The Torbay Lions Collective is the winner of the Faculty of Public Health Public Mental Health Award 2016. **Gerry Cadogan** explains how this ground-breaking initiative began in a barber's shop...

THE inspiration behind the Torbay Lions Collective is the men of Torbay. To many people, the English Riviera is seen as a seaside area with beautiful beaches and blue seas. The reality is that, like many seaside towns, the three towns of Torquay, Paignton and Brixham hide the type of statistics that tourist boards don't tell you. We have the highest male suicide rate in the south west of England, higher than the England average. Similarly, we have the highest percentage of relationship breakdowns, the highest proportion of people with no, or only Level 1, qualifications. I could go on.

So our story started with a man and is about men. Barber Tom Chapman's friend took his own life two years ago, and, because it was so unexpected, Tom decided to do something about it. He started talking to his colleagues nationally and internationally, and the Lions Barber Collective was born. When this hit the headlines, Public Health Torbay contacted him, and we had a long chat about our suicide audit and the implications and what needed to be done in Torbay. And also that there was a group of Young Farmers we were talking with about suicide prevention, and some service veterans for whom mental health issues and suicide ideation was a daily challenge.

It all focused on the men of Torbay and the question: Why? And so the Lions Collective was born, wider than the Barber group, with the aim of answering that question. As time progressed, the work increased, a telephone helpline opened over the weekend, and we got Arts Council funding to develop the Just Ask project for men. We obtained funding to develop Applied Suicide Intervention Skills Training (ASIST) in Torbay and to train service veterans in mental health first aid. We may have problems in Torbay, but we are certainly doing something about them!

> **The majority of men who have taken their lives in Torbay have never been near mental health services, and sometimes not even to a GP**

What is the challenge? It is the stigma attached to suicide – those myths that so many people believe. The reality is that the majority of men who have taken their lives in Torbay have never been near mental health services, and sometimes not even to a GP. We recently did some questionnaires in the barber shop, and, worryingly, 50 per cent of men said that, if they were feeling hopeless, they wouldn't talk to anyone. So we need to get the message across that we do understand: sometimes the pain of living is too much to bear, but there are other options than suicide.

The Mental Health Award will help get that message across and break down the barriers. It can put Torbay on the map in a positive way and let the men of Torbay know that there is somebody rooting for them and wanting to help in a practical, not patronising, way. Somehow the reasons why don't matter anymore – what is important is that men can see that there is another option.

What have I learnt from all of this? I asked Tom recently what kept him going with the work, in spite of life and his business giving him little time. "It is public health," he said. "You keep on at me, like a terrier. We can't give up now."

To me, that is what public health is all about. The art of perseverance. The science of persistence.

Gerry Cadogan
Public Health Principal
Torbay Council

Information

ISSN – 2043-6580

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If you have an idea for an article please submit a 50-word proposal and suggested authors to news@fph.org.uk. The subjects of the remining special features for 2016 are: Arts and humanities (Autumn), What has public health ever done for us? (Winter).

All articles are the opinion of the author and not those of the Faculty of Public Health as an organisation

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Welcome

IN INTRODUCING this, my last issue of *Public Health Today* as President of the Faculty of Public Health (FPH), I would like to acknowledge the commitment and creativity of the editorial team under the leadership of former president Alan Maryon-Davis. As always the present offering is of extremely high quality, and I know from members' feedback that it is always greatly appreciated as a source of up-to-date information and ideas.

I would also like to take the opportunity of thanking David Allen and the remarkable team at St Andrews Place for their superb work over the past three years. Under David's leadership this team has consistently punched above its weight, with vision and grit. Almost all areas of FPH work have been reviewed and much fundamental change and rejuvenation achieved. Just consider our new strategy and the focused and practical manifesto which flowed from it for last year's general election. This will continue to guide our work over the next two or three years. The policy team has been a motor for significant contributions in the form of the support given to the All-Party Parliamentary Group on Health in All Policies, supporting the President and others in giving evidence to the Parliamentary Health Select Committee on a number of occasions and in responding to a never-ending series of requests for input on public health questions by various bodies. It is important to remind ourselves how small the permanent staff team is compared with its output. Our communications team has transformed our ability to present ourselves to the outside world with real and increasing impact, which I am sure will continue in the years to come.

Whether it is the work done behind the scenes to ensure that our governance arrangements are fit for purpose, the formidable effort that has gone into rethinking the curriculum and having it passed by the General Medical Council, the relaunching of our international work under the new Global Health Committee led by Neil Squires or the well-oiled machine that is our examination system, all those involved have reason to be proud. But it can't and won't stop there.When I assumed the presidency I said that the real strength of FPH is our membership and that I wished to mobilise everybody's assets. We have begun to do that with the steadily growing numbers of Special Interest Groups. Nor have I failed to notice the hundreds of our members who contribute their time freely as tutors and mentors, as examiners, journal reviewers and in many other ways. I would like to thank you all and to encourage others to join in. I always believe that the way to get something done is to ask a busy person.

Since David joined us ,one thing we have identified most clearly is the need to reach out and engage with all those who have an interest in protecting and improving public health. We have begun to do this through our partnerships with all the members of the public health network, through the development of corporate membership and through the creation of new pathways into membership categories especially initially that of 'practitioner'.

During this past year, I have chosen to put particular emphasis on public mental health, something dear to a psychiatrist who has long been frustrated by the inability to move upstream. This year's Brighton conference will reflect that priority with some excellent products and tools emerging from the Mental Health Committee, so passionately and ably chaired by Sarah Stewart Brown.

In closing , I would like to thank you all for having me and to say what a privilege and pleasure it has been to serve as your president for the past three years. Many years ago , I learned that one of the most important secrets of success is to surround yourself with people who are better than you are. I would modestly suggest that in that respect, I have had a successful presidency. I believe that with John Middleton as president (interviewed on page 4), David Allen as Chief executive , a refreshed and dynamic board of officers and an increasingly active and growing membership with dynamic partnerships, the Faculty is in very safe hands.

John Ashton

Illicit drugs policy must be evidence-based

THE Faculty of Public Health (FPH) has written to the President of the UN General Assembly, Mogens Lykketoft, to urge him to commit to an evidence-based drugs policy that recognises the importance of prevention, early intervention and social reintegration, and to measures minimising the adverse public health and social consequences of drug abuse. FPH's broad recommendations included:

- Illicit drug policy must be rooted in the most up-to-date evidence-base, as set out in the Lancet Commission on Public Health and International Drug Policy
- A harm-reduction approach is fundamental to evidence-based outcomes, including non-time-limited opiate substitution therapy, needle and syringe exchange and Naloxone access
- Educational approaches for young people must be evidence-based, interactive and peer-led. Personal, social, health and economic education should form part of school curriculums
- Minor, non-violent drug offences, eg. use, possession and petty sale should be decriminalised and health approaches prioritised
- Investment in evidence-based drug service provision represents strong value for money. More research is required into the evidence-base for different types of drug treatment.

You can read FPH's recommendations in full at http://bit.ly/1WKFEsi and learn more about the recent UN General Assembly Session on the World Drug Problem at http://bit.ly/1SOOlQU

Mark Weiss
Senior Policy Officer
Faculty of Public Health

EU strengthens rules on tobacco

WITH its strong focus on preventing people from taking up smoking, the EU Tobacco Products Directive (TPD) (http://bit.ly/1BLFPql), which came into force on 20 May, is good news for public health. The TPD strengthens the rules on how tobacco products are manufactured, produced and presented in the EU. The directive:

- Prohibits cigarettes and roll-your-own tobacco with characterising flavours
- Requires industry to submit detailed reports to member states on ingredients
- Requires picture and text health warnings on tobacco and related product packaging
- Sets minimum dimensions for warnings and eliminates small packages for certain products
- Bans all promotional and misleading elements on tobacco products
- Introduces EU-wide tracking and tracing to combat illicit trade of tobacco products
- Allows member states to prohibit internet sales of tobacco and related products
- Sets out safety and quality requirements for consumer electronic cigarettes
- Obliges manufacturers to notify novel products before placing them on the EU market.

The TPD comes into force only two weeks after the European Court of Justice rejected a legal challenge to the standardised packaging of tobacco products (http://bit.ly/1W8qpuR), which it ruled does not go beyond what is necessary to protects consumers. Standardised packaging, to be introduced at the same time as the TPD, is a significant milestone in our efforts to protect people, particularly children, from the harms of smoking.

Preventing cigarettes from being sold in glitzy packaging will help to protect the next generation of children and young people from starting to smoke. Two thirds of current smokers started when children, and half all lifetime smokers will die from smoking-related disease. The introduction of standardised packaging is a public health priority in FPH's manifesto, *Start Well, Live Better* (http://bit.ly/1wDfDv0)

Mark Weiss

News in brief

India hospital transfusions infect thousands with HIV
At least 2,234 Indians have contracted HIV while receiving blood transfusions in hospitals in the past 17 months, says the country's National Aids Control Organisation.

Diabetes: Children 'not getting recommended checks'
Almost 75% of older children in England and Wales with diabetes are not getting key health checks, a study suggests. Data from 27,682 children and young people showed just 25.4% of those aged 12 and older had all seven recommended annual checks, such as eye screenings, according to the audit by the Royal College of Paediatrics and Child Health.

Utah declares pornography a public health hazard
The US state of Utah has become the first to declare pornography a public health risk in a move its governor says is to "protect our families and our young people". The bill does not ban pornography in the mainly Mormon state but calls for greater "efforts to prevent pornography exposure and addiction".

