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CONTRIBUTION OF SOCIOLOGY TO  
PROGRAMME DEVELOPMENT IN THE REGIONAL OFFICE FOR EUROPE

Report on a Consultation

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## 1. Scope and purpose of the Consultation

The meeting was organized by the WHO Regional Office for Europe to consider the contributions which sociology might make to the development and implementation of the WHO regional programme of policy and research. Three main issues had been identified before the meeting and discussions were organized around these three issues. They were:

- how could sociology be used in the planning process, especially with regard to problem identification;
- in what regional programmes could sociology be most profitably involved;
- how could such involvement be best organized.

In pursuit of these issues, discussion was intended to include not only the potential benefits and opportunities of a sociological involvement, but also the limitations and difficulties inherent in the involvement. The participants in the Consultation (see Annex) were selected medical sociologists working in the Region on problems of health and health service organization, and Regional Office staff members particularly concerned with programme development and with four specific medium-term programmes of potential interest to sociologists. These four programmes were chosen to exemplify the nature of the contribution which sociology might make, but it was recognized that they were merely examples selected to permit detailed examination during the three days of the Consultation. Sociological perspectives might well have relevance across the wider range of WHO programme activities.

Dr Leo A. Kaprio, Director, WHO Regional Office for Europe, welcoming participants and introducing the main themes for discussion, noted that the Consultation was the realization of a long-term plan for closer cooperation between WHO in Europe and the growing body of European sociologists who concerned themselves, at national and international levels, with issues of health and health system organization which were directly relevant to the objectives and activities of WHO. The timing of the Consultation was particularly appropriate because of recent changes in the long-term objectives and strategy of WHO, both globally and regionally. He drew attention especially to the guiding principles and issues underlying the long-term strategy of achieving health for all by the year 2000. National societies, acting individually and in collaboration with WHO, faced, and recognized, a series of difficult and apparently intractable problems whose solution required the coordination of diverse viewpoints and skills. The ideas about health and its attainment explicit in the policy statements developed by WHO in recent years reached out beyond the formal and traditional health sector. The Organization was concerned with the health of populations as well as of individuals and with the way in which aspects of social structure generated continuously a series of health problems which were formally the responsibility of the health sector but which had origins in and implications for many other sectors of social and governmental activity. WHO was increasingly interested in the concept of lifestyle, with its direct and indirect implications for the health-related behaviour of individuals, families and populations. These issues and concepts were the particular professional concern of sociologists and WHO was seeking the knowledge, perspectives and skills which sociologists would apply to them.

Dr Kaprio said that Mrs Pflanz had written expressing her best wishes for the success of the Consultation. Participants, some of whom had worked closely with Dr Manfred Pflanz over many years, remembered the fundamental contribution he had made in the field of health sociology and regretted his untimely death.

## 2. Programme development and new directions in WHO strategy

Dr Asvall and Dr Zöllner guided the participants through the necessarily complex process of converting the general orientations evolved by WHO's policy-making bodies into strategies, objectives, targets, programmes and activities which would implement those orientations at national and international levels. The key principles which would guide all WHO activity over the next 20 years were laid down in the decisions of the Thirtieth World Health Assembly in 1977, and especially in resolution WHA30.43, which stated that "the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." That resolution was further developed in the Declaration of Alma-Ata in 1979 (endorsed by the Thirty-Second World Health Assembly), which identified primary health care as the key to attaining the target of health for all by the year 2000. Policy statements, targets and the identification of primary health care as a key mechanism were, however, only the beginning of a long and complicated process whose constituent elements involved: discussion and agreement at successive stages with national bodies both individually and collectively; the application of global

conduct studies which documented the experience of patients and potential patients in their encounters with the service, and in that way to substitute empirical and observational evidence for administrative material.

