buy' recommendations including a national screening and brief intervention programme, marketing and display restrictions, and server training.

While we are not yet at our destination, the journey has been an interesting and fruitful one.

Peter Rice
Chair
Scottish Health Action on Alcohol Problems

Online network fighting gender stereotyping

IT IS well acknowledged that play is a crucial part of children's social and educational development. Games and toys offer the chance to practise skills they will need for the rest of their lives, from turn-taking to spatial awareness.

Yet toys remain an area rife with gender stereotyping. Walk into a toy shop and you will likely find toys split down the middle, with one side for boys and the other for girls. Sometimes this split is explicit, with huge signs declaring who should play with what; sometimes it is much more subtle, using pink/blue colour coding or with themes such as Pirates and Princesses.

This less explicit division is particularly difficult to counter. When raising these issues, we are often told: "But there's nothing to stop a girl buying the boys' version." This is of course true, but children are well versed in the gendered messages they receive from marketing and peers. We regularly hear of girls being told by other children that their favourite space toys are for boys, or of little boys told that their beloved dolls are for girls.

These messages limit children, turning them away from toys and games that they once loved through a desire to fit in and 'stick to the rules'. Let Toys Be Toys is trying to change this. We want retailers and manufacturers to make packaging and marketing inclusive to boys and girls.

Ours is part of a new breed of campaign based almost entirely on social media. Our volunteer campaign team are spread across the country, and not all of us have met in person. Being online allows us to fit campaigning around work and family lives. We've checked in everywhere from the daily commute and school run to the gym and the supermarket.

Using social media does bring challenges. Whilst Twitter and Facebook are hugely popular, we struggle to reach offline audiences or those less confident with social media. Despite this, social media has provided a platform for campaigns such as ours, allowing us to campaign together and reach hugely diverse audiences, all from the comfort of our own homes.

Sally-Anne Betteridge
Campaigner
Let Toys Be Toys

DEBATE: Should your advocacy organisation accept industry funding? Liz Carroll says she just needs to keep full control, while Katherine Brown says it could distort her goals

Money from pharma is our lifeblood

YES

YES, advocacy organisations can accept industry funding without compromising their values.

We are the only UK-wide charity that supports people with bleeding disorders. The NHS provides fantastic clinical support, but many families affected by bleeding disorders feel very isolated. Bleeding disorders are genetic, but we believe that around a third of cases are spontaneous. Some parents are falsely accused of child abuse at the time bleeding first occurs, before finding out their child has a bleeding disorder.

People with a bleeding disorder often have home treatment for a lifelong condition that has a massive impact on their daily lives. We enable people to feel less isolated by providing services that allow them to meet up and get peer support. We help people understand their rights and make sense of what is happening to them.

We campaign for better information and support, particularly compensation for people who received contaminated blood products in the 1970s and 80s. Unlike with other charities, a whole generation of our community was lost due to contaminated blood.

We would not be able to provide services that benefit patients and families without funding from pharmaceutical companies. As an organisation, we find many of the more traditional methods of fundraising are more difficult. Most people in the general population will not know someone who has a bleeding disorder or the impact they can have on people's lives. We don't have the benefit of being in the public's mind. We need to make sure we are sustainable and funded for the long-term.

Our income is about £650,000 a year, roughly £90,000 of which is from pharmaceutical companies. We have sponsorship through almost every pharmaceutical company that treats bleeding disorders. We are very careful that we don't favour one company over another and ensure we have total decision-making control over any work that is funded by a pharmaceutical company.

We work with our members and clinical advisers to set our objectives and plans for the year; these could include renewing our patient information, creating a new website or developing new services for our members. We will then ask pharmaceutical companies if they are interested in supporting our plans. We maintain full editorial control of services that would otherwise not exist.

For us, the priority is delivering services that our members need in the most cost-effective way. We are not guided or led in any way by pharmaceutical companies in what we deliver.

Liz Carroll
Chief Executive
The Haemophilia Society

Beware the wolf in sheep's clothing

NO

TODAY'S tough economic climate makes funding for public health organisations a massive challenge. In the field of alcohol, turning down additional resources would seem inconceivable.

While there are no hard and fast rules on accepting drinks industry funding, it is essential that public health professionals are fully aware of the risks associated with working in partnership with an industry whose profit motives present a direct conflict of interest with public health goals. World Health Organization (WHO) Director General Dr Margaret Chan has said: "The alcohol industry has no role in the formulation of alcohol policies, which must be protected from distortion by commercial or vested interests."

Given that the alcohol industry and public health community have competing interests in influencing alcohol policy, it is not surprising that they use divergent ways of framing alcohol harm. The industry argues that alcohol is a problem for a small minority of irresponsible drinkers, stressing the importance of protecting the rest of the population from heavy-handed state regulation. For public health, alcohol affects society as a whole, with everyone paying the costs to public services.

Industry policy solutions tend therefore to be orientated towards the irresponsible minority, whereas public health solutions focus on the product itself and regulating the supply chain. The evidence to support such industry initiatives as education programmes and responsible drinking messages is thin, whereas price controls and regulating the availability and promotion of alcohol are identified by the WHO as the three 'best buy' interventions for tackling alcohol harm. Perhaps more concerning are the obstructive activities of drinks industry bodies, opposing public information campaigns about alcohol and cancer and mounting legal challenges to price controls – all very reminiscent of tobacco company tactics.

In an environment with abundant resources for public health programmes and a comprehensive framework of policies to regulate the upstream drivers of alcohol harm, engaging in drinks industry partnerships would be less of a threat to public health goals. However, the real situation is very different, with the current government reluctant to introduce evidence-based policies, such as minimum unit pricing, while affording the drinks industry responsibility for delivering public education programmes via Drinkaware. Engaging with industry partnerships in this context not only diverts resources away from implementing evidence-based policies, but also adds legitimacy to industry's claim to be part of the solution, rather than part of the problem.

Katherine Brown
Director
The Institute of Alcohol Studies

Land of the living

The twin arguments of morality and sound business sense have been key in persuading employers to implement the living wage, says Gillian Owen

DURING our economic 'recovery,' when over half the families living in poverty are in work, there's a long way to go before those earning the least feel optimistic that a recovery is even happening. With low-paid jobs increasing and the cost of living squeezing household incomes, the reported 5.24 million people in the UK being paid less than the living wage is an issue to be addressed.

The earliest written evidence in support of a living wage dates back to factory worker conditions in the 1890s, with Liberal MP for Dewsbury, Mark Oldroyd, pressing the need to "maintain the worker... in the highest state of industrial efficiency, with decent surroundings and sufficient leisure". The current living wage is a voluntary measure and the result of a decade of campaigning by low-paid workers questioning why it is you can work several jobs, forsake all your free time and still not have enough to live independently.

This year's UK living wage rate was calculated at £7.65 per hour by the Centre for Research in Social Policy and is based on the Minimum Income Standard for the UK. The living wage does not have room to include lavish luxuries; it is a social consensus about what people need to make ends meet.

The living wage is a voluntary rate and enjoys cross-party support. There are more than 850 accredited living wage employers, including NHS Trusts and more than 30 local authorities. These public sector organisations are now outnumbered by private sector employers who see the living wage as a moral and sound business decision, with household names including Nationwide, HSBC and Nestlé all accrediting as living wage employers. These organisations agree to pay all staff on their premises, including subcontracted workers, no less than the living wage.

> **Poverty wages create a depressing hand-to-mouth existence**

A study examining the business benefits of implementing a living wage policy in London found that more than 80% of employers believed that the living wage had enhanced the quality of work of their staff, while absenteeism had fallen by approximately 25%.

Two thirds of employers reported a significant impact on recruitment and retention, while 75% of employees reported increases in their work quality as a result of receiving the living wage.

