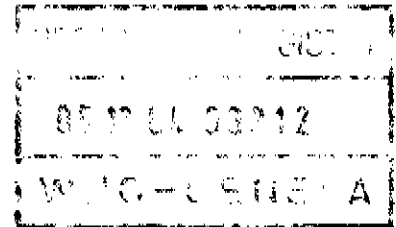


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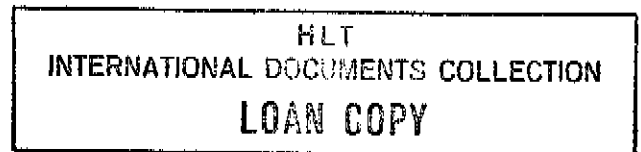
SELF/HEALTH/CARE AND OLDER PEOPLE

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A Manual for Public Policy and Programme Development

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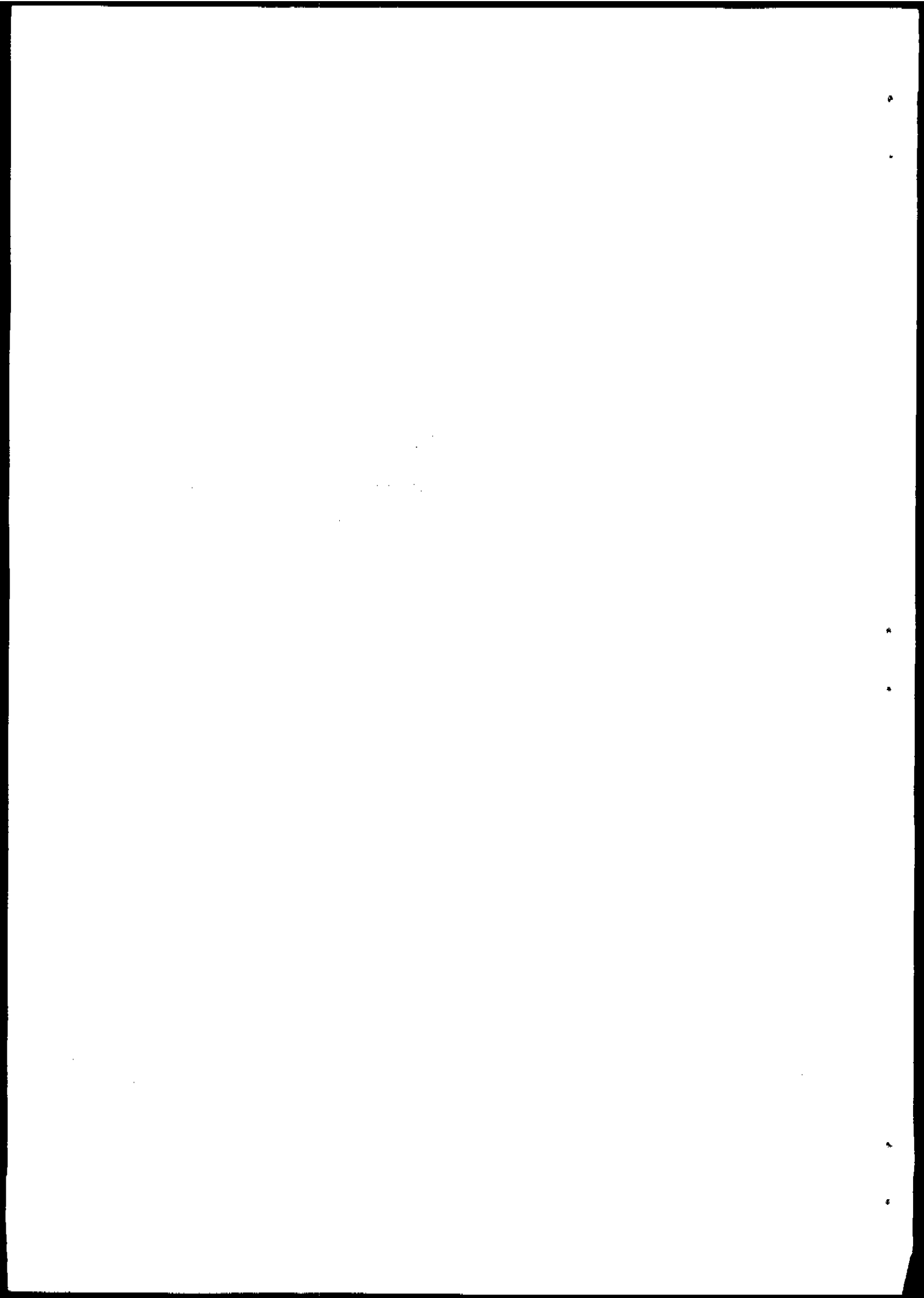
ORIGINAL/DUPLICATE II

GLOBAL PROGRAMME FOR HEALTH OF THE ELDERLY
THE WORLD HEALTH ORGANIZATION (WHO)

THE KELLOGG INTERNATIONAL SCHOLARSHIP PROGRAMME
ON HEALTH AND AGEING INSTITUTE OF GERONTOLOGY,
THE UNIVERSITY OF MICHIGAN

THE NATIONAL INSTITUTE ON AGEING (NIA)
THE NATIONAL INSTITUTES OF HEALTH,
UNITED STATES OF AMERICA

INSTITUTE OF SOCIAL MEDICINE,
THE UNIVERSITY OF COPENHAGEN



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Note

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The views expressed are those of the authors and of those participating in the WHO Workshop on Self Health Care and Health Promotion in the Elderly and do not necessarily reflect the policy of the World Health Organization.

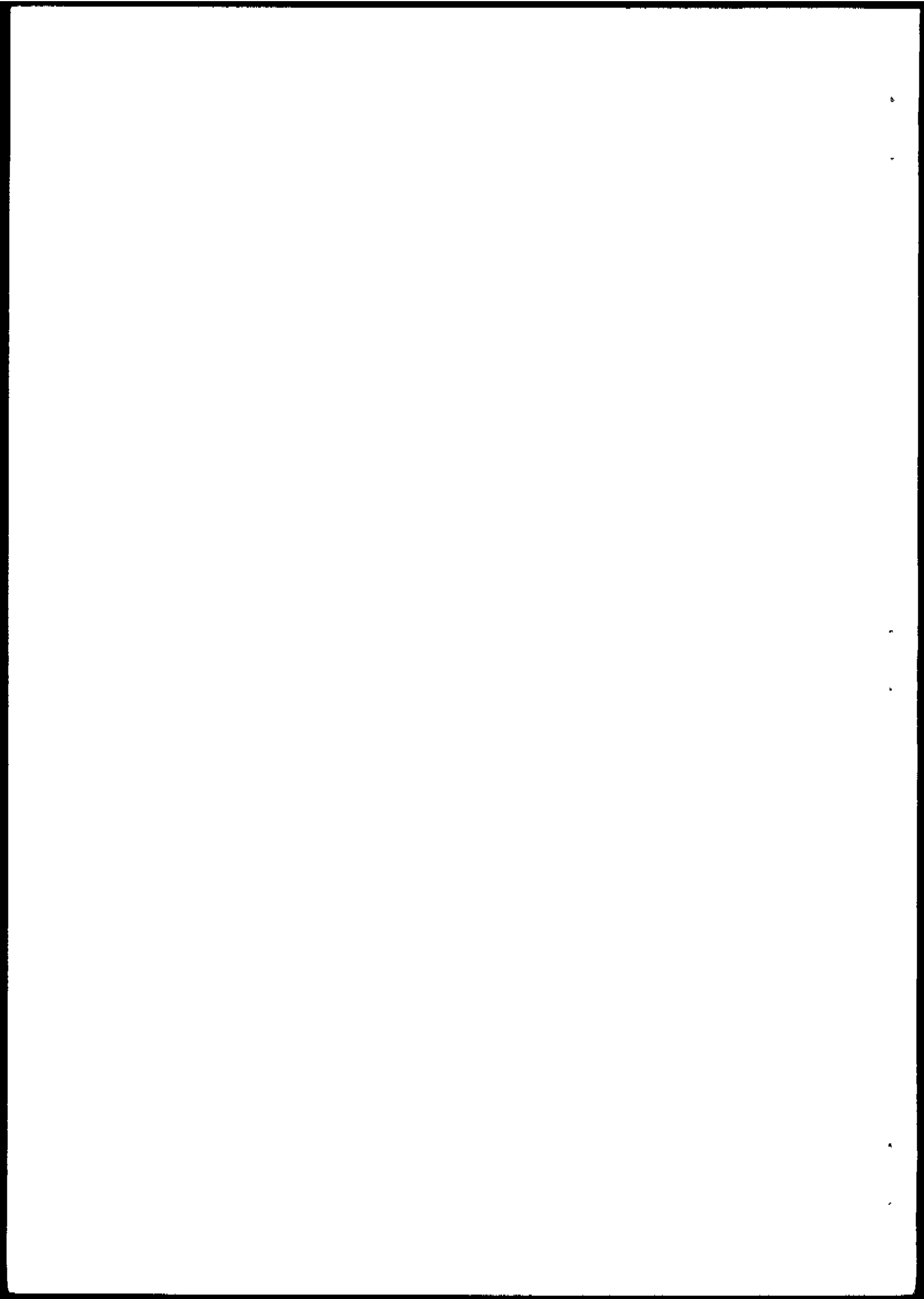
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This manual was prepared by:
Larry C. Coppard, Associate Director
Institute of Gerontology, University of Michigan, U.S.A.

In collaboration with
Matilda White Riley (NIA)
David M. Macfadyen (WHO)
Kathryn Dean (Univ. of Copenhagen)

In addition to basic research assistance, sections of the manual were written by Mary Jo Gibson, International Federation on Ageing; and Susan Juster, Institute of Gerontology, University of Michigan. The final draft manuscript was reviewed by the NGO/WHO Collaborative Group on Aging, May 1984.

Earlier versions of the manuscript were reviewed and helpful comments made by: T. Franklin Williams, Director, The National Institute on Aging, David Mechanic, Dean, Rutgers University, Antti Hervonen, Professor, University of Tampere, Finland, William Kerrigan, Secretary General (ret.), World Assembly on Aging, John W. Riley, Jr., Center for Corporate Public Involvement; Eloise Snyder, Institute of Gerontology.



August 1984

SELF/HEALTH/CARE AND OLDER PEOPLE

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- 1.4 How Is Self/Health/Care Related to Professional Health Care?
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2. HOW IS SELF/HEALTH/CARE PROMOTED AMONG OLDER PEOPLE?