Anti-cancer jab piloted in gay men
A vaccine to reduce the risk of cancer is to be offered to homosexual men in England in a pilot scheme. The jab protects against human papillomavirus, which increases the risk of oral, anal and penile cancers. It has been offered to school-age girls, to protect them from cervical cancer, since 2008.

Cut in antibiotic prescriptions
GPs in England have "dramatically" reduced the number of antibiotics they give to patients, latest figures show. NHS Improvement says prescriptions for all types of antibiotic were down by more than 2.6 million on the previous year to about 34 million in 2015-16.

Dr Heimlich saves choking woman with manoeuvre he invented
The 96-year-old American inventor of the Heimlich manoeuvre has used the technique himself for the first time to save a choking woman at his retirement home in Cincinnati, USA. Dr Henry Heimlich dislodged a piece of meat with a bone in it from the 87-year-old woman's airway.

INTERVIEW

John Middleton was England's longest-serving director of public health until he retired two years ago after 26 years in the job in Sandwell, in the West Midlands. Now he is the Faculty of Public Health's new President. Here he tells *Public Health Today* what were his proudest achievements and what he plans to do over the next three years

It's the best job in the world

You can be scientific and artistic, says John

What made you decide to specialise in public health?
I had one or two essays as a medical student that were about public health, but I didn't realise it was an entity in its own right then. While I was working in casualty I enrolled for the Liverpool School of Hygiene diploma. A third of the course was about public health.

What would you say are the key ingredients for success in public health at a local level?
Partnership is crucial, because there are some things that partners can do that give you a health outcome. Town planners putting in a 20mph speed limit, for instance. You can do things for partners, such as reducing crime through good harm-reduction drug treatments. You can also achieve more through multi-agency partnerships. For example, regeneration of a whole area requires better housing, street lighting, community services, health services and so on. Sometimes agencies working together achieve much wider benefits. It's coming back into vogue at the moment. It should never really have gone away.

Also, being patient and able to work over long timescales. Looking back at 25 years of coronary prevention work in Sandwell, we could see the point at which we introduced thrombinolytic drugs to prevent coronaries, stop smoking services and bystander CPR training. Over 25 years, cardiac deaths reduced by two thirds. Our reductions were bigger than the trend across the country to the extent that we reduced health inequalities through reducing cardiovascular disease.

Some of this work is intergenerational; with teenage pregnancy for instance, some of the children who were three or four when Sure Starts were introduced are now 16 and not having babies. The benefits of Sure Start maternity grants, working tax credits and the minimum wage are still having an effect on the children who grew up under them.

Were there any particular high points during your time in Sandwell?
When we became a Health Action Zone in 1999, we had over 400 people attend the first Healthy Sandwell conference. We were part of the first wave of Health Action Zones and had to submit proposals for reducing health inequalities and were allocated government funding to deliver them.

In the second year, the innovation fund was a special grant we had to compete for. We had a scheme called Ahead – the Agency for Health and Economic Development, and did work on various projects including social enterprises for health and a time bank. Although Health Action Zones went out of vogue, we managed to keep quite a lot of our schemes going and saw considerable benefit from their work.

Sometimes it's the smallest things that are important. During the mid-90s, we got funding for six computers in six libraries. It started homework clubs which were unheard of at the time. It gave a lot of kids the chance to use a computer for the first time. It contributed to community safety goals and gave the kids a fun thing to do.

Working with the police and criminal justice system has been a long-term interest of mine. Back in 2004 or 2005, I was chair of the drug action team, and we doubled the number of people in drug treatment in a year. The domestic burglary rate fell by a third. It was more than we had expected from the research. People were also designing out crime through measures like street lighting and increased home security.

What are the main lessons that you took from your two terms as FPH Vice President for Policy?
The big message is that, as we've seen with the sugar tax, you plan and expect policy change not to happen for five years and sometimes things give in a hurry. Smoking with children in cars didn't seem to be going anywhere, and then it did. [The sugar tax] also gives the lie to the Responsibility Deal and the idea that we have to exhaust all other methods before introducing laws that change behaviour. It shouldn't be acceptable to wait 10 years and then legislate.

> **The blues has a lot of themes that emanate from major public health disasters, such as the pellagra epidemic, tuberculosis and syphilis**

Sometimes, national policymaking seems very clunky, and you ask yourself why you do it. But if we weren't there, there would be unbridled exploitation of everyone, if you think about tobacco, sugar or gambling. The nanny state has protected rich corporations. What do some people have against nannies? We should recognise the role of strong government in protecting people's health.

What do you hope to have achieved when you step down as President?
I would hope that by the end of my term, the manifesto priorities of protecting kids from the marketing of unhealthy food will have been achieved. I hope we will have turned a corner on the worst excesses of austerity policy, and government will have reinvested in early years. That 1,001 Critical Days agenda is so important. The assault on Sure Start, children's centres and supporting parenting is the reversal of what was an improving situation with child poverty. I would hope that the Chancellor means what he said about not being able to face the next generation about sugar – he needs to do a lot more to protect them on housing, poverty and early years education too.

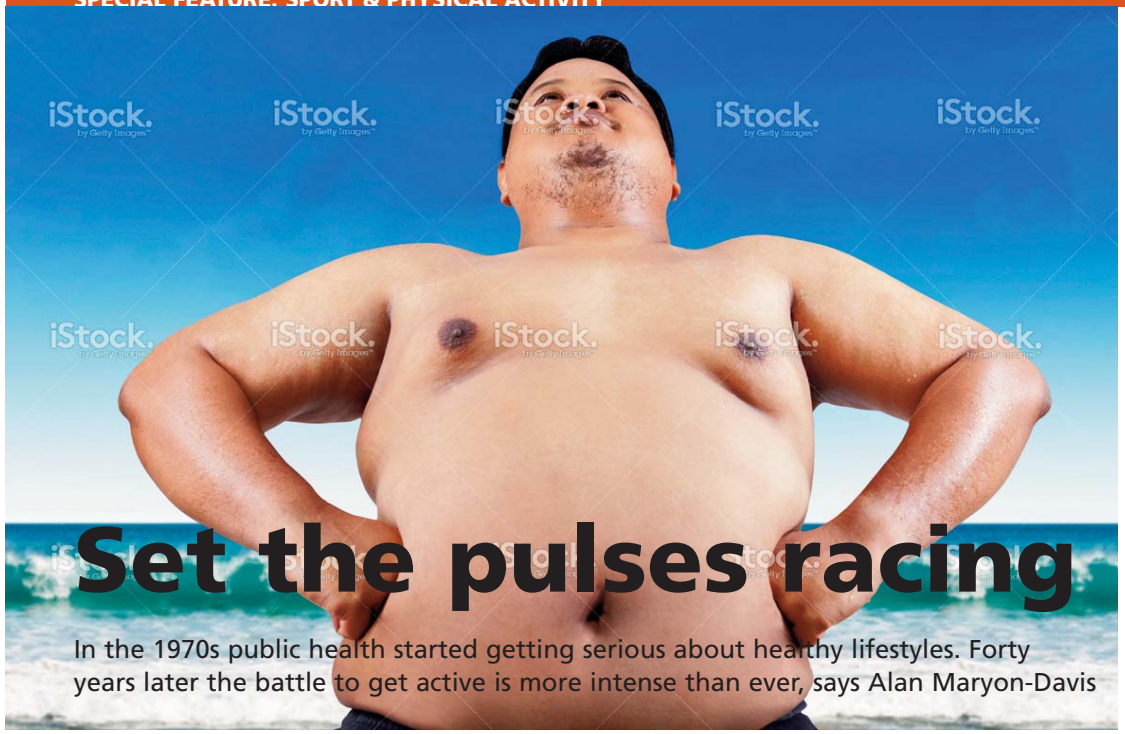
In terms of the public health system, we are in a period of retrenchment. At some point, we have to hold a line that things won't get any worse. By the time of the next public spending round, a measure of that success will be an increase in spending.

We need to capitalise on the brilliant intake of registrars we are recruiting each year. I would like to see the practitioner grade of membership take off. We need to be working more closely with other primary-care practitioners, nurses and midwives and local government. I am concerned that we have lost a lot of capacity for health protection and emergency planning.

If someone was asking you for career advice now, would you advise them to work in public health?
Go for it! It's still the best job in the world. You have an opportunity to be creative and work with the scientific and artistic part of your personality. You'll never have the same two things to do on two days running. You may get dangerous or difficult, you will get conflict, but it's not a routine or mundane drudgery. You have an opportunity to see people's health improve over time. What better job could there be?

How do you plan to combine your music with your Presidency?
Actually, the blues has a lot of themes that emanate from major public health disasters, such as the pellagra epidemic, tuberculosis and syphilis, the Mississippi floods, and the Red Cross Stores set up to answer emergency human needs. There's a Leadbelly song about it. You can find that on YouTube.

Interview by Liz Skinner



Set the pulses racing

In the 1970s public health started getting serious about healthy lifestyles. Forty years later the battle to get active is more intense than ever, says Alan Maryon-Davis

"YOU'LL enjoy sex more with a pair of plimsolls," claimed the full-page tabloid advert for Britain's first massive healthy-lifestyles campaign, nearly 40 years ago. It was the Health Education Council's (HEC) Look After Yourself! Campaign and the blurb went on to say that being physically fitter would do wonders for your sex life. The saucy headline drew predictable complaints from Disgusted of Tunbridge Wells (and tons of extra publicity).

