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Sultanate of Oman Ministry of Health

April 2008

Community Health & Disease Surveillance Newsletter

Inside this issue:

The First Quarter Reports on Communicable Diseases will be published in **Issue # 3 (May'08)**

The 2nd Omani PHC Conference & the 1st Meeting of the Omani Society for Family & Community Medicine

Our Collaborators: *Oman FAMCO Society, Sultan Qaboos University & Gulf Cooperation Council*

Introduction

The 2nd national Primary Health Care conference and the 1st meeting for the Omani society for Family & Community Medicine (FAMCO) was held in Sultan Qaboos University (SQU) on 5th— 6h April 2008. The Ministry of Health (MoH) decided to hold PHC conference on a periodic basis every year with the aim of discussing the progress of PHC services in the Sultanate as well as exchange of current knowledge about family health practices and PHC. This year conference was about exploring the growing debate about the shape of primary health care and family medicine in the near future in Oman.

The 2nd PHC conference was organized by The Department of PHC-MoH and Department of Family Medicine –SQU in collaboration with the WHO and the Executive Board of the Health Ministers' Council for GCC States.

Conference Objectives

- To update Family practitioners and Public health specialists on the most current changes in the trend of diseases.
- To discuss the appraisal process at primary health care settings.
- To train FAMCO on how to design an effective CME for the health care professionals
- To discuss the latest issues concerning integration of chronic diseases at PHC settings.
- To review the current PHC services in Oman and discussing the future strategic directions.
- To explore the growing debate about the shape of primary health care and family medicine.
- To review the challenges related to health care delivery at PHC centres.
- To discuss the Integration of specialty care at PHC in Oman: Achievements & Obstacles.

Deliberations of the conference

The conference was held in Sultan Qaboos University on 5th— 6h April 2008. Over 150 participants were registered for this confer-

Dignitaries at the Inaugural Ceremony

"This year conference was about exploring the growing debate about the shape of primary health care and family medicine in Oman in the near future ".

ence since only limited registrations were permitted.

The conference was inaugurated by HE Dr. Ahmed bin Abdelqader Al Ghassani, the Undersecretary for Health Affairs of Ministry of Health.

The guest of honour were HE the chancellor of Sultan Qaboos University, HE Director General of executive board of the health ministers for GCC States, HE Assistant Undersecretary for Planning in ministry of health in Kuwait.

The inauguration speech was delivered by HE Dr. Ali Jaffer Mohammed, the Advisor of

Health Affairs. He highlighted the importance of such events and elaborated on the development of primary health care in Oman. He further stressed on this year's conference theme on exploring the growing debate about the shape of PHC and family medicine in the near future in Oman.

Scientific Programme

Day-1; 5th April 2008

Key Note Speech: FUTURE CHALLENGES IN DELIVERY OF PATIENT CARE

Prof. Abdullah Tavabie: GP Dean and Deputy Dean Director for Postgraduate Medical Education in the Kent, Surrey and Sussex Deanery, UK

Plenary Session 1

- International comparisons of primary care
- 30 years after Alma-Ata: future perspective
- Primary Health Care: WHO new development
- Designing sustainable PHC system that can deal with chronic diseases epidemic
- Promoting general practitioner researcher: working together to improve PHC in Oman
- Planning effective CME for GPs in Oman : issues and challenges

Workshops

Workshop I: *Primary Care: Questions and Answers*

Workshop II: *Appraisal process in Primary Care Setting*

Workshop III: *Teaching in Practice : Making it Easier for Family Doctors*

Day-2; 6th April 2008

Key Note Speech: THE PLACE OF PHC & FAMILY MEDICINE IN THE REFORM OF HEALTH CARE SYSTEM

Prof. Salman Al Rawaf: Director of Public Health Wandsworth Primary Care Trust and Hon. Professor of Public Health Medicine School of Health and Science, Middlesex University, London

Plenary Session 2

- Is chronic (diseases) care the same or different from primary care?
- Frequently encountered mental disorders in PHC
- Poly-pharmacy in elderly
- Health seeking behaviours
- Integration of specialty care at PHC in Oman: Achievements & Obstacles
- Obesity management in PHC
- Meeting for the memeber of the Omani Sociaty for FAMCO

Workshops: same as on Day-1.