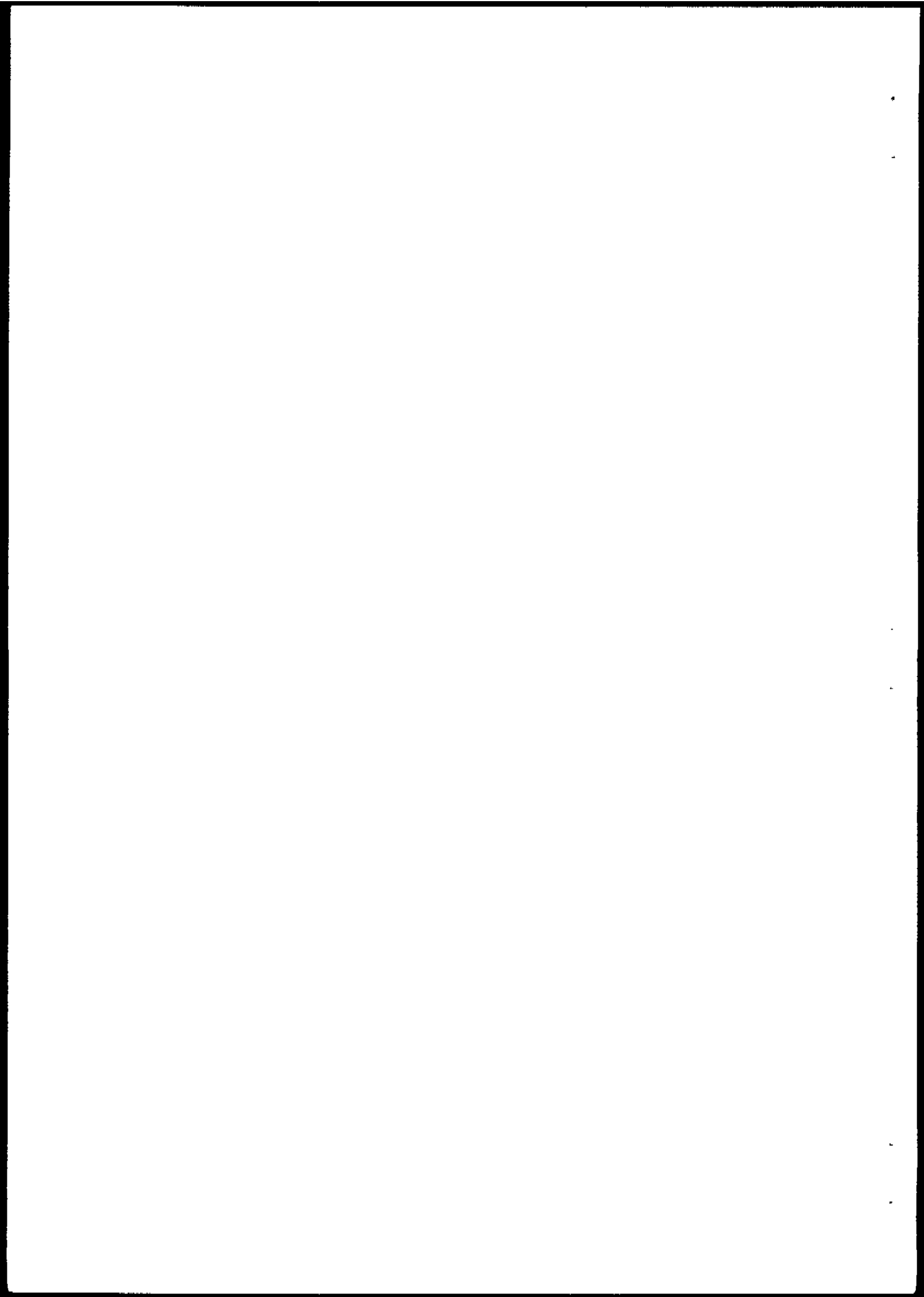
- 2.1 What Types of Programs Facilitate Self/Health/Care?
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"...if health doesn't start with the individual, the home, the family, the working place and the schools, then we shall never get to the goal of health for all. Even if we take the example of the industrialized countries, self-care, self-responsibility, self-coping in the individual, family and community represent 50-60% of all care... Any significant improvement in the physical, mental and social well-being to a large extent will depend on the individual's and the community's will to fend for themselves."

H. Mahler Director-General World Health Organization, 1977

ABOUT THIS MANUAL

The increasing number of persons who live into old age and the greater use of health services by older people are straining existing health systems in all parts of the world. At the same time, there is growing concern about the health of older people and the quality of health care they receive. Improving health knowledge and self-care behaviour is viewed by many as having high potential for enhancing the health of the elderly. Initiatives in this area are being taken in many countries by health care professionals, governmental and non-governmental organizations, and groups of elderly persons themselves. Self-care and health promotion activities that are sensitive to cultural and social differences could well assist in improving the health of older persons and the health knowledge and behaviour of their families.

The potential of self-care in maintaining and enhancing the health of the elderly is the subject of this manual. The manual draws upon the experience and research of scientists, practitioners, and policymakers throughout the world. The proceedings of four international meetings provide perspectives for much of the text: the International Research Symposium on Self-Care and the Elderly, held in Ann Arbor, Michigan, in October 1981; the United Nations World Assembly on Aging, held in Vienna in the summer of 1982; the International Symposium on

Health and Aging: European and North American Perspectives on Health Behaviour and Self-Care in Old Age, held in Oxford, England, in May 1983; and the WHO International Workshop on Self-Care and Health Promotion Among the Elderly held in Copenhagen, Denmark, in August, 1983. In one important sense, this manual was "written" by participants in the last-mentioned workshop, since the manual is built upon the experience of a growing number of examples of self/health/care programmes for the aging in several countries. A deliberate decision was made not to list all the documents drawn upon, nor to reference by name the many small and local programmes that now exist to encourage self/health/care. Rather the effort has been to report as faithfully as possible what seems to be the current consensus of opinion and experience surrounding this not yet well-defined form of health care for the elderly wherever they may be living.

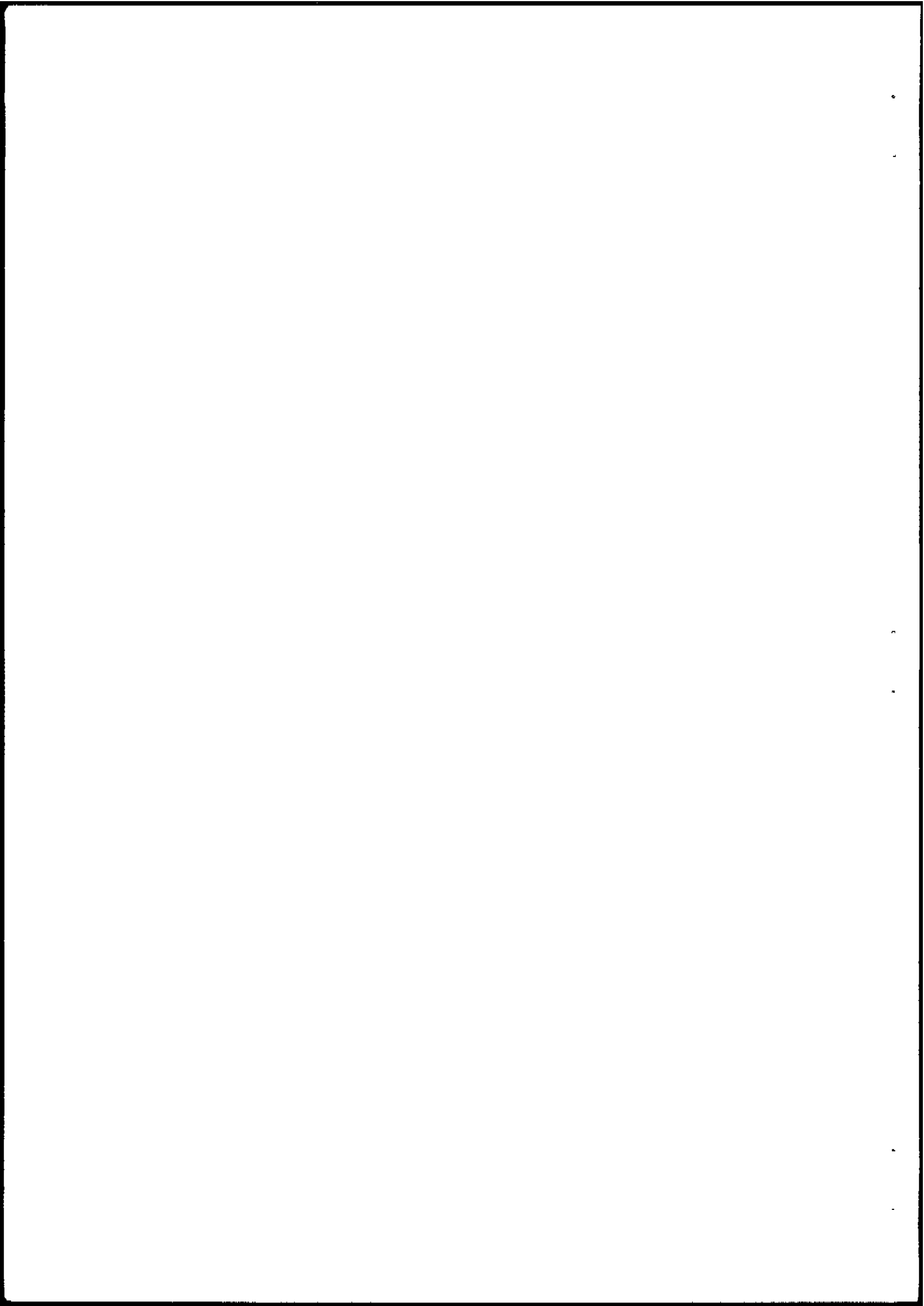
This manual, then, is about the role of self-care in the health of older people. It is concerned with programmes for the elderly and by the elderly. Its purpose is to stimulate both dialogue and action among health and social service providers, policymakers, and the elderly themselves. Those who would like a current listing of publications related to self/health/care and the elderly should write to the:

IFA/WHO Information Centre on Self/Health/Care
International Federation on Ageing
c/o Age Concern
Bernard Sunley House
60 Pitcairn Road
Mitcham, Surrey CR4 3LL
UNITED KINGDOM

The Centre acts for WHO as a repository of self/health/care material. It receives manuals, leaflets and other instructional material on self/health care and disseminates such information on request.

SECTION 1

WHAT IS MEANT BY SELF/HEALTH/CARE?



1.1 Is There a Good Definition of Self/Health/Care?

The sponsors of this manual are satisfied that the following statement will serve as a working definition of self/health/care:

Self/health/care consists of all the actions and decisions that an individual takes to prevent, diagnose, and treat personal ill health; all individual behaviours calculated to maintain and improve health; and decisions to access and use both informal support systems and formal medical services.

Self/health/care thus includes several different components. There appears to be general agreement that at least five quite specific individual skills are involved:

- simple diagnostic skills which the individual can practice in making an estimate of his/her health status, e.g., checking temperature and pulse rate, breast self-examination;
- skills relevant to simple acute conditions, e.g., treatment of the common cold and everyday illnesses, first-aid for non life-threatening injuries;
- skills needed to treat chronic illnesses, e.g., self-monitoring, following prescribed regimens;
- skills required for disease prevention and health promotion, e.g., exercise, diet, avoiding tobacco and alcohol abuse, good dental hygiene, healthy life styles;
- health information skills, e.g., knowledge about what steps to take prior to seeking professional treatment, how to obtain health information, how to gain access to formal care.

It is significant that most of these skills are relatively easy to teach and pose few risks for health complications even in the absence of a professional.

One further distinction needs to be made. This manual treats self/health/care as being one form of the more general practice of lay care. In this view, lay care, in contrast to care provided by professionals, includes all of those activities performed by the individual on his or her own behalf and those activities performed by family, friends, neighbours, volunteers and voluntary agencies on behalf of another person's health. Lay care implies that the individual shares the responsibility for his/her own health and that of others across the whole health continuum from prevention, maintenance, acute care, care of chronic conditions, to terminal care.

This manual is further guided by a number of WHO publications which make reference to self/health/care or its equivalent. One expression of the WHO position is to be found in the 1978 Declaration of Alma-Ata which, in calling for actions to promote the health of all peoples of the world, refers to self-care with such descriptive phrases as: "fending for one's self," "the spirit of self-determination," or "self-reliance." In recognition of the need for a more substantive statement on self-care, WHO's Report to the World Assembly on Aging on "Health Policy Aspects of Aging" contains the following statements:

"Aging people and their families should be more involved in their own care. Health educational information on the promotion of health and prevention of disease is required, as are simple handbooks of personal care. Knowledge of locally available services and social support systems represents another important element of prevention, and will assist aging people and their families seeking health care. Too often the aged fail to seek care in the belief that ailments are part of the aging process."

"New orientations are [also] required on the part of care providers to help aging people maintain independence, support self/health/care, and prevent disability. Such support to aging people must be provided by practitioners who are knowledgeable on the subject of aging, who are interested in aging people and their families, who are skilled in working with them, and who are concerned about the quality of care given."

1.2 Is Self/Health/Care a New Concept?

While research-based literature on self/health/care is a relatively recent phenomenon, the actual practice is certainly not new. Health has always been viewed as a matter for individual concern and responsibility. In all of human experience, symptoms of illness have been self-treated and subjected to some degree of self-care.

Medical anthropologists are quite clear on this point. Despite large cultural differences, individuals at risk of ill health are always to be seen in two contexts: in relationship to family, friends, and other informal supporters in the community, on the one hand; and in relationship to medical care providers, including native healers and professional health care personnel, on the other. Put another way, cross-cultural research in medical anthropology demonstrates that self-care in any health care system not only is the primary form of care but tends to be the most important, and that it intersects both the professional and lay care sectors. The following examples of self/health/care and lay care for mental and physical disorders, drawn from both developed and developing nations, illustrate this point.

In many parts of Africa, the elderly in rural areas resort to traditional healing practices. For example, enemata prepared from the bark of trees, herbs, or soap and water are administered to relieve abdominal pain. Another aspect of self/health/care for the rural elderly is the exercise they obtain from daily long walks to their farms, where their farming responsibilities typically provide physically demanding exercise.

