Towards 2000: abstracts from the plenary sessions of the 11th Conference of the World Organization of National Colleges, Academies, and Academic Institutions of General Practitioners/Family Physicians

MATERNAL AND CHILD HEALTH

'Better child health' — what could we do

Leela De.A. Karunaratne, Honorary Secretary, Sri Lanka College of General Practice

Achieving health for all by the year 2000 is a difficult task and a great challenge. Many may be inclined to give up, yet there is a great deal we can do towards making this a reality, and any contribution is valuable. The health charter states that primary health care should be the key to health for all, and this places great responsibility on all those involved in primary health care.

In Sri Lanka family physicians provide primary health care for about a third of the population, alongside the national health services, and most of the care they provide is for children. Child survival is not a major problem in Sri Lanka, but the challenge for better child health comes from the fairly high morbidity and mortality from diseases that are preventable and the widespread undernutrition among children aged under five years. Strategies advocated by the World Health Organization/United Nations Children's Fund (WHO/UNICEF) for child survival and development have already been implemented by the State. These strategies are acceptable to the people and involve low cost interventions that are easy to manage. Most of them could be translated into a workable programme for family practice.

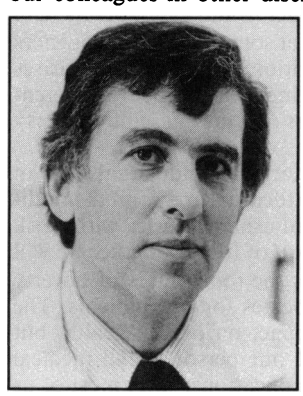
A family physician can achieve 'Better child health' by implementing the following: maternal health care, family planning, promotion of breast feeding and better weaning, growth monitoring, immunization and control of diarrhoeal disease.

However, along with all these measures for health promotion and prevention, it is important to pay attention to the psychosocial needs of children if 'Better child health' is our aim. Much of this has already been done and is therefore practicable in the context of family practice in Sri Lanka.

Maternal and child health in Canada

A natural experiment is taking place in Canada. In different provinces, different proportions of maternal and child health care are provided by family doctors compared with other types of primary care physicians — yet general health and disease are approximately the same in all provinces. This phenomenon can shed light on a number of recommendations of the Alma-Alta Conference, especially those relating to the utilization of appropriate health workers trained for, and practising in locations where they can serve the people and those relating to the application of appropriate technology for each level of care.

In contrast to the USA, Canada's 18 000 family physicians are the principal medical resource, and we provide most maternal and child health care. There are only approximately 1100 obstetricians and 1200 paediatricians, and 70–80% of them work in the major cities where the 16 medical schools are to be found. The consultative role versus the primary care role provided by our colleagues in other disciplines varies greatly by region.



Michael Klein, Professor of Family Medicine, McGill University, Canada

Yet pressures for family doctors to give up obstetrics (with obvious consequences for child health and family care) are strong. Traditionally, Canadian family doctors have worked both in the community and the hospital, and consultants, especially in the Western and Atlantic provinces, have supported this system. Recently, technological advances have eroded this system and the consequences for mothers have been unfortunate.

Falling birth rates, physician overproduction and professional and societal demands for unachievable perfection have led to the medicalization or technicalization of birth. This is best illustrated by the rising Caesarean section rate but recently more procedures of all kinds have been employed in the care of pregnant women with resulting consumer dissatisfaction which is not associated with improved maternal and fetal health. The rising Caesarean section rate is not uniform in all provinces — it varies from 13–14% to 20%. It is highest in those provinces where obstetricians provide most maternity care and lowest where family doctors are the principal providers. Similarly, those provinces with relatively more obstetricians per capita and the lowest birth rates have the higher Caesarean section rates.

Paradoxically, the increasing procedure rates are not associated with improved fetal health as the perinatal mortality rate plateaued out in 1977 and since then has been approximately 10 per 1000 births in all provinces. Nor has excess morbidity been associated with the less interventionistic style of family doctors, but family distress, maternal depression and attachment

failures have been a consequence of misapplied technology.

In this, and other areas, parental confidence and competence has been undermined and the slow departure of family doctors from obstetric care comes at a time when our patients need us most as advocates, interpreters, buffers and principal care-givers.

The College of Family Physicians of Canada has pioneered the development of training programmes that have placed its certificants in the communities where they are needed and increasingly in rural areas as well. Governmental restriction into specialty training will further consolidate the appropriate relationship between family doctors and consultants. All Canadian medical schools have accredited university departments of family medicine and the quality of the medical students choosing our discipline is high.