Professor Sir Michael Marmot's *Fair Society Healthy Lives* states that getting people into work is of critical importance in reducing health inequalities and that those jobs should offer a minimum level of quality to include a decent living wage.

Poverty wages create a depressing hand-to-mouth existence. The best part of the Living Wage Foundation's work is meeting people who, through the impact of the living wage, can now plan their future, contribute to and be a part of their community.

Public health specialists play a vital role in highlighting the negative health impacts low wages have on society. Adding this information to the argument that the living wage is both a moral and sensible business decision can only strengthen the case for implementation. Professional bodies from across the sector should show leadership, accredit as living wage employers and champion living wage contracts through their commissioning roles.

The best employers are voluntarily signing up to pay the living wage now. The living wage is a robust calculation that reflects the real cost of living, rewarding a hard day's work with a fair day's pay.

Gillian Owen
Head of Communications
Living Wage Foundation

Hillary's Story: case worker Eileen Brown and Hillary Fleming (right) with her two children

How a thank-you letter became a film script

SINCE we all tend to advocate for our own self-interest, how should a local governmental agency 'advocate' for its services without the perception of bias? Recent advances in communication theory suggest that sometimes the messenger is the message.

The mission of Mecklenburg's Child Support Enforcement Department is to enhance the quality of life of children and families by providing child support services to families affected by divorce or separation. Special judges and courts set the amount of financial support the non-custodial parent is required to provide to the parent with custody. The amount is based upon interviews, wage information and need. If the non-custodial parent does not comply with court-ordered child financial support, Child Support Enforcement's task is to act on behalf of the children.

Anecdotal data collected by the department indicates a high level of anxiety, ambivalence, uncertainty and mistrust in custodial parents who need to request child support enforcement services. The department approached the county's Public Information Department for help in developing a communication strategy that would reduce client anxiety. Child support staff shared a letter from a client who was a mother of two children. She thanked the department for the sensitive, personal care and attention she had received from her case manager.

To staff, the letter was proof that they were advocates for children, providing a good service under difficult circumstances.

To the Public Information Department, the letter was the script for a client orientation video. The author of the letter, Hillary, agreed to tell her story through video, photos and her own words.

An audio recording was made of Hillary reading her letter, her photos and documents scanned, and some more photos and several video clips shot to round out the story. The emotion in her voice and her tears of relief and joy spoke directly to the heart of the viewer. Questions were answered and fears allayed, and new clients entered the process better equipped to handle their own situation.

The video was first shared across North Carolina, and then across the US by the Federal Office of Child Support. The video was awarded a coveted Telly Award for Social Responsibility and a National Association of City and County Information Officer's Award.

Hillary's Story is a good example of how to achieve one of the key principles of health communication: giving a voice to your audience. Rather than designing, testing and sending messages, we are charged to support the people affected by an issue and let them have their say. *Hillary's Story* allowed us to be a more effective advocate for children by reducing the fear associated with a difficult and stigmatising process.

Gary Black
Public Information Specialist
Mecklenburg County
North Carolina
USA

Personal stories can shape policy if well handled

I HAVE been a researcher in mental health for more than 20 years and currently lead a specialist mental health research charity. In all this time I have been challenged to make sure research work has practical relevance to everyday lives, informing policy developments and practice decisions. I have learned that, for policy-makers, lived experience accounts are very important.

In academic research networks this is known as 'public and patient involvement', and there is guidance on how to do this well (see www.invo.org.uk) to ensure that research studies are designed to address things that matter most to individuals and develop recommendations tailored to the policy challenges of the day.

Another crucial element in translating research into policy and practice is networks of influence. Across the mental health sector, policy networks involving coalitions of professional bodies, third-sector organisations and other providers have become the 'go to' networks that the Department of Health, Public Health England and NHS England approach to co-produce strategies that are informed by the views and experiences of people on the ground.

Lived-experience accounts anchor policy decisions in real-life challenges, provide support for initiatives and translate complicated messages into stories that ordinary people can relate to. But we have to proceed with caution. Case material has limitations and can alienate people as well as draw support for a policy. Personal experiences may be received as biased, partisan, lacking credibility or not sufficiently 'on message'. The systematic nature of research can help in identifying suitable personal stories for use in policy work, and working carefully with the narrator on producing these accounts can ensure both policy messages and personal narratives are not distorted.

It is clear this strategy takes time to develop and sustain but can lead to change. I have seen this through the funding of the Time to Change anti-discrimination programme, setting up early intervention in psychosis teams and inclusion of parity of esteem in the national mental health strategy No Health Without Mental Health.

Vanessa Pinfold
Research Director
McPin Foundation

Girls on film

With advances in technology, filmmaking, once the preserve of professionals, is now open to all and can be a highly effective campaigning tool, says Pamela Luna

Pamela Luna views a scene from *Girl Rising*

THE use of film is becoming widely recognised as an effective tool for promoting population health and reaching millions of people worldwide. The American Public Health Association's film festival began to showcase films last year that serve as catalysts for large-scale social change. This year in the UK, the Public Health Film Society and the Faculty of Public Health (FPH) made films and storytelling a focal point for their annual meetings. Meanwhile, the Royal Society of Medicine has announced plans for a global public health film festival.

What is fuelling this use of film is debatable. Certainly the widespread access to, and consumption of, films on varied digital platforms is significant. Filmmaking, once the domain of seasoned professionals, is now accessible and cost-effective for creative amateurs using smartphones and personal computers.

> **Both films are well made and have received acclaim in the documentary film world**

All of this is why the FPH annual conference featured films with public health impact that focused on the portrayal of girls and women in the media. I was honoured to consult with FPH in organising this session and serve on the expert panel. Two of the films screened, *Girl Rising* and *Miss Representation*, have become models for launching global movements.

These films are worthy of closer examination because they are proving to be successful in the trickiest part of using films in public health: creating and sustaining significant and scalable change. Both films are well made and have received critical acclaim in the documentary film world. *Girl Rising* has been screened in 50 countries, and *Miss Representation* has reached millions in 48 counties.

They both artfully frame the issues, deliver facts, tell compelling stories and present interviews that capture attention and prompt the viewer to act. Both are centrepieces in action-oriented initiatives and offer readily accessible tools and support for those inclined to take the next step. Social media fuels the initiatives along with well-designed instructional tools for use in schools, universities and community settings. The initiatives drive people to websites and social media platforms in order to be a part of the 'movement' and take a pledge to promote change. Both have extensive mailing lists to keep people informed and engaged.

Girl Rising has a plethora of practical tools for anyone who wants to host a screening of the film. The Representation Project has successfully taken on sexist media

advertising by creating the #notbuyingit app designed to stop offensive marketing campaigns worldwide. Strategic partnerships with key organisations, alongside ongoing promotional components to keep them current and visible, are a hallmark of these initiatives.

Films prompt people to take action. After the conference film session, FPH members enthusiastically voted to create a Special Interest Group on the use of film in public health. To join, visit http://bit.ly/1whrSCj

Pamela Luna
Co-Chair
American Public Health Association Film Festival

Many voices of health

The PHE conference sent out the message that the very future of the NHS depends on effective prevention and public health, writes Alan Maryon-Davis

THERE was a terrific buzz about this year's Public Health England (PHE) conference at Warwick University. Jeremy Hunt had to pull out of making the opening address, but PHE chief executive Duncan Selbie deftly filled the 45-minute slot with sage words and pregnant pauses: "I do silences well."

He seamlessly ranged over the big lifestyle risk factors and health inequalities, touched on TB and antimicrobial resistance and homed in on giving children "the best start in life". He observed that the harm from alcohol was the leading cause of premature death in working-age adults and "the one long-term problem going in the wrong direction". Selbie went on to talk about tackling dementia and enthused about new horizons in social media: "The most exciting thing is to be working in the behavioural sciences in the digital age."