There was some discussion about the relative values of the so-called hard epidemiological-type material and that collected in the observational and interactionist studies frequently conducted by sociologists. The two types of data were not necessarily contradictory and should be complementary. If it were necessary to make choices between them, a large body of experienced field researchers in medical sociology would opt for qualitative material as a superior and more flexible reflection of reality.

Sociologists also felt that it would be necessary for WHO to diversify sources of information and advice from Member States. Governmental data would be useful at one level, but it would be important to have inputs from other interested and knowledgeable groups within societies and to have access to first-hand research data.

(e) Sociologists noted a tendency for much research in the medical and health fields to be concentrated upon the behaviour of individuals. They felt, however, that insufficient attention had been paid to the study of social structures and organizations. It was frequently possible to interpret individual behaviour, e.g. non-use of services, as being due to a fault in the operation of the services themselves or in the behaviour of service providers rather than a fault in the individual. In the implementation of regional plans, it would be necessary to shift attention away from individuals and towards the structures within which they were located and the organizations that were responsible for the delivery of service. That would be the more necessary, in that service provision inevitably varied widely from country to country in its nature and organization, so that it might be impossible to estimate which institutions with similar names in different countries performed similar functions. Study of the organization in its own right was therefore as important as study of the individual.

(f) In the contact between informal groups and formal organizations, the sociologists noted a tendency for the latter to dominate, colonize or absorb the former. It was, however, rare that the formal organization and a spontaneous movement performed the same functions. The problems that professionals encountered in being accountable to a bureaucratic structure led them to take over and replace informal services rather than support them. It was therefore necessary to start with population needs and to examine the relevance of various informal and formal groups in meeting those needs, rather than to assume that if something was good it should be taken over. In the same context, it was noted that there were moral and ethical dangers in attempting to change the behaviour of individuals and populations. Questions of that kind needed to be examined more carefully.

(g) The participants noted the large resources available to governments, research councils, academies and universities within national boundaries. It was an administrative problem for WHO to ensure that it made the best possible use of the vast volume of research being carried out across the European Region, instead of attempting to substitute centralized research for spontaneous decentralized activities. There were, moreover, strong intellectual doubts and objections concerning the value of standardized epidemiological-type research when it came to the study of anything other than the most simple and discrete entities. The use of that particular methodology frequently meant that the ends were dictated by means and that therefore the real issues went unexplored. The participants recognized that WHO would have a difficult job in keeping in touch continuously with the flow of national research and in coordinating individual efforts to a European objective. Experimentation was probably needed to obtain the best solutions.

### 3. Review of medium-term programmes

Four medium-term programmes (1980-83) were chosen for review during the Consultation. The principal aim was not to conduct a comprehensive review, but rather to use these programmes as examples of how sociology might contribute to problem definition and the content and conduct of such programmes, and to consider how sociological perspectives and methodologies might coincide with, or diverge from, those employed within the programmes as they were currently framed. That necessarily implied a critical examination of definitions, perspectives and methodologies in which sociologists drew upon the theoretical and methodological basis of their discipline and the findings of sociological research on related topics.

### 3.1 Primary health care

The mandate and the guiding principles of the programme on primary health care were derived from the Declaration of Alma-Ata, with its emphasis upon primary health care as a philosophy permeating all health-related services. Within that perspective emphasis was placed upon community participation, self-care and the integration of medical and social services, and, later in the programme, upon supporting specialized personnel at the secondary and tertiary levels and upon certain areas or high-risk groups representing special difficulties. Anticipated difficulties in developing a commonly acceptable conceptual framework, in mobilizing political and popular support for the concept, in evolving an organization capable of ensuring cooperation and interservice integration, and in developing appropriate technologies, management systems and manpower resources underlined the objectives and strategies of the programme. Those concerns were reflected in the schedule of studies and activities being promoted by the Regional Office. Studies on aspects of primary health care would deal with self-care, community participation, organization, and with teamwork and the integration of primary health care in hospital and other specialized services. Further studies on the management of primary health care and on appropriate technology were planned. Certain special issues relating to problems of care in urban and circumpolar areas reflected the particular character of the European Region.

