Personal Reflections from Dr Linda de Caestecker

I am writing this introduction from a different role than my Director of Public Health post, having been fortunate to be given the opportunity to work for the next year for an international charity to promote women's reproductive health in low resource countries. I have long retained an interest in international public health since working in Ghana as an obstetrician and gynaecologist in the 1980s. In fact, it was while working in Ghana, in a large busy maternity hospital with very high maternal and perinatal mortality rates that I decided that I wanted to address the causes of maternal and child mortality. This led me to specialise in public health. As I move into the field of international development, I am reminded that the challenges of improving public health are similar the world over and in whichever sector one works; the challenges of changing clinical practice using the best possible evidence, of involving front-line staff in change, of demonstrating the impact of new initiatives and managing pressures on resources are similar in this new post. Equally similar is the joy of working with people totally committed to making a difference to improving health.

I am delighted to write the introduction to this DPH report, the fifth one since I took up post. In previous reports we have taken a series of themes based on analyses of the major public health challenges in NHS Greater Glasgow and Clyde but this report goes back to basics and presents a range of information to inform planners, policy makers, service providers and politicians on the health needs of people in Greater Glasgow and Clyde. Some could say that the wealth of information available from a range of sources has made this type of report less necessary. There is certainly no shortage of good quality data in Scotland but this report attempts to prioritise and summarise the large amount of data and information that is currently available. It also presents the results of the most recent Greater Glasgow and Clyde Health and Wellbeing Survey which enables us to review trends in health behaviours and social capital over time.

There is an important chapter on Asset-based approaches in this report. I admit to previous episodes of scepticism about assets-based approaches, wondering how one could build on assets for people who have suffered multiple disadvantages through abuse and trauma, addiction problems, homelessness, limited social networks or frequent offending. I was wrong. My work with the Women's Justice Centre, Tomorrow's Women, my personal roles with Glasgow City Mission and the Simon Community Scotland and my recent travels to villages and towns with extremely limited physical resources of any kind have shown me that not only do assets based approaches work, they are actually the *only* approaches that work.

As I reflect on the past five reports, I am delighted to think about how much has been achieved in Greater Glasgow and Clyde through the efforts of many people with an interest and role in public health, many who don't have "public health" in their job titles. These have been as diverse as the establishment of the bike hire scheme in Glasgow and the work of the Poverty Commission in Renfrewshire as well as primary care developments in chronic disease management and strengthening child health surveillance. Some of the recommendations in previous reports and the ensuing actions have had their critics, such as commissioning weight management services from a commercial company, smoke free policies that include e-cigarettes, expansion of the Triple P positive parenting programme, giving financial incentives to help pregnant women stop smoking. But one thing I have learnt in public health is that we have to be courageous and we have to take some risks. I agree with Mark Zuckerberg that "the biggest risk is not taking any risk…..in a world that is changing really quickly; the only strategy that is guaranteed to fail is not taking risks". In public health, we must give ourselves opportunities to learn, to adapt, and to improve constantly. I have also learnt to persevere. Programmes such as Triple P take time to be embedded and mainstreamed and to be flexible to meet local needs. We have to adapt as new evidence is generated, for example there has to be regular review of the evidence about the safety and risks of e-cigarettes and a willingness to change policies based on new evidence.

The project I now lead in six countries is about “Institutionalising” new practice on postpartum contraception and I take many lessons from achievements in Greater Glasgow and Clyde with me, especially the need for clinical champions, having front-line staff fully on board understanding the rationale and evidence for change and the need to be in for the long haul, change takes time.

The unrelenting pressure on acute services and the ageing of the population mean that developments in public health will not always receive the priority they deserve but I strongly believe that if we are to see real improvements in health, compression of morbidity and a shift in the balance of care, NHS Greater Glasgow and Clyde and its partners must find ways to continue to prioritise prevention, early intervention, early years programmes and to prioritise investment in areas that will truly improve health not just extend the end of life i.e. housing, employment and education. Politics is at the heart of improving health and we all need to use our influence and our energy to make Scotland fair and equitable. I have experienced significant support from the Board of NHS Greater Glasgow and Clyde in my advocacy on these issues.

As I have travelled in recent weeks, two incidents in particular have stayed in my mind. One is of a medical officer of health in Ghana discussing community health developments with the elders of a village. In Ghana the common way to carry everything from water to groceries is on your head. The Medical Officer asked, “What you would do if you had a heavy load to lift onto your head, would you just stand there and look at it? No you would lift it first to your lap and then ask for help to get it on your head”. She made it clear that there were responsibilities on both sides; the charity and public sector would provide resources and services but the village community itself had to be involved and take leadership for improving their own health. The subsequent planning was truly in partnership. It was a real example of community development and it seemed we had much to learn from resource poor countries on this issue. The other example was seeing facilities with 100% breastfeeding where the major focus of promotion and education about breastfeeding was targeted at grandmothers, understanding the importance of families in health behaviours.

I look forward to using much of the experience and learning from Greater Glasgow and Clyde in the implementation of large scale initiatives to promote women's health in low resource countries but also in developing collaborations and shared learning to benefit NHS Greater Glasgow and Clyde.

Thank you to everyone that has contributed to this report and I hope you find it a helpful resource.

Linda de Caestecker
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