As in other developed countries, medical care (as usually defined) accounts for only 10% of the differential mortality between different populations, and Canada has some wide differentials between the poor and native populations of the south, subarctic and arctic regions.

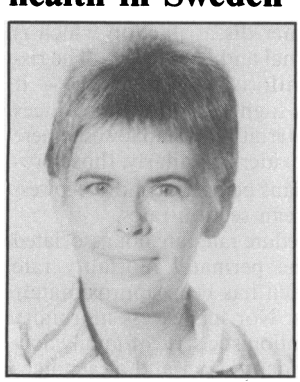
Among teenagers (especially native peoples) traffic accidents and other violent deaths are the principal cause of mortality. With teenage unemployment at more than 25%, depression and antisocial behaviour are common, and the suicide rate among teenagers (12.9 per 100 000 people) is the highest in the world. Contributing factors are family disorganization and divorce, the nuclear arms race (we are strategically placed between the USA and the USSR), concerns about the planet and the stresses of modern life.

Until now, family doctors and other health care workers have been able to successfully chip away at some of the consequences of poverty — principally poor nutrition and infectious diseases — but as mortality rates have declined, the hardcore differentials come down to those conditions that are caused by poverty itself in pure form.

Family physicians will have to decide as individuals and in groups whether we will continue to focus narrowly on the traditional medical role to a point of diminishing returns, with a risk of contributing to the medicalization of life or whether we will broaden our world view to address the root causes of poverty and in so doing become true advocates for our patients. The latter would have an increased impact on overall health, but would mean a total reordering of our personal and medical priorities with obvious financial implications, since most of us do not get paid to look after society. Yet to do otherwise is to treat symptoms and not disease.

Medicalization of these areas is unwise, but we family doctors and our organizations, capitalizing on our position in society, can collaborate in addressing these issues. To do so may have an impact on the health of women, children and families in the goal of reaching the next level of improvement of health as envisioned by the Alma-Alta Conference.

Towards 2000 — maternal and child health in Sweden



Anna-Karin Furhoff,
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Since the 1930s maternal and child health care has been a cornerstone of the Swedish health system. High quality preventive care is offered to all pregnant women and young children (more than 95% attending). During the last 20 years these services have become part of the growing primary health care system. The maternal mortality rate (less than five per 100 000 births) and perinatal mortality rate (seven per 1000 births) have been stable for the last few years but there are still small differences in gestation length and birthweight correlated to social class.

The task of the maternity health care centre is not only to provide health care for the pregnant woman; much emphasis is also placed on the prevention of unwanted pregnancies.

Accidents are now the major single cause of deaths in children, being responsible for about 40% of mortality in children aged one to 14 years. More than half of all fatal accidents take place on the roads. Work to diminish the incidence and severity of accidents includes nationwide campaigns for road safety, modifying the local environment and health education for children and parents.

Many traditional childhood diseases have lost their former importance thanks to vaccination programmes and improved social standards. Today, respiratory tract infections (including otitis media) account for the bulk of consultations among children. Extensive epidemiological research is needed in order to gain the knowledge necessary for prevention. There are, for instance, indications that the incidence of otitis media in small children could be connected to the type of daycare provided for them.

Tobacco, alcohol and narcotics are serious threats to the health of young people. The use of these drugs among schoolchildren is slowly decreasing, owing to a large extent to intense educational efforts.

Sweden may have succeeded in eliminating most of the health problems in children caused by bad social conditions but we are facing new problems associated with the external environment, for example a high incidence of allergic conditions. We are also becoming increasingly aware that relationships within the family can be the cause of illness and disease in children.

Parenthood education, which began some five years ago, could play an important part in supporting the young family. The aim is to increase the parent's knowledge of child development and parenthood through information and the mutual exchange of experiences with other parents. Some 30% of parents (both fathers and mothers) are now participating regularly during pregnancy and the child's first year.

Perhaps we have now reached a point where further significant advance requires new approaches. Epidemiology will probably become an increasingly important tool in the work to elucidate the causes of accidents, respiratory tract infections and other physical disease, as well as psychological and psychosomatic illness. There is a growing awareness that a psychosocial approach is needed to improve the health and well-being of children and their families.

Most of the work is, and must be, multidisciplinary. But the Swedish general practitioner — family doctor as well as the community physician — is well suited to play a key role in this development. A general practitioner has a wide network of contacts, including medical personnel (nurses, specialized physicians), social workers and other important people in the community. Together, we should be able to improve the care and support given to parents and children. A special challenge is to find a balance that allows the full utilization of medical science without undue medicalization of normal life events.