Discussion of the programme centred upon issues identified by the sociological participants:

- (a) The absence of comprehensive and synthesized empirical knowledge about the practice of primary health care in the countries of the Region, as opposed to formal statements about its organization, inevitably dictated an approach which began with organizational, managerial and technological issues. That created a gap between the ideology of the Alma-Ata Declaration and its operationalization in the medium-term programme. The conceptualization of the new approach was thus rendered secondary to organizational and managerial concerns.
- (b) Conceptualization of the new approach should begin with needs, and that would require a range of knowledge and data about the primary health care of individuals and populations which was not catered for in the research and study proposals of the medium-term programme.
- (c) There seemed to be some contradiction within the proposals, in that, on the one hand, the intention was to remodel primary care to meet more effectively the needs of the population while, on the other, the primary health programme and also related programmes seemed to concentrate heavily upon an unintegrated concept of self-care.
- (d) Implementation of a remodelled system of primary health care would inevitably encounter difficulty and opposition in some Member States because its philosophy threatened the attitudes and interests of significant sections of the existing health system and its introduction would entail the dismantling of that system. The fee-for-service model was cited as being fundamentally contrary to the practical implementation of the Alma-Ata objectives, although it was only a single example, albeit an important one, of wider contradictions in social policy. The programme did not confront the political and attitudinal problems inhibiting free and full access to the comprehensive range of services. Again, at least as a preliminary, combined studies of national systems were required to identify the nature and volume of unmet need, the compatibility of the system with the new principles of primary health care and the implications for structural change. Otherwise organizational, professional and managerial factors would take precedence over conceptual principles.
- (e) One particular manifestation of the above problem related to the substitution of health care for medical care. Training took place within specialized professional groups which maintained and organized separate functional spheres. A question requiring urgent attention was whether teamwork could be more than rhetoric and wishful thinking if the team members continued to be trained separately and if professional organization remained the basis of the division of labour.

### 3.2 Health care of the elderly

Problem definition in this medium-term programme emphasized the increase in the number of elderly persons, the continued aging of the population, the absence of information on the frequency of disease and impairment, and the high rate of service utilization by elderly persons. The programme perspective stressed comprehensive care rather than medical services, the need for closer integration of national services and programmes, the identification of technology appropriate to the diseases, disabilities and dependence of the elderly, and the development of technology to prevent diseases of old age. The objectives and strategies concerned the need:

- to define the physical, mental and social profiles of the elderly and the possible effects of increased numbers on existing social structures;
- to develop appropriate technology, including preparation for retirement, health promotion and disability prevention and alternative modes of care;
- to promote new organizational models for the care of the elderly;
- to develop training programmes;
- to promote cooperation between bodies concerned with the health and social problems of the elderly.

The programme envisaged a wide variety of activities conducted in association with governments and advisory bodies, studies of the organization of services, management of the care of certain disease and disability groups, education in the appropriate care of the elderly, the use of medication in the care of the elderly and epidemiological studies of care.

The sociological participants agreed that these activities and studies should constitute part of any comprehensive programme. Until recently the care of the elderly had been a relatively neglected area of medical practice and of the social services and that was further reflected in the lack of basic knowledge and research.

Sociological approaches and priorities would have differed in several respects from those embodied in the medium-term programme.

(a) The problem defined by the programme centred upon the increasing number of elderly persons in the populations of the Region. Increasing numbers did not, however, in themselves constitute a problem. The problem lay in the failure to shift resources from other sectors to meet the needs implicit in growth. That alternative definition of the problem had important implications for the construction of a medium-term programme and would entail a different content and different priorities. Two related strategies were necessarily involved in improving the care of the elderly: first, a more effective and efficient use of existing resources and, second, a shift in resources from other parts of the medical and social services towards the care of the elderly. The medium-term programme was focused almost entirely upon the former and did not begin to confront the factors which had led to a progressive impoverishment of services for the elderly. The biomedical priorities of past decades had led to a concentration of resources on acute illness, hospital medicine, and other age groups and conditions. Among the professional groups dominant in health systems, it was generally felt that care as an activity, the elderly as a patient group and geriatrics as a specialty had low status. The core of activities and research should thus focus upon how to shift priorities and resources in services dominated by contrary ideologies.