I was working at the HEC at that time and, as well as developing a sudden and inexplicable enthusiasm for jogging, I was very much involved in spreading the word about the joys of physical activity, healthy eating and stopping smoking. We worked closely with the then Sports Council producing guidelines, conducting surveys and co-sponsoring mass participation events.

Look After Yourself! spawned a national network of health trainers and helped to kick-start the trend towards more active living in the UK. By the late 1980s exercise referral schemes were popping up all over the country, and there was a burst of research interest in evaluating the health benefits of physical activity. In 1994 the late Professor Jerry Morris, a giant in the field of cardiovascular epidemiology, felt able to describe exercise as "the best buy in public health".

> **By the late 1980s exercise referral schemes were popping up all over the country**

Now, as we're once again about to be immersed in a wall-to-wall Olympian mega-fest, it seems timely to take a dip into the current state of play with sport and physical activity and the impact on public health. Our Big Debate kicks off with the key question of the moment: Do major sporting events boost public health? On the 'Yes' side we have Helene Raynsford describing how London 2012 spawned the impressive legacy project, Motivate East. On the 'No' side Ignacio Packer talks about the huge human costs of the forthcoming Rio games.

We look at a couple of terrific national initiatives: the This Girl Can campaign, a physical-activity-based confidence-building programme for women, outlined by Jennie Price; and Mike Graney describes the phenomenal success of parkrun.

We have great examples of local programmes in action: Liz Orton on the Everybody Active, Every Day challenge in Leicestershire and Rutland; Tim Woodhouse on how a love of football can boost men's mental health in Kent.

Cornelia Gruell, David Ogilvie and Mike Kelly discuss parallels with smoking in shifting the culture towards more active living. Rachel Aldred makes the case for radical improvements to the cycling infrastructure. And Justin Webb describes the positive role of physical activity for people living with and beyond cancer.

And on the negative side we have Paul Dimeo on doping in sport, Paul Hope on the close ties with gambling and Graham Kirkwood and Allyson Pollock urging action to tackle head injuries in school rugby. So, no shortage of stuff to get your pulse racing.

Now, where are those plimsolls?

Alan Maryon-Davis
Editor in Chief

SPECIAL FEATURE: SPORT & PHYSICAL ACTIVITY

Physical activity as social practice: the lessons from tobacco

HUMAN beings are social animals, but most interventions to address even 'wicked' public health problems tend to focus on individual behaviour. Physical inactivity is a case in point. It is a major risk factor for obesity and other chronic conditions with complex social determinants. A variety of multi-layered, socio-ecological frameworks aim to capture this complexity. These typically map individual behaviour and circumstances, community life and context, socio-cultural norms and values, and political-economic structures. In these models, however, 'behaviour' often remains a stubbornly individual concept.

Social science can help understand how people interact with each other and act together in these complex social worlds. One way is to investigate health behaviours as social practices. This approach focuses on the networks of people engaged in an activity, and the relations between that activity and other activities. For example, whether we walk or cycle to work (active commuting) depends on other commuters and on other practices such as the school run, shift work and shopping. Practices are distinct from the individuals doing them. Many people commute at the same time, and commuting has socio-cultural meaning recognisable even to those who do not commute themselves. This meaning is often particular to a time and place: 'active commuting' has different meanings in Glasgow and in Cambridge and had a different meaning again in decades past.

It is one thing to study physical activity in this way. The next and more important step is to learn from these insights to inform a more effective physical-activity strategy. In this, we can learn from the history of tobacco control. The gradual reduction in the prevalence of smoking is often attributed to the holistic strategy adopted and can be thought of as a test case for the social-practice approach. Strong pathological and epidemiological evidence for the harms of smoking was complemented with social research, for example relating smoking to other practices such as taking breaks at work and going out. Tobacco control strategies now include smoking bans to influence where people smoke and with whom. Alongside taxation, labelling, media campaigns and smoking-cessation services, these innovations have gradually shifted

the socio-cultural, fiscal and political climate – not only reducing the acceptability, desirability and prevalence of smoking, but also changing the practice and meaning of smoking.

Few countries have achieved comparable success in shifting physical activity patterns, but a similar approach may be promising. Public Health England's national physical activity framework emphasises the need to promote physical activity in all domains of life and across society, reflecting a shift in perspective towards a more holistic notion of 'active living' at work, at home and in transport rather than merely promoting sport and exercise. This may entail creating more conducive physical and social environments (such as safer routes for cycling), as well as changing the balance of economic incentives to favour active travel and public transport over car use. Packages of measures like this can change the socio-cultural landscape over time. Famously, Amsterdam was a car-centric environment in the 1970s but transformed itself through radical urban planning into the bicycle capital of the world. Tackling physical inactivity with the vigour previously applied to tobacco control might reap similar benefits.

Cornelia Guell
Research Fellow
David Ogilvie
Programme Leader
MRC Epidemiology Unit and Centre for Diet and Activity Research
University of Cambridge
Mike Kelly
Senior Visiting Fellow
Department of Public Health and Primary Care
University of Cambridge

Families swap four wheels for two feet

WE KNOW that encouraging more children to walk to school is one of the best ways to start tackling the inactivity crisis. The majority of children (79%) are not getting their recommended 60 minutes of daily exercise. Walk to School Week encourages families to swap four wheels for two feet.

Teachers say that pupils who walk to school are more alert, ready to learn and get better grades than those who come by car. Fewer cars mean fewer traffic jams and less pollution around the school gates. Despite these benefits, just 46 per cent of primary school age children walk to school, compared with 70 per cent of their parents' generation.

Inactive lifestyles are causing serious health issues with one in three children leaving primary school obese or overweight. Not only are we experiencing an obesity crisis, we're also facing a rise in mental health and wellbeing problems. We know that keeping active is a major part of the solution. Living Streets's research has found that more than half of parents see a noticeable improvement in their children's happiness after they've walked to school.

The theme of this year's Walk to School Week in May was 'Strider's Walk in the Wild', with resources focusing on the walking habits and environments of different animal species. Over 14,000 classes took part; that's approximately 400,000 children walking to school. Our mascot, Strider, visited schools across the UK, including a tour through Wales and a trip on a ferry to see Shetland schools.

The main event of Walk to School Week, Happy Shoesday, saw thousands of children and staff in over 300 schools wearing the shoes that make them the happiest and donating to Living Streets. The money raised will go to our work with schools, disability groups and local communities.

Walk to School Week is a great way to celebrate walking and can be a stepping stone to WOW – our year-round walk to school challenge. WOW allows children to experience the mental and physical health benefits of walking all year-round and has been shown to increase the number of children walking to school by 23 per cent on average. Most importantly, children love taking part.

Kathryn Shaw
Media and PR Coordinator
Living Streets

DEBATE: Do major sporting events boost public health? Helene Raynsford says they can build a platform for participation, while Ignacio Packer says the costs may be too high

Games have made thousands more active

WHEN news of London winning the race to host the 2012 Games broke, I was in a public health team meeting at the Government Office for the south east of England. There was celebration, but at the time I did not comprehend how the Games could unite the country or provide a platform to improve the health outcomes of those with chronic conditions.

Four years on and the London Legacy Development Corporation (LLDC)'s Motivate East project has used the legacy of the Paralympics to engage 17,961 individuals with disabilities and chronic health conditions in physical activity living within the seven boroughs neighbouring Queen Elizabeth Olympic Park. The programme has created strong partnerships between local authorities, the NHS, leisure providers and the voluntary sector that have been integral to its success in surpassing its Sport England target by 200%.

Although the programme provides opportunities to use the facilities in the park, it also provides 1,454 pieces of equipment to local clubs, community centres and clinical settings. It has created more than 700 opportunities for volunteers with disabilities, some having attained formal qualifications and employment. The legacy of the Games is not just about

YES

encouraging the nation to be more active, but demonstrates the impact of the Games on the wider determinants of health in a population group often at a disadvantage.

Motivate East is now starting 'phase two', taking the values of paralympic sport to those with mental health conditions, dementia, chronic pain, HIV, cancer and complex disabilities. The strengths of Motivate East lie in the local networks that have been built with strategic leadership from London Sport and the LLDC. Engaging families and carers has been integral to increasing participation by those with complex chronic conditions. Some sessions have been delivered in healthcare settings such as mental health inpatient facilities. Activities were better attended when we did not target a particular population but advertised the activities as open to all in specific settings relevant to the intended target population.

It has been an honour and a privilege to represent my country at sport. But away from the lake, sport has given me rehabilitation, employment, social circles and most importantly to me, independence. As we approach the Rio Games, it is time to think about how we use the local offer of sport as a tool to engage people with chronic conditions and to ensure activity is included in the management of all chronic disease.

Helene Raynsford
Chair
Motivate East Board
Paralympic Gold Medallist in rowing

The Rio legacy: violations of human rights

THE Olympic Games and the Paralympic Games will take place in Rio de Janeiro this summer. A consideration in bidding to host these kinds of events is the potential for the Games to generate a wide range of benefits for the population of the host city. Such assumed benefits – often collectively termed the 'legacy' – include improvements in employment levels, the economy, housing, national and local pride, the environment and sports provision. These outcomes represent key socio-economic determinants of health, suggesting that the investment has the potential to improve health.

A large amount of research on the impact of mega sporting events on host populations is available, but this body of evidence is not sufficient to confirm nor refute expectations about the health or socio-economic benefits for the host population of previous mega sporting events. Until decision-makers include robust, long-term evaluations as part of their design and implementation of events, it is unclear how the costs of mega sporting events can be justified in terms of benefits to the host population.