In Western Samoa, older persons practise many types of self/health/care. People extract their own teeth and rely on a variety of home remedies such as ti-leaves, or rags tied around painful parts of the body. These self-

remedies may be supplemented by a massage, either by a family member or a local specialist, the fofo. If older persons do enter a hospital, family members are their principal caregivers, providing them with food, clothing, bedding, personal care, and companionship during their stay. But above all, they instruct the patient in self/health/care.

Self/health/care for mental disorders is also common in a number of developing nations. For example, in the Sudan, "therapeutic villages" promote various types of self-awareness to treat mental disorders, especially among women, with a strict religious regime. In these villages, faith healing is the primary form of treatment for psychiatric disorders that are not considered sufficiently serious to warrant the expense of professional care.

Among the Bakongo of Lower Zaire, "palaver" as a form of group therapy serves as the first step in diagnosing mental illness and in developing a plan of action for healing. The healer, typically an elder, calls members of the clan together and plays the role of intermediary between the "self" and his or her kin so that broken relationships may be healed.

Self/health/care and family care are the predominant form of care in most developed nations as well. It has been estimated that fewer than 25 percent of all episodes of illness in the industrialized nations of Western Europe and North America result in contacts with professional sources of health care. Of those who do seek formal medical care, a large proportion have already endeavoured to treat their own disorders.

In many countries older persons have access to regular medical examinations and are occasionally treated for acute or chronic illnesses, but still much of their health care is self-administered. They typically remain active, may exercise, are alert to symptoms that may signal serious conditions, and treat minor illnesses themselves. In the United States of America with the recent growth of home medical tests, as well as formal self/health/care programmes that teach individuals various medical self-care skills, some older persons are monitoring their own blood pressure and other chronic conditions, such as diabetes.

Family members in developed as well as developing nations typically supplement self/health/care and provide the bulk of the care received by impaired older persons. For example, family caregivers to physically and mentally ill older persons whose self/health/care skills are limited provide a broad range of nursing and personal care services. These caregivers, who are typically women (wives, daughters, and daughters-in-law), may administer medications, lift and turn bedfast patients, monitor their diets and their overall health status, assist in rehabilitation activities, alter the home environment to make it safe, and serve as their relatives' liaison to formal medical and social services.

1.3 How Does Self/Health/Care Fit Into the Continuum of Health Care?

How the concept of self/health/care forms just one part of any system of health care may be seen if we imagine a two-dimensional typology, each axis of which has four points:

| | <u>Health Status</u> | | | |
|---------------------------------|----------------------|-------------|-----------------|-----------|
| <u>Providers of Health Care</u> | Healthy | Acutely Ill | Chronically Ill | Bedridden |
| Self | | | | |
| Family | | | | |
| Community | | | | |
| Professional | | | | |

This matrix provides a kind of conceptual map. The extreme upper left hand cell represents the role of the individual in maintaining a healthy life. The cells to the lower right illustrate the role of the professional at times of chronic, and more disabling illnesses. Likewise, the other cells represent the different roles that the individual, family, community and professionals play in providing care at different times. Implied here is that there is interaction among all levels of care.

The total picture is complex. The roles of self/health/care and other health care providers change depending on the health status of the individual. The picture is further complicated by differences in societies, their health care systems, the health conditions of their populations, and the health care resources available. But in all cases, the individual, family, community, and health care professionals have important, often different, but complementary roles to play in maintaining health and in providing care when illness occurs.

1.4 How Is Self/Health/Care Related to Professional Health Care?

It is the premise of this manual that all societies would benefit from encouraging competent self/health/care as a complement to their systems of professionally provided care. The forms of self/health/care that a society might promote will, of course, depend upon the particular characteristics of that society. Ideally, self/health/care and professional care should work in a partnership, combining their resources and abilities in a particular health situation in a way that most appropriately utilizes each type of care. In some cases, professional and self/health/care may have equally heavy responsibilities (e.g., for the person recuperating at home following a stroke or hip fracture), or professional care may be the predominant form (e.g., at the critical phase of a heart attack or kidney failure). In other instances, self/health/care may be primary (e.g., diabetes maintenance, accident prevention, or exercise). The appropriate mix of self/health/care and professional care will always be determined by the individual situation and the resources available.

The ideal mix of self/health/care and professional care is rarely found in any society. In most industrialized societies, health care is synonymous with care provided in hospitals, clinics and doctors' offices, while the importance of self/health/care is frequently minimized. Too often health care professionals do not encourage the elderly to care for themselves. Under these conditions, persons engaging in self/health/care may become unsure of themselves; instead of becoming more competent and developing their abilities, they back away and leave health care to the professionals. When this happens, everyone loses.

1.5 Do Older People Have the Capacity for Self/Health/Care?

Almost all elderly people have the capacity to engage in some self/health/care and most are able to provide some care, even if quite limited, for other old persons around them. Nevertheless, self/health/care is often resisted and discouraged because professionals and lay people, including the

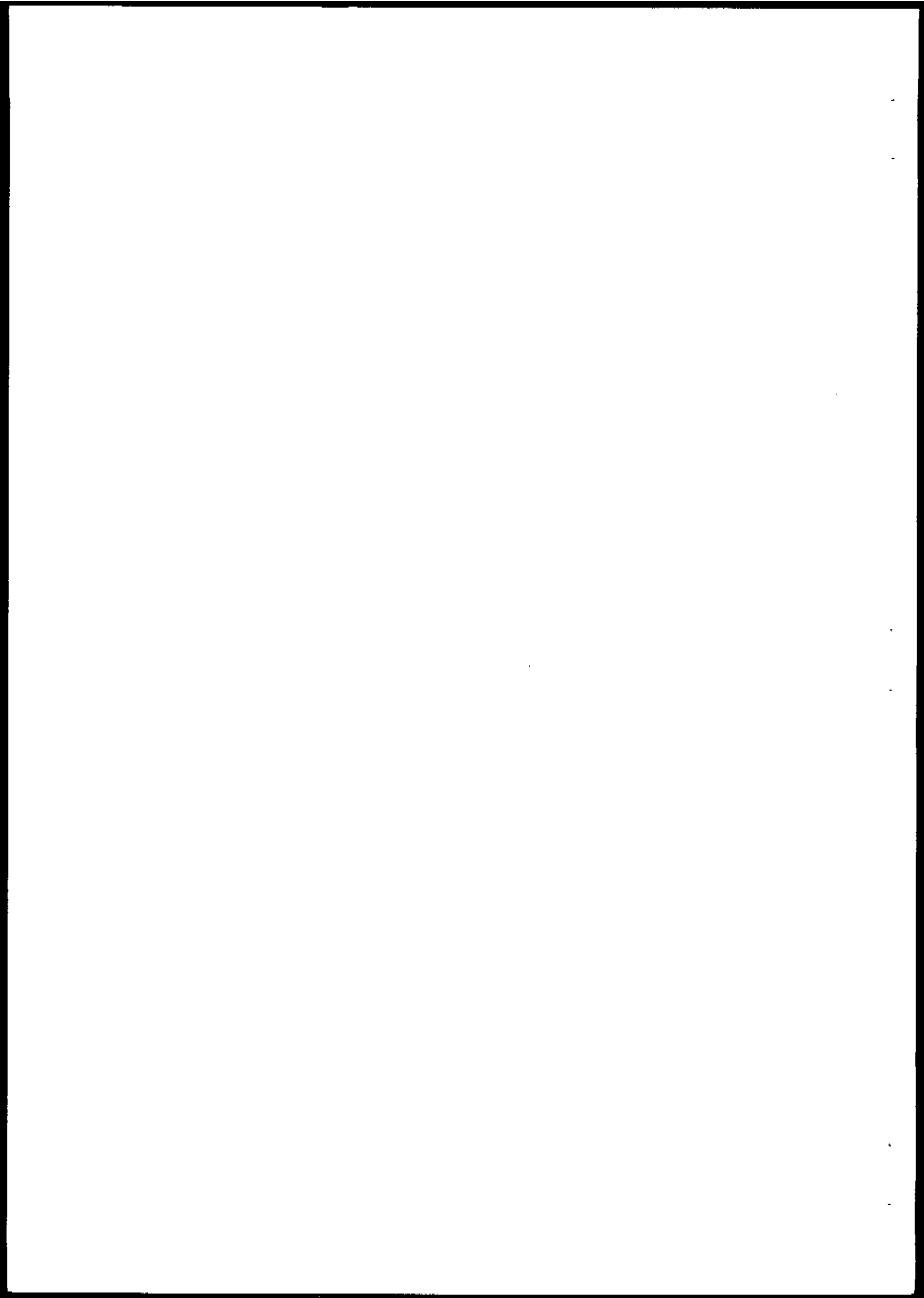
elderly themselves, hold mistaken and negative views of what it means to grow old and to be old. It is simply not true that, because of aging, old people are destitute, ill, facing inescapable losses, cut off from society, rigid in attitudes, sexually incapacitated, despondent, or unable to reason or remember. The truth is quite different. None of these conditions is inevitable.

In the world's industrialized societies, men and women typically live well beyond age sixty-five. As advances in public health are made in developing countries, life expectancy in these countries is also climbing. The world population is aging, and the great majority of the aged are healthy and rarely require institutionalization. This is good news, for no society could afford to have a high proportion of institutionalized older persons.

Elderly people do, of course, get sick. They suffer from more chronic illnesses than young people do. And because there are so many of them, they account for a larger proportion of formal health services than younger people. None of this, however, should distort the general picture of old age as potentially a time of relatively good health. It is because of this that self/health/care is particularly attractive and appropriate for elderly people. Even those who are chronically disabled are, for the most part, able to perform much of the care they require. Most older persons are also able to provide some care to others. And the majority of the health conditions they face are of the kind that lend themselves to some degree of self/health/care. (For research findings on some of these health conditions, see sections 3.2 and 3.3 of this manual.)

SECTION 2

HOW IS SELF/HEALTH/CARE PROMOTED AMONG OLDER PEOPLE?



2.1 What Types of Programs Facilitate Self/Health/Care?

In all societies people of all ages learn about basic self/health/care in many different ways: through the experiences of everyday life; from neighbourhood and local networks and the popular media; and by participation in their own health crises or those of others. More sophisticated levels of knowledge about self/health/care, however, are typically achieved through participation in more formal educational programs.

Although programmes designed to impart self-care skills to older persons are relatively new, interesting examples are to be found in many nations. Such programmes may have a primary focus on one skill area, such as good nutrition or physical exercise, or they may teach multiple skills. These programs are being offered in a wide variety of settings, including senior centers, nursing homes, and community health centers, and by a range of sponsoring organizations, such as national and local health councils, voluntary organizations, advocacy groups for the elderly, and public health agencies. There is also wide variation in the instructional methods used in the programs, ranging from individual counselling sessions to small or large groups, from one-hour classes to workshops lasting months or years. Target groups for these programmes include both the well elderly and those who are disabled due to chronic illness. In addition, family caregivers to the impaired elderly are increasingly being recognized as important targets for training and support interventions.

Highlighted below are various types of self/health/care programmes for and by older people that have been implemented in nations at different stages of development. The examples have been selected to show the diversity of sponsoring organizations, differing content and methods, and the types of target audiences.

It is important to note, however, that self/health/care programmes are

rarely discrete entities. They must be seen in their relationships to both informal support and formal care systems.

2.2 How Is Health Education Related to Self/Health/Care?

A. Initiatives on the National Level

In the countries of Eastern Europe, which have a long tradition of preventive medicine, considerable attention is devoted to health education for the aging. National councils for health education in such nations as the USSR, the German Democratic Republic, Hungary, and Romania coordinate the dissemination of health information to older persons through such means as radio and television, popular science literature, and public "universities of health and longevity." The USSR uses its geriatric consulting rooms to provide instruction in disease prevention measures as well as direct medical treatment. Soviet physicians may also refer older patients to "health groups," where they obtain information on health maintenance, first-aid techniques, and the importance of exercise.