(b) Lack of information about the elderly, their impairments and their disabilities was frequently cited as a problem. That tended to concentrate attention upon the elderly themselves and implied that if one knew more about them the problem would be resolved. It could be argued, however, that, while better information and indicators were always useful, sufficient information existed to estimate needs and to indicate the lines of advance. Some societies already possessed good information, but the problem remained because the services themselves, not the elderly, constituted the problem. Thus, studies should not be of an epidemiological type which concentrated on individual characteristics, but should be sociological in nature, documenting the social processes which dictated the nature of the service offered and the experience of patients or clients in their interaction with services.

(c) One urgently needed set of studies related to population attitudes and practices. Was the low status and priority given to the elderly in the attitudes and practices of the professions and services matched by similar attitudes in the population at large? It was frequently assumed that an increase in family and "community" care was particularly appropriate for the elderly; yet the available data suggested that such informal care was already massive and that, without it, the services would collapse. Was there scope for an increase? If so, at what cost to families and to the elderly? What were popular attitudes towards the allocation of responsibility between families and the medical and social services? What forms of formal support did families themselves perceive as essential?

(d) The programme correctly drew attention to discriminatory practices and stigma, while aiming mainly at the improvement of measurement tools. It was the source of discriminatory practices, however, which constituted the problem for research, not its accurate

quantification. Elsewhere in the programme, attention was drawn to preparation for retirement. Retirement pensions were originally devised to ameliorate the life of the elderly after their chosen age of retirement. They had since become a means of enforcing the compulsory retirement of persons at stated ages, whatever their functional abilities and motivations. Furthermore, to solve problems of unemployment for younger people there was a tendency for earlier retirement ages to be fixed. It could be argued, however, that the source of both discrimination and of isolation and dependence was the withdrawal of persons from professional or working life. That was an intersectoral problem which required examination. It was likely that such an examination would change concepts about the state of being elderly.

(e) In general, therefore, participants felt that the emphasis of the programme should be changed from study and quantification of the elderly and their characteristics to the more fundamental question of how society, and the services in particular, created, maintained and reinforced "the problem of the elderly". That did not, of course, mean that existing resources should not be used effectively or that attempts should not be made to improve caring methods through preparation and training.

(f) Regarding mechanisms of study and cooperation, it was suggested that too much reliance might be placed upon the nine directors of institutes of gerontology. Not all countries possessed such institutes and many relied on a more diffused effort. There had been a remarkable growth in recent years in the volume of research on the elderly, spread across many organizations and disciplines. The programme of work in medical sociology alone (and there were several other relevant social science disciplines) was now very substantial. However, it might not be well represented in established institutes of gerontology, where traditional, and particularly medical, disciplines were entrenched.

### 3.3 Maternal and child health

It was noted that the maternal and child health (MCH) programme formed part of the wider section of family health and that certain topics, particularly family planning, were thus excluded from the MCH programme. Some doubts were expressed about the desirability of such an arrangement and about its consequent impact upon conceptualization of the field and its problem areas.

In defining the problem, the MCH medium-term programme identified the family as the key element at all levels of health care from promotion through prevention and treatment to rehabilitation. It drew attention to the relationship between the family and lifestyle, behaviour and environment, and noted that in the more developed countries of the Region the family as a social unit was undergoing changes which had brought new health problems. The programme objectives specified five main trends as the focus of activities:

- changing functions of women and changing patterns of human reproduction;
- shifting emphasis in the perinatal period, from mortality to morbidity;
- changing patterns of feeding and nutrition of infants and children;
- increasing importance of chronic diseases in children;
- a new awareness of the need for active health promotion, including a change in lifestyles among children and adolescents.