Primary Health Care Development in Oman

Dr. Said Al Lamki,
Director of PHC Affairs, Ministry of Health, Oman

Primary Health Care is considered as the most important point of entry to our health system. The existing primary health care settings have been built to serve certain functions especially that related to preventive care. But now the functions have changed . The change in epidemiological picture towards chronic diseases with the new challenges such as increases in clients demand and shortage in skilled manpower, create new conditions that need a new PHC concept with dynamic approach to address the new and existing health problems. Therefore we need to look beyond the health centre buildings (which we may need to upgrade as well), and create a parallel supportive services that detect and manage the problem at its earlier stages.

Development in Method of Delivery

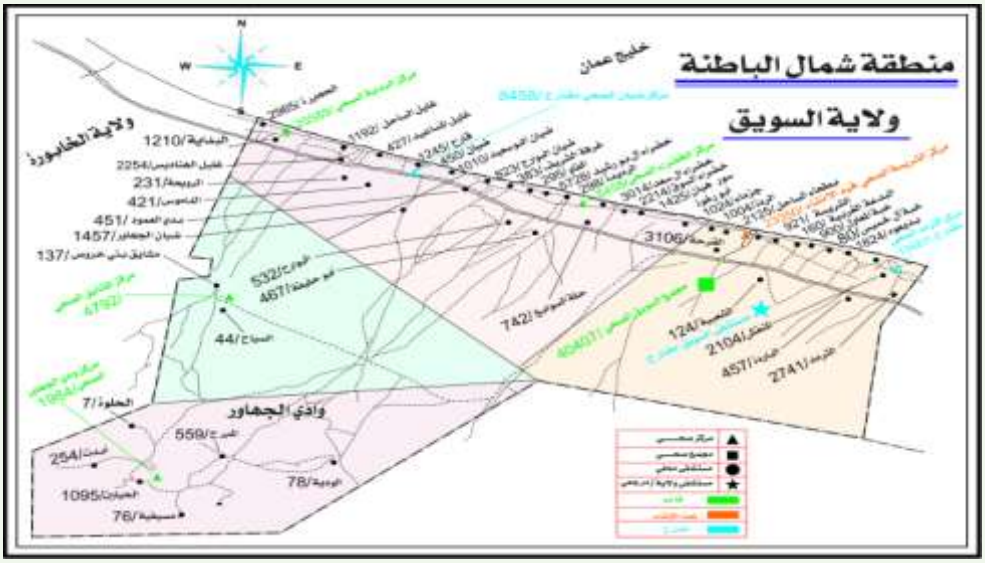
During the last few decades, there have been a lot of changes occurred in the delivery of PHC in Oman that had come out in response to the changing in the trend of diseases, changing in the needs of the population, as well as increases in the cost of health care. During this period, the health care system in Oman has focuses in building basic health infrastructure by establishing PHC institutions that are able to incorporate the Alma Ata declaration in its daily practice. This was evident from the PHC policy which was formulated by the MoH after Alma-Ata declaration. The policy statement had considered the availability, accessibility, continuity , the comprehensiveness of care, and community participation as the main entrance towards establishing a strong and organized PHC service. PHC services have expanded and covers almost 95% of the population in the Sultanate. Furthermore, to strengthen PHC role and to make sure that sustainability of services towards service users, families and the communities, the PHC has emphasis in three main issues: strengthening the PHC at

Table-1: PHC Institutions by Regions: 2007

Region	Health Centres	EHC	Local Hospital
Muscat	24	1	1
Dhofar	28	0	5
Musandam	3	1	2
South Batinah	9	3	4
North Batinah	15	5	3
South Sharqiyah	15	2	2
North Sharqiyah	10	1	4
Dakhliyah	16	3	3
Dhahira	17	1	3
Al Wustah	6	0	2
Total	142	17	29

"By 2007, the number of PHC institutions raised to 188, consisting of 142 Health Centres, 17 Extended Health Centers, and 29 Local Hospitals".

Fig-1: Catchment Area Plan of a Typical PHC Centre



the central level, decentralization of the service to the Wilayat (district) level and integration of different specialty care at health centre's level.