Initiatives in health education and self/health/care for the aging are also being taken at the national level in the United Kingdom, where the national Health Education Council has developed a range of self-care publications aimed at older adults, conducted a national campaign on hypothermia, and disseminated new approaches to providing health education in retirement preparation courses. The Council has targeted a number of groups in addition to the elderly themselves, including family members and other informal caregivers, community health workers (such as home helps) and health care professionals. It is now planning a broader campaign in conjunction with Age Concern England, that country's largest organization representing volunteers who work directly with the elderly. Along with Age Concern, the Council is planning to (1) promote and fund local self-care initiatives with an eye toward national dissemination;

(2) encourage mass media campaigns, monographs for professionals working with the elderly, and training courses and materials; and (3) carry out research among older persons to determine the effectiveness of the proposed messages, and activities. Age Concern recently published a manual to help older persons retain or improve their fitness, take measures to prevent disease, and use health services to their best advantage. It has also worked actively to influence groups such as pharmacists to see themselves as health educators to the elderly.

Similarly, in Denmark the Prevention Council within the Ministry of Interior is introducing a multi-faceted program in health promotion and self-care for seniors. Proposed activities include establishing local councils for health promotion and stimulating health education for health professionals, e.g., by including health education in the list of services for which general practitioners are reimbursed from public funds. In addition, the Council plans to initiate a national campaign to prevent falls among the elderly (hip fracture in older women due to falls is the most common cause of hospitalization in Denmark), and to stimulate interest in research on self-care by the Danish Research Council and other major foundations.

A national model for health education for seniors, including information on accident prevention, self/health/care, and nutrition, is also being developed in Finland. Health education directed toward the elderly is considered a key function of Finnish primary health care, and is an integral part of service to older persons who visit health centers, either as out-patients or as in-patients. Some health centers have also developed group programs in health education for older persons. Typically, an announcement is placed in newspapers, or older persons are personally invited to a meeting arranged

especially for them in their health district. In remote regions, efforts are made to provide such programs at sites other than health centres if these are not easily accessible by the elderly.

In Japan, recent national legislation in health care for the aged now provides for a variety of health education and self/health/care programs directed toward persons as young as forty. These programmes, which will be offered at nominal cost, include general health education, health check-ups, health consultation on specific mental and physical health concerns, rehabilitative training to assist impaired persons in regaining their independence, and self-care instruction for disabled and bedridden persons.

In the United States of America, a nationwide advocacy organization representing over 15 million older Americans promotes health education and self/health/care. In 1981, over 500,000 older persons attended programmes organized by the Health Advocacy Services of the American Association of Retired Persons (AARP). AARP trains older health advocates to work in their local communities, and has prepared a series of health education packages to be used as resources by the community groups. These packages, which include both visual and printed material, present information on such topics as physical fitness, arthritis, cardiovascular health, nutrition, hearing loss, and the safe use of medications.

Another important force on the national level in the USA in promoting self/health/care for older persons is the National Institute on Aging (NIA). In addition to conducting basic research, the NIA publishes a series of one-page fact sheets which summarize, in easily understandable language, professional knowledge and recent research findings about health concerns of the elderly. The leaflets are distributed widely in supermarkets, drug stores, senior centres, hospitals, and by state agencies. The NIA has also published a

guide to individual and group efforts to promote medical self-care among the elderly in the United States. The guide also reviews both educational materials and programmes.

B. Initiatives at the Community Level

Local sites where older persons congregate also serve as important bases for providing health education. In Hong Kong, for example, social centres, multi-service centers, and residential units for the aged offer lectures on health issues which reach approximately 5 percent of Hong Kong's older population. Health issues are covered regularly in a weekly radio programme for the elderly and in the four newspapers published especially for older persons, which contain contributions by both medical experts and Chinese herbalists.

Senior citizen clubs are the base being used by the Thai Red Cross in providing health education, exercise programmes, and other services to the elderly living in refugee camps and borderline areas. The Thai Red Cross is training health volunteers to work with older persons who have migrated to these areas and are without family support.

In Egypt, efforts are being made to structure health education for the aging around the religious life of the community. Meetings are arranged to coincide with prayer times, especially on Friday when the elderly gather at the mosque to discuss their concerns and recite the Koran. In the Christian community, priests are encouraged to talk about self-care to the elderly and their families before and after Sunday prayer.

In Mexico, the Sociedad de Geriatria y Gerontologia has proposed health education programs in places where the elderly gather, such as community centres and homes for the aged. In addition, a very simple self/health/care manual,

designed for older persons and younger family members, would be distributed through natural leaders in the community. Mass media would be used to communicate self-care messages in rural areas. Mexican gerontologists, like many others, stress that negative stereotypes about aging, such as the idea that disease and incapacity are inevitable concomitants of the aging process, must be combatted if self-care programmes are to be successful in most Latin American nations.

Day clubs and residential homes for the elderly have been the site of health promotion programs in Spain. These programs, provided under the auspices of the Servicio Social de la Tercera Edad, include: (1) general health education and preventive physical activity programmes; (2) consciousness raising in older persons about the need for periodic medical examinations; and (3) offering such examinations at its day clubs and homes for the aged and communicating results to the pensioners' family physicians.

In Yugoslavia, clubs for the elderly have been established in metropolitan areas through the initiative of health councils operated by neighbourhood associations. Public health nurses who have undergone training in self/health/care, health education, and community organization provide leadership for the clubs.

Senior centers are also the sites for many health promotion programmes in the United States of America. For example, a "wellness" program at senior centers in Seattle covers such topics as stress management, nutrition, and exercise. The project utilizes a variety of means to reach potential participants, including local media coverage, informational brochures, fact sheets, and presentations by programme staff at public and professional meetings.

Health education programmes can also evolve out of other community-based programmes which are often organized by older persons themselves. For example,

a "drop-in" centre for pensioners in England began offering a ten-week self/health/care course covering such areas as "you and your doctor," chiropody, coping with sensory impairments, and nutrition. A cooperatively run food shop, which provides groceries at prices well below those of supermarkets, complements the nutrition component of the course. The health education course then spawned a weekly "keep fit" class which combines vigorous physical exercise with health-related films and discussion. This flourishing club is controlled by the seniors themselves, who manage their own finances and organize a range of other activities.

Experiments are under way in other nations to provide health education and self/health/care to older persons, such as the housebound, who cannot attend group programmes. In Vancouver, Canada, home care nurses were trained to provide health education as well as direct nursing care to residents of apartment complexes for the elderly. Interestingly, these residents have shown significantly greater health knowledge and have reported more healthy behaviours than did residents who received only direct nursing care.

Home nurses in Finland also provide health education to patients and their relatives on such topics as the appropriate use of medications, nutrition, accident prevention, exercise, and the promotion of social contacts as a means of preventing mental disorders. Some training in self/health/care is achieved through district nurses and health visitors in Great Britain and the United Kingdom's national Health Education Council is exploring the potential key role that paid home helpers can play in providing training to both older persons and their family caregivers.

Home visits by interdisciplinary rehabilitation teams may also be considered an important form of self/health/care. In some programmes in the United States of America, for example, such visits are made to older persons with multiple disabilities or sensory impairments and to those who have been

hospitalized for prolonged periods. Such programmes provides an opportunity to teach methods of compensating for functional impairments, how to increase safety in the home, and other self/health/care skills.

Health education and training courses are also being developed for family members who are caring for impaired older persons in the home. These carers frequently engage in nursing care tasks which are both physically and mentally demanding, and are in need of skills training and other forms of support. A coordinated service programme for the aged in the Netherlands, for example, offers simple courses to family members on nursing care in the home; these cover such topics as increasing the older patient's mobility and improving nutrition, as well as the administration of medication and other nursing skills. The coordinators of the program have developed a manual to help other groups start similar courses. In the United States, a university-sponsored programme organizes health-focused support groups for caregivers of older persons, and has developed a health guide for use by participants and teachers. Students in medicine, nursing, and social work assist staff members in organizing the groups. In addition to providing training in nursing skills, courses such as these frequently offer information on coping with one's relative's mental or physical impairments, techniques for handling family problems, and information about community resources and services.

One approach to reaching older persons who are isolated is to develop mobile units that carry staff trained in health education techniques to areas where their services are needed but not available. Such mobile units are seen as especially important in developing countries. For example, Helpage India, a voluntary organization, operates a mobile medical unit to assist the elderly in poor resettlement colonies of Delhi. The programme currently offers direct health and social work services and medications, but is expanding to include health counselling for the elderly and their family caregivers. In addition,

the group hopes to develop a manual on self/health/care which will then serve as the basis for radio and television features.

Mobile health agents who travel to villages in many Latin American nations are also being trained under the auspices of an international non-governmental organization, Catholic Relief Services, which has adopted an age-integrated primary health approach to self-care. It has developed and disseminated educational materials such as visual aids and puppet shows in order to reach persons who are illiterate. Education and information is provided on such topics as how better to prepare local food, how to maintain a family or community garden, and how to build and use a latrine or sewage system. These activities occasionally generate income for elderly participants, further encouraging their active involvement in community life.

2.3 How Is Self/Health Care Related to Medical Skills?

While health education is an important component of self/health/care programmes for the elderly, it is certainly not their sole focus. Such programs in some nations are now teaching older persons to perform tasks typically the domain of professionals and how to interact effectively with the formal health care system. Some successful models for these programmes are increasingly evident in the United States.

In a programme developed at the Dartmouth Medical School, senior citizens are educated in medical self-care, illness prevention, and the appropriate use of health and social services. Older persons participate in 13 two-hour sessions, which rely upon active engagement in the learning process to promote self reliance in health. Instructional techniques include group discussion, role playing, skills training, and self observation and record keeping. Health and social service professionals are trained to be core instructors, while senior volunteers act as facilitators. Follow-up activities have included

self-care contracts, support groups, class reunions, and a newsletter. An evaluation found that, compared to a control group, programme participants are better able to perform self/health/care skills, have more confidence in their abilities, and have made more attempts to change unhealthy lifestyle behaviors.

An interesting development at the National Institute on Aging is a special workshop set up by the Surgeon General in collaboration with related agencies to implement a plan to educate older people about the risk of falls and the preventive measures which need to be taken.

The "Growing Younger Program" in Boise, Idaho, also teaches older persons how to talk to their doctors and practise self-diagnosis skills, while encouraging their social involvement in community life. Workshops are held at senior centers and other local facilities, and participants are encouraged to meet informally at least once a week during the course of the workshop and to continue meeting as a group after the conclusion of the formal programme. Over 1,500 neighbourhood groups in Boise have been exposed to the program within the past three years, and it is now reaching the frail elderly as well as the more vigorous seniors in the community.

In the western USA, a regional self/health/care programme strengthens the relationship between older individuals and their physicians or other health professionals. Participants learn to recognize common disease symptoms, perform simple diagnostic procedures, and make more effective use of the health care system. The courses are conducted by trained health professionals, with senior volunteers acting as community coordinators in rural areas. A local group composed of health care professionals and seniors oversees the programme.

A particularly interesting experiment, in which family physicians are compensated for their efforts to keep people well, is currently under way in

various parts of the USA. Sponsored by the American Council of Life Insurance and the Health Insurance Association of America, this project, if successful, promises to become a new force in the delivery of health care. The hypothesis is that physicians should be compensated not only for treating sick people, but for promoting self/health/care as well.

2.4 What Do We Know About Focused Programmes: Exercise, Nutrition?

A. Exercise Programmes

Switzerland has had perhaps the longest and most successful history of any nation in promoting senior participation in sports. According to the Swiss Association for Senior Gymnastics, in 1981 some 60,000 seniors participated in gymnastics groups. In addition to the 3,400 weekly gym classes, there were 600 other groups of seniors engaged in hiking, swimming, and other sports. These impressive statistics trace back to the pioneering efforts of Pro Senectute, a voluntary organization serving the elderly, which began training senior gymnastics leaders in 1964, later joining forces with the Swiss Red Cross. Together, they have provided high quality training courses and inspired an esprit de corps among senior gym leaders, who numbered 3,000 in 1981. Prospective leaders attend training sessions which are continually updated to reflect the changing needs of successive cohorts of older persons, each of which has desired a more challenging gymnastic programme. The success of this programme underlines the importance of coordinated efforts among several organizations in promoting exercise among the elderly.

Denmark also has a national association to promote physical exercise by seniors, formed over a decade ago by gymnastic leaders. To date, almost 700 gym teachers have been trained, and 60,000 older Danes participate in some form of exercise or sport. In addition, exercise is often part of daily routine in Danish nursing homes and day care centres.

There are extensive gymnastic facilities for pensioners throughout Sweden as well, where a national policy exists to encourage physical exercise as an important preventive measure. A national foundation to promote exercise by the elderly, which receives government subsidies, was also recently formed in the Netherlands.