Economic and political factors will decide what can be achieved before the year 2000. After a period of decline in the 1950s and 1960s, Sweden's primary health care system is now being reconstructed as the basis of the health care system. I believe that in 15 years time a strong community-based primary health care system will be indispensible for the continuing improvement of the mental and physical health of the population, and especially of the weaker groups in our society.

HEALTH EDUCATION

Health education — the general practitioner's pivotal role

P.M. Barham, Sir William Goodfellow, Director of Continuing Medical Education in General Practice, University of Auckland, New Zealand

A recent national conference to decide the role of the doctor in New Zealand society received many submissions from a wide cross-section of the community. It was clear from these submissions and from the findings of the conference that encouraging health rather than the treatment of disease should increasingly become a major focus of the health services. The conference saw health education as ideally a part of every medical consultation.

The ultimate aim of health education is to modify health related behaviour. Many complex factors influence behaviour patterns, but the general practitioner occupies a pivotal role in the area of health education. The general practitioner's influence is considerable and can be either good or bad. Because of the position he/she holds as a recognized and respected authority in health matters and the circumstances in which he works (the health education can be related to the patients' presenting problems), the general practitioner has the potential to be more effective with individuals than most other educators, often being the catalyst causing the patient to act on what previously were just ideas gained from a variety of sources. In addition, because in many countries a majority of the population are seen by their general practitioners in any one year, the cumulative result of effective general practitioner health education can be extensive, and more likely to change the health related behaviour of a nation than many other forms of education.

On the other hand, by his attitudes and behaviour, the general practitioner can undo groundwork laid by other educational agencies and discourage people from behaviour which will promote health and prevent or minimize the effects of disease. Certain skills and strategies can measurably improve a general practitioner's effectiveness as a health educator.

The World Health Organization's aim of 'health for all by the year 2000' does not just imply disease treatment and control, but also positive aspects of health. General practice as a widespread discipline is well-placed to accept the challenge that health education in the general practice setting offers. General practitioners, by improving their patient education skills and working with other educators both in their own practices and in the community at large, could make a significant contribution to the aim of the World Health Organization.

The changing concept of health education and the role of general practitioners

Ž. Jakšić, Professor, A. Stampar School of Public Health, Zagreb, Yugoslavia

A doctor is a teacher. His or her effectiveness largely depends on the ability to communicate, to understand and to influence. Therapeutic abilities, social role and even diagnostic skills are closely connected with educational potentials and vice versa. A generalist, wanted more every day and found less and less, is the physician expected to guide a patient through the growing jungle of information.

However, it seems that health education means something else in a 'public health' world, and is often thought to be a separate, formal health service. Other disciplines and experts dominate this service — psychologists, marketing experts, pedagogues, sociologists and now and then medical professionals with a wide range of backgrounds and interests. There is often a hidden interest or expected profit behind their involvement.

Although health education is highly praised by medical professionals it is regarded as second rate work for which there is often not enough time available.

Different schools and ideologies coexist under the name health education. The health education which dominates today is an aggregate of past experience and different theoretical practice (rationalistic, behaviouristic, psychodynamic and sociodynamic). It developed in parallel with changes in prevalent health needs, new health policies and understanding of the role of the health services.

The self-help groups in Zagreb were begun by primary health care teams trying to diminish the workload of chronic diseases and to satisfy groups of sick people and local communities, schools and work organizations. The first initiative came in most cases from health professionals but a great deal of enthusiasm came from groups and organizations (volunteers, politicians, social workers and so on). Most of the self-help groups called themselves 'clubs'. The majority of clubs concentrated on a certain problem, at least initially, and hypertension was the most common. As the groups developed their title remained the same but the actual content broadened. In the case of hypertension measurements of weight and blood pressure were accepted as amusing rituals by the group, but social relations were more important for the members.

The outcome of the work of the most numerous groups has been evaluated by individual general practitioners and other experts and they found that:

— The groups (clubs) attracted mostly elderly and 'middle class' chronically ill patients.

— There was a different pattern of utilization of health services and a better compliance with preventive and curative procedures by members of clubs.

— An increase in knowledge on health matters was shown by club members.

— After several years of observation life expectancy was reported to be longer in club members and the follow-up of weight and hypertension was more satisfactory than in control groups.

— The number of clubs was increasing but 'many of the older clubs are becoming rather staid and set in their ways; member-

ship is static, the same people have held office in some clubs ever since they began . . ?