To a parallel session on the Licensing Act 2003. James Nicholls, Director of Research and Policy Development at Alcohol Research UK, described the current licensing regime as "permissive" (the vast majority of applications are granted). He noted how ill-suited it is to tackling issues around the meteoric rise in supermarket sales, the focus being very much on particular pubs and bars and driven mainly by the crime and disorder agenda. The challenge for public health in England, said Nicholls, is to get regulatory authorities to "think health". Sharon Sawyers, Lead Officer for Health at the Trading Standards Institute, observed that public health and trading standards people should learn more from each other's knowledge and culture.

Quick cup of coffee, dash round the plethora of exhibits and posters, then into another parallel session. Hilary Burton of the PHG Foundation was talking about genetic susceptibilities to risk factors and how genomics could hugely improve risk stratification. She also outlined the potential in terms of personalised medicine, variations in response to treatments, drug tolerance and efficacy. Despite these rapidly evolving developments, Burton was still struggling to get public health into genomics thinking. Even today the approach was predominantly biomedical, she said.

> **Harm from alcohol is the one long-term problem going in the wrong direction**

Back to another plenary. Jane Ellison, Minister for Public Health, focused on personal responsibility for health and the importance of providing the public with reliable information to enable informed choices: "The public should be part of the conversation." Her other theme was accentuating the positives in life, rather than constant finger-wagging: "We mustn't let public health be put in the killjoy pile." She was avowedly passionate about the issue of female genital mutilation (FGM): "FGM is very much my mission issue." Her pay-off challenge was for PHE "to be the engine of change in public health, and to make the messages resonate with the public".

Packed lunches in the sun and lots more parallel sessions on subjects ranging from emerging infections to sustainability, and from loneliness to public health leadership.

Finally, the closing address by Simon Stevens, the new chief executive of NHS England, asking why the NHS spends more on bariatric surgery than preventing type 2 diabetes: "Obesity is the new smoking… it could bankrupt the NHS if left unchecked." He rammed home the importance of a health-conscious NHS workforce promoting public health in local communities. In summary, Stevens declared: "The sustainability of the NHS... depends on a radical upgrade of prevention and public health."

Music to our ears – all the way home.

Alan Maryon-Davis

Data bombshell proves new law packs a punch

THURSDAY 17 July 2014 is unlikely to be a date that the global tobacco industry will ever forget.

At 1am in the Australian morning an embargo was lifted on a set of numbers that drove a stake deep into the heart of Big Tobacco's best efforts to deny that plain tobacco packaging had made any impact on Australians' smoking. It showed that this was a public health policy that worked.

The Australian Institute of Health and Welfare released the results of its latest survey of tobacco use, involving 23,855 people. These surveys have been conducted every three years since 1991, when 24.3% of Australians aged 14 and over smoked on a daily basis.

In December 2013, this figure had almost halved to 12.8% with another 3% smoking less than daily. Together, this makes Australian smoking prevalence the lowest in the world

So what caused the most recent dive? Other than routine twice-yearly tax increases, bans on point-of-sale retail displays, a continuation of anti-smoking campaigning throughout the period in question, and measures such as smoke-free restaurants and pubs that have been in place for years, the elephant-in-the-room explanatory variable was the implementation of plain packaging in December 2012.

In the weeks before this data bombshell, the *Australian* newspaper ran a campaign involving three front-page stories, and a full page of articles by journalists and contributors, some of whom are affiliated to Big Tobacco. They drew on internal tobacco industry data that was never made available for public scrutiny. The timing coincided with a final consultation period in England preceding a final decision on a stated intention to introduce plain packs.

> **Like *Monty Python*'s Black Knight talking about "just a flesh wound" after losing all four limbs, this is not likely to be the last round of denials from big tobacco**

The mystery data purported to claim a 0.3% increase in consumption following plain packs, with British American Tobacco stating in a press release that the fall was "in line with historical trends". It wasn't. Between 2010 and 2013 the fall was a record 15.2%; the biggest percentage fall ever recorded since the surveys commenced.

Public opinion is firmly in support of the legislation, which is also supported by both the new Coalition (conservative) government and the Labor opposition which introduced it. Global investment advisers Citi wrote that the figures provided "the best data" to support the British government's imminent decision on plain packs and that it would "substantially undermine" the industry's argument that there was no good evidence that plain packaging would work.

Like *Monty Python*'s Black Knight talking about "just a flesh wound" after losing all four limbs, this is not likely to be the last round of denials from Big Tobacco; and for countries such as the UK that stand on the brink of legislating, following the Australian example to counter Big Tobacco's claims is vital. In doing so, a '17 July' moment in Britain may only be a few years away.

Simon Chapman
Professor of Public Health
Sydney University
Matthew Day
Consultant in Public Health Specialised Commissioning
Public Health England

Adapted from an article that previously appeared on Australia's ABC The Drum website

Use meetings, briefings and hard evidence

FOR more than three years the British Lung Foundation (BLF) has been leading the campaign to ban smoking in cars carrying children. Finally, in February of this year, after the Labour Party came out in support of the campaign, the amendment to the Children and Families Bill was voted through with a majority of 269 votes in the House of Commons and is now in the process of being implemented into law.

We used a variety of tactics to achieve this successful outcome. We worked with politicians from all parties to persuade them of the necessity and practicality of a ban, meeting and briefing many MPs ahead of every debate. The BLF press team worked to keep the issue in the media and public eye. We also employed social media and digital platforms to grow public support for the issue, making it easy for as many people as possible to contact their local MP expressing support, right at the end of the campaign. Being part of existing networks such as the Smokefree Action Coalition was also important, as many organisations rallied behind us when we needed them most.

However, the campaign was only possible because it was underpinned by compelling evidence on the scale of the problem and its impact on children's health. Using newly-published government data, the BLF found that nearly half a million children in England were exposed to smoke in their family car at least once a week. This was invaluable information to use during both parliamentary debates on the subject and in the media.

Tamara Sandoul
Public Affairs and Policy Officer
British Lung Foundation

Do mass media campaigns improve health?

OUAGADOUGOU, Burkina Faso: we are a year away from proving that a radio campaign promoting healthy behaviours can reduce the burden of under-five mortality by 15%. How did we get to this point?

Aid organisations have used radio and television to promote health in Africa for decades, promoting condoms and bed nets as well as the uptake of services when needed. There is no doubt that mass media campaigns reach large audiences in Africa, even in rural areas. But do they really improve health outcomes?

The evidence is remarkably thin. Evaluation designs are rarely robust, with a reliance on before-after studies, no comparison groups, and dependence on reported rather than observed behaviours. Yet decisions about which interventions to fund are taken by professionals strongly influenced by the rigour and discipline of epidemiological research.

I founded Development Media International (DMI) in 2005 to redress this imbalance. I had spent eight years at the BBC World Service Trust running health campaigns on radio and television in countries such as India, Vietnam and Brazil. Although I'd developed a system of 'comprehensive campaigns', broadcasting on multiple health issues on a rotating basis to maximise impact, we had no idea how many lives were being saved. So I worked with epidemiologists at the London School of Hygiene and Tropical Medicine (LSHTM), creating a mathematical model to estimate this.

> **Although I'd developed a system of comprehensive campaigns, we had no idea how many lives were being saved**

The model combined the impact of previous media campaigns on behaviours, the media audience in each country and local supply-side constraints that might limit impact (such as access to primary healthcare). It applied these behaviour-change predictions to the Lives Saved Tool, developed by Johns Hopkins University, which estimates the number of lives saved when coverage of interventions such as breastfeeding or malaria treatment increases in a given country. The model predicted that comprehensive campaigns could reduce child mortality in most African countries by 16%-23% at a cost per disability-adjusted life year (DALY) in the $2-10 range. These were dramatic predictions: the cost per life saved was as low or lower than any existing health intervention.