In the USSR, exercise programmes for the elderly are commonly provided in health care institutions, residential homes, outpatient clinics, and at the workplace. Health zones have also been established recently in public parks and suburban areas to help older persons and the general public improve their fitness.

Efforts to discourage a sedentary lifestyle among older persons are also under way in a number of developing nations. Peru is addressing the problem of inactivity among its older population by holding exercise programs and regular walks at senior clubs and social centres. In Cuba, the National Institute of Physical Education and Recreation has implemented a number of exercise and sports programmes for the aging. Other programmes arrange for volunteers to visit homebound aged persons to teach them exercises which can be performed at home.

Both the People's Republic of China and Hong Kong encourage older persons to participate in shadow boxing, a traditional Chinese exercise. Taijiquan, a type of shadow boxing that calls for flowing movements and deep, even breathing, is particularly popular among the Chinese elderly because of its slow and gentle movements, and has been used successfully in the treatment of high blood pressure. It has been estimated that almost one-eighth of the Chinese population aged 60 and over participate regularly in some form of exercise or sport. In Hong Kong, older persons represent a significant proportion of those engaged in shadow boxing, and many also enjoy early morning hiking.

It is increasingly being recognized that even persons who are confined to

wheelchairs can engage in useful and pleasurable forms of exercise, and such fitness programmes are now common in nursing homes and day care centres in a number of nations. A long-term care facility in the Washington, D.C., area of USA, for example, provides a variety of exercise programs to help residents improve their fitness and maintain their mobility. The more physically able residents participate in morning calisthenics programmes and have had access to a "health spa" on the premises, in which they may ride bicycles, take whirlpool baths, and engage in active sports. Residents with specific disabilities, such as those who have suffered strokes, engage in movement therapy and wheelchair exercises geared to their specific needs.

B. Nutrition Programmes

Since malnutrition and poor nutrition are common among subgroups of the older population in both the developed and the developing countries, nutrition education is one important type of self/health/care for the aging.

One innovative approach to nutrition education is to enlist the support of older persons themselves as instructors. In a programme in the USA, a cadre of older volunteers was recruited and trained to provide nutrition education to their peers, primarily at senior centre sites. These seniors conducted sessions which reached and were favourably received by some otherwise uninvolved older persons. Central to the success of this program was a strong training support system through which the peer educators could obtain reliable nutrition information and educational materials. The results were most positive in those situations where the peer educators shared similar socio-demographic characteristics (in addition to age) with the participants.

Similarly, the results of an evaluation of a nutrition education programme for older persons in France showed a high degree of participant interest. The organizers of this programme stressed the importance of respecting and utilizing the experience and knowledge of older persons themselves, and avoiding a

"lecture" approach. Older persons were involved in designing the program materials, and participants were invited to talk with their families, especially their grandchildren, about the importance of good nutritional habits.

In Scandinavian nations, nutrition education is one of the most popular topics for groups of older persons meeting in "study circles," a widespread form of adult education. In Denmark, programs for older persons at folk high schools frequently focus on nutrition.

2.5 How Are Self-Help Programs Related to Self/Health/Care?

Self-help groups concerned with the needs of persons sharing similar health problems have proliferated rapidly in many nations in recent years. In many cases, these are properly classified as self/health/care programs. Typically initiated by the patients themselves or by their families, these groups hold regular meetings in which members share their problems and coping strategies, sponsor guest lectures by professional speakers, publish newsletters, and conduct educational activities for the community.

Self-help groups for persons who have suffered acute illnesses, such as strokes or heart attacks, are growing in a number of nations. For example, "Mended Hearts," a national organization for heart surgery patients in the United States, stresses collaboration among physicians, medical researchers, and patients. Activities include annual conventions, newsletters, group meetings held in hospitals, and lectures by medical experts on heart problems and treatment. A hospital visitation program has been developed in which trained volunteers counsel potential heart surgery patients and act as liaison between professional staff and patients.

Yet other groups reach those suffering from chronic illnesses such as arthritis, cancer, Parkinson's disease, and diabetes. For example, the Arthritis Self Management Program in the United States, sponsored by a

university medical school, trains persons with arthritis to work as volunteers with groups of their peers in developing self/health/care techniques for managing arthritis. Many chapters of the Arthritis Foundation also sponsor self/health/care sessions, and the Foundation has recently published a manual for persons with rheumatoid arthritis.

The American Foundation for the Blind has prepared an extensive package of materials for organizing self/help peer discussion groups for older persons with sensory impairments. It encourages older people to work together to identify their needs, to modify their physical and social environments to meet these needs, and to compensate for the loss of one sense through the better use of others. The package provides "how-to" information for organizers, tips for discussion moderators, and specific information on four major topics: making your personal environment work for you, near and far vision, hearing and understanding, memory and recollections. The discussion guidebook is available in English, French, Spanish, and Italian.

Nor should the addictive illnesses be omitted from this review. Substance abuse, particularly alcohol and drugs of various kinds, has been attacked successfully through mutual support groups and self/health/care techniques for people of all ages. Alcoholics Anonymous is the oldest and best known of these groups and is today a world-wide organization.

The rapid growth of self-help groups for families of persons who have some form of dementia, such as Alzheimer's disease, is also a cross-national phenomenon and should be considered as one type of self/health/care. These groups lessen the caregivers' isolation by putting them in touch with others who share similar experiences, impart information that helps them provide better care to their older relatives, and, perhaps more importantly, maintain or improve their own health.

Such groups have mushroomed so fast within the past five years that they have become national organizations in at least five countries - Canada, the USA, the United Kingdom, Japan, and Australia. All share similar goals: (1) to help organize local family support groups where families can exchange experiences and coping strategies; (2) to sponsor educational materials and forums for both lay persons and professionals on various aspects of dementia; and (3) to serve as vigorous advocates for increased funding of research on the causes and possible cures for dementia, and for more supportive services for families. The practically simultaneous cross-national development of these organizations attests to the common concerns faced around the world by the families of persons with dementia, their unmet needs, and the growing recognition that they must become advocates on behalf of their elderly relatives and themselves. As a result of the numerous inquiries which it has received from other countries, the National Alzheimer's Disease and Related Disorders Association in the United States is now planning to spearhead an international organization which will represent the victims of dementia and their families.

In addition, self-help groups have been formed to help persons adjust to lifestyle changes, such as widowhood. These groups can be viewed as playing an important role in preventing physical and mental illness during times of particular stress in the later years. In the United Kingdom, a non-profit organization, CRUSE, helps widows (primarily older women) through its professional and peer counselling programmes, and its information, social, and educational activities. CRUSE has a number of branches throughout the United Kingdom. A similar programme in the United States, the Widowed Persons Service of the American Association of Retired Persons, also provides outreach and support to many thousands of widows and widowers each year. A key factor in its success has been the strategy of mobilizing a number of health, social service,

and other organizations to act as programme co-sponsors in local communities. On the international level, an association of groups offering support to the widowed has recently been formed to act as a clearinghouse for programmes in various countries. The Federation Internationale des Associations de Veufs et de Veuves publishes a newsletter, facilitates communication among organizations for widows and widowers, and works to improve the economic and social status of the widowed around the world.

The proliferation of self-help groups for all types of problems (not only health-related) has been so great that umbrella organizations are being formed in a number of countries to serve as information clearinghouses on self-help at both regional and national levels. For example, a provincial association for community development in Belgium coordinates and publicizes self-help efforts in its area through publications, a data bank, and a "switchboard" to provide information and referral to the general public. Similarly, a Canadian province has compiled a directory of self-help groups that operate in the region. Copies are distributed to individuals, and to health and social service agencies. In the USA, a national clearinghouse on self-care activities publishes a bi-monthly newsletter, local directories of self-help groups, and training manuals. It also organizes conferences and assists in establishment of regional clearinghouses to promote similar activities on a local basis. Self/health/care thus should be viewed as an informal component in the more formally organized activities of self-help groups.

2.6 What Can We Learn From These Programmes?

Although the self/health/care movement is still too new to have generated a body of evaluative research which specifies the criteria for successful programmes, some common characteristics stand out in the various programmes cited above.

(1) Many of the apparently successful self-care programmes have capitalized on the social activity patterns of the elderly in their communities by presenting programmes at sites that attract large numbers of older persons. These sites, of course, vary across national boundaries, and range from religious settings to senior centres.

(2) Vigorous publicity methods and active outreach to older persons who are isolated are also characteristic of many of the programmes. Their publicity methods range from radio and TV ads, to brochures and newsletters, to more direct communication with older persons, such as distributing leaflets in local flats. Some programmes provide transportation for those with impaired mobility. Other programmes are bringing instruction to older persons in isolated areas.

(3) Yet another common theme in these programmes is the involvement of older persons themselves in various stages of programme planning and implementation. A number of programmes, for example, have advisory groups that include older persons, and some utilize their skills as instructors or group facilitators.

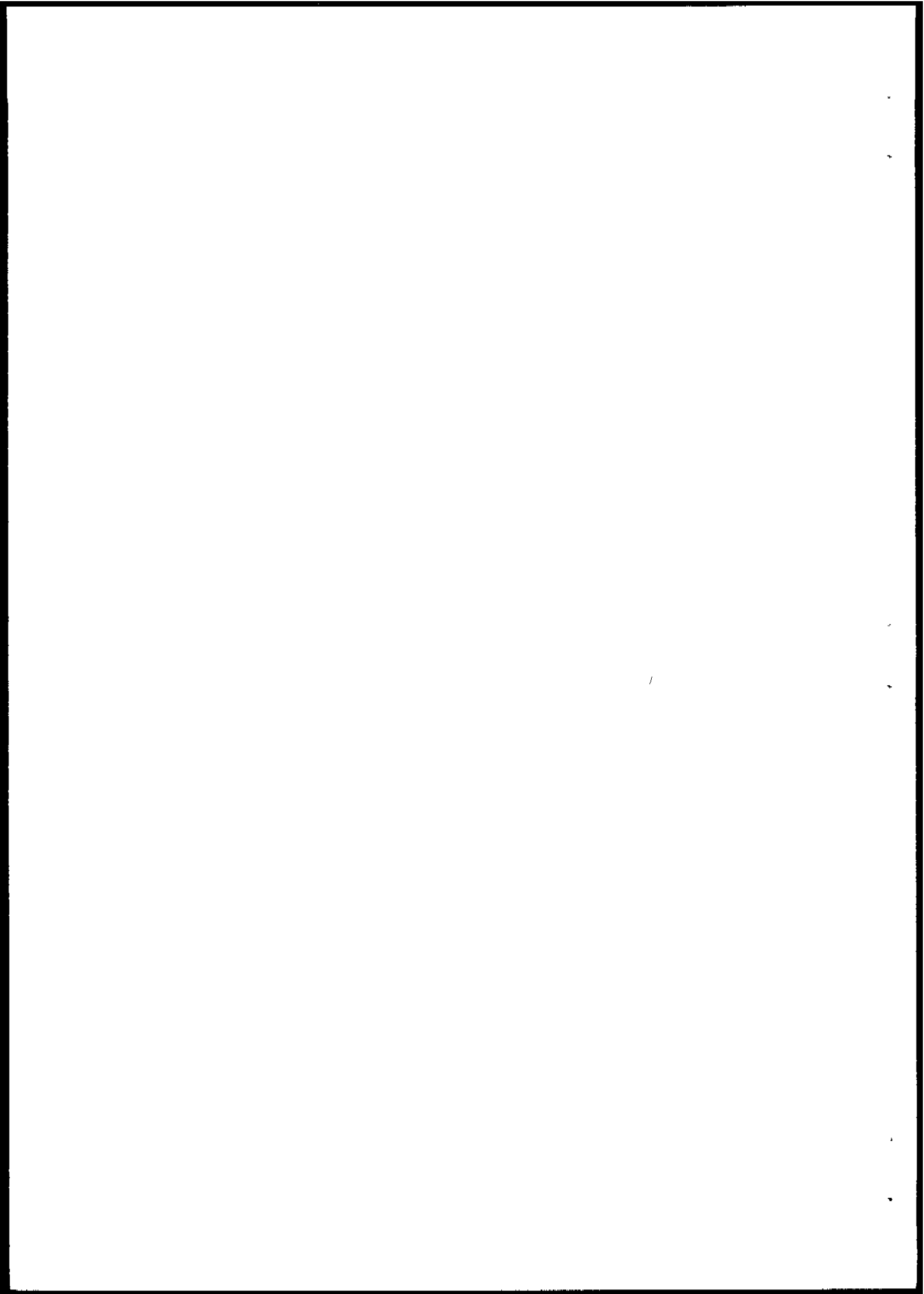
(4) Multiple sponsorship is another characteristic of many of the programmes. There are numerous examples of the joining of forces by professional and lay groups and by public and voluntary organizations in order to reach wider audiences and draw upon multiple resources.