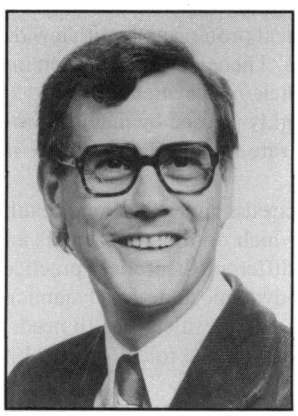
A political effort was made to publicly recognize the clubs and this was formally successful. However, the impact of the clubs on medical standards and public organizations has so far been limited.

It can be concluded that many of the aspects of self-help and self-care activities are discussed but not well understood.

The attitudes of general practitioners towards self-help activities and the new 'socio-dynamic' health education vary considerably. They will depend on local circumstances, general social policy, available resources, organization of health services and professional and other interests.

The primary health care approach is offering new challenges, but is also asking for changes. The position of the general practitioner as a professional interface between services and patients is strengthening. The energy exists, somebody has to organize it.

Health education in general practice



Harald Siem, Oslo City Health Department, Oslo, Norway

The World Health Organization's slogan 'health for all by the year 2000' is becoming a guideline for health service workers all over the world. Doing things right is no longer enough; doing the right things is the current challenge. Health for all means that epidemiology must be included in our everyday clinical routines. It means being aware of the distribution of disease in the population, and of the factors which affect public health. It means relating consciously to a defined population, giving importance in our work to whichever denominator we apply.

In countries like the UK or Denmark, where physicians have their own lists of patients, this is a familiar way of thinking, as it is to physicians in other countries serving local rural communities. However, to general practitioners in urban areas, whose practices consist mainly of patients who call on them, this may be a new and exciting challenge.

In Western countries the major health problems are cardiovascular diseases, malignancies, accidents, mental disorders and diseases of the skeletomuscular system. However, our way of life — what we eat, whether we smoke, how we cope with our family lives and human relationships — to a large extent determines whether we live to a ripe old age.

Most doctors today accept that in order to bring about improvements in health more effort must be put into prevention. This can be aimed at general living conditions which are often beyond the control of health authorities. A number of measures have proved their usefulness in promoting health by influencing people's habits and life-style. They include: marketing and advertising restrictions; restrictions and quality requirements imposed on products; price policies; planning of the physical environment; education in schools; local community measures; use of the mass media; and training for the medical professions. Measures of this kind are only a challenge to general practitioners in an indirect sense.

It is prevention at the level of the individual that presents a real professional challenge to general practitioners and their best opportunity of exercising an influence on major health problems may come during consultations. It has been stated that a consultation contains four elements: assessment of current symptoms and problems; assessment of former or continuous symptoms and problems; assessment of the patient's use of medical services and self-care; and an opportunity for primary and secondary prophylaxis. In primary and secondary prophylaxis early diagnosis, assessment of risks and health education are important. The greatest potential for influencing public health probably lies in health education.

In the 'Oslo study' 40-year-old men were examined in 1972 and later. Half of those who gained high scores for cardiovascular disease risk factors (high cholesterol, high blood pressure, smoking and obesity) were selected at random for intervention. Six hundred men had half-an-hour's conversation with a doctor and were given advice on diet; 600 men formed the control group. Those in the intervention group were subsequently given half-an-hour's further advice on their life-styles once or twice a year. In the following 10 years 28 men in the control group and 14 in the intervention group died of cardiovascular disease (infarction, sudden death and strokes). Eight members of the control group underwent major heart surgery compared with one in the intervention group.

Simple advice given by general practitioners at ordinary consultations can also help patients to stop smoking. It has been suggested that general practitioners who register smoking habits, advise their patients to stop smoking, back up their advice with printed material and make follow-up appointments can expect 25 long-term successes each year. It may be argued that such results can only be expected in the first year but Norway's National Council on Smoking and Health has presented statistics that suggest greater optimism. Over the period 1950–84 there has been a linear reduction in the numbers of both men and women doctors who smoke, giving a projection that all Norwegian doctors will be non-smokers before the year 2000.

However, it is unreasonable to expect the population as a whole to achieve the results projected for Norwegian doctors. Physicians are particularly aware of the harm done by smoking; they are also under pressure to set an example to the rest of the population. Nevertheless, the conclusions are inescapable: we do have opportunities to influence people's health habits, to reduce the likelihood of serious cardiovascular disease and to reduce smoking.

Any consultation provides opportunities for primary and secondary prophylaxis. However, a project carried out in the county of Troms from 1983 to 1986 employed a different strategy. In cooperation with the general practitioners in 11 municipalities an age-specific programme was worked out for preventive intervention. People of various ages from 25 years upwards were sent invitations to consult their doctors. Twenty-minute consultations were arranged, comprising procedures that varied according to the client's age. Elements such as simple medical examinations, risk assessment and health education were involved in addition to arranging help for anyone found to need it. The older the patient the more frequent the consultations. By the end of 1985 25 000 people had been called in and the attendance rate was 64%.