We now needed to prove that the model worked in practice. We selected Burkina Faso, which combines high child mortality with a localised media environment,

Community radio station in Bogande, Burkina Faso

permitting a randomised controlled trial (RCT). The RCT, funded by the Wellcome Trust and Planet Wheeler Foundation, randomly divided 14 areas into seven intervention zones and seven control zones. We are broadcasting radio spots 10 times per day (and radio dramas every evening) for three years on seven community radio stations. LSHTM is surveying mortality (100,000 children) and behaviour (5,000 households) before and after the intervention. Our midline results show that the net improvement in behaviours (the 'difference in difference', subtracting control zone changes from intervention zone changes) is substantial (8.5% to 23.3%) for 6 out of 10 behaviours. This is the first RCT to demonstrate that mass media can change behaviours. We will have final results in late 2015, including the impact on mortality (predicted to be 15.7%). If we are successful, we hope to persuade donors to fund the scaling up of this approach to 10 African countries, saving one million lives in five years.

Roy Head
Chief Executive Officer
Development Media International

Well, at least we've got some sun cream now

SO GLAD I managed to get the Local Resilience Forum to take on an adverse weather plan – thanks in part to this summer's heatwave. In fact the council has been quite good about our skin cancer prevention work. They even regard public health as being truly integrated – ever since we bought all those giveaway sun hats and sun cream through their Procurement Team.

Reflecting on the latest advice on hot weather from Public Health England, I wonder whether this might spawn yet another network to help us DPHs meet our local challenges? Given the plethora of succouring networks already created by our PHE mother ship, I'm not sure how many more we can cope with without having to give up the day job.

Unfortunately, I've not yet managed to get our key councillors to meet with PHE – partly because they have other things on their minds, like the 30% cut to the council's budget. But, I'm sure when it does happen they'll be fascinated to hear how PHE is successfully metamorphosing from an organisation in 'transition' to one in 'transformation'.

I have to confess I'm not entirely sure myself what kind of organism will eventually emerge from the PHE primordial soup. But I've no doubt it will provide all sorts of tools and templates to help make my population a little healthier and my life a little easier.

And the real bonus? This embarrassment of riches will doubtless free up time for me to engage with some of PHE's supportive networks. Plenty to look forward to then.

The FPH Annual Conference 2014 was one of the most successful of recent years. Held at the University of Manchester, it attracted more than 400 delegates and speakers from all over the world. On the next four pages, those who couldn't make it can get a taste of what they missed

Making a world of difference

Film Special Interest Group launches with world premiere screening

THE Faculty of Public Health (FPH) Film Special Interest Group (SIG) was launched at the annual conference with a screening put on in association with Pamela Luna and Gary Black, co-organisers of the American Public Health Association's Film Festival.

The films shown highlighted the sexualisation of the media and its importance for public health, and included the world premiere of a short trailer for *Hot Girls Wanted*, a hard-hitting documentary about the exploitation of girls and young women in the amateur sex industry. The screening was followed by a panel debate, chaired by Professor Sue Bailey, past president of the Royal College of Psychiatrists, and covered in a subsequent issue of the *British Medical Journal*.

Dr Luna said the films highlighted how "we have left our kids vulnerable; as adults we've missed something, which is what is happening in the media". She called for the public health community to come together as a top priority to tackle the media's sexualisation of youngsters.

Another panellist, Jacqueline Smith, a film maker working with the charity Best Beginnings, said: "We can perhaps create a different set of imagery to change the context in which these images exist and perhaps to connect with audiences in ways that show them that this is one world you could inhabit, but there are others."

Conference delegates were also able to take a tour of the BBC's Mediacity in Salford and attend a workshop run by Mr Black about making films with mobile phones.

For more information about the FPH Public Health Film SIG, please join the virtual group at http://new.fph-groups.org.uk/groups/ or email the FPH network administrator at networkgroup@fph.org.uk

Ruramayi Rukuni
Chair
Faculty of Public Health Public Health Film Special Interest Group

Setting up FPH Special Interest Groups

THERE are two kinds of Special Interest Groups (SIGs). In one, FPH works closely with an external organisation; for example, the Transport SIG works with the Transport & Health Study Group (THSG). At the conference I gave an account of how THSG, which I co-chair with Jenny Mindell, built itself up since its initial meeting of seven members in 1989 to its present position as an organisation with a European committee spanning six EU member states, our own parliamentary advisers and our own journal, as well as a link with FPH, whose Transport SIG we manage. At the conference there were a number of ideas for new SIGs jointly established with other organisations, such as Visual Impairment with the RNIB and Economic Policy with MEDACT.

In the other type of SIG, a number of FPH members get together and organise a group entirely under FPH's aegis. At the conference, I attended the inaugural meetings of Public Health Africa and a healthy ageing SIG, both of them enthusiastic and committed.

Stephen Watkins
Director of Public Health
Stockport Metropolitan Borough Council

Education for sustainable healthcare

THERE are tremendous opportunities to build on the synergies between human health and the environmental sustainability of health systems. In 2013, UK academics, doctors and healthcare students conducted an international consultation on how to integrate learning objectives for sustainability into the medical curriculum, resulting in a consensus of three priority learning areas:

- **How the environment and human health interact at different levels**

Human dependence on ecological systems; the contribution of human activity and population size to climate change, biodiversity loss and resource depletion; the mechanisms by which environmental changes affect human health; the features of a health-promoting local environment in community and healthcare settings.

- **How to improve the environmental sustainability of health systems**

Definitions of sustainability; effects of demographic, technological, climatic and resource availability trends on healthcare provision in future; environmental impacts of healthcare provision; ways to improve the environmental sustainability of health systems; synergies between sustainability practices and those that promote health.

- **The duty of a doctor to protect and promote health**

Personal values and ethical tensions in resource allocation and the unequal distribution of impacts of environmental change; legal and organisational policies for reducing carbon emissions.

Stefi Barna
Co-Director
Sustainable Healthcare Education Network

ANNUAL CONFERENCE HIGHLIGHTS

The arts: authenticity and exchange

THE idea of arts and health has been growing exponentially over the past 30 years, arguably born in Manchester, from a tradition of radical thinking and grassroots activism. The field has evolved from its early days of humanising clinical environments to its current affiliations with the public health agenda. The director of Arts for Health, Clive Parkinson, introduced this session at the FPH conference by offering delegates a focus on the "science and art" of public health, emphasising knowledge, political advocacy and imagination.

The foundation of the National Alliance for Arts, Health and Wellbeing and the recently established All-Party Parliamentary Group for Arts, Health and Wellbeing signals that a political appetite for re-imagining public health is clearly emerging in the UK. But advances in this multi-disciplinary field require continual intellectual engagement which moves beyond the dehumanised forces of the market and addresses complexity. In her paper, *Exploring the Longitudinal Relationship between Public Health and Arts Participation*, Dr Rebecca Gordon-Nesbitt, Principal Investigator in Arts for Health at the Manchester School of Art, launched an evidence base that informs research into the relationship between arts engagement and public health.

This evidence base was compiled as part of a six-month project, funded by the Arts and Humanities Research Council, and involved extensive scoping and consultation in the UK and the Nordic countries. The process yielded 14 of the key studies that have explored the relationship between engagement in diverse cultural activities – far beyond the clinical environment – and a range of public health outcomes over time. Delegates were presented with a brief overview of the approaches used and findings reported, together with a consideration of the physiological mechanisms thought to underlie any positive associations observed between arts engagement and health. The constructively critical response received at the conference has helped to shape further dissemination of this international resource.