Improving Accessibility to Facilities

PHC delivery is strengthened by establishing a wide network of primary health care institutions covering all regions. By 2007, the number of PHC institutions raised to 188, consisting of 142 Health Centres, 17 Extended Health Centres, and 29 Local Hospitals (*table-1*). This expansion in health care delivery is complimented with identification of the catchments area of each health centre (fig-1).

an increase in the latest medical equipment and provision of extra medical, technical and administrative staff to meet the demands of the health system. Like all PHC systems overall the world, our PHC policy considers 'Equity' of health, accessibility, availability, continuity and comprehensiveness as a prerequisite to PHC provision..

PHC currently covers a wide range of activities and elements: from provision of health services for the mother and child to the prevention and treatment of chronic diseases , and education and awareness about common health problems and how to prevent these problems (table 2).

Improving Accessibility to Services

Primary health care became a core policy for MoH soon after the Declaration of Alma -Ata on primary health care in 1978 and the subsequent development of the Global Strategy for Health for All by the Year 2000. Thirty years after the declaration of Alma Ata, PHC system in Sultanate has succeeded in tackling the main health problems scoring high grades in performance. And in the context of the development in the infrastructure of the health centres PHC has a great potential in improving health care indicators for the Omani population. The impact of application of PHC as defined in Alma Ata declaration, and the subsequent development to cover management of communicable and non-communicable diseases, this has a great impact on improving of critical indicators such as infant and maternal mortality; increasing life expectancy and improving the quality of life.

Table-2. Services available in PHC

1.	Maternal & Child Health Care
2.	Control of Communicable Diseases.
3.	Control of Non-Communicable Diseases
4.	Control of Specific Diseases.
5.	Malaria Eradication.
6.	AIDS and STD's
7.	School health
8.	Screening for chronic diseases
9.	Dental care
10.	Health education
11.	Nutritional advice
12.	Adolescent & elderly health + home care

The type of services that being provided to patients currently (table 2) is a combination of preventive and specialized curative services. And in spite of such services, still the demographic and epidemiological shift, the NCD challenges, and the combined burden of disease especially with the aging of the population, will lead to a different mixture in the magnitude and intensity of demand for care. This will definitely require a new approach and a new change in PHC services delivered through the health centres. A shifting burden of disease is a decisive factor driving this method of care delivery. Non- communicable disease, injury and problems associated with mental health, chronic obstructive airy way diseases are comprising a growing proportion of overall health needs. Accordingly, community demands/needs have also shifted placing a growing importance on a more individual and customized vision of patient care with the individual needs of patients becoming of ever increasing concern to health care providers. Patients are demanding more frequent & longer duration of care, repeated access to the same physician and for advice not only relating medical treatment but for support and guidance on medically-related problems. The new challenges that have arisen cannot be solved by the processes of existing PHC setting . New experiences, needs, demands and expectations are inevitable components of the system and therefore impart a need for devis-

"Non- communicable disease, injury and problems associated with mental health, chronic obstructive air way diseases are comprising a growing proportion of overall health needs".

ing new solutions for new problems. Giving more focus on greater attention on life-styles, behavioural change and improved continuity of care, and promoting self-care.

Human Resources Development

Manpower is one of the pillars for proper planning of health care delivery system. Staff working in PHC system are distributed among different categories There are currently 1182 physicians working at PHC institutions, of whom 251 are Omani (21%). Among the Omani there (77%) females. Similarly, during 2007 the number of staff nurses working at PHC has increased to 2500 of whom 65% are Omani. Other categories like laboratory technicians, x-ray technicians, health educators, medical record staff , and others have also increased , and all together representing about 2700. at present the expatriate workforce is a characteristic of the our PHC.