One major feature observed in the project was the embarrassment suffered by doctors when confronting healthy people or those who are only running a moderate risk of subsequent illness. General practitioners are well qualified medically, but lack the skills necessary to mention smoking and exercise to a 46-year-old, or to ask a 65-year-old about preparations for retirement.

For effective health education in the consultation four points need to be emphasized:

1. Keep the message simple.
2. Repeat the message.
3. Combine written and oral information.
4. Make follow-up appointments.

Experience shows that it is important not to expect too much of each patient to begin with. Slight improvements and results that can be achieved without too much delay should be the main objective.

Provision of health information takes time and general practitioners are always busy; some have asked whether they might have help in this enterprise. For example, Norwegian public health nurses traditionally provide mothers and children with health information and they could also play important parts in individual prevention programmes for adults. However, some of the time devoted by general practitioners to diagnosis and treatment might be better spent on health education.

Let me sum up my views. Health information provided by general practitioners in consultations should be concerned with major diseases and it must be structured and specific to various age groups. Getting the message across to individual patients takes practice, practice and more practice.

Although population studies do not provide direct proof that intervention by general practitioners has a decisive effect on public health, I believe that any doctor who engages wholeheartedly in health education will derive great personal satisfaction from the results he or she sees among individual patients.

NUTRITION

Nutrition and primary health care

W.P.T. James, Director, Rowett Research Institute, Aberdeen, UK

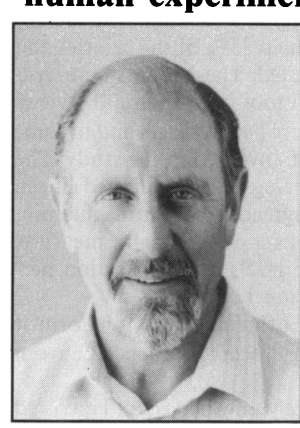
Nutrition should be a dominant consideration in primary health care in both affluent and developing societies but few doctors recognize the impact of diet on the development or management of the diseases they seek to treat. Primary and even secondary preventive measures are usually neglected in favour of drug or other therapies which seem to have a favourable impact.

Nutrition is now accepted as playing an important, if not the principal, role in the major causes of death in Europe, namely cardiovascular disease, digestive disorders and cancer. In addition, at least 40% of adults are overweight. In developing countries nutritional deficiency remains a major concern but patterns of disease are changing rapidly; adults are increasingly displaying 'Western' diseases and hypertension will be a huge public health problem for the year 2000 unless its environmental (nutritional) bases are identified and preventive measures implemented soon.

Professional ignorance is not the only obstacle to change. Many of the nutritional diseases develop by mechanisms which still have to be identified and the sense of uncertainty delays the development of preventive policies. Clinical nutritionists are changing their ideas in developing as well as developed countries, for example the problem of protein deficiency in the aetiology of 'malnutrition' is increasingly seen as an energy deficit. The dilemma is therefore how to develop a coherent preventive medical and public health policy when there is persisting scientific uncertainty. Fortunately the diet appropriate for prevention can be accepted even though the nutritional requirements for health remain obscure. Public health policy demands a pragmatic approach which accepts uncertainty and operates on the basis of judgement and probabilities. This is little different from the decision-making of physicians when dealing with many conditions. A justified cautious approach in scientific policy-making thus has to give way to a vigorous campaign of health education if change is to occur and allow effective prevention to have a chance.

This contrast in styles between the scientist and the health educator means that few policy-makers are suited to the educative process: the task should be left to doctors and those health educators who are more concerned with the welfare of the community and less anxious about their scientific credibility.

The secret bread tests: confessions of a 'human experimenter'



M. Kamien, Professor of General Practice, University of Western Australia

After working in a number of Third World countries, I entered general practice in an isolated outback area of New South Wales 500 miles west of Sydney. My patients were largely Australian Aborigines whose state of health was often worse than anything I had encountered in the Third World. In the first six months of practice I diagnosed one case of kwashiokor and three cases of scurvy in what was one of the prime citrus growing areas of Australia. Many children had angular stomatitis, iron deficiency anaemia was common and much of it was related to intestinal infestation with *Giardia lamblia*. The staple diet of the Aborigines was white bread usually eaten with golden syrup, jam or honey and washed down with large quantities of

sweetened tea, whitened with full-cream powdered milk. It seemed to me that in addition to health education one simple method of improving the health of the Aborigines would be to fortify their bread with iron and vitamins.