Maya Twardzicki, Public Health Lead at Surrey County Council, shared two projects that evaluated the use of drama and comedy in raising awareness and challenging the stigma of mental health in community and military settings respectively. A range of evidence-based approaches were piloted in an area of high mental health need and were tailored to community, employer and college settings:

- Short bespoke plays and forum theatre
- Mental Health Ambassador scheme (providing meaningful 'social contact' opportunities with the public)
- Mental health awareness educational sessions – with input from ambassadors.

Pre- and post-intervention questionnaires included validated knowledge and attitude measures used by the Time to Change campaign. Results showed statistically significant improvements in participants' knowledge, attitudes and confidence in supporting people with mental health problems. Mental health ambassadors reported increased confidence and sense of purpose through their public contacts.

A scene from Acting Out Productions © *Flashpoint*

The play was effective in making an impact and generating interest in and uptake of the project. Comprehensive evaluation helped secure roll-out funds from partners. Reflective practice from the pilot helped to improve the quality of the roll-out.

This session explored research and practice, linking the arts, health and authenticity. If public health success is as much about imagination as it is about knowledge and advocacy, public health practitioners must regularly interrogate their motivation, reconnect with their values and dare to confront inequalities. In this effort, the arts and culture offer a powerful vehicle for precipitating social change.

Clive Parkinson
Director
Arts for Health
Rebecca Gordon-Nesbitt
Principal Investigator in Arts for Health
Manchester School of Art
Maya Twardzicki
Public Health Lead
Surrey County Council

Just tell it how it happened – end of story

MAG Connolly [Faculty of Public Health Head of Corporate Affairs] invited Narativ to give an experiential workshop on storytelling at the annual conference. More than 40 people signed up, but at 1pm the corridor outside the room was quiet. At 1.01pm a bearded man came in and said: "We can start now." Over the next 10 minutes, people arrived and all the chairs in the circle filled up until I gave up mine and was standing in the middle. I began: "There is a reciprocal relationship between listening and telling. What that means is that the way you are listening to me now is going to create what happens in the next hour."

The objective was to give a taster of Narativ's methodology. I began by focusing on this idea that listening creates telling, and, using a listening meditation, we discovered the multiple obstacles people have to listening openly and being present. I told a personal story to model a specific way of telling. Together, with a lively discussion, we deconstructed it, enabling me to introduce our method of simply telling what happened, removing judgement, interpretation and comment.

This technique makes a story as vivid and memorable as possible by pulling the listener empathetically into your experience. I gave a story prompt, and participants worked in pairs, practising telling a story of their own. The energy in the room was buzzing as people wrestled with this simple yet surprisingly difficult technique. John Ashton came in with Dame Tessa Jowell, took me by the arm and said: "This is fantastic, isn't it?"

Afterwards someone reflected: "It felt boring to speak without interpretation." Her partner jumped in: "But it was actually the opposite, much more interesting, more powerful." Another woman said: "I stuck to the 'what happened', but my listener made really insightful interpretations – so he was getting it even though I wasn't saying it. That was powerful."

At the end of the session John Ashton asked Dame Tessa if she would like to say anything. "I don't want to say too much actually," she replied. "There's a real sense here of an explored magic."

Jane Nash
Director
Narativ, Inc

Urgent message from RNIB: you must not lose sight of sight loss

AT THE FPH conference, the Royal National Institute of Blind People (RNIB) challenged FPH to become an exemplar organisation that is accessible to and inclusive of blind and partially-sighted people. We are confident that with the commitment to eye health shown by FPH President John Ashton and CEO David Allen, FPH will take up this challenge.

Preventable sight loss needs to be more of a public health priority. Around 1.8 million people are currently living with significant sight loss in the UK. By 2050 this number is expected to double. Half of this sight loss is preventable.

People with sight loss are significantly more likely to suffer from depression and have an increased risk of falls. Effective eye care pathways can help reduce unnecessary sight loss, and effective social care support can help individuals successfully adapt to a life with sight loss. Improved detection and treatment of eye conditions can improve other health outcomes for condictions such as stroke, dementia and learning difficulties. With the preventable sight loss indicator in the Public Health Outcomes Framework, the Department of Health in England has begun to recognise that more needs to be done. Prioritising eye health will ultimately reduce health and social care expenditure and improve outcomes for people with or at risk of sight loss.

RNIB is the leading charity for everyone affected by sight loss in the UK. We aim to make every day better for everyone affected by sight loss: by being there when people need us, supporting independent living, creating an inclusive society and preventing avoidable sight loss. We do this through influencing government, industry and service providers on issues such as healthcare, treatments, travel, technology and retail.

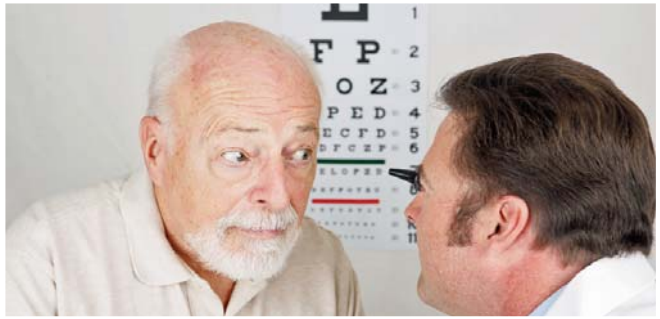
> "Effective eye care pathways can help reduce unnecessary sight loss"

Our influencing work is informed by the research we undertake and commission to develop evidence about the needs of blind and partially-sighted people and those at risk of sight loss. We provide a wide range of services and support through products, a telephone helpline, and face-to-face and online support. We also run residential care homes, schools and colleges.

At www.rnib.org.uk/healthprofessionals RNIB provides valuable resources and tools for FPH members such as the Sight Loss Data Tool, guidance on commissioning eye care services, prioritising eye health and addressing it in Joint Strategic Needs Assessments.

Working together, RNIB and FPH can do much to reduce avoidable sight loss and create a more inclusive society for blind and partially-sighted people.

Helen Lee
Evidence & Service Impact – Prevention Manager
Royal National Institute of Blind People



Manifesto for the North West

JULY 2014 saw the publication of *Top Ten for Number Ten: A Public Health Manifesto* (http://phlive.org.uk/phmanifesto/) from the North West Directors of Public Health. The report listed the 10 public health priorities with potentially the biggest impact on health and wellbeing.

There has been significant work undertaken over the past 10 years on improving public health, but clearly there is a great deal more work to do, for example the implementation of standardised packaging and continued discussions about price and taxation policies for both tobacco and alcohol. Substantial health inequalities still exist in the North West and national policy is really important in helping to drive improvements.

The manifesto was presented at the Festival of Public Health held in Manchester on 1 July and at the FPH conference and received a very positive reaction with lots of discussion and debate both about the priorities identified and how they are to be progressed.

Matthew Ashton
Director of Public Health
Knowsley

Nurses at the forefront

IT WAS great to have the opportunity to highlight at the FPH conference the value of nursing to public health. This is widely acknowledged, but more needs to be done to engage with nursing and midwifery staff in all areas and to promote its role and value.

Nurses and nursing teams are often at the forefront as the biggest clinical workforce. It is however essential that we make sure we work together across professional and organisational boundaries.

The Royal College of Nursing (RCN) has a membership of around 415,000 registered nurses, midwives, health visitors, nursing students, healthcare assistants and nurse cadets. It is the voice of nursing across the UK. The RCN has a very dynamic and committed Public Health Nursing Forum with members from a wide variety of areas of practice.