There is however evidence of negative effects on socio-economic determinants of health directly linked to the organisation of mega sporting events. The disappearance of street children in Rio ahead of the Olympic

NO

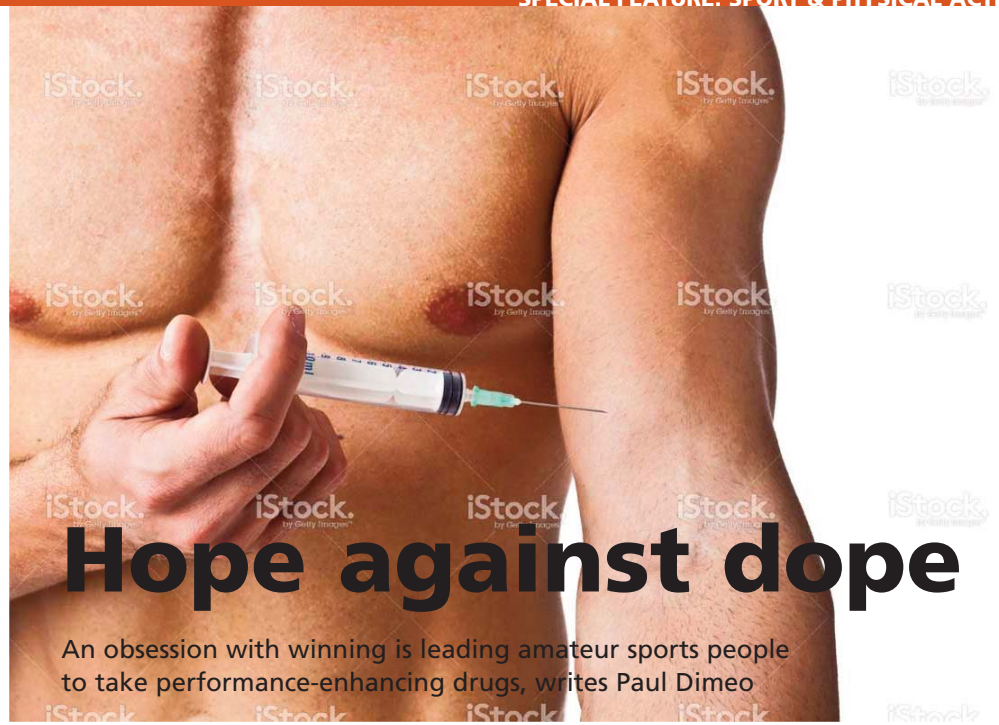
Games has been widely reported. In order to 'clean up' tourist areas for visitors to the Games, many street children were taken to young offenders' units, where they reported violence and humiliation. Others simply disappeared. In Rio, over 4,000 families have already been evicted from their homes to make way for projects directly or indirectly associated with the Games.

The impact of these actions on children ahead of the Olympic Games in Rio are documented by the campaign Children Win (www.childrenwin.org) co-ordinated by the child rights organisation Terre des Hommes (www.terredeshommes.org). Academic research, investigations and the views and opinions of young people report on how for thousands of children, the dream of the Rio Olympics brings detrimental effects on their health and wellbeing.

Through the International Olympic Committee (IOC) Agenda 2020, the IOC has made advances with regard to its responsibility for transparency, accountability and human rights. Building on the progress achieved to date, there is a need and opportunity to go even further. A set of additional policies and practices to be adopted by the IOC will offer the potential to better embrace the public health risks and opportunities before, during and after the Olympic and Paralympic Games.

Ignacio Packer
Secretary General
Terre des Hommes

SPECIAL FEATURE: SPORT & PHYSICAL ACTIVITY



Hope against dope

An obsession with winning is leading amateur sports people to take performance-enhancing drugs, writes Paul Dimeo

THE culture of amateur sport is increasingly reflecting that of professional sport with the use of personal trainers, high level equipment and serious competition. And with this has come the use of performance-enhancing drugs and all the associated health risks.

Anti-doping policy is primarily targeted at elite athletes, as highlighted by the Lance Armstrong and Dwain Chambers cases. However, 'clean' athletes also need to be regularly tested. One of the main challenges in tackling drug use in amateur sport is the cost of testing. A single test can cost £500-800, depending on the circumstances and the suite of drugs being tested for.

When amateur rugby players Shaun Cleary and Ryan Watkins were caught doping last autumn, Cleary still had cocaine in his system, which he had used three days before he was tested after a match. Cocaine is only banned in-competition, so in some ways he was unfortunate. Watkins, on the other hand, was using the anabolic steroid nandrolone and the stimulant methylhexaneamine; his attempt to cheat through artificially enhancing performance was more purposeful and deliberate. Perhaps even more seriously, the Lincolnshire amateur, Dan Lancaster, was banned for four years after admitting he ordered 300 ampoules of anabolic steroids that were seized at the UK border.

Rugby is not the only amateur British sport to have seen doping cases. Cyclists Dan Stevens and Jason White were banned for two years, the latter for refusing to provide a urine sample. Stevens was a 39-year-old low-level club rider who had his ban reduced by three months after helping an international cycling investigation. He has spoken publicly about an English doctor whom he claims told him that he was prescribing doping drugs to over 150

> **The Olympics is focusing on specific sports, arguably at the cost of others**

British sports men and women.

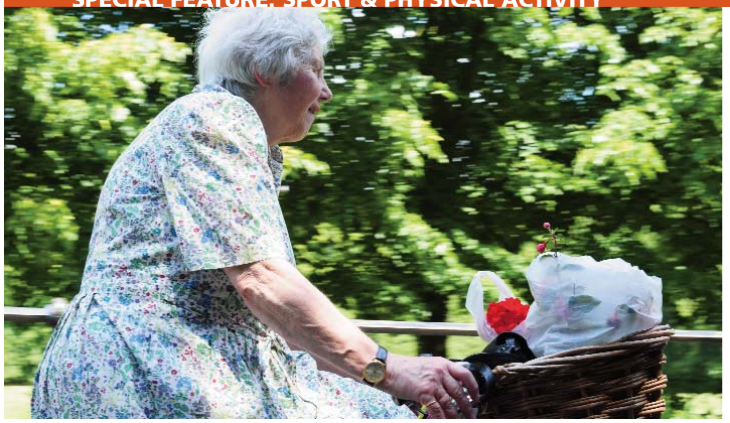
Weightlifting and bodybuilding are sports generally associated with a culture of tolerance when it comes to illegal muscle-building and fat-reduction drugs. Recent media reports claim that up to a million people in UK are regular steroid users, including police officers and military personnel. The health implications of such widespread patterns of abuse are not very clear. Steroids are often associated with heart and organ problems and changes in personality, but the evidence is patchy and there are many long-term users who successfully manage their own health issues.

The Olympics is focusing efforts on specific sports, arguably at the cost of others which are being left to drift. UK Anti-Doping (UKAD) works alongside sports organisations, but the former only has a budget of £7m to cover 40 sports.

For health and sports practitioners working with aspiring athletes or with those who simply want the health benefits of an active lifestyle, education and cultural values are essential in creating an anti-doping environment. Suspicious behaviour can be reported to UKAD who might organise a 'targeted test', though the policy only covers people who take part in competition. Potential users might be reminded of the health risks. Steroid users need to use safe needles and get the right advice on dosages. Even legal supplements can be risky: in 2013 Claire Squires died during the London Marathon after using a supplement that contained the amphetamine DMAA.

A health-based approach for amateurs needs the support of medical experts and the promotion of a culture of participation, community, respect and health, rather than an obsession with winning.

Paul Dimeo
Senior Lecturer in Sport
University of Stirling



Real infrastructure, not just paint and helmets

CYCLING has huge potential to improve health, building physical activity into everyday life. This is particularly true if cycling is normalised across the life-course: older people gain most from increased physical activity. However, in the UK, cycling's share of trips is stuck at 2%. In other European countries, it can be as much as 25%.

How can public health practitioners help cycling again become a mass-transport mode with all the associated benefits? In UK transport policy, cycling is traditionally individualised, not seen as a system of provision. Rather than follow high-cycling countries and spend at least £10 a head annually on good quality infrastructure, we've spent pennies on paint and saying "cycling is good for you". Most people find the prospect of riding with HGVs and buses terrifying, so promotion hasn't been very effective.

We've responded to these fears by telling people to wear helmets and high-visibility clothing. This is problematic because cyclists pose little danger to others, but face relatively high risks themselves. Shaming or scaring them into wearing personal protective equipment inverts the risk pyramid and distracts from the need for safe, comfortable cycling environments. Where cycling is normal, people don't wear fluorescent yellow to ride to the shops.

Focusing on individual behaviour change is a 'downstream' response to a systemic problem and risks stigmatising individuals. Instead, transport policy needs to learn from the 'upstream' public health tradition of changing systems that constrain individual choices.

> **Where cycling is normal, people don't wear fluorescent yellow to ride to the shops**

People say having to mix with motor traffic is their major barrier to cycling and they want separation. Women and older people tend to feel this particularly strongly. Parents fear letting children ride, including on residential 'rat run' streets.

In countries with a network of pleasant, direct utility routes – including protected infrastructure and measures to stop rat-running – cycling is more common and more equitably distributed. This is the crucial 'upstream intervention' needed, which public health practitioners and organisations should prioritise at national and local levels.

They are also well placed to lobby for change in transport appraisal practices, challenging the assumption that saving extra seconds on motorists' journeys should be equated with and prioritised over public health gain. This bias has been used to block safe cycle infrastructure proposals and justify wasteful, unhealthy road schemes. Transport practitioners who want a different approach need the help of a strong public health voice.