I sought the assistance of the infant health and community health sisters in starting a health education programme. Neither was willing to initiate any change of direction which did not come from their head office. Senior doctors in the Health Department granted me a short audience but seemed disinclined to heed my views mainly because a special report of the National Health and Medical Research Council had been 'unable to locate any evidence that any section of the population apart from alcoholics was suffering from an insufficient intake of thiamin'. To further dampen my enthusiasm, my application to attend a national conference on 'Better health for Aborigines' was rejected on the grounds that participation was limited to doctors experienced in the field of Aboriginal health. I noted that nearly all of these experienced doctors were academics who had little continuous first-hand contact with Aborigines. Their major experience was in writing papers about them.

Since these academics wielded so much influence in Aboriginal health policy, it seemed to be a good tactic to emulate them by doing a survey. Roche Vitamin Laboratories had just developed a method of performing vitamin profiles on individuals and they were interested in studies which would contribute to defining the degree of vitamin deficiency among the economically underprivileged in Australia. Spokesmen for the Aboriginal population insisted on questioning Roche and then they agreed to the testing of a random sample from varying age groups in the community. Standard anthropometric and physical examinations were performed together with fasting blood samples for the vitamin profiles. At the same time a detailed one-week investigation of the diet of two typical Aboriginal families was performed using the precise weighing method.

Biochemical vitamin deficiencies were found throughout all age groups especially in children under the age of three years and in women of child-bearing age. The mean blood levels for all ages were worse than had been found in any previous surveys in any deprived or hospitalized group in Australia. The dietary study confirmed that bread contributed 35% of the calories and 30% of the protein of the families tested. These results were written up and proved to be a powerful tool in changing the views of the Health Department, community health sisters and to some extent the Aborigines who had been involved in the study. The local baker was less impressed, but being a public-minded citizen and leading Rotarian in the town agreed to add iron, thiamin, niacin and riboflavin to the bread as a public health measure. The amount added was within the levels of fortification permitted by the New South Wales Pure Food Act.

The first problem concerned riboflavin. In its wet form it turned the bread yellow and in its dry form it crunched between people's teeth.

The second problem was completely unexpected and involved Australia's investigative newspaper *The National Times*. They produced the banner headline 'The guinea-pigs of Bourke: the secret bread tests'. The article made the point that the baker did not label his bread packaging as containing additives which as far as the population of Bourke was concerned made the test secret. It also asserted that people with Cooley's anaemia could be put at risk of developing haemochromatosis. Over the next 10 weeks a considerable correspondence took place in the newspapers, most of it taking the view that the study and the people involved in it were worthy of commendation rather than condemnation. However, I became wary of newspaper reporters who sounded as if they were on your side and I learnt that the editor always has the last word.

Other large newspapers visited the town trying to get expressions of outrage from the local citizens. Although they did not succeed, the local baker ceased to fortify his bread. A re-examination of the previously tested sample of Aborigines shortly after the fortification of the flour had ceased showed a significant improvement in the blood levels of those vitamins added to the flour. In addition, the physical signs attributed to vitamin B group deficiencies — glossitis, angular stomatitis and xerosis — had virtually disappeared. At the same time the blood levels of vitamins not added to the flour had remained unchanged or had worsened. Although many countries fortify their bread, this has been done on theoretical rather than experimental grounds. This was one of the few studies which provided objective evidence of the benefits of fortification in nutritionally compromised communities.

As for the people of Bourke, neither Black nor White care whether their bread is fortified or not. On my last visit to the town I discovered only two exceptions to this general feeling. Both of them were White men who stopped me in the street and said 'Gee, we have been feeling crook since you took the vitamins out of the bread'.

'So they did eat, and were filled and became fat': an Israeli viewpoint

Philip H. Sive, Primary Care Unit, Ben Gurion University Medical School, Beersheba, Israel

Nutrition or diet is the behavioural component of care that has undergone the most significant change during our professional lives in family practice, at least in the more affluent societies. The emphasis has shifted from the prescription of traditional and often quite unscientific diets and dietary restrictions for a large variety of common diseases, to general advice regarding food habits for the prevention and control of degenerative disease, such as the atherosclerosis–obesity–diabetes complex and possibly certain malignancies.

During the four decades of its existance, Israel has made the transition from features of undernutrition in the population to a predominance of the morbid effects of overnutrition. The prevalence of iron deficiency anaemia, particularly in infants, is still an uncomfortable reminder of an anachronistic hiatus in our nutritional care of certain patient groups.