Table-3: Manpower in PHC Centres

Manpower Categories	Total
General Practitioner	1182
Specialist/ FAMCO Doctor	105
Dental Surgeon	136
Dental Technician	108
Nursing Staff	2505
Laboratory Technician	348
X-Ray Technician	164
Diet Technician	64
Pharmacist	13
Assistant Pharmacist	371
Administrator	60
Medical Records Clerk	435
Health Information Officer	42
Health Educator	105
Medical Orderly	715
Watchman	122
Driver	97
Total	**6572**

Decentralization of Authority

Decentralization at PHC is a growing phenomenon. It is now a main feature of the organization of our primary health care services. The most recent structure introduced especially in Muscat Region is the Wilayat Health Directorate. The WHD is supported with a team in order to look after the health services in the Wilayat including the smooth running of the health centres at the Wilayat with its different functions this process also aiming at strengthening PHC by building communication channels with the community and other health related sectors. Currently there are 16 WHDs. Because there is a need to balance the decision making process to become in the bottom up direction, the terms of reference of the WHD has revised to upgrade public health agenda within the catchment's area of the health centre.

Family Practice & Continuity of Care

Users of PHC services are demanding comprehensive and integrated care. Users want to be seen by the same health care practitioner and when referred to have a smooth, quick and supportive care at the referred level. The management of chronic disease requires long-term plan. Family practice has increasingly becoming a feature of the modern international PHC service. And with prevailing chronic diseases in our community the boundaries between levels of care i.e. the HC and the Hospital have become blurred. The support of specialist care has become built in the continuous care of NCDs. For example in Diabetes care it is not only the initiation of the treatment protocol but as well the complications of Diabetes like retinopathy and diabetic foot. Patients seen by frequently changing physicians at the health centre might not encourage patient-doctor relationship, which is important for establishing rapport to influence patient's behaviour. Thus, the number of contacts is now more, of varied needs and for longer time period, and some concern was expressed regarding the long waiting time of referral to specialist care at hospitals which takes some weeks. Based on this outcome, PHC has started a new way of managing chronic problems at the health centre, the new ABC approach of patients care that is based on family practice is currently implemented in the health centre in Muscat where the catchments area is divided into three blocks, each under one team. The process at the end aiming at improving the continuity of care, and reducing un-necessary referral to higher health care level.

"The management of chronic disease requires long-term plan. Family practice has increasingly becoming a feature of the modern international PHC service".

Continuous Professional Development Program for GPs

Dr. Maryam Al Khusaibi
PHC Department, Ministry of Health, Oman

"Continuous medical education is one of the tools PHC department utilizes to strengthen and improve the training skills and knowledge of its general practitioners in the regions".

Introduction

As per the Ministerial Decree (Qarar #40/2007); The PHC department is responsible in receiving all registrations regarding activities related to CME and instituting a database for all and further analysis. At present, the PHC Dept is in the process of establishing a CME center to look at the different activities in the department , other departments in DGHA and Wilayat. Activities concerning continuing professional education and career development of the all the staff in the PHC (GPs, Assistant pharmacists. X-ray technicians, laboratory technicians, Nurses) will be held under the umbrella of PHC CME center.

Currently, the PHC CME center will cover the GPs in-service training scheduled to start in the 2nd quarter of 2008. The remaining categories will be included in the near future once the center is established.

The regulations applied in the CME center will be same as those applied by DGET.

Continuous medical education is one of the tools PHC department utilizes to strengthen and improve the training skills and knowledge of its general practitioners in the regions. From its definition; "CME consists of educational activities that serve to maintain, develop or increase the knowledge, skills and professional performance and relationships a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public". From here this initiative of accredited CME for the GPs was set in motion.

The aim

- To improve the performance of the PHC doctors carrying out all the GPs related programs within the PHC institutions.
- To strengthen the communication skills of PHC doctors thus nurturing relationship between doctor and patient.
- To enhance the overall service delivered by the PHC doctor.

The target GPs

- All GPs with priority given to senior doctors serving in the PHC.
- All GPs with experience in the field of PHC.

Module criteria

Need analysis questionnaire was distributed to all regions to be filled by all GPs. According to the needs mentioned in the questionnaire and the discussion made with the concerned personnel, the module theme was decided.

Method of delivery of training

The module leaders working together with the taskforce and the PHC department decided on the different methods of delivery of the presentations. All presentations should be interactive. (Flexibility according to the speaker).

Methods

- Lectures.
- Groups discussion. (small groups Vs Large groups)
- Case presentation.
- Video presentations.
- Tutorials.

In addition to the different methods, module leaders discussed the references that may be used in the course beside the text books such as the various manuals, SOPs and clinical guidelines.