The proposed activities of the programme were clearly related to those five strategic issues and involved advisory work and studies on family health, genetic counselling, the new role of mothers, population groups and perinatal risks, the definition of new morbidities, and health promotion and lifestyles. Specially designed programmes were being developed for Algeria, Morocco and Turkey.

Sociological comments ranged from general approaches to matters of detail. The main and recurring themes were:

(a) Despite the inclusion of items dealing with the role of women and new morbidities stemming from change, the programme had an old-fashioned look. It reflected traditional MCH concerns both in its content and in its approaches. This seemed to be due partly to the subdivision of the family health area and the administrative exclusion of family planning from the MCH programme. A number of imbalances and significant omissions were noted. They included social class and class-related inequalities, unemployment and its impact upon

adolescents, the effect of private and public systems of care, the effect of private business and of the mass media on nutritional habits, the role of the church, antenatal care, children's rights, sex and age discrimination in relation to children, and major aspects of parenting.

(b) The European Region contained a range of societies at different levels of development. The programme concentrated heavily upon changes and problems characteristic of the most developed countries. There was a need to consider separately the special problems of intermediate areas such as Spain, Portugal, Greece and some of the eastern Europe societies.

(c) While the proposed attention to the new roles of women was welcomed, the problem was insufficiently conceptualized. It was heavily influenced by demographic and medical considerations such as population growth, adolescent fertility and changing patterns of reproduction. It fell into the "feminist trap" of restricting attention to women instead of dealing with the related roles of men and women, of mothers and fathers and of girls and boys. Not enough attention was paid to sex differences and sexual discrimination and the different patterns of upbringing and behaviour of boys and girls. (It was mentioned that few larger differences existed than those between boys and girls and between social classes in relation to the frequency of accidents.)

(d) The conceptualization of the topic "new morbidities of children and adolescents" was quite inadequate. The terms were vague and undefined; yet it was proposed to develop new indicators and new terms of health promotion to monitor and modify them. No clear theoretical analysis underpinned the selection of problems, which therefore had a random appearance. Why so much attention to the fertility and drug behaviour of adolescents, for example, and so little to their unemployment and to their own perceptions of what was problematic? What were innovative approaches?

(e) In general, the implications of the main policy documents had not been worked out; in particular, the emphasis on lifestyles, on the social determinants of illness and on social components of health had not been operationalized. The result was an imbalanced medicalized and medicalizing approach at odds with the policy guidelines.

### 3.4 Health education

The health education programme was based on four main conceptual dichotomies:

- health promotion vs. health prescription;
- individualistic behaviour modification vs. a systematic approach;
- medical dominance vs. lay competence;
- social hygiene vs. coping (illness management).

A wide range of activities and studies resulting from the above conceptualization and from the perceived inadequacies and failures of traditional health education had been planned. The field was, however, under revision and more subject than the others to present and future modification. While the total programme was briefly described, the participants chose to concentrate their expositions, and consequently the discussion, on one major component, self-care, which was perceived to be both the most controversial and the most pertinent to sociological conceptualization. It had been estimated that as much as 85% of all care was lay-provided and that, on the whole, it was safe and relevant care. Discussion of the health education programme was preceded by the presentation and discussion of a sociological paper on concepts of health and illness in industrialized societies. This provided theoretical justification for the partial deprofessionalization of health care and from the positive but careful incorporation of the principles and practice of self-help in formal and informal health care systems. The general sociological discussion, which restricted itself almost entirely to the concepts of self-care and self-help, included the following major themes:

(a) The terms "self-care" and "self-help" were often used interchangeably, and because of a clear lack of definition and difficulties of terminology they tended at times to include many components which were intrinsically different from each other. Distinctions needed to be made between no care, self-care, personal use of medical techniques, self-diagnosis, self-treatment, self-referral, family care, diagnoses, treatment and referral, neighbouring activities at formal and informal levels, mutual support groups in personal illness, mutual support groups in caring for dependent disabled relatives, pressure groups, official lay

consultative machinery, general practitioners, committees of patients, etc. Each definition implied different functions, different support systems and different relationships and articulation with health services. They might have different implications for the programme of activities. It was noted that workshops had been arranged to discuss some of those issues.