Rachel Aldred
Senior Lecturer in Transport
University of Westminster

Football helps tackle stigma of male suicide

SUICIDE is the leading killer of men under 45 in Kent. In 2013 only 20% of people who took their life in Kent were known to secondary mental health services. This means supporting men in the community who are at risk is difficult, as we don't know who they are.

In order to reach as many men at risk as possible, the public health team in Kent partnered with the Kent County Football League and used their communication channels, including fixture lists, website and emails, to raise awareness of Mental Health Matters, a 24/7 helpline. This helpline is commissioned by Kent County Council to support individuals who are stressed, depressed or anxious with expert support and advice. We also provided training in mental health first aid to football clubs to enable each club to have a mental health expert.

The campaign used existing services to reach approximately 6,000 men, including players, officials and volunteers, across Kent on a weekly basis throughout the football season.

The campaign received excellent coverage in print, online and on the radio. This convinced us to create a larger campaign to reach men across the whole Kent population. We commissioned an agency to help us develop the Release the Pressure campaign. This uses social marketing tactics to encourage men to call the 24/7 helpline. We have created striking visual images which are displayed where men have time to reflect and take in the message, such as on petrol pump nozzles, in service-station toilets and on pub beer mats.

League One team Gillingham FC had a Release the Pressure advertising hoarding around their ground and made their manager available for media interviews. Release the Pressure does not have the words 'mental health' in the new campaign. Instead, we highlight life events, such as divorce, debt and bereavement. We are using a detailed evaluation framework and are pleased with the results so far. During the first seven weeks of the campaign, calls from men to the helpline, which now takes over 300 calls a week, have increased by around 20%.

Tim Woodhouse
Public Health Programme Manager
Kent County Council

It's in the can

Many more men play sport than women. This Girl Can aims to get women moving, regardless of shape, size and ability, says Jennie Price

ONE of the youngest women in the room stopped me on the way out of a meeting. "I loved This Girl Can," she said. "I saw it every morning at my bus stop, and it just made me smile. I felt like it was talking to me."

The This Girl Can campaign set out to change the way women thought about themselves when getting active, help them build confidence and inspire them to get involved. The campaign was born in January 2015 via an advert during *Coronation Street*. Within an hour, the internet went a bit crazy. #ThisGirlCan was trending at number two on Twitter. Women were talking about fear of judgement, being hot and not bothered and digging out trainers from their wardrobes to go for a run with their girlfriends. It soon spread around the world; to date, the ad has been viewed 37 million times on Facebook and YouTube alone and was being talked about on social media every single day last year.

But we needed to know why the campaign connected to so many women, and if they did anything other than just talk about it. We commissioned independent research which revealed that 2.8 million women, aged 14 to 40 and who recognised This Girl Can, said they had done some activity as a result. Almost 148,000 more women were active for at least 30 minutes once a week, every week in the 12 months up to September 2015, compared to the 12 months up to March 2015. For a campaign in its infancy, especially one tackling such an ingrained and personal issue, this is a really significant change.

Last year, we also commissioned an in-depth study of a group of 50 women over a period of six months. They formed an online community, discussing how they felt about sport and exercise, what they were doing, and what was influencing them.

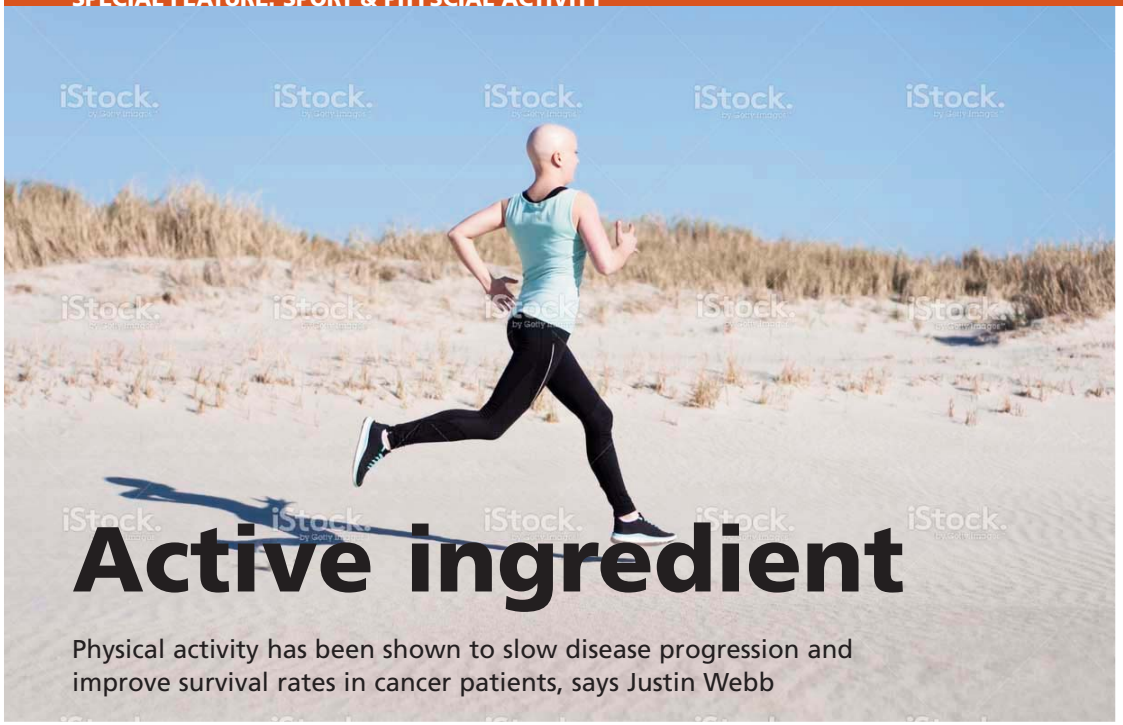
> **The word 'exercise' provokes negative images – from glossy airbrushed bodies to sheer grind with no pay off**

To make sure the results weren't biased, our researchers mentioned This Girl Can only at the very end of the research. That didn't stop them talking about the campaign: one or two even suggested the researchers should talked to us! These women were very helpful because they were honest and willing to discuss their feelings and what was influencing their choices. We learned a lot from that study, particularly that the fear of judgement – of their appearance, their ability or the fact that they were choosing to spend time on themselves – tended not to leave women completely. They managed it by building confidence and resilience and by actively avoiding environments that make them feel uncomfortable.

This Girl Can is helping women who are in the very earliest stages of thinking about physical activity, including those who have written off exercise as not being for them. Some women, who had hated sport since school, began to think that maybe they could go swimming, join a Zumba class or go for a bike ride. That's a huge step if you've not even contemplated physical activity for years.

Overwhelmingly, the word 'exercise' provokes negative images – from glossy airbrushed bodies to sheer grind with no pay off. This Girl Can reminded women it can be fun. We had 600 pages of research – that's just the summary – that told us how women thought and felt about sport and exercise. That has guided every decision we've taken about the campaign and is probably the most important lesson I've learned: listen, test, then listen some more.

Jennie Price
Chief Executive
Sport England



Active ingredient

Physical activity has been shown to slow disease progression and improve survival rates in cancer patients, says Justin Webb

IT IS estimated that the number of people living with a cancer diagnosis in the UK is 2.5 million, and this is set to rise to four million by 2030. Unfortunately, many of those will suffer from long-term physical and psychological adverse effects that are not only uncomfortable but also affect the quality of life of both the individual and their family. These side effects can be financially damaging and often require more frequent and costly medical interventions.

Leading a physically active lifestyle both during and after cancer is linked to an improvement in many of the adverse effects of cancer and its treatments. An active lifestyle helps to overcome fatigue, anxiety and depression, whilst protecting the heart, lungs and bones. Being active can support the maintenance of a healthy weight, improve physical function and enable people to return to work. In some cases, being physically active has been shown to slow disease progression, improve survival and reduce the chances of recurrence. What is more, the benefits of physical activity span several common cancer types involving a range of treatments, including surgery, radiotherapy, chemotherapy, and hormonal and biological therapies.

It is advised that people living with cancer avoid inactivity and are as active as their abilities allow, even those with an existing disease or undergoing difficult treatments. Where possible, people living with cancer should gradually work up to the standard age-appropriate guidelines for physical activity. Despite the proven benefits, only 23 per cent of people living with cancer are active to recommended levels.

A cancer diagnosis often offers a window of opportunity in which patients are more receptive to lifestyle changes. People living with cancer need to know that it is safe to become and stay active at a level that is right for them, listening to their bodies, starting slowly, building gradually and planning around treatment cycles and physical limitations. These messages need to come from trusted healthcare professionals and should be delivered at every opportunity, making every contact count. Messages should be delivered sensitively, with signposting onwards to resources and further support.

> **Despite the proven benefits, only 23% of people living with cancer are active to recommended levels**

Qualitative research by Macmillan Cancer Support showed that people living with cancer are motivated to be physically active with family, friends, and pets, wanting it to be part of family time rather than competing with it. Family members and friends would benefit from receiving advice along with their loved ones on physical activity to encourage their involvement in discussions, planning and taking part.

The use of terminology when talking about becoming and staying active is important and could affect whether people are engaged or put off. Language should focus on 'moving more', 'increasing everyday activities', and 'reducing sedentary time'. Use of the phrase 'increase physical activity' could be off-putting for some, particularly those who were not engaged in formal exercise or sports before their diagnosis.