Module duration

Total duration course will be 72 hrs (3 months) - (6 hrs per week)

Trainers

Each region to provide trainers for their own program.

Criteria for eligible as trainers

- Family physician.
- Specialized personnel in the concerned field.
- GPs interested in teaching.

Implementation of the course

The course implementation will be decided by the PHC department and the module leaders in collaboration with the regions regarding timing and resources needed. PHC department will assist in providing these resources during the course period.

Registration

Participants register online or through registration form e-mailed to the regions and then to the PHC department.

(Website under construction)

Evaluation

- Initially each module will have a pre-test and a post-test.
- Pre-test and post-test questions have to be approved by the PHC department and the module leaders.
- Instructors and method of delivery will also be evaluated at the end of the sessions

Accreditation

The CME modules will be accredited by the Kuwait Institute for Medical Specializations (KIMS). The centre will be affiliated to the Royal College for General Practitioner once it is well established.

Revision

The course will be revised after its first implementation for evaluation and updating and upgrading its content.

Optional Vs Compulsory

Currently the training course could be optional till the program is mature and solid. However points gained from the course can assist and be taken as a requirement for the promotion and career development of the GPs in future.

Course scheduling

The course to be available for the GPs in the following hrs: (to choose one only, according to the regions preference)

- From 16.30pm-19.30pm twice a week OR
- Full one day once a week (Release the staff from routine duties).

Total number of participants in each course:

20-25 candidates

"The course implementation will be decided by the PHC department and the module leaders in collaboration with the regions regarding timing and resources needed".

Table 1: CPD Course Scheduling

Module	Duration in hrs	Duration in days	
		Twice weekly	Once weekly
GP	36 hrs	6 Days	12 Days
Chronic diseases	15 hrs	3 Days	6 Days
Mother & child health	21 hrs	3 ½ days	6 days
Total			72 hrs

Integration of Elderly Care in PHC settings

Dr. Yaqoub Al Maghderi,

PHC Department, Ministry of Health, Oman

Background

Global population ageing is a product of the demographic transition in which both mortality and fertility decline from higher to lower levels. Currently, the total fertility rate is below the replacement level in practically all industrialized countries. In the less developed regions, the fertility decline started later and has proceeded faster than in the more developed regions. In all over the world people are increasingly likely to survive to older ages, and once there they are tending to live longer, as the gains in life expectancy are relatively higher at older ages.

The older population is growing at a considerably faster rate than that of the world's total population. In absolute terms, the number of older persons has tripled over the last 50 years and will more than triple again over the next 50 years. In relative terms, the percentage of older persons is projected to more than double worldwide over the next half century. However, notable differences exist between regions in the numbers and proportions at higher ages. Although the highest proportions of older persons are found in the more developed regions, this age group is growing considerably more rapidly in the less developed regions. As a consequence, the older population will be increasingly concentrated in the less developed regions.

Situation in Oman

The population in the elderly age group is growing in the Sultanate due to the impressive health, social and economical development. There is a marked decline in the mortality (CDR = 2.48 per 1000 population) and reduction of fertility (CBR = 24.17 per 1000 population and TFR = 3.19 per women) and increase in the life expectancy at birth (74.29 years, higher in female 75.43 years than male 73.18 years). The elderly people represent 5% of the Omani population according to the last census in 2003 (Fig. 2). However, this percentage is estimated to show considerable growth and it may go up to 10% by the year 2025 according to UN and WHO estimations. The increase in the elderly age group is creating a demand and pressure on the health services due to vulnerability of the elderly to a spectrum of morbidity related to their age especially the non-communicable diseases. It is also important to have programs working on rendering the current and future elderly to have what WHO describe as "active ageing" to enhance healthy, quality life with keeping their dignity through it.