(b) Anxiety was expressed about possible repercussions of promoting self-care. One danger was that official services would seize opportunities to unburden themselves of unwanted responsibilities and thus reduce their accessibility to patients or clients for problems defined as important by the patient. A corollary might be the devotion of official resources to more professionally-defined interests. The attempt to innovate might go too far if it was not carefully evaluated.

(c) There were parallel doubts about the efficacy of education in self-care. It was probable that it would be most effectively taken up by middle-class educated groups and that it would be least understood and least efficacious among those groups most in need of care, i.e. the disadvantaged classes, the most vulnerable age and sex-groups, and in health systems which were already underfinanced.

(d) The concept had been accepted before there had been adequate discussion of the content of care. Much more thought was needed about what self-care implied in terms of practical action in the face of a wide range of illness conditions and social problems.

(e) The family performed many functions, some of which were beneficial. It was also a generator of problems and pathologies. Protection might be needed for family members, and again the most vulnerable (e.g. children, the elderly, the mentally ill, etc.) might suffer if the family was too easily defined as the source of care.

(f) Self-care as a concept might be embraced for many different reasons. Private business might set up a potentially dangerous self-care industry. Others might embrace it as part of a general antimedicalization philosophy and in the literature of self-care there was sometimes a nihilism reflective of the more negative, aggressive components of Illich's thought.

(g) Opposite dangers were discussed, especially the danger that over-enthusiastic acceptance and promotion of the concept by the official services, amounting to a take-over, would kill the spontaneous nature of self-help and of popular movements.

#### 4. Sociology and its potential contribution to WHO activities

As a general discipline, sociology had grown considerably over the last two decades in personnel numbers, in its theoretical and methodological sophistication and in the body of knowledge about contemporary societies which it had accumulated in its empirical research. Medical sociology had increased correspondingly and now constituted the largest single section of the sociological community in some countries. Figures were cited showing that in some countries the number of sociologists specializing in health and medicine had grown to 200-300, a substantial proportion of these being full-time research workers. There were, however, considerable variations in the European Region, so that there were only one, two or even no medical sociologists in other countries. The direction of medical sociology had also changed with its growth, and many sociologists were involved in national programmes of health services research, working with or alongside service organizations and advising at local and national levels on health and social policy and on research strategies and programmes. Some of the larger institutes and departments now constituted an important national resource for governments and services.

Medical sociologists had further clarified their role in many respects. They remained an integral part of sociology, and the Consultation showed at various points how they drew upon basic theoretical work in the definition of problems and the design of research. They had now, on the basis of specialized experience, begun to feed back their knowledge into general sociology at all levels. They had also identified more clearly their subject matter. Whereas two decades ago they were imported into medicine as social epidemiologists, they now considered that, like any other sociologists, they were dealing with questions of social structure, social processes occurring within and between structures, and the ways in which structure and process influenced the social relationships of both groups and individuals. Their concern was now with health, health policy, health systems, health beliefs and health behaviour and they were no longer narrowly confined to matters of medicine. Medical sociologists differed widely in their interests: at one end of the range there were those whose main concern was with theory and methodology as a part of sociology while at the other extreme there were those employing their knowledge and skill on discrete and limited problems.