Other defining features of many of the programmes are strong training programmes and educational resource materials developed for trainers, instructors, and programme participants. These back-up resources frequently include visual material (e.g., films, slide-tape presentations, posters) as well as printed materials (e.g., self-care manuals, guidebooks for group leaders, self-scoring checklists).

The great majority of the programmes rely upon active engagement in the learning process rather than on "lecture" approaches to achieve their goals.

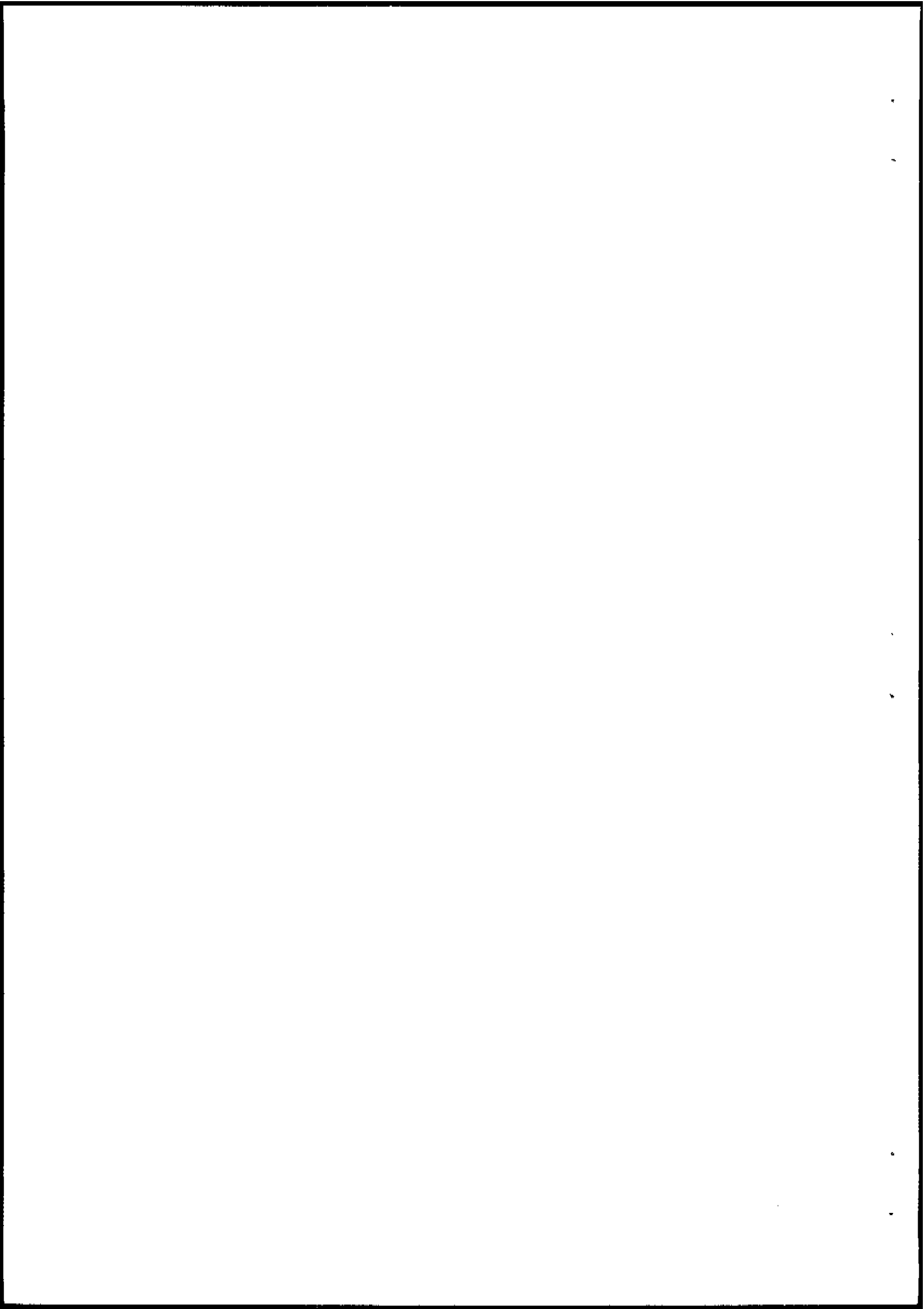
Group process techniques can encourage self confidence and facilitate behavioural change while strengthening social relationships. Perhaps as a result of this emphasis on social support among participants, some of these programmes have become self-sustaining beyond the conclusion of the formal sessions.

As illustrated above, national organizations have played central roles in stimulating self-care activities in a number of countries. For example, several nations with very strong programmes of physical exercise for seniors also have national associations to promote such programmes (Switzerland and Denmark). National councils for health education encourage self/health/care for older persons in a number of nations (e.g., in Eastern Europe and the United Kingdom). And national advocacy organizations for older persons are increasingly promoting self/health/care initiatives in countries such as the USA and the United Kingdom. These organizations serve a variety of functions: providing information clearinghouses, publishing newsletters and manuals, conducting research and disseminating research findings, serving as advocates for policies and funding to stimulate self/health/care, and offering other kinds of help.



SECTION 3

DOES SELF/HEALTH/CARE HAVE A FUTURE FOR OLDER PEOPLE?



3.1 What Problems in Promoting Self/Health/Care Need to be Overcome?

The many different types of self/health/care programmes being developed around the world are testimony to the increasing recognition of their importance to the elderly. Nonetheless, a number of problems in promoting the concept still must be surmounted. Among the difficulties is the diversity of sub-populations of the elderly in any society, with their widely differing educational levels, social and economic backgrounds, and health status. The challenge of assisting large numbers of heterogeneous people to develop the skills and knowledge to support competent self/health/care is formidable.

A better understanding of the diverse health beliefs and attitudes held by the elderly is of vital importance in targeting self/health/care programmes to different groups of older persons. Beliefs about the aging process and the causes of health and illness vary widely among and within nations. In some cultures, for example, it is assumed that illness results from sin, witchcraft, or transgression of a group norm. Even in societies where a scientific approach to the causes of illness is the dominant paradigm, many older persons hold religious views that attribute illness to the manifestations of the will of God. These beliefs quite directly influence health behaviour, whether individuals react actively or passively in the face of illness, and whether they seek medical care. Older persons' self/health/care behavior is also influenced by their assumptions about the aging process itself. The myth that illness and disability are inevitable results of the aging process is prevalent in developed and developing nations alike, where many older persons account for their health problems as being "just my age." Persons holding such beliefs are as unlikely to undertake appropriate self/health/care measures as they are to seek medical treatment. Other salient beliefs are the myth that exercise tends to "wear one's body out" and that assistance from the public sector is a form of charity with a stigma attached--ideas more widespread among older than younger persons

in a number of countries. These are just a few examples of the subtle but powerful beliefs that may influence self/health/care behavior by older persons and to which persons wishing to expand such programs must be sensitive.

Another obstacle to self/health/care is found in the attitudes of some health and social service providers, as well as some members of the general public concerning older persons' capacity for self-care. It is sometimes argued that self-care is good for the young and well-educated but hardly worth the effort for the elderly. This contention ignores the growing body of scientific evidence that many health problems of the aging yield well to self/health/care. The notions that older persons as a group are more passive, less confident in their abilities, particularly concerning health, and less interested in active roles than are younger persons need to be countered. One thing is certain: pessimism about older persons' interest and ability to take on increased self-care responsibilities will be an obstacle to any effort to promote self/health/care. Support and encouragement from health and social service providers is essential.

Yet another challenge in promoting self/health/care lies in striking the appropriate balance between professional care and self-care. One of the strengths of self/health/care is its relative independence from professional care providers. This useful and healthy independence, however, can be destructive if it breeds hostility on either side. Self/health/care efforts that are fundamentally anti-medical and purposefully divorced from professional resources will ultimately be ineffective and even dangerous. Conversely, professional providers who ridicule legitimate self-care efforts by attempting to medicalize, control, or simply ignore self-care will deny an important health care resource to the people they are supposed to be helping.

Finally, economic obstacles to the expansion of self-care and health promotion for older persons cannot be ignored. One major barrier to the

expansion of health promotion efforts is that the recognition of their importance came at the same time in many nations as the economic recession and spiraling health care costs of the late 1970's and early 1980's. In such a climate, governments have been reluctant to undertake any new health initiatives, particularly those without a short-term "pay-off." By their very nature, health promotion and many self/health/care efforts are long-range investments. Not only are efforts to promote self/health/care inadequately funded, but they may be viewed by some policymakers and health service providers as an excuse to cut health care benefits and avoid serving some populations. The promotion of self/health/care should not be used as an argument for reducing needed medical services--nor should it be viewed as "second class medicine" for the poor, but rather as an integral and effective component of any health care system.

Conversely, the object in promoting self/health/care should not be seen as one of economic expediency. There are those who argue that self/health/care should be expanded so that some care now provided by health professionals can be taken over by the elderly themselves at a major cost savings--their hope is understandable. Health care costs in most countries are growing at dramatic rates due to many factors, including high personnel costs, escalating hospital costs, and increasing reliance on expensive technology. At the same time, larger numbers of elderly people are placing increasing demands on health systems. This situation is creating intense competition for limited funds between primary care and hospital-based care, to say nothing of the competition between health and other national priorities. At this point, however, self/health/care as a strategy for immediately realized savings is merely a hope with little evidence to support it. Where savings have been observed, it may be that the costs have simply shifted from the health care system to individuals who provide services but are not paid. In other cases, existing

self/health/care programmes have made consumers more sophisticated, but no less frequent, utilizers of formal medical services. It may be that such programmes will lead to more appropriate health care costs, but not necessarily lower ones.

If society is to realize significant economic benefits from self/health/care programmes, these are most likely to come in the long-term results of effective preventive measures.

3.2 What Does Science Have to Say About Self/Health/Care in the Perspective of the Life Course?

Despite several economic and attitudinal barriers to the promotion of self/health/care, scientific evidence which underscores its potential for improving the health and independence of the elderly is accumulating.

Recent research has demonstrated with reasonable success that (1) old age disabilities are not universal; (2) such disabilities are not necessarily irreversible; and (3) the disabilities associated with aging are not determined solely by biological processes, apart from social, psychological, and behavioural factors.

Much is already known about certain of the social and behavioural factors that threaten good health as people grow older. Many such factors are cumulative, beginning early in life and leading toward the chronic afflictions of later life. Yet they are often within the individual's control and are susceptible to modification at any point in the life course. For example:

--Smoking is generally recognized as the single most important preventable cause of morbidity and death, implicated in many problems of later life including heart disease, chronic bronchitis and emphysema, various cancers, and stomach ulcers;

--Inappropriate dietary habits can contribute in complex ways to such disorders as heart disease, adult-onset diabetes, and high blood pressure;

--Physical inactivity is associated with increased risk of coronary heart disease;

--While the nonmedical use of drugs (including alcohol) tends to decline somewhat with age, the overall use of drugs (both prescription and over-the-counter) increases with age. Three potentially hazardous practices put the older population at special risk: self-medication, over-prescribing by doctors, and the combined use of two or more drugs.

Once understood, the controlling social and behavioural factors in smoking, food consumption, exercise, and drug use should be susceptible to self/health/care and modification--preferably early in life, before the pathological outcomes have ever begun, but also in late life to promote the optimum maintenance or improvement of function.

3.3 Is There Any Scientific Evidence that Functional Incapacities in Older People Can Be Reduced by Self/Health/Care?

The United States of America's National Institute on Aging has recently reviewed the scientific evidence on the value of self/health/care among older people who have already experienced declines in functioning. Here are just two examples of its conclusions:

-- Intellectual decline with aging (when it occurs) can often be slowed or reversed by relatively simple self-training. Research has demonstrated that older people's performance on tests of intelligence improves with added practice on the tests, with instructions about strategies for approaching the problem, and with incentives introduced to increase motivation and attention. In another example, research data show that physical training not only enhances physical well-being but also improves intelligence and conscientiousness, and reduces levels of anxiety. It has also been demonstrated that older people can learn to, and often do, compensate for declines in reaction time, memory, and other

age-related deficits by using mnemonic strategies or by exercising care and persistence.