Fig.1: Life Expectancy at Birth by Gender 1950-2050

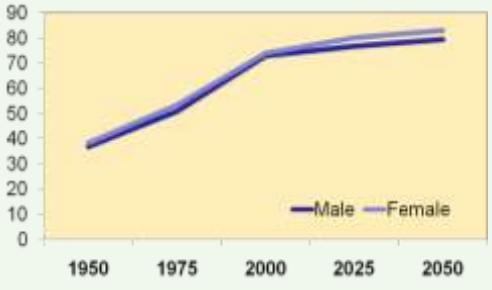
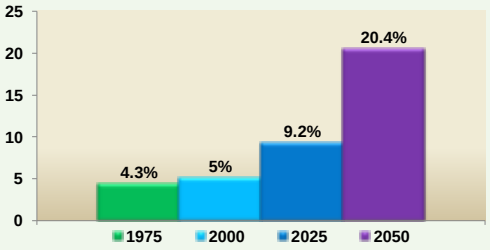


Fig.2: Percentage of Omani Population Aged above 60 years: 1975-2050



Why we need elderly care programme

With the expected increase in the elderly group the health services will have to be prepared and expanded. Human resource working in the health system definitely will need to be developed to cope with the future increase of older citizens and their difficulties. Integration and strengthening of PHC services to meet the unmet special need of old people will be definitely needed. The purposes Quality health care for the elderly which is provided by health workers are:

- Promoting health and minimizing limitations in the elderly.

"The increase in the elderly age group is creating a demand and pressure on the health services due to the vulnerability of the elderly to a wide spectrum of morbidity related to their age ".

- Maintaining independent lifestyles for the elderly in the familiar surrounding of their communities.
- Supporting family members in their efforts to sustain the well-being of their older relatives.
- Cooperating to create a community which can provide a comfortable life for the elderly.
- Restoring function following an illness when necessary.
- Doing such things with sensitivity to the rights and dignity of older persons.
- the speed of population ageing is much faster in developing countries
- developing countries will have less time to adjust to the consequences of population ageing.
- Moreover, population ageing in the developing countries is taking place at much lower levels of socio-economic development .

However, Ministry of heath realizes the importance of integrating the elderly care in the band of PHC services. Therefore, the elderly care was included in the new seventh fifth year plan for ministry of health through the plan of primary health care domain, which aims to reduce morbidity in elderly age group and early detection of old age diseases and their complications.

Need For Age-Friendly PHC

The epidemiological transition of diseases pattern from infectious to chronic or non-communicable diseases as a challenges facing all the health systems in the countries make it very important to build a health system responding to the needs and prospects. The reflection of the life long accumulation of the risk factors for such diseases which reinforces the importance of health promotion and disease prevention throughout the life course.

Patterns that lead to disabilities and chronic illnesses are costly in economic and human terms to individuals, families and community. A life course approach including healthy lifestyles and due recognition of the impact of environmental, socio-economic and other conditions, can break the cycle that lead to many disabling diseases later in life. Once older people develop these diseases, they must be closely managed through community level interventions, such as ongoing care, medication management, and health education to prevent potentially catastrophic consequences. From midlife chronic diseases make up the vast majority of all diseases and are responsible for most deaths all over the world. There are proven strategies (e.g.. primary prevention, behavioural management) that can change the future picture to older living longer, more healthy and productive.

Most health care, particularly PHC level, is currently organized around an acute, episodic model of care- a model that does not meet the needs of the patients especially the older on of them.

The 2002 WHO report, *Innovative Care for chronic condition building blocks for action* proposed a comprehensive framework for updating health care systems to meet changing population needs and the need for affordable chronic diseases management.

In Oman the will established and developed health system and especially PHC system is capable to involve the care for old person by integration in the existing system. The idea of age-friendly PHC is applicable to Oman since the infrastructure of the PHC is nearly will established and what is needed is building the capacity and development of the human resources to cope with the current and future needs of the old citizens.

What is active ageing?

Active ageing is the process of optimizing opportunities for health, participation and security of older people in order to enhance the quality of people's life as they age. Active ageing depends on a variety of influences or "determinants" that surround individuals, families and nations. Understanding these determinants helps us to design policies and programs that work. The determinants of active ageing are: economic and social determinants, physical environment, personal and behavioural determinants and health &social services.

Attaining the goal of active ageing requires action from multiple sectors, in addition to

"Active ageing is the process of optimizing opportunities for health, participation and security of older people in order to enhance the quality of people's life as they age".

health and social services. The three pillars of health, participation and security are policy proposals which address the:

- Prevention and reduction of the burden of excess disability, chronic disease and premature mortality;
- Recognition and enablement of the active participation of people in economic development activities, formal and informal work and voluntary activities, according to their individual needs, preferences and capacities;

Assurance of the protection of the security and dignity of older people by addressing the social, financial and physical rights and needs of people as they age.