Activities and classes need to be appropriate for the patient's particular condition, led by people who understand their needs and in an environment where the patient is not concerned about social stigma.

Physical activity has been described as a "wonder drug". However, it remains an under-used one.

Justin Webb
Physical Activity Engagement Manager
Macmillan Cancer Support

Time to tackle the issue of head injuries

IN APRIL 2016 the Department for Culture, Media & Sport announced a 'sport duty of care review' to "make recommendations to government and its agencies on the establishment and content of a formal 'Duty of Care' to athletes and participants, in both elite and grassroots sport". Our response covers five key areas:

- **Conflation of benefits of physical activity with benefits of sport.** Ministers, policy makers and some medical professionals conflate physical activity and its benefits with sport. We argue that this distinction must be maintained, not least because of the commercial pressures inherent in sport governed by corporate sporting bodies. If children are to be protected, governance of all school sport, including the rules of play in schools, should be determined by the Department for Education.
- **Compulsory participation in school sport.** Children and parents should be able to exercise choice as to whether they play particular sports within school and be free to do so without coercion or pressure. This is often not the case. In an as yet unpublished survey carried out last year of 116 private schools, 76% were found to have compulsory full-contact rugby. In a survey in 2016 the *British Medical Journal* (*BMJ*) found 72% of UK doctors thought school rugby should be made safer.
- **Injury monitoring and risk assessment to inform prevention and management.** There has been a failure by all governments across the UK to put in place comprehensive injury surveillance systems to monitor and communicate the harms and risks of injuries from sport at grassroots level and in schools. Injury data are vital for prevention strategies and risk assessment; the relevant authorities cannot comply with their health and safety and human rights obligations without the right data.
- **Safeguarding policies should be grounded in the United Nations Convention on the Rights of the Child and Safeguarding and Health and Safety Legislation.** We would argue that compelling children to play any sport, failing to inform them about the risks of injury and the absence of injury monitoring systems and primary prevention strategies places the government in dereliction of its duties under this convention.
- **Primary prevention of injury including concussion should be the priority while management of injury protocols must also be evaluated.** While concussion awareness and return-to-play protocols are important, prevention of concussion and other more serious traumatic brain injuries is essential, but not the primary focus of schools. Sports which involve repetitive head trauma need to be made safe for children to play. Protective equipment, it has been shown, has no role to play in this; thus rule changes are required. In a *BMJ* survey,65% of doctors thought the rules of rugby needed to change to reduce the risk of concussion.

We recommend removing the contact element of rugby for children as the quickest and simplest way to make it safer in schools. As a replacement, touch or tag rugby can be played by children to enable them to learn the rules and techniques of rugby, both Union and League, in a safe environment.

Graham Kirkwood
Research Fellow
Barts and the London School of Medicine and Dentistry Centre for Primary Care and Public Health
Allyson Pollock
Professor of Public Health Research and Policy
Queen Mary University of London

Fitness for all is up and running in the park

OUR MISSION at parkrun is to make the world a healthier and happier place. In the UK we see more than 80,000 weekly runners at nearly 500 free events across our Saturday 5km and Sunday 2km junior parkrun series. We have 1.5m UK registrants and add another one every minute. At registration we collect data on gender, age, postcode and current activity levels. We plan to collect data about disability, ethnicity and sexual orientation as we strive to make parkrun as accessible as possible to all.

The previously inactive are our fastest growing group, up 54 per cent in 2015, although they are over-represented in the group who have registered and not yet run. Last summer we surveyed our non-runners, and "not feeling fit enough" was a key reason given for not participating. Since then we have made it clearer that we welcome walkers, and results show that 5km times over 50 minutes are growing at twice our overall growth rate. Females make up 41% of total parkrun performances, on a 10-year positive trend, with our new runners in 2016 being mostly female.

We use government deprivation data, partnering with bakers Warburtons in October 2015, to encourage children and families from deprived areas to be active. Since then we have launched 13 junior parkrun events in deprived areas.

We feel that volunteering provides as many benefits as running, and 8,000 volunteers deliver our events each week.

We would be delighted to collaborate with public health professionals to share insights and welcome their thoughts on maximising our impact.

Mike Graney
Head Data Analyst
parkrun

Everybody works together every day

WE HAVE been set a challenge to get 'everybody active, every day': encouraging the most inactive to become active and build physical activity back into daily lives. We need to do this with less money. Making it happen will require a radical review of how the whole system works to identify and capitalise on co-benefits. For example, by increasing active travel opportunities we can reduce road congestion, improve air quality, increase footfall in shopping areas and at the same time improve physical and mental health.

We can only identify and achieve these co-benefits if partners work together to make best use of our funding and our community assets. It's not that we have solved this in Leicestershire, but we have developed a way of working that is helping to deliver more benefits to our population than could be achieved by public health alone.

In 2012, we established a sport and physical activity group, formed of partners from the county council (public health, environment/transport, chief executives, children and families, adults and communities and corporate resources), the district and borough councils and the county sport partnership (Leicester-Shire & Rutland Sport). Together the group co-designed a county-wide sport and physical activity plan that has evolved to take a whole-system view of physical activity. The plan is delivered through grant funding from public health and Leicester-Shire & Rutland Sport, awarded to our seven district and borough councils. The districts and boroughs set out

> **District and borough councils bring their own funding to the table**

their plans to deliver the county plan and implementation is monitored by Leicester-Shire & Rutland Sport. Monitoring includes throughput, cost/attendance, equity and physical activity outcomes.

We have decided on priorities that sit with a whole system. These are:

- **Moving at scale:** large-scale behaviour change programmes (eg. mass participation events and campaigns) that target inactive people, maximise assets such as workplaces and green spaces and complement other council commissions such as active travel schemes.
- **Inactive young people:** delivered through school sports and physical activity networks and focusing on the development of fundamental movement skills (key stage one), inactive girls and wider programmes such as active travel-to-school, Bikeability and weight management.
- **People with long-term conditions/frailty:** delivery of community-based exercise on referral, cardiac rehabilitation and active-aging programmes, eg. postural stability instruction.

Funding is weighted on the prevalence of health inequalities and population size and by using this partnership approach, district/borough councils bring their own funding to the table. Between 2012 and 2016, just over £4 million was invested in the plan by public health. Leicester-Shire &

Rutland Sport and district/borough partners have contributed nearly £5million in matched funding.

Work continues outside the plan to align physical activity provision and clinical pathways via our place-based Better Care Together programme with clinical commissioning groups, including supporting initiatives such as the National Diabetes Prevention Programme. We are also developing links with academic partners to build research-receptive localities that can support the delivery of research in return for expert academic input and innovative interventions.

However, there is still work to do on the whole system, particularly around the 'place'. We need to work better with town planners, the Local Economic Partnership and the charitable sector and explore the role of technology as a motivator of behaviour change. Finally, it's not clear yet where devolution will take us, but it could provide the architecture that we need for system-wide work to get 'everybody active, every day'.

Elizabeth Orton
Consultant in Public Health
Leicestershire County Council

We should not gamble on the public's health

IN RECENT years, increased coverage of sport on TV has coincided with significant growth in gambling advertising. There were more than 14 times as many TV gambling ads in 2012 as there were in 2005. And in the 2015/16 football season, seven out of the 20 Premier League teams had a gambling company on their shirt, and every team has an official gambling partner.

These changes have increased the presence of gambling images and inducements in our homes. Should we be concerned? The impact of advertising on gambling-related harm is poorly understood. But there is no doubt that gambling-related harm is a major public health issue.

The majority of people who gamble do so safely most of the time. Yet evidence suggests there are around 250,000 problem gamblers in Great Britain, with a further 470,000 people at moderate risk of experiencing gambling-related harm. And gamblers' families, friends, communities and employers can all suffer as a result.

The Responsible Gambling Strategy Board, which advises the Gambling Commission, recently published its National Responsible Gambling Strategy. This contains 12 priority actions, many of which fall to the gambling industry. However, the strategy argues that gambling-related harm should be tackled in a comprehensive way alongside other public health issues. So, a wider range of public and other organisations, including those involved in mental or other health services, will need to work in partnership if the strategy is to succeed.

Paul Hope
Programme Director
Gambling Commission

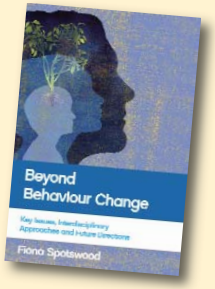
Changing the way we change behaviour

IMMERSED each day in organisations where decision-makers believe that enlightening people that something is bad for them will make them choose healthier options, it's all too easy to find yourself pushed into colluding. A chief executive once told me that reducing obesity was actually fairly simple: "If only poorer families realised that it's just as cheap to make your children healthy brown bread sandwiches as..." Immersed daily in that kind of attitude, how easy to stick with the 'how to' manuals.

This book takes some steps back, examining the complexities of behaviour change and the multiplicity of factors such as the media, public support and political aspects needed to change population health. It still needs to be accompanied by the practical guides, but unless we update our academic knowledge, how easy to end up only ever reading systematic reviews.

Some chapters examine theories, legislation, design and evaluation. Others analyse the sheer complexity of persuading complex alliances of organisations to do all the expensive things needed to influence large numbers of people to do healthier things that are difficult and go against habit, comfort and relentless advertising. But to influence physical activity, eating, drinking and smoking, we do need a more academic understanding of recent research into 'behaviour change', and its interactions with policy change and politics. Examples illustrate the factors distinguishing cities that successfully changed road design and increased public cycling tenfold from those where they changed the roads but the cycles stayed rusting under the stairs. It is important to get this right when you have a multi-organisational city alliance understandably hesitant about investing lots of money in a major traffic permeability system. And when trial results from another country may be difficult to apply.