-- Sensory declines in older people can also be alleviated in various ways. For instance, one study has shown that choice of particular styles as well as sizes of type can facilitate reading among many whose vision is impaired. Older people--even those with normal visual acuity--often have greater difficulty than younger people seeing large objects in low contrast. Household rearrangement to provide high contrast can help offset this impairment. Older people can also learn strategies for dealing with changes in dark adaptation.

In sum, research is beginning to show that the course of disabilities can often be reversed. Even in nursing homes, research findings indicate that many helpless, dependent, and unhappy patients can recover a degree of functional independence through daily regimens encouraging interaction, self-care, and a sense of mastery. Several studies suggest that stimulation of independent behaviour among nursing home patients can result not only in increased alertness and involvement but also in improvement of general health. While such examples suggest a general knowledge base of scientific support for self/health/care, many specific programmatic questions remain. (Some of the questions that need to be examined at the national level and cross-nationally may be found in Appendix A.)

3.4 Why Promote Self/Health/Care Now?

There is a clear consensus. Self/health/care is practiced so widely in all societies, undoubtedly with many positive and possibly some negative consequences, that it cannot be--nor should it be--ignored. Instead, elderly people should be encouraged to gain the knowledge and abilities they need to perform self/health/care as competently as possible. To ignore the potential of self/health/care is naive, and not to seek ways to make the practice of it more competent is irresponsible. Although there are obstacles to the promotion of self/health/care and a need for further systematic study, many health care professionals and lay people are actively urging immediate action while at the same time encouraging additional research. Here are some of the arguments being made to support the promotion of self/health/care by older people, while the emergence of the current science base continues.

Professional Accountability

Self/health/care is promoted by those who are dissatisfied with current practices in medicine. Consumerism, a growing phenomenon in many societies, challenges health care professionals to be more accountable. Some attribute this challenge to a broader public understanding of the limits of medicine and a reaction to the negative attitudes held by some health professionals regarding the individual's role in health. It is not uncommon, for example, for health care providers to view people as either passive victims of pathology or to blame them for their "silly" health beliefs or practices. Reacting to this view, many now argue that elderly people need to become better informed about their own health and take more control of it. By doing this, they can make professional providers more responsive to their needs, combat iatrogenesis and improve the quality of care.

Better Diagnoses and Treatments

Self/health/care has served as a means of improving the relationship

between the elderly person and professional health providers. A better informed lay person can provide important information to the professional about symptoms, early detection of serious conditions, maintaining continuity from one illness episode to another, the body's reaction to treatment, the side effects of drugs, and determination of what works and what does not. The pairing of a knowledgeable person and a sensitive professional can promote health, prevent some disease and improve the chances for accurate diagnosis and appropriate treatment when necessary.

In many cases, it is reasonable to assume that an elderly person, either by him/herself or with the help of family and others, can take some of the responsibility for treatment, particularly of chronic conditions. Experience with diabetic control, home kidney dialysis, maintenance of colostomy devices, and blood pressure monitoring has shown that it is possible to teach lay people to perform functions that typically have been done by professionals. It seems reasonable to assume that many other activities are within the realm of the possible. Most would admit that there is a great need for creative solutions to the health problems of the whole population and particularly the elderly. It can be argued that by encouraging elderly people to be more active in health care, they will discover and create new forms of care, in part because they have different perspectives than professional providers.

Special Benefits for Older People

Another argument for promoting self/health/care is based on the gradual shift in the past 50 years (especially in industrialized countries) from acute health problems to chronic conditions. Elderly persons represent most of the chronic cases. This situation suggests the need for an emphasis on care rather than cure. At the same time, the trend in much of modern medicine has been for greater investment in high technology and hospital-based care, often at the

expense of investment in primary care or self/health/care. People with chronic conditions, it is argued benefit least from high technology and hospital care but could benefit most from self/health/care.

Emphasis on Rehabilitation

In a similar vein, it is increasingly recognized that rehabilitation programmes to help impaired older persons regain or maintain their functional capacities are a crucial part of the health care continuum. Such programs are directly related to self/health/care for older persons and emphasize many of the same goals and methods. For example, instruction in attitudes and behaviour which encourage self-reliance rather than dependency is as crucial to the rehabilitation philosophy as it is to self/health/care. Experts in the field of rehabilitation have long recognized that what may appear to be small gains in functioning, such as being able to transfer one's self without assistance from a bed to a wheelchair, can make all of the difference in whether an older person remains in the community or is institutionalized. Training in self-care skills such as these to help older persons regain their independence is now becoming an accepted part of all phases of the rehabilitative process.

More Emphasis on Social Determinants of Health

Yet another argument for promoting self/health/care is based on the increasing realization that social and biomedical factors interact and both contribute to the individual's condition in nearly any health situation. In some cases, social factors may be dominant; in others; biomedical factors are more important. Professional health providers are trained to care for the biomedical factors. Many also have some understanding of social factors, but the perspective of medical personnel is often limited exclusively to biomedically oriented considerations. Frequently, the orientation of professional treatment is abnormality and pathology, while the motivation in lay

care is to normalize. Lay people are particularly well-situated, even without formal training, to bring understanding and useful perspective to a health situation and to attend to the social factors that contribute to a person's health. A case in point that is particularly relevant to older people involves persons with chronic conditions. When everything medically possible has been done, too often the person is ignored, frequently resulting in a decline in functioning. Lay people are often in a good position to help chronically ill individuals improve their functioning by providing social support, opportunities for meaningful activities, and access to community services

Responsive to Human Needs

Sometimes individuals reject certain forms of medical care because these infringe upon their quality of life. Some may find self-care and that provided by the family simply more convenient or satisfactory than trips to a physician or visits by a nurse to the home, or a stay in a hospital. A person may be able to live a more satisfying life by relying on self/health/care supplemented by professional care. Experience with home care services and hospice care in many countries would seem to support this conclusion.

New Focus on Prevention

Preventive measures are also often seen as an important aspect of self/health/care. Many preventive measures are matters of public policy, such as safe and healthy working conditions and an environment that promotes health. It may be that the biggest contribution to prevention can be made by encouraging

self/health/care at an early age to reduce the chances of certain health problems in tomorrow's older population. By the time people are old, they are reaping the benefits or suffering the consequences of past behaviour. Many preventive actions, however, are still possible during the later years. Stopping smoking, wearing seat belts, and good nutrition are just as crucial to good health in the later years as earlier. Accident prevention can be even more critical as a person grows older since the consequences of a fall may be more severe. Maintaining body tone through exercise and working to improve functioning may also help in moderating the effect of future health problems.

3.5 Are Future Action Plans for Self/Health/Care and Older People Currently Feasible?

The answer to this question was partially formulated at the WHO International Workshop on Self-Care and Health Promotion Among the Elderly. Participants agreed that action plans to promote self/health/care are indeed feasible, and that their objectives should include: (1) maintaining or improving functional capacities in old age, as well as preventing illness; (2) improving the skills of coping with chronic disease and disablement among the chronically ill and disabled elderly; and (3) improving the interaction between the elderly and the health services system by supporting older persons as informed consumers and increasing the interaction skills of professionals.

All the participants were also asked to suggest the types of self/health/care programmes which might be most appropriate for their respective nations. A broad continuum of plans emerged, ranging from mass national campaigns on topics such as accident prevention among the aging to informal, personalized counselling services. There were, however, a number of striking commonalities in the suggestions. It was generally agreed that self/health/care programmes for older persons at any level, either national or local, should be characterized by:

- (1) methods that inform, motivate, and enable older individuals to practise self/health/care and do not merely "exhort." Such methods should include sensitivity to group process, thereby creating a supportive environment which encourages self-confidence and strengthens social relationships;
- (2) commitment to reach one category of older persons for whom self/health/care is of critical importance but for whom it is not presently available, i.e., the unknown elderly who are not recognized by any agency, who do not participate in any organized programme. One of the great challenges for the future of self/health/care is to devise ways of identifying and reaching those older persons who do not read or respond to advertisements, who are not members of self-help groups, who have no families, who are isolated and insulated from the world. It is these unknown elderly persons who are most likely to be at greatest risk;
- (3) active participation of the elderly in the identification of problems and solutions related to their health.
- (4) the use of a variety of media, both visual and printed, in carrying the self/health/care message. In developing countries, many older persons have not had the benefit of formal education, and educational levels vary widely among subgroups of older persons in developed nations as well. Hence, mass media, posters, and other visual materials need to complement printed educational materials;
- (5) coordination of efforts among a wide range of providers, including health and social service agencies, professional and lay groups, public and voluntary organizations. Multiple sponsorship of programmes is recommended whenever feasible;

(6) flexibility, so that the content of the programmes can be made relevant to participants' lives, and so that programmes can be tailored to meet individuals' changing needs;

(7) follow-up activities after the conclusion of the formal programme to solidify the knowledge the participants have gained (for example, refresher courses, or group "reunions").

These are generally the same characteristics reflected in the illustrative programmes of self/health/care described in Section 2 of this manual.

For the future development of self/health/care programmes, experience to date suggests that a distinction be made between action plans designed to facilitate national and local efforts, on the one hand, and global efforts on the other. The successful development of national and local programmes will lie in identifying appropriate sponsoring groups. The first step is to get the topic of self/health/care on the agendas of the right organizations. There is broad agreement that the right process will produce the right content. If key national and local groups of consumers and health practitioners will assign increasing emphasis to self/health/care and the elderly in their future agendas, the future of self/health/care among the elderly will be assured. Such groups would include:

Pensioner groups, trade unions and associations of retired professionals. Professional institutes, colleges and associations (including physicians, nurses, social workers, pharmacists, health care educators, researchers, etcetera).

Policy institutes and university departments concerned with health care, social, or economic policy analysis.

Agencies for the promotion of health education, adult education and adult literacy schemes.

Appropriate ministries, statutory authorities, and local authority associations within the fields of health care, the personal social services, and adult education.

Specialized voluntary agencies with an exclusive or major interest in older people.

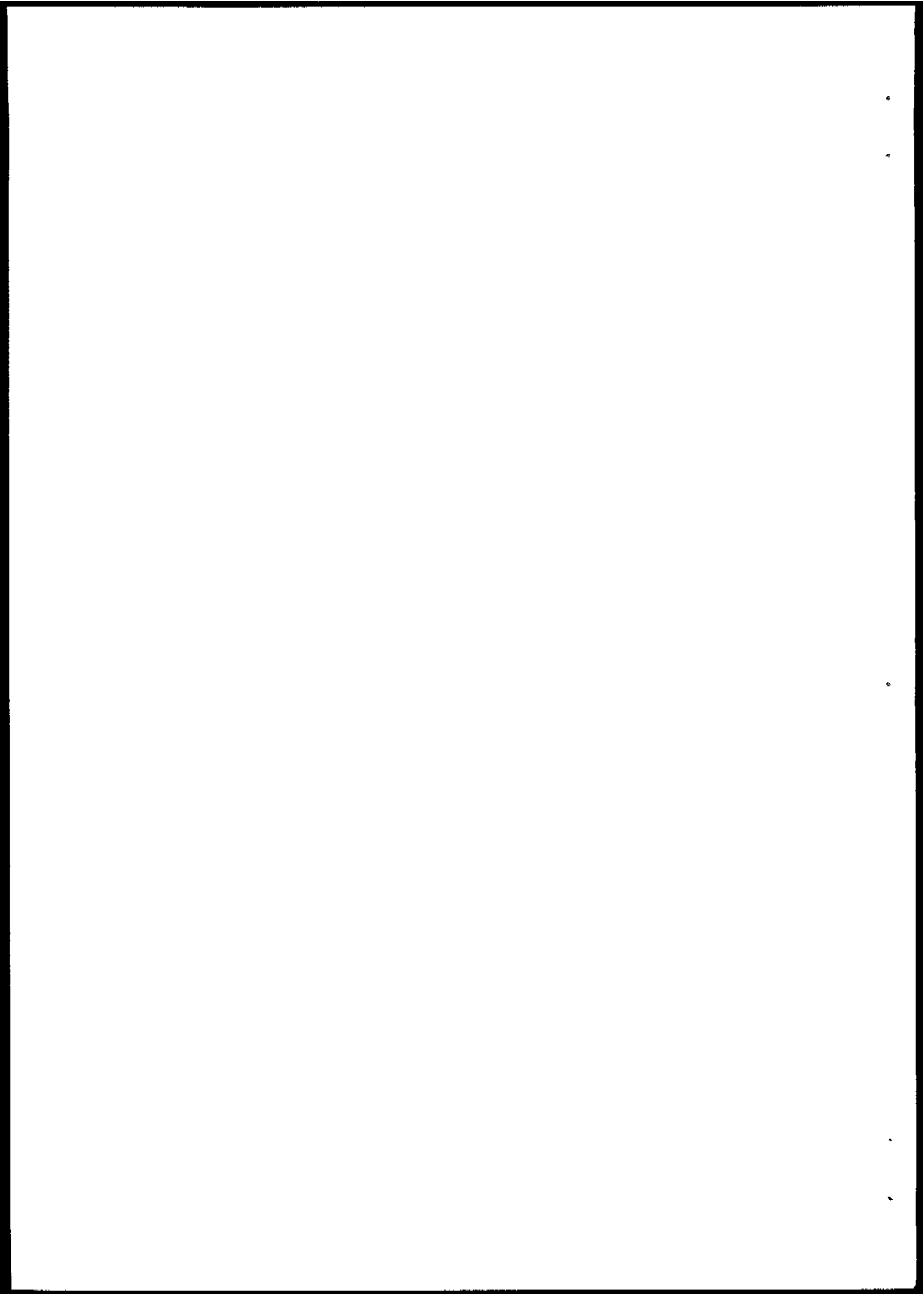
Membership organizations with special influence on family life (for example, women's organizations, churches).