WHO's priority areas of work on ageing focus on primary health care centres' preparedness; the INTRA project (integrated response of health care systems to rapid population and ageing); age-friendly primary health care centres; and elder abuse prevention and training. In conclusion, through healthy ageing, societies can build social wellbeing, cohesion and inclusion.

Home health care for elderly

Home health care is defined as health care which is provided by an organized or professional group and delivered in the patient's home. It brings the services closer and deeper in the community and enables more chance for health education and promotion. The sole reference of the home health care is the PHC centres in term of technical and human resources. Therefore, home health care should be developed as a component of PHC services. Therefore, the ministry of health piloted a Home Health Care program in Al Amerat , which was initiated in August 2004. the service now expanded to involve two other Wilayat in Muscat governorate. MoH looking forward to expand this service to involve more regions. The focal centres for this home care pilot is the PHC centres serving the catchment area where the service available.

Proposed strategies for elderly care

In order to formulate a proper strategy for elderly care we should concentrate on the following:

- Establish national multi-sectoral (governmental and non governmental organizations) central coordinating committee chaired by a high authority in MoH in order to adopt and monitor the implementation of all action required in elderly care.
- Establish a national program for elderly care under the umbrella of PHC, to initiate, coordinate and monitor the activities in the subject of elderly care.
- Implement family health model in all primary health care centres. This will lead:
  - ⇒ *To develop a database system based upon a family file.*
  - ⇒ *To develop a Management Information and Decision Support systems.*
  - ⇒ *To plan for community-based researches depending upon the existing databases.*
  - ⇒ *To enhance the community participation in the primary health care delivery system.*
- Establishment of elderly care clinic in primary health care centres.
- Develop a strategy for non-communicable disease control especially diseases common in elderly.
- Introduce the concepts and principles of active ageing, and elderly care in the curricula of all health professionals, including continuing education programs of the existing health professionals.
- Develop short term and long term plan in order to train of all health providers in the primary health care centres in elderly care.
- Improve the referral system especially the feedback between different level of health care for proper management and follow up.
- Develop appropriate technical guidelines and manual, to support active and healthy ageing and care for the older population at all levels.
- Support community and NGOs to initiate elderly friendly activities.
- Adopt a set of standardized indicators that should be gender-sensitive to strengthen the capacity of health information systems and raise awareness of the importance of data collection and utilization
- Support researches, studies and surveys on the various determinants of ageing,

"The sole reference of the home health care is the PHC centres in term of technical and human resources. Therefore, home health care should be developed as a component of PHC services".

Effective CME for GPs in Oman: Issues and Challenges

I.G. Premadasa
Medical Educationalist, Director, CME Centre & Medical Education Unit
Kuwait Institute for Medical Specialization, Kuwait

Introduction

A question that often surfaces, especially in circles of practitioners who are not initiated into involving themselves in life-long activities is, "Does CME work?" The reply to this query would be, "Yes. Many CME interventions are there and, if appropriately used, they could lead to improvement in clinical care". A key phrase in this response is "if appropriately used". It is related to the issue of the activities being derived from the best available evidence. Research studies that have been undertaken in the past two decades including those by Fox, Slotnick, Davis and Dixon and their co-workers, some of which included meta analyses of controlled studies, reveal the value of CME in enhancing the practice of the health professional. The significant conclusion that emerged from these reports is that CME would be effective when the educational activities build upon the questions physicians develop based on problems they encountered in their own practices.

What is CME?

A CME event is defined by the Association of American Medical Colleges (AAMC) as a distinct and definable activity that supports professional development of physicians and leads to improved patient outcomes. It encompasses all the learning experiences that physicians engage in with the conscious intent of regularly and continually improving their performance.