The kaleidoscope of Israeli society provides a number of nutritional object lessons related to the immigration of different ethnic groups such as the Yemenites and Black Hebrews, and to varying life-styles such as that of the kibbutz with its communal dining room.

It would be presumptuous to claim that general practitioners originating from a host of medical cultures could thus far have had an impact on dietary customs in Israel. The recent immigra-

tion of the majority of the Jewish community from starving Ethiopia provides an interesting challenge to the community health services to prevent the killer Western diseases. It is uncertain how far this challenge can be met in the face of the compelling effects of ambient society.

However, our growing generation of committed and trained family physicians must exert their concerted influence at individual, community, and political levels in inculcating nutritional habits that will be conducive to health for all by the year 2000.

COMMUNITY PARTICIPATION

Role of community participation in primary health care programmes

R.S. Arole, Director, Society for Comprehensive Rural Health Projects in India

The ultimate aim of primary health care is self-reliance in health care. This self-reliance can only be achieved by people's participation and a change in the attitude of professionals towards the people. Demystification of health matters and administration, sharing of knowledge, simplification of procedures, transfer of proper values and willingness to listen to the problems of the poor are some of the factors contributing to increased community participation.

Community participation means that people both rich and poor, men and women, educated and illiterate are accepted as part of the health team and as such play a responsible part in planning, implementing, evaluating and reviewing their own health care programmes.

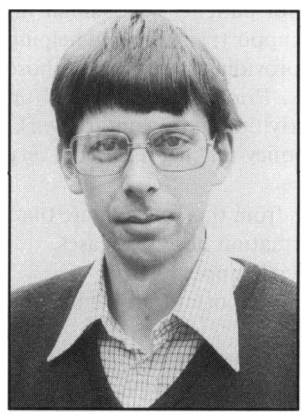
Health cannot be considered alone, it is part of a total development process. Economic, social and political development affect the health of any community.

Given knowledge, trust and the opportunity poor and illiterate men and women are capable of identifying their health needs by conducting house to house surveys. Once the community identifies its own health problems it can plan and implement programmes which call for community action and acceptance such as environmental sanitation, changes in the status of women and in food habits and the organization of supplementary nutrition programmes. This type of approach ensures that the community understands the root cause of ill-health and often leads to the community addressing itself to these root causes, for example problems of agriculture and social injustice.

People can actively participate in specific health care programmes such as mother and child care, control of tuberculosis and leprosy and prevention of blindness. Given the opportunity and understanding people can help in the rehabilitation of the handicapped in a manner that suits their culture and lifestyle.

Health education and family welfare programmes are important components of primary health care. These programmes can be effectively carried out by the people and may help to remove bad traditions, superstitions and social evils. By not only planning and implementing but also evaluating and reviewing their own programmes people have been able to substantially reduce infant mortality and other indicators and work towards achieving positive health.

Community participation: from theory to practice



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The World Health Organization International Conference on Primary Health Care (Alma-Ata, 1978) and the Committee of Ministers of the Council of Europe both recommended that their members should implement programmes to stimulate the active participation of patients in the maintenance, promotion and recovery of their health and of others. This idea is accepted in most countries.

Many countries have developed activities involving patient participation, for example there are more than 700 self-help groups in Flanders which has a population of about five million. However, patient participation in policy making has encountered difficulties and constraints.

Patient participation groups, which are developing in almost all west European countries, involve policy making. In the UK, there are approximately 70, in the Netherlands 110, in Flanders 10. Most of these groups are attached to group practices or community health centres. They are concerned with:

— Patient information, for example patient newsletters and information evenings.
— Social support, for example the voluntary collection of drugs for elderly patients.
— Support of therapeutic processes, for example stop-smoking groups, slimming groups and fitness groups.
— Negotiations with health workers about complaints with the health care services.
— Participation in practice policy making at hearings, advisory boards, general meetings and executive committees.
— Participation in community actions against social factors, for example problems with the environment, road safety and unhealthy housing conditions.
— Political matters, for example the cost of drugs and the financing of primary health care.

In 1984–85 surveys were carried out at the Collingham Health Centre, Nottinghamshire, UK and the Community Health Centre, Ledeberg, Belgium. A similar questionnaire was used at both centres which ran similar patient participation groups. The questionnaire aimed to assess the general awareness of the

patient participation group and its function, to ascertain attitudes towards patient participation and to provide feedback on the value of functions already carried out or planned for the future. At the Collingham Health Centre 140 questionnaires were analysed and at the Ledeberg Health Centre 200.