One of the key challenges is to help people adopt healthier lifestyles. The RCN has just launched a resource for anyone who has a role in motivating them to change their behaviour: www.rcn.org.uk/development/practice/cpd_online_learning/support_behaviour_change

Helen Donovan
Public Health Nursing Adviser
Royal College of Nursing

Undergraduate Curriculum for UK Medical Schools 2014

GUIDANCE from the General Medical Council, *Tomorrow's Doctors 2009*, outlines the knowledge, skills and behaviour that medical students must demonstrate by the time they graduate. While each medical school can design its own curriculum to suit its own circumstances, the overall curriculum must allow students to meet the outcomes specified in *Tomorrow's Doctors*.

Public Health Educators in Medical Schools, in collaboration with FPH, launched a consensus statement (http://tinyurl.com/nsvlkn8) at the FPH conference to facilitate this public health education in medical schools. This document is a comprehensive guide that identifies core curriculum content to support and enhance the development of undergraduate public health education and describes potential educational approaches and assessment methods, and opportunities for introducing public health throughout the clinical curriculum.

Veena Rodrigues
Clinical senior lecturer
Norwich Medical School

'My conference': a delegate writes...

FOR several reasons, 2 July 2014 was a unique day. It took me back 36 years, to when I was engaged in my postgraduate studies at Manchester University. It gave me the opportunity to visit the department and my former supervisor, Professor Tim Lee. My wife and I enjoyed reminiscing about our days in Manchester.

More importantly, I was humbled to be awarded Fellowship by Distinction by Professor John Ashton, President of FPH. I can't express enough how honoured I am that FPH has recognised my academic and community work. This award signifies my persistence in and commitment to enhancing the field, in particular for my beloved country, Iraq, which has been the subject and inspiration of my work. Dr Wasan Al-Alwan, health attaché at the Iraqi Embassy in London attended the ceremony on behalf of the Iraqi Ministry of Health.

During my visit, I had the opportunity of getting in touch with colleagues and possibly building future collaboration highlighting the World Health Organization mission of ensuring the health of individuals across the globe. Events such as the dinner helped me learn about others' experiences. This opportunity was invaluable.


FPH CEO David Allen (left) with Professor Jamil

I was able to tell people about an ongoing project I have been working on: the National Iraqi Public Health Project. An example of international collaborative work to expand the field of public health into third world countries, this proposal, which has the potential for collaboration between my department at Wayne State University, FPH and the American Public Health Association, aims to change the attitudes and behaviour of Iraqi people toward public health.

Hikmet Jamil
Department of Family Medicine and Public Health Sciences
Wayne State University, Detroit, USA

Faculty of Public Health Annual Conference 2016 – an invitation

The Faculty of Public Health is looking for a venue for its 2016 annual conference.

If you would be interested in hosting it, please contact Mag Connolly, FPH Head of Corporate Affairs, at magconnolly@fph.org.uk or tel 0203 696 1469

You will wish you had read it ages ago

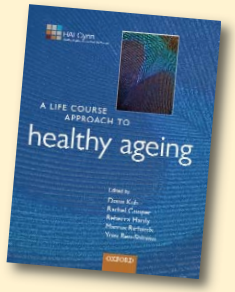
THIS book combines a life-course approach with various metabolic, physiological and genetic aspects of ageing using a range of qualitative and quantitative research methods and has even included some key health improvement chapters addressing wider determinants of health such as where we live. The layout encourages the reader to continue on and learn more, and it maintains interest throughout some really heavyweight topics.

Each chapter is self-contained, with an introduction, main body of text, future directions/conclusions and a reference section. This means that the reader can dip in and out or read from cover to cover to gain the full experience of the life-course approach to ageing. The text is broken up by diagrams and figures to help explain the concepts being discussed. Furthermore, the material used and referenced is, on the whole, up to date but also includes some of the early relevant seminal pieces of work such as the Whitehall Studies.

This book gives readers the basic foundation knowledge needed in each area covered and then develops this to provide a greater understanding within the context of ageing. This is so for all chapters, from genetics and various research methods to more practical but complex issues such as diet and lifestyle.

Part II of the book moves rapidly through different methods of studying ageing from a life-course and interdisciplinary perspective. These chapters move from basic methods into more complex modelling and statistics. Part III provides several chapters addressing different body systems, organs and cells and demonstrates how these alter during the life course and how they affect the ageing process. The genetics and epigenetics chapters are both fascinating and, if you struggle with genetics like your reviewer does, a little scary, as they link more general concepts of genetics to the ageing process. The final section of the book, entitled 'The way we live', explains how healthy ageing relies upon healthy living – and makes the reader wish they had thought about their old age earlier!

Overall, this is an excellent book. It is a comprehensive public health text book which exposes its reader to just about



every key area of public health but somehow never manages to lose sight of its main focus: healthy ageing.

Ruth Goldstein

A Life Course Approach to Healthy Ageing
Edited by Diana Kuh, Rachel Cooper, Rebecca Hardy, Marcus Richards and Yoav Ben-Shlomo

Published by Oxford University Press
ISBN 9780199656516
RRP: £44.99

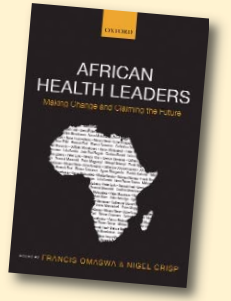
The perfect cure for our fallacies about Africa

African Health Leaders is an excellent antidote to popular European notions that what Africa needs are Western experts introducing modern strategic programmes and logistics, community engagement, research design and health leadership, while sick villages passively languish.

Dozens and dozens of vivid examples show that African health leaders' achievements often dwarf what we do on UK health and wellbeing boards. We could learn a lot from them. Uche Amazigo, for example, led the development of community-directed treatment for river blindness, "a devastating blinding disease that has afflicted some of the most remote villages… but can be prevented…" Yet "more than half a million community distributors have delivered more than 600 million treatments to prevent blindness and thereby saved an estimated 2.5 million disability-adjusted life years". The manufacturers provided the drug free of charge but the biggest problem was developing and implementing a way of getting it to massive numbers of remote communities, where health facilities were ill-equipped to distribute it. Research led to the development of an approach in which communities designed their own distribution and were empowered to do so. "Within four years of community directorship the number of people who received treatment increased from 1.5 to 20.4 million… Community-directed distributors would go from household to household and from village to village delivering ivermectin on an unpaid voluntary basis."

There are many more examples. These African health leaders achieved amazing outcomes in the face of difficulties and shortages that many of us would find hard to imagine. Africa still has a huge chunk of the world's burden of disease, but how much larger would it be without the success stories told here?

You can open this book at any page and learn how African public health people, government health advisors and senior doctors faced the most enormous resource shortages, epidemiological, political and programme-management problems, and social, economic and cultural barriers and still succeeded in improving health and reducing inequalities. It made me feel a bit like the village policeman reading about the work of the entire Metropolitan police force. It is essential reading for public



health programme leads… though it may well tempt you to head for Bamako or Johannesburg to work alongside these people and learn.

Andy Beckingham

African Health Leaders: Making Change and Claiming the Future
Edited by Francis Omaswa and Nigel Crisp

Published by Oxford University Press
ISBN 9780198703327
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From the CEO

SO, what *is* the best way to deliver effective advocacy? There are of course multiple answers and unsurprisingly, they don't always agree with each other.

FPH has tended to 'do' advocacy through its elected officers and committee structures – with support from a small Health Policy and Advocacy team based at St Andrew's Place. Views are debated, consensus sought (and sometimes reached) and 'positions' stated and communicated on a UK or national basis.

But I came across another sort of advocacy last month, when I accepted an invitation to spend some time with a group of folk practising asset-based community development (ABCD).

Members came from a variety of backgrounds, but all with a core belief that the spirit of 'association' is more powerful than that of 'institution' – and that well-channelled community action derives both health and practical benefits for those who engage. It is an interesting idea – based as it is on a positive identification and use of assets, rather than a more perhaps traditional 'deficit' or 'needs-led' approach.