The relationship of sociologists with and within WHO had not changed to anything like the same extent. They were still selectively, but not too frequently, co-opted for particular purposes, mainly as temporary advisers on special topics. Their ability continuously to inform WHO was limited; yet they considered that their skills were particularly valuable at the stage of problem definition and in relation to intersectoral issues. At the same time, WHO had begun to evolve policies and perspectives which either derived from sociology or needed sociology for their explication and implementation because they too were dealing with human needs and social environments, social structure and social processes.

Their empirical work was now substantial and its collation, synthesis and focusing on WHO issues could be intrinsically valuable and lead to a saving of scarce research funds. They knew, moreover, the often misleading nature of official information in their countries, compared with the reality of patient experience and service operation. Key sociologists in most countries were intimately familiar with current research work and its findings over the whole range of WHO concerns. The general plea of sociologists present at the Consultation was that ways should be found of linking the knowledge and skills of sociologists at national levels with the ongoing activities of WHO in a more systematic way than had so far been possible.

#### 5. General discussion of medium-term programmes

The Consultation was so arranged that a WHO staff member described each programme, a nominated sociological participant offered a detailed critique, and this was followed by comments from the other sociologists. The very brief time left over at the end of each session for a more general discussion meant that this interchange was often brief and unsystematic. Such discussion suggested, at times, that programmes were under review or being constantly elaborated, and that WHO staff were not unaware of many of the points made by the sociologists. Sometimes, as in the discussion on self-care, WHO staff had structured their presentations specifically to elicit the critique which followed. The sociologists, too, were aware that they were unfamiliar with the process of programme development in WHO and were only seeing in the four programmes a part of the relevant general programme.

#### 6. Conclusions and recommendations

All participants agreed that the Consultation had been valuable and that arrangements should be made to continue the exchange of views and ensure a further sociological contribution to WHO activities. Dr Asvall reported that:

- a medical sociologist had already been appointed to the Regional Health Development Advisory Council (RHADAC);
- a post in the Research Promotion and Development Unit was already available and that it was the intention of the Regional Office to appoint to that post a sociologist whose primary concern would be with methodological issues;
- a sociologist was already employed as a consultant to the Health Education Unit.

The following additional possibilities were discussed:

- (1) An advisory committee on medical sociology and/or membership of advisory committees on particular programmes. The sociologists stated that they would welcome membership of programme advisory committees where, as specialists, they could contribute to particular fields having a strong sociological component. They were convinced, however, particularly in the light of the experience gained during the Consultation, that their potential contribution was wider than that of a topic specialist and that their expertise lay in the application of their knowledge in problem definition and conceptualization across topics. That had become evident in the Consultation as they related concepts and definitions in one programme to issues arising in others. They could be more effective collectively than separately. If, therefore, the two possibilities were alternatives, they strongly preferred an advisory committee on medical sociology to membership of selected programme advisory committees.
- (2) Use of external sociologists in evaluating research programmes, studies and applications. The sociologists said they would welcome this form of participation. Dr Asvall suggested that sociological views on the next (target) stage of HFA2000 would be useful.
- (3) Clearing-house/collaborating centres. While the sociological participants were unsure of the Office mechanisms, they advocated a means whereby, on a systematic basis, WHO could be made aware of:

(a) the names, interests and specialist skills of medical sociologists working in the Region;

(b) the nature of relevant projects being carried out in countries of the Region, specifying the topic, design, methods, staff, institution and time-table.

Doubts were expressed about how far such a facility could cover the full range of medical sociology or whether it should be restricted to selected topics. The mechanism of collaborating centres might be preferable to a clearing-house, considering the size both of the Region and of the sociological enterprise. Dr Nuyens mentioned that a member of his staff was currently reviewing the state of medical sociology in Europe.

The principle was therefore agreed, but the exact mechanism was left open for further thought and discussion.

(4) Public health in Europe. Dr Asvall said that it might be possible to reserve a special issue of Public Health in Europe for a directory and review of European medical sociology. The suggestion was welcomed.

Annex

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