This is a realistic, pragmatic collection, exploring what fails as well as what works, and the uphill work of influencing political change. The examples of how smart tracking technology for self-monitoring has proven effective in increasing people's regular physical activity stand alongside cases of where it hasn't lived up to expectations. Finally, and essentially for those public health people working in organisations where it's heresy to acknowledge the possibility that giant commercial interests may have any influence on health behaviour, the chapter 'Stakeholder marketing and the subversion of public health' explicitly covers just that. So, not comfortable reading. But very helpful in enabling us to take a step back from our often narrow focus.



Andy Beckingham

Beyond Behaviour Change
Edited by Fiona Spotswood

Published by Policy Press
ISBN 978-1447317562
RRP: £21.59

How Dame Bewley made it to the top

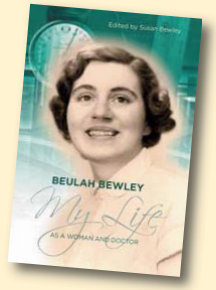
THIS autobiography of Dame Beulah Bewley, an Ulster Protestant born in Derry/Londonderry. After a varied medical career, Dame Bewley became a public health consultant and senior lecturer with the London School of Hygiene and Tropical Medicine. She also played key roles in the General Medical Council, as honorary treasurer, and in the Medical Women's Federation, ultimately becoming its president. In addition to the significant achievements in her career, recognised by a damehood, she was mother to four children, one of whom, Susan, edited this book.

Dame Bewley portrays growing up first in Northern Ireland and then in the Republic in the 1930s and 40s and the everyday manifestations of divisions between Catholics and Protestants at the time. She then describes her life as a doctor, predominantly working in London, providing rich detail on her family life with her husband Thomas and her four children.

Characters and episodes are introduced, and then reintroduced and elaborated upon later in the book. This creates a conversational and at times meandering tone. Gems of sentences are found in the midst of factual descriptions, my personal favourite being: "Somebody commented that my perineum looked like the battle of Mons", appearing in a passage about the author's experience of life-threatening post-natal complications. Deadpan lines like these point to the resilience characteristic of those from Dame Bewley's generation.

The author's strength of character is also revealed by how little she makes of the likely struggles she fought to gain success in her career. She frequently mentions barriers she faced due to sexism but seems to have overcome these with steady determination and by maintaining a sense of quiet self-confidence. In her own reflections at the end of the book, she quotes Baroness Wootton who said: "I have never had any problems [encountering sexist attitudes] with mature and intelligent men."

Her evident characteristics of resilience and determination do not prevent the author from sharing moments of self-doubt. Like all mothers I know, she worries that she could have done more for her children, particularly for Sarah, her second child, who had Down's syndrome and congenital heart disease. These frank admissions add humanity and vulnerability to her story.



The book ends with concerns about the future of the NHS, an emphasis on the on-going need to support those juggling family and medical careers, and a re-emphasis in society on prevention rather than cure.

Helen McGeown

My Life as a Woman and Doctor
Beulah Bewley

Published by SilverWood
ISBN 978-1781324196
RRP: £25

From the CEO

LIKE many, I have always had an on-off relationship with sport. Since I was a child I have rarely been happier than when outside kicking a ball, climbing a hill, wielding a bat or just running around for the love of it. I have played football, cricket and badminton, run sprint, hurdles and numerous 10km races and half and full marathons. I've walked the highest mountains, climbing up and abseiling down rock faces along the way. I have cycled, canoed and run from coast to coast in England, Scotland and Wales. Even in my mid-to-late forties, I learned to ski, ballroom dance and joined a triathlon club.

So why an on-and-off relationship? Well, there is a lot that can put you off sport. It can cost a lot of money. As a child, not getting picked to play can damage self-confidence. Many adults are concerned about looking the part – body image and fitness levels can put folk off before they even start. At a personal level, the cuts, bruises and broken bones don't hurt as much as non-participation through injury. Exercise lifts my spirits, reduces tension and improves my mood like little else – and when I can't exercise the opposite effects kick in!

I'm lucky to have had the opportunity, time, encouragement and money to participate – and I have gained enormously from the experience. So it's easy to understand the greater barriers to participation for people without these resources or opportunities. I place great emphasis on the softer qualities that sport and exercise can give: confidence and determination, as well as team and social skills.

How sad then, to hear of the recent decision by a local parish council to charge parkrun for the use of a park. parkrun is a free, 5km timed run in local parks, staffed by volunteers (see page 13). Established in 2004 it has now attracted a million people in 400 locations to run an average 10 times.

The council's argument highlights the perceived costs of wear and tear and the duty of an organisation with a few paid staff to pay its way. Aside from the great shame that budget cuts mean such courses of action are considered, councillors have ignored the enormous health and economic benefits despite the support of the Chief Medical Officer!

So there is much still to be done to advocate for sport and exercise opportunities – a clear role for the Faculty of Public Health and our members. This is all part of tackling health inequalities and – if you'll excuse the pun – creating a level playing-field.

David Allen

INTERNATIONAL PUBLIC HEALTH ATTACHMENT: SOUTHERN AFRICA

We are looking for a senior public health trainee who is interested in spending a 6 - 12 month attachment in Swaziland during 2017 and 2018. This is a great opportunity to develop personal public health skills and make a major impact on the health of the population in a rural African region.

Public health programme

Over the last ten years a partnership of NHS and the Nuffield Centre for International Health has developed a very popular and highly successful public health training programme for UK trainees in Swaziland. The programme has been effective in assessing local health needs and planning and implementing community-based TB, HIV/AIDS and chronic disease programmes.

Training attachment

We are looking for a motivated and dynamic individual who is interested in gaining experience and training in international public health and specifically the implementation and evaluation of TB and HIV/AIDS prevention and treatment programmes. For further information and past trainee reports visit: http://www.bradfordresearch.nhs.uk/our-research/international-public-health

Flights and accommodation will be paid for by the programme, with trainees seconded on salary from their existing training programme. The programme has been accredited for training secondments by the Postgraduate Medical Education and Training Board. For further details please contact: **Professor John Wright, Consultant in Public Health & Clinical Epidemiology, Bradford Institute for Health Research, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ. Email: john.wright@bthft.nhs.uk • Tel: 01274 364279**

In memoriam

Clifford Shaw FFPH
1919 – 2015

CLIFFORD Shaw was the last medical officer of health (MoH) at Sheffield City Council prior to the transfer of public health responsibilities to the NHS in 1974. When I took public health back into the council from the NHS, I thought it would be interesting to meet to compare our experiences and perspectives, which we did in November 2014, when he was 96.

Dr Shaw qualified from Barts in 1942. After three years in the army immediately after graduation, he gained a Diploma in Public Health and then worked in Ipswich, Nottingham and Rotherham local authorities, before moving to Sheffield as Deputy MoH in 1956. After the incumbent MoH retired in 1965 he was appointed to the post by the Chairman of the Health Committee without the post having been advertised, a fact which worked to his disadvantage later. At that time he was responsible for 1,100 staff, providing services ranging from ambulances to health visiting.

He told me he always enjoyed working with politicians. His main link was with the Chairman of the Health Committee, whose views he "always kept in mind". In fact, he said that his own views on policy matters were "certain to be the same as those of the council", though we did not discuss how this happy state of affairs was reached. Among the issues of the day were slum clearances, in particular prioritising which areas were to be cleared first, the implementation of the Clean Air Acts, and establishing family-planning services.

When public health moved from the council to the NHS, Dr Shaw, as he put it, "got my come-uppance", because, having not been 'properly' appointed to the MoH role, he could not transfer to the post of Area Medical Officer. (It was his former Deputy who was appointed to the role.) Instead he became one of three district community physicians in the city, "managing the hospitals", a role which he gave the impression he did not much enjoy. Nevertheless, he continued to work in the NHS (and to teach at the medical school) until he retired in 1984. After retirement he developed further his interest in film, writing a book about Sheffield's cinemas, and even being a member of the jury of Sheffield Documentary Film Festival at the age of 95.

I asked him whether he preferred working in the council or the NHS. Without a moment's hesitation he said it was the former.

Jeremy Wight

Sydney Baigel FFCM
1928 – 2015

BORN and brought up in Dublin where he qualified in medicine in 1953, Sydney did his house jobs in and around London before specialising in anaesthetics and moving to Manchester 1956, eventually with a residency at the Royal Infirmary.

In 1965 he switched to medical administration joining the North West Regional Hospital Board where he rose through the ranks and, as principal senior medical officer, oversaw the redevelopment of the Tameside and Oldham general hospitals.

In 1974, when public health moved from local government into the NHS, Sydney transferred to Salford Area Health Authority as specialist in community medicine responsible for ensuring effective links with social services around the health and wellbeing of vulnerable and excluded people in the community. In a later reorganisation he transferred to North West Regional Health Authority, retiring in 1993.

Sydney was a gregarious and forthright man with great character and charm. For many years he was an energetic member of the Manchester Medical Society, as honorary secretary and eventually president in the late 1980s. He was also a prominent and highly active member of the Jewish community both in Manchester and nationally, and a lifelong advocate for Zionism.

Elizabeth Ann Harris FFPH
1937 – 2016

ALTHOUGH 'Ann' had five children, her first child just after second Bachelor of Medicine and her second after qualifying, she never forgot the words of her mother "your medical degree will be your most valuable possession".