In endeavoring to involve such national and local constituencies, it is essential that the initial approach be supported with appropriate and compelling material, some of which will may well come from this publication.

On the global level, in view of its longstanding interest in self/health/care and the elderly, there is ready consensus that WHO should continue its leadership role in at least four specific respects:

- (1) In line with the present report, WHO should undertake to produce various types of materials designed to make expert advice more readily available to interested groups (e.g., audio-visual presentations, how-to-do-it kits)
- (2) In collaboration with non-governmental organization and, in particular, with the International Federation on Ageing, WHO should make available models of self/health/care which are deemed successful in various parts of the world and under various cultural traditions.
- (3) WHO should monitor progress in self/health/care developments and prepare periodic reviews for world-wide distribution.
- (4) WHO should work collaboratively with other specialized bodies of the United Nations, such as UNESCO, and with relevant international non-governmental organizations to see that self/health/care programmes receive attention.
- (5) WHO should promote curriculum changes in the education of all health professionals for the introduction of courses relating to self/health care.

In line with this global emphasis, it is the collective judgment of the sponsors of this manual that the issues of health and self-care know no political or cultural boundaries; that the industrialized countries have as much to learn from the developing countries as the other way around; that there exists a great need for intensified international cooperation both in research and in the provision of programmes for the aging; that each country must at the same time be free to allocate its efforts within the framework of its own priorities; and that older people, irrespective of where they might have grown up and grown old, should have the opportunity to fully participate in and contribute to the society in which they spend the last years of their lives.



APPENDICES

APPENDIX A: Self/Health/Care Issues Requiring Further Research

As scientific knowledge (not only biological and medical, but also social, psychological, and cultural) about self/health/care becomes more precise, so the practice will be more effective. Some of the questions specific to older people that need to be examined nationally and cross-nationally are:

Quality of Health Care

--What specific aspects of health and health care can be improved if a more active role is taken by older people?

--What particular forms of self/health/care and health behaviour should be promoted or discouraged among the elderly?

--How do particular attitudes of the public and the elderly toward health and health care systems affect the character and quality of self/health/care?

Policy Issues

--Are savings possible if the elderly take a more active role in health care? Are there hidden costs?

--What are the policy implications of increased self/health/care activity by the elderly? For health care? For social services? For education?

--How do existing health policies serve as incentives or disincentives to self/health/care by older people?

The Health Care Professional

--In what ways will the roles of the health care professionals change if the elderly take a more active role in health care?

--What concerns might professionals have about these changes?

- How might health care professionals be trained so they are better equipped to join in a partnership with elderly persons in health care?
- In what ways can professionals and lay persons best work together with the elderly to promote the latter's health?

The Role of the Elderly

- What special strengths and limitations of elderly people must be recognized in encouraging them to assume more responsibility for their own care?
- How do older persons' attitudes and beliefs about health affect their self-care activities?
- Under what specific conditions will the elderly be most likely to accept a more active health care role for themselves?
- Who shares in the responsibility to encourage and facilitate participation of older people in self/health/care?
- What attitudes toward health found among younger people are likely to affect their capacity for self/health/care when they reach old age?

Ethical Issues

- What ethical problems are involved in promoting self/health/care among the elderly?
- Who should decide what types of self/health/care are to be promoted?

These are only examples of the types of questions that still remain to be answered. The list is a long one.

APPENDIX B: The Objectives of the WHO Workshop on Self/Care and Health

Promotion among the Elderly, Copenhagen, August 1983

A ten-point challenge to the participants, was to leave the workshop:

1. With information on self/health/care practices and how they influence the well-being of elderly persons.
2. With illustrative examples of programmes and projects that have been used to reorient and educate health professionals and the elderly themselves to the approach of self/health/care.
3. With information on health conditions (and how to identify them), that lend themselves to improvement through self/health/care.
4. With information about the factors that influence an elderly person's capacity for self/health/care.
5. With knowledge of educational techniques that have been successful in promoting self/health/care practices among the elderly.
6. With the shared experience of the workshop community of how self/health/care can be promoted.
7. With sources of information and case examples of actions elderly individuals can take to care for their health.
8. With enough background information to proceed with the planning and development of self/health/care projects (e.g. manuals, group sessions, counselling, mass media).
9. With outlines of self/health/care projects for further development in the participants' countries.
10. As members of a communication network, committed to exchange of information on new initiatives in self/health/care for elderly citizens.

Attention to this ten point agenda produced most of the substance for this manual.

Appendix C: Participants in WHO Workshop on Self/Care and Health Promotion
Among the Elderly, Copenhagen, August 1983

Region of Africa

Mr. M. Alexandre
Technician in Social Activities
(Responsible Officer,
Handicapped and Aged Persons)
Ministry of Health
Maputo
Mozambique

Mrs. E. Sangmorkie Saki Quartey
Principal Nursing Officer
Ministry of Health
Korle Bu Teaching Hospital
Korle Bu
Accra
Ghana

Region of the Americas

Dr. J. Gonzalez Aragon
President
Mexican Geriatric and
Gerontological Society
Jojutla 91, Tlalpan
Mexico, D.F. 14090

Address for correspondence:
Ave. Cuauhtemoc Ote. 34
Chalco, Edo. de Mexico ZP 56600

Miss H. F. Clarke
Assistant Professor
University of Victoria
School of Nursing
Box 1700
Victoria, B.C. V8W 2Y2
Canada

Miss N. Johnston
Director of Field Instruction
School of Social Work
400 Ford
224 Church Street, S.E.
University of Minnesota
Minneapolis, MN 55455
USA

Mr. J. A. Murdock
Associate General Secretary
Health and Welfare Ministries
475 Riverside Drive - Room 350
New York City, NY 10115
USA

Dr. J. W. Riley
Center for Corporate Public Involvement
1850 K Street, N.W.
Washington, DC 20006
USA

Dr. E. Uruchurtu
Bosques de las Lomas
C.P. 11700
Mexico City
Mexico

Department of Geriatric Medicine
Withington Hospital
Manchester
United Kingdom

Region of the Eastern Mediterranean

Dr. M. Essam Fikry
Chairman, Department of Internal Medicine
Chief, Geriatric Unit, Faculty of Medicine
Alexandria
Egypt

Dr. M. J. Hirschfeld
Lecturer
Tel-Aviv University, Dept. of Nursing
National Coordinator and Consultant
Care of Aged and Chronically Ill
Merkaz Kupat Holim
Arlosoroff 101
Tel-Aviv
Israel

Region of Europe

Ms. A. Bjørn
Director
Danish Institute for Health and Nursing Research
1, Fensmarkgade
2200 Copenhagen N
Denmark

Miss N. Delmotte
Nursing Service
University Hospital St. Raphael
Kapucijnenvoer 33
3000 Leuven
Belgium

Mr. B. Holstein
Institute of Social Medicine
University of Copenhagen
323 Juliane Maries vej
2100 Copenhagen O
Denmark

Dr. B. Henricson
General Practitioner
Vardcentralen
(Care Centre)
S-93090 Arjeplog
Sweden

Mr. J. Huntington
Assistant Director of
Continuing Education
The Health Education Council
78 New Oxford Street
London WC1A 1AH
United Kingdom

Dr. M. K. Thompson
General Practitioner
Woodside Health Centre
London SE 25
United Kingdom

Region of South East Asia

Mr. D. R. Kohli
Director
Helpage India
Massey Hall
1 Jai Singh Road
New Delhi 110001
India

Mrs. S. Lohsoonthorn
Senior Lecturer
Thai Red Cross College of Nursing
Paridatra Building
Chulalongkorn Memorial Hospital
Bangkok 10500
Thailand

Region of Western Pacific

Miss G. Pragnell
Director of Health and Welfare
New Zealand Red Cross Society
P.O. Box 12140
Wellington North
New Zealand

Dr. T. Imo
General Practitioner
P.O. Box 910
Apia
Western Samoa

Advisers:

Dr. L. Coppard
Associate Director
Institute of Gerontology
The University of Michigan
300 North Ingalls
Ann Arbor, MI 48109
USA

Dr. K. Dean
Project Director
Studies in Self-Care Behaviour
Institute for Social Medicine
University of Copenhagen
Juliane Maries vej 32
2100 Copenhagen
Denmark

Dr. K. Elliott
Independent Consultant in International
Health and Public Health
24 St. Georges Court
Gloucester Road
London SW7 4Q2
United Kingdom

Dr. Matilda White Riley
Associate Director
Behavioral Sciences Research
National Institute on Aging
Bethesda, MD 20205
USA

Non-Governmental Organizations:

League of Red Cross Societies
P.O. Box 276
CH-1211 Geneva 19
Switzerland

Represented by Mrs. S. Lohsoonthorn and
Miss G. Pragnell

Christian Medical Commission
P.O. Box 66
CH-1211 Geneva 20
Switzerland

Represented by Dr. Tofaeno Imo

Catholic Relief Services
11 Rue de Cornavin
1201 Geneva
Switzerland

Represented by Miss L. Gottraux

Age Concern England
Bernard Sunley House
60 Pitcairn Road
Mitcham Surrey CR4 3LL
United Kingdom

Represented by Mr. D. Hobman

Help the Aged
32 Dover Street
London W12 2AP
United Kingdom

Represented by Mr. D. R. Kohli

International Council of Nurses
3, rue Ancien-Port
CH-1203, Geneva
Switzerland

Represented by Mrs. E. Sangmorkie Saki Quartey

International Federation on Ageing

Bernard Sunely House
60 Pitcairn Road
Mitcham, Surrey CR 4 3LL
United Kingdom

Represented by
Ms. S. Greengross, Secretary General

International Association of Gerontology

An der Schlosskirche 1
D-5300 Bonn 1
Federal Republic of Germany

Represented by
Dr. H. Kirk
Deputy Medical Officer
National Board of Health
Store Kongensgade 1
1264 Copenhagen K
Denmark

Ensomme Gamles Vaern (The Society for the Care of Old People)

Tingskiftevej 2
2900 Hellerup
Denmark

Represented by
Mrs. Maria Ropke
Chief Consultant

WORLD HEALTH ORGANIZATION

Regional Office for Europe

Dr. P.O. Petersson
Director,
Development of Comprehensive Health Services

Dr. H. Hermanova
Regional Officer
Elderly, Disability and Rehabilitation

Regional Office for the Americas

Dr. E. Anzola-Perez
Regional Adviser on Programmes for Care of
the Elderly

Headquarters, Geneva

Dr. A. Mangay Maglacas
Senior Scientist for Nursing

Global Programme, Health of the Elderly

Dr. David M. Macfadyen, Manager
Ms. G. Meehan, Temporary Assistant