The similarity between the results was striking: almost half of the patients knew of the patient participation group; three in four patients agreed that it is important for doctors to involve their patients in decision-making; and the knowledge of patient activities was very limited. When patients were asked for their expectations the same four activities were mentioned first at both health centres — organizing clinics for the early detection of illness; organizing groups for patients with similar illnesses, to exchange ideas and give support; visiting and helping the sick, elderly and disabled; and providing transport for those who cannot reach health facilities. Priorities were placed on patient involvement in practice activities and voluntary work, while participation in health care policy-making received a very low score.

The most important conclusions from this research are that:
— Patients expect to receive information about diseases.
— There is a lot of interest in social support.
— Distribution of information is an important problem and a patient newsletter may be a solution.

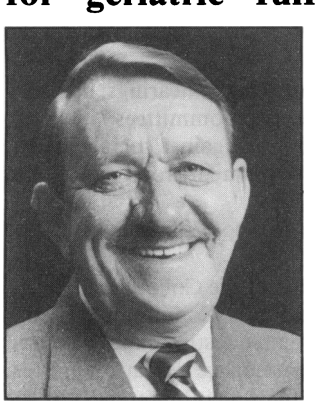
One major problem of patient participation is continuity — patients are often only 'patients' for a short period and therefore only interested in patient participation for that period. Self-help groups for chronic diseases are an exception. All voluntary work, and also patient participation, has to deal with lack of motivation and social involvement from a large part of the population.

Publicity is a further problem. How far should a patient group go in advertising its activities? This may be regarded as an advertisement for 'good doctors'. It is also difficult to determine whether participating patients are representative of the whole body of patients. Many groups fall apart because they have indistinct goals and some meet opposition from doctors and health workers.

Patient participation groups play an important role in local health education, in mutual support of patients and in policy modification. Doctors, who are unfamiliar with such groups are often sceptical initially, but this attitude quickly changes after their first contact with the activities of participation groups.

When patients participate in primary health care, general practitioners will find themselves involved with health and not just with measuring blood pressure or prescribing drugs.

The Shepherd's Center concept: a model for geriatric fulfilment and service



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The USA is experiencing a demographic revolution which is challenging us to devise new institutions, particularly for our ageing population. The proportion of older people in our population has soared from 3% in 1900 to 12.5% today. As we have shifted from a predominantly rural society to an urban society the structure and function of the traditional family has changed and it no longer carries the major responsibility for the social welfare of the elderly. Mandatory retirement deprives older people of significant social roles and support systems and often brings financial problems with it. Yet one-third of life may be lived beyond the usual retirement age. The loss of spouses, friends and associates weakens other supportive social systems. The promise and expectation of government in fulfilling many of these social needs through entitlement programmes has been helpful but for the most part inadequate and inordinately expensive while stifling innovation, initiative and self-reliance.

It is within this context that the first Shepherd's Center concept grew to fruition. It stemmed from the concern of one pastor to find a way to serve the elderly more effectively. A Shepherd's Center is more a concept than a physical facility and has four important characteristics:
— Older people are seen as potential resources, with skills, wisdom and experience, rather than as social problems to be solved.
— Older people are challenged and empowered to assume responsibility for their own lives and to develop programmes for themselves and their community as a whole.
— The concern is for all older people, not merely the disabled or disadvantaged.
— Every effort is made to gain the support and sponsorship of all the religious congregations and service agencies in the neighbourhood served.

Based upon these concepts, a Shepherd's Center mobilizes the tradition of volunteering which is deeply engrained in American culture. It is the story of the empowerment of older adults, linking them together in conceiving and implementing programmes and services which help some to survive and others to find meaning for their lives.

While the original Shepherd's Center is located in a comfortable, middle-class community, more than 60 other Shepherd's Centers across America have been formed in inner cities and rural areas. The idea will work wherever there are older people willing to help each other. Every service and programme is managed and run by volunteers who are given the authority to make decisions and to take action. The only task of a very small paid staff is to enable the volunteers to function.

The Shepherd's Center concept focuses on four levels of work:
— Life maintenance: meals-on-wheels, home health services, home repair services, employment and companion aids and so on.
— Life enrichment: programmes in adult education, volunteer service, health education, support groups and so on.
— Life reconstruction: programmes dealing with retirement, widowhood, alcohol recovery, mental health and so on.
— Life celebration: unique programmes and events which give special meaning to life.

The Kansas City Shepherd's Center has pioneered an innovative life enrichment programme in which up to 600 persons gather on 43 Fridays each year for a choice of seven classes each hour taught by volunteer teachers or leaders. The largest recent growth at the Kansas City Center has been in the health enrichment programme. This programme involves more than 100 volunteers, many with former health careers, coming together to promote health education, health maintenance and health advocacy among older adults.