Therefore, following a short break after pre-registration jobs to bring up her family, she returned to a wide-ranging career in family planning, public health, paediatrics and audiology. She founded the first child handicap register in Hackney, London and was honorary lecturer in community child health at Barts and the London. Subsequently she became Director of Public Health for Great Yarmouth and Waveney.

After retiring from full-time work due to deafness and ill health secondary to long-term ulcerative colitis, she became part-time consultant in public health in Basildon and Thurrock.

In later life she worked for the courts and tribunal service and was highly valued for her ability to ask gentle but penetrating questions. Recently she suffered from poor health and progression of her deafness. This lead to some interesting parallel conversations, notably with her children, as she felt that it was "not worth putting in hearing aids for the family".

Predeceased by her son Tom and first husband Neal, she leaves four children, a grandchild Jessie and her second husband Raymond to whom she had been married for over 25 years.

Raymond Harris

Deceased members

The following members have also passed away:

James Dunlop FFPH
Peter Lambert FFPH
Graham Scott FFPH
David Simpson OBE HonMFPH

Negotiating our way through globalisation

Nadeem Hasan was awarded the Sian Griffiths International Award, the June & Sidney Crown Award and the British Association for Counselling & Psychotherapy Travelling Fellowship to attend the Executive Course in Global Health Diplomacy at the Graduate Institute, Geneva. The course runs every year in June.

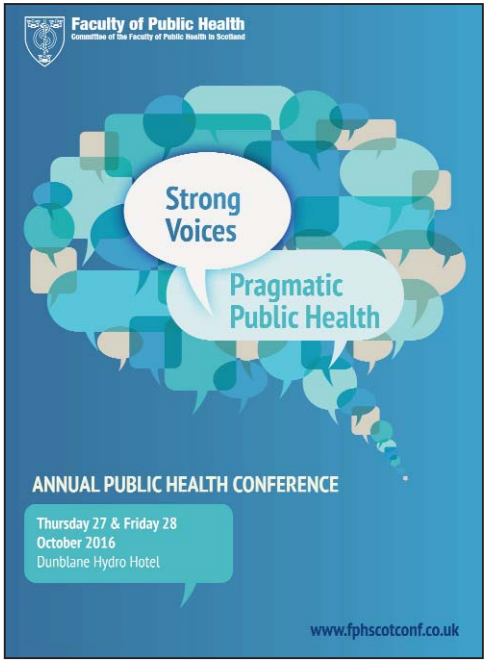
THE Executive Course in Global Health Diplomacy (GHD) defined the central purpose of GHD as "the pursuit of health, health equity and human rights as a collective goal". This involves negotiating the political choice for health in the face of other interests, improving relationships between states and other actors through health, creating alliances for global health outcomes and contributing to health security and peace-building. The importance of diplomacy was highlighted by an exploration of the difficult political choices faced by countries, and the clash of norms and ideologies and its impact on areas ranging from health services to climate change. The message was that diplomacy and negotiation are increasingly important tools in improving public health in a globalised world.

A major theme running through the course was a focus on the 'reality' of negotiations. Negotiation is both a science and an art, requiring careful preparation in understanding the perspective and interests of one's own organisation or country as well as those of other parties. This is essential to understanding the 'zone of possible agreement' prior to entering into any negotiation. However, the art of negotiating comes into play once the negotiations actually begin – through creating a positive atmosphere and a relationship of mutual trust before dealing with the content of the problem. A key quote that was explored with real examples was "you can be no more as a negotiator than you are as a human being" – recognising that ultimately we are human and that understanding human psychology is a critical factor in negotiating successfully.

The highlight of the course for many was the practical negotiation simulation. Each participant took on the role of a representative of a country or interest group. Each role came with a mandate from the respective country/organisation, areas of the negotiation where there were flexibilities as well as 'red lines', and likely coalition partners. The formal negotiation sessions were punctuated by breaks during which informal discussions took place, coalitions were built and most of the progress was made – mirroring the way negotiations in the real world work.

The course closed with a discussion entitled 'Today everyone is a health diplomat', with David Heymann, head of the Centre on Global Health Security at Chatham House and Chair of Public Health England, on the prominence of health diplomacy, particularly in the context of global health security. The session underlined the importance of effective diplomacy skills in the health workforce. The Ebola outbreak may be the most recent reminder that health outcomes are determined by factors that cross borders, but it is far from the only example. As the forces of globalisation continue to shape the flow of goods, people and ideas, skills in negotiating higher up the political agenda and forming alliances for health outcomes will be crucial if we are to make real progress in improving health.

Nadeem Hasan
Specialty Registrar



Practitioner Master Classes

Oxford, 28 June & 13 July 2016

FACULTY OF PUBLIC HEALTH

The Faculty of Public Health, in partnership with Health Education England, has developed a series of workshops to support public health practitioners who wish to develop their professional competence and expertise. This programme provides half-day workshops to support public health workers who are:

- working on their portfolio for practitioner registration
- thinking about developing a portfolio
- seeking to address shortfalls in their knowledge and understanding about public health, eg. those who have recently moved into public health from another discipline/area of work

Further information at www.fph.org.uk/the_practitioner_masterclass_programme_2016

Welcome to new FPH members

We would like to congratulate and welcome the following members who were admitted to FPH between February and May 2016

Fellows
Abina Varadarajan
Alexis Macherianakis
Catherine Morris
Danaseela Nugegoda
Daniel Chandler
Diane Bolton-Maggs
Dominic Mellon
Gillian McLauchlan
Ifeoma Onyia
Jane Bethea
Jenny Hacker
Joanna Peden
Louise Sigfrid
Margaret Simons
Monica Dent
Naab Al-Saady
Natasha Azzopardi Muscat
Nicholas Hicks
Noreen Kickham
Rachel Richards
Richard Firth
Sandra Husbands
Sara Corben de Romero
Suzanne Odams
Vivienne Speller
Celia Briffa-Watt
Fiona Watson
Gareth Hughes
Jane Thomas
Jennifer Hall
Joanne Cameron
Lydie Dalton
Marta Busana
Natalia Clifford
Ruksana Sardar-Akram
Sally Hogg
Sharon Frances Stoltz
Valerie Miller
Wendy Brownbridge
Yung Yan Terence Cheung
Victoria Spencer-Hughes

Members
Abigail Knight
Alison Forrester
Alison Walker
Andrew Dalton
Anna Lyon
Balsam Ahmad
Claire Beynon
Helen Skirrow
Jonathan Wai-Kin Fok
Robin Poole
Susan Roberts
Victoria Head
Ashley Goodfellow

Diplomate Members
Ali Hasan
Caroline McLuskie
Chi Hong Wong
Damani Goldstein
Jenny Wares
Joanna Goodson
Julie Northcott
Marina Buswell
Rebecca Devine
Samantha Taplin
Saran Shantikumar

Specialty Registrar Members
Christopher Cartwright
Colin Sumpter
Duncan Fortescue-Webb
Gunveer Plahe
Holly Jenkins
Katherine Comer
Megan Harris
Rachel Doherty
Rhosyn Harris
Ruth Du Plessis
Sarah Wilkinson
Sepeedeh Saleh
Yannish Naik

Practitioners
Lynette Anear
Joseph Akanuwe
Mohamed Syed
Julia Robson
Renuka Godawatta
Roya Bartlett
Victoria Fenwick
Melissa Juniper
Linda Hindle

New public health specialists

Congratulations to the following on achieving public health specialty registration:

UK PUBLIC HEALTH REGISTER

Training and examination route
Giles Ratcliffe
Richard Firth
Valerie De Souza
Lucy Douglas-Green
Jane Bethea
Diane Bolton-Maggs
Dominic Mellon
Julia Steiner

Defined specialist portfolio route
John Goodall
Linda Smith
Janet Thompson
David Whiting

GENERAL MEDICAL COUNCIL REGISTER

Christina Atchison

Equality & Diversity Task & Finish Group

ON 10 MARCH 2016 the first meeting of the Faculty of Public Health (FPH) Equality & Diversity Task & Finish Group met to discuss its works. The volunteers who gathered covered the range of membership from registrars to board members, honorary fellows to the President, each bringing different talents and experiences to the table. Chaired by Ian Basnett, we started with the task of working out what we were going to do.

After a wide-ranging discussion, it was felt by all members that equity and diversity had to be at the heart of the FPH's work. It needed to be embedded, not only in internal policies and staff employment, but should underpin all aspects of the FPH's role including training, education, validation and advocacy. This meant a lot of work not only for our group, but also for other committees and groups. To make equality and diversity a key element of all FPH's work, all committees would have to look at their activities, outcomes and outputs.

If FPH and its membership are dedicated to working towards a fairer and healthier society with reduced health inequalities, then all our behaviours, attitudes, advocacy and activities must reflect the key role that equality and diversity play in this. Equality and diversity is more than the Equalities Act and having an equality and diversity policy in place for staff. It must become the heart of the work we do, both consciously and unconsciously, as equality and diversity is critical to the ethos and effective delivery of public health.

An action plan is in development and covers six key areas that embrace both internal and external work of FPH:

- FPH equality and diversity policies and practices
- Equality and diversity in FPH's training and education
- Monitoring of equality and diversity
- Investigating equality duty and best practice for implementation
- Changing cultures of FPH
- Equality and diversity in FPH's external work.

We will be sharing our work on the FPH website in the coming months and would welcome ideas, suggestions, comments and help with achieving our aims.

Megan Harris
Specialty Registrar