People are drawn together by common concern and interest to act collectively; such groups have a capacity to respond in times of crisis; it is self-empowering and self-multiplying; and it can be a truer and more inclusive representation of 'democracy in action' than the work of many an elected politician.

This is not a million miles away from the concept of Special Interest Groups – drawn from the UK Public Health Association – which we want to re-introduce into FPH as a basis for advocacy engagement. We can no longer rely on the expertise of a select few officers and members – we need to act collectively.

In my first eight months in post I have tracked more than 30 different 'advocacy' topics as they have come through the FPH office, from alcohol to work capability assessment. And yet this barely scratches the surface of the range of subjects and topics that FPH members feel passionately about.

So here is the opportunity: as well as a professional body, you are an association – a community. You have told us you want to engage and give your time – particularly to advocate on issues about which you are passionate – and now we have a mechanism to do just that.

Without significantly greater funding – or a growth in capacity drawn from the membership – it is difficult to see how we can deliver ever wider, effective advocacy. We need help.

Let FPH use the assets that you bring to advocate for the kind of world we all seek: a fairer, more equal, more sustainable, humane and ethical world which has 'better health for all' as its focus.

David Allen

Changes to FPH CPD policy – key advice

IN APRIL 2014 the new Faculty of Public Health (FPH) Continuing Professional Development (CPD) policy came into force. Some members will have already been producing CPD documentation that meets the requirements of the new policy, but others will need to take action now to ensure that their CPD for 2014/2015 is documented adequately.

From 2015, your annual CPD return must be with FPH by the end of April. This is the return which states how many CPD credits you will be claiming for the previous year. In earlier years, participants had until 30 June to submit their annual returns or claim exemption from CPD. The change brings forward the audit process so that those selected for audit will not be submitting during the main holiday season and will receive their results earlier.

The following are now requirements of the CPD policy and will form part of the standards assessed at audit:

- At least 50 CPD credits must be undertaken each year
- There must be a balance of types of CPD activities with no single type of activity normally accounting for more than half CPD credits claimed
- At least 25 CPD credits must directly relate to a professional development phase (PDP) for the relevant period
- There must be reflective notes for all CPD credits claimed
- At least 40 credits must be supported by reflective notes assessed as 'good'. There is guidance in the CPD policy as to how reflective notes are assessed. There is also useful guidance on writing reflective notes on the FPH website
- A reflective note must only cover up to five CPD credits. If you attend an event lasting several days, write a separate reflective note for each day.

As part of its quality-control procedures, FPH audits a proportion of participants each year. There is a requirement that everyone is audited at least once in each five-year cycle, and therefore a non-random sample of 20% participants is selected for audit. To ensure that participants are motivated to maintain their documentation every year, an additional random sample of 2% is audited. Anyone who fails to submit an annual return or who had an unsatisfactory audit the previous year is automatically included. This means that a small proportion of participants may be selected for audit in consecutive years.

It is not compulsory to use the online CPD log which is available to all members via the FPH website, but it is strongly recommended that you do so. It facilitates the production of reflective notes; there is a facility to link your CPD directly to your PDP; and, if you are selected for audit, you can download documents for submission.

I encourage you all to look at the FPH CPD policy now so that you can ensure you are meeting FPH requirements during the year and for more information on the audit standards. Further guidance is available from the FPH website (click on the 'CPD' tab) and from CPD Advisers – http://www.fph.org.uk/faculty_advisers

Lorraine Lighton
FPH Director of CPD

In memoriam

Mervyn Susser FFPH
1921 – 2014

Dr Mervyn W Susser, world-renowned South African epidemiologist and civil rights activist, began his career running a clinic in Alexandra, a black township in Johannesburg, where, together with his doctor-wife Zena Stein, he developed close links with Joe Slovo, Walter Sisulu, Nelson Mandela and other pioneers of the emerging Anti-Apartheid Movement.

In 1955, political pressures forced Mervyn and Zena to leave South Africa for England where their close friend Professor Jerry Morris helped them find academic posts in the Department of Social & Preventive Medicine at Manchester University. Whilst there, Mervyn took on the role of Medical Officer of Mental Health for Salford and, jointly with Zena, set up a psychiatric registry which led to the first large-scale study of the incidence of mental disorder in an urban population. Also at this time, with anthropologist Dr William Watson, he co-authored the pioneering textbook, *Sociology in Medicine* (1962).

Ten years later, Mervyn was appointed professor and head of epidemiology at Columbia University New York where he subsequently founded and directed the Sergievsky Center for the study of developmental disorders of the nervous system until his 'retirement' in 1991. A series of lectures at Columbia became the basis for arguably his most famous book, *Causal Thinking in the Health Sciences* (1973), among the first to expound the concept of social determinants of health inequalities.

In his later years, Mervyn, together with Zena, became increasingly involved in the struggle against HIV/AIDS – initially in New York and later in their native South Africa. They helped to organise a conference in Maputo in 1990 in an attempt to persuade African governments to take HIV/AIDS more seriously. They were also appointed as joint directors of the newly-founded Africa Centre for Health and Population Studies in KwaZulu-Natal carrying out an extensive research programme in HIV prevention and control.

Across his career Mervyn Susser produced more than 350 peer-reviewed papers, more than 100 occasional papers and 12 books – his last being *Eras in Epidemiology*: the evolution of ideas, jointly with Zena in 2009. It is fair to say that his and Zena's enduring and incredibly productive partnership has formed the bedrock of much of our public health thinking today.

John Bryden FFPH
1932 – 2012

We have only recently been informed of the death of Dr John S Bryden, a true pioneer in the emerging field of computerised health databases who played a key part in the early development of Scotland's system of healthcare informatics.

After qualifying in medicine at Glasgow in the 1956, John did his National Service in the Royal Army Medical Corps, specialising in trauma orthopaedics, followed by a spell of general practice in Govan, before settling into a 35-year career in public health, medical management and, his main passion, computerised health information systems.

During the early 1970s, back in the days of punched cards and optical character recognition, John pioneered an innovative computerised database for a large Glasgow health centre and, as chief administrative medical officer for Argyll & Clyde (1973-81) the first 'community health index' for his local population. He also helped to shape the first hospital patient administration system in Scotland. Later, his epidemiological research and informatics attention focused on head injury disability and care, and he was involved in developing a national database for Scotland.

Following his retirement from the NHS, John continued as a freelance consultant in health informatics and was a prominent member and fellow of the British Computer Society, chairing its health informatics committee for several years. Alongside his work in Scotland, he had been influential at the European level for several years and from 1998 to 2008 John was Executive Officer for the European Federation for Medical Informatics. In 2009 he was awarded an honorary fellowship of the federation in recognition of his considerable lifetime contribution to this important field.

Christopher Parish FFPH
1917 – 2014

Mr Christopher Parish was a pioneering cardiothoracic surgeon at United Cambridge Hospitals.

Christopher qualified from Manchester in 1940 and served as a surgeon to the Eighth Army in the desert and northern Italy during the Second World War. On landing at Salerno in September 1943, he worked through 36 hours non-stop operating on wounded soldiers on the front line. The Germans were attacking and at one point a Brigadier handed him a rifle and told him to get into a ditch. He showed his Geneva Red Cross identity card and refused. His batman was killed a few yards away. On another occasion, he found himself having to perform an emergency heart operation in a poorly equipped field hospital, at a time when few chest surgeons would dare to touch the heart. The patient survived, and this experience convinced Christopher that heart surgery was his true metier.

Back in the UK after the war he was appointed thoracic surgeon at what was then a tuberculosis sanatorium in Papworth, Cambridgeshire. It was Christopher who, virtually singlehandedly in the 1950s, fought to transform the small isolation hospital into a thriving cardiothoracic centre, recruiting and developing skilled surgeons and taking on ever more complex cases. The first successful British heart transplant was performed at Papworth, as was the world's first combined heart-lung-liver transplant.

Later in his career, Christopher was increasingly involved in medical education, becoming director of postgraduate education for East Anglia Regional Hospital Board and dean of postgraduate medicine at Cambridge University. His main contribution to public health was his steady support for community medicine training in the early days of the specialty.

Deceased members

The following members have also passed away:

Luke Collins MFPH
John Davies MFPH
John Hutchby FFPH
Anthony Lane FFPH
Manmohan Matharu FFPH
David Paterson FFPH
David Weeks MFPH
Elizabeth Whiteley MFPH

FPH BALLOTS

Proposal to convert FPH to a charitable company
As advised on 20 May 2014, FPH is now balloting members on a number of changes to Standing Orders. Ballot papers have been sent by post to all members in good standing. Please complete and return the ballot paper no later than noon on **11 November 2014** to the Independent Scrutineer. Contact 020 3696 1469 if you have any questions or queries.

Elections
Elections are to be held over the coming months to fill the following posts which will become vacant from the FPH Annual General Meeting in 2015:

- Vice President for Policy
- Assistant Academic Registrar
- Local Board Member, Yorkshire & the Humber
- Local Board Member, Scotland
- Local Board Member, Northern Ireland

Full details of the elections timetable for 2014-15, together with nomination papers, can be found in the FPH online members' area or are available on request from Caroline Wren (carolinewren@fph.org.uk, 020 3696 1464). Nominations opened on **15 September 2014** for the election of a Vice President for Policy and close on **27 October 2014.**

Welcome to new FPH members

We would like to congratulate and welcome the following new members who were admitted to FPH between May and September 2014

Honorary Fellows
Georges Benjamin
James Chauvin
Lindsey Davies
Karen Dunnell
Tessa Jowell
Timothy Lang

Fellows through distinction
Badreyya Al Harmi
Jeffrey Braithwaite
Benjamin Cowling
Maznah Dahlui
Benedict David
Noran Hairi
Hikmet Jamil
Jasvindar Kaur
Ahmed Mandil
Monica Medina
Ziad Memish
Sok King Ong
Antonella Sammut
Judit Simon
Karen Vincenti
Dong-Qing Ye

Fellows
Victor Aiyedun
Charles Beck
Jonathan Cox
Helen Elsey
Irfan Ghani
Stephen Gunther
Fiona Hamilton
Matthew Harris
Baldish Kaur
Samia Latif
Lise Llewellyn
Janice Lowndes
Barbara Paterson
Mohit Sharma
Katrina Spence
Sharon Stoltz
Yat Hung Tam
Jayne Taylor
Ruth Twiggins
Louise Wallace
Lawrence Wong

Honorary Members
Claudia Allemani
Ali Batarfi
Robert Dingwall
Anita Donley
Danny Dorling
Rhiannon Edwards
Wei Gao
Nicholas Harding
Roger Harrison
Iona Heath
Karen Hughes
Eileen Kaner
David Kidney
Martin O'Flaherty
Lucy Reynolds
Donna Sager
Richard Smith
Paul Ward

Members through distinction
Nadhim Ghazal Noaman

Members
Sarah Addiman
Liann Brookes-Smith
Elizabeth Crowe
Rose Dunlop
Samantha Fox
Ashley Gould
Mary Lyons
Angelique Mavrodaris
Oyinlola Oyebode
Rachel Scantlebury
Martine Usdin
Emma Waters

Diplomate Members
Simona Baracaia
Victoria Hall
Stuart Keeble
Rebecca Nunn

Specialty Registrar Members
Leslie Jones
Julie Northcott
Oliver Quantick

Chair, Part A MFPH examiners

FPH is recruiting for the role of Chair of Part A MFPH Examiners. Accountable to the Academic Registrar and Head of Education and Training, the Chair plays a vital role in the delivery and maintenance of the standards for the Part A examination. This is an opportunity to take a lead in the examination process while gaining exposure to personal development opportunities. Criteria for appointment can be found in the job description and person specification on the FPH website at http://www.fph.org.uk/work_for_fph

If you are interested in applying, please send your CV and a citation (no longer than 500 words), explaining why you feel you would be suitable, to educ@fph.org.uk by **31 October 2014**.

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Ian Ashworth
Alisha Davies
Siobhan Farmer
Amanda Fletcher
Ruth Harrell
Sion Lingard
Susan Matthews
Suzanne Meredith
Mary O'Brien
Donald Read
Hamira Sultan
Sarah Theaker
Jayne Thomas
Dean Wallace
Toni Williams

Defined specialist portfolio route
Sundus Hashim
Karen Fitzgerald
Rabia Khan
Mary Lyons
Campbell Todd

GENERAL MEDICAL COUNCIL REGISTER

Sarah Couper
Elizabeth Crowe
Iain Kennedy
William Maimaris
Muhammad Sartaj
Sonya Scott

Were you in a senior public health post in the 1970s or 1980s?

Jenny Wright, FFPH, is researching women doctors working in public health in the 1970s and 1980s for a PhD at Oxford Brookes University. She would be interested in talking to women who were Specialists/Consultants in Community Medicine/Public Health during that period in England.

If you would like to speak to Jenny to tell her about your experiences from this time, please email her at jenny.wright@brookes.ac.uk and she can provide you with further information.

The AIDS epidemic taught us that stigma can seriously hinder effective disease control and treatment. We need to remember those lessons when dealing with the Ebola outbreak, says **Rachael Jolley**

"STIGMA remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."

These are the words of UN Secretary General Ban Ki Moon in 2008. And six years on, as reported cases of the Ebola virus rise swiftly in West Africa, those words feel just as relevant today, not only to AIDS work, but just as pertinently to public attitudes to Ebola.

Where societies shun or make moral judgements about those with particular health conditions, individuals are less likely to come forward and seek help. They may delay reporting illness, so action is delayed. They may deny to themselves they are infected and continue to travel and risk infecting others.

Again and again, the way people are treated by their wider community has impact on the ability to treat diseases. A 2005 International Center for Research on Women report on HIV and stigma said: "The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected."

Despite South Africa's formal recognition of gay rights, a 2013 survey found only 32% of respondents agreeing that homosexuality should be accepted by society. Condom use fell in South Africa from 2008 to 2012, and this was linked by some to perceived societal attitudes to masculinity and sex, prompting men not to wear condoms.

"Where societies shun or make moral judgements about those with particular health conditions, individuals are less likely to come forward"

As with AIDS and HIV, those with Ebola face societal stigma if they seek healthcare, and if their condition becomes publicly known. So they self-censor, they fail to report, don't check in with a doctor or clinic, and the outbreak spreads even faster. In some societies infections such as HIV or Ebola are considered a moral judgement on lifestyle, or a religious judgement on some kind of wrongdoing.

Medical ethicist and barrister Daniel Sokol told the BBC that there was a long history of stigma related to Ebola, with survivors being chased from their communities and their homes being burned. It is no wonder then that people who may have Ebola symptoms might be wary of reporting them.

Clearly, good public information and encouragement of open discussion can conquer fears and address stigma, breaking down barriers to reporting illness. But that journey can be a long one, with shifts in public attitudes often taking decades. Frank discussions by national, regional and religious leaders, debunking myths about Ebola, as has happened with HIV/AIDS in many countries, may hopefully go some way towards dispelling stigma and encouraging people to report symptoms.

Rachael Jolley
Editor
Index on Censorship

Rachael Jolley writes here in a personal capacity

Information

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

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