The term CME, or continuing medical education, has traditionally been used to refer to all educational activities that physicians engaged in after the phase of undergraduate education and, in the case of those who opted to do further training, that of obtaining postgraduate qualifications in a chosen specialty. In the past, many such activities had been conducted on the initiation of and with the sponsorship of private commercial establishments. The themes dealt with at these CME sessions nearly always were those selected from medical subject content, highlighting major developments. Others were related to novel treatment modalities or equipment that was being introduced for performing investigative or patient management procedures. An additional feature of the past CME was that the

(Continued on page 12)

"CME would be effective when the educational activities build upon the questions, physicians develop based on problems they encountered in their own practices".

disseminate the findings and build these results into a database.

- Encourage advocacy activities aimed at dissemination of information to policy makers, legislators, religious leaders and the mass media to highlight the importance of healthy lifestyles throughout the life course and to promote active ageing.
- Develop strategy for dissemination of information about the elderly care within the community and family members.

Conclusions

In conclusion the rapid increase in the number and proportion of elderly people in the country will push the needs of the elderly to the forefront of the public health agenda. Better statistical information and research are needed, national policies and program need to be formulated, policies which promote health throughout the life course should be adopted, and any plan of action should be based on participation, and partnership in creating age-friendly policies. To achieve these goals certain strategic directions should be adopted, to:

- create and keep an updated database;
- create multidisciplinary national networks;
- incorporate health care of older persons into primary health care systems;
- provide appropriate knowledge and skills needed for self-care and health protection and promotion for older persons;
- support research and training in the field of health of older persons.

References:

1.*Ministry of Health, Annual Health Report, 2006*
2.*Active Ageing: Towards Age-Friendly Primary Health Care, WHO, 2004*
3.*Active Ageing: A Policy Framework, WHO, 2002*

"When the Director of the Wilayat health care services shares the Wilayat health care vision with all the MOICs of the health centres, their role and responsibility is be clear and explicable".

activity was invariably a formal lecture or a lecture series, often given by reputed workers or authorities in the field whom the organisers would invite. Such associations and practices led to the perception in the minds of most medical professionals that the avenue open for engaging in CME is attending a conference or seminar at which a team of speakers would present lectures on important medical topics.

CPD – an Alternative Concept

CPD or continuing professional development is gaining increasing acceptance as a term for referring to life-long learning undertaken by medical practitioners. Stanton & Grant describe CPD as educational methods beyond the didactic, embodying concepts of self-directed learning and personal development, and considering organizational and system factors. An important distinction between the concept of CPD and CME is that CPD covers not only the narrower clinical dimensions but also the broader field of practice management, ethical decision-making, evidence-based care, managed care principles, etc. It includes a variety of learning interventions – reminders, audit and feedback, academic detailing, and web-based guidelines. Moreover, the venue of learning, too could get shifted from the formal lecture hall to a setting that facilitates interaction. An additional advantage of the expression is that different groups of health professionals – dentists, nurses, pharmacists and other categories - the term acceptable, also allowing for the conduct of multi-professional activities.

The purpose of CPD or life-long learning that medical practitioners undertake is the maintenance of professional competence by being abreast of the developments in one's own specialty and in fields that have a bearing on one's own practice. The final outcome would be the improvement of individual and population health.

Needs Assessment

An important consideration prior to planning any CME event is ascertaining the learning needs of the prospective participants. The needs so identified should be directly related to issues important in the practice environment if the new competencies that would be gained from the learning were to have any impact on the service provided by the practitioner.

The methods available for undertaking needs assessment could be formal or informal. Among the formal strategies are questionnaires and structured interviews, critical incident techniques, gap analysis, objective knowledge and skills tests, self-assessment packages, observation, re-validation, video assessment and peer review. These approaches could be supplemented with data obtained through practice audit, practice profiling, portfolios (which include documentation of practice experiences, educational opportunities, profiles of demonstrated competencies), morbidity patterns, adverse events, patient satisfaction surveys and risk assessment.

Planning CME in Oman

The Sultanate of Oman, with its land area of approximately 309,500 sq. km covers a relatively large land mass when compared with most other countries comprising the Gulf Cooperation Council. Extensive distances separate the capital Muscat from the governorates and the administrative regions, entailing many hours of travel if one were to use land transport.

If planners of formal life-learning activities were to go by the traditional concept of continuing education, the distant locations where the GPs are based and their service commitments would make it difficult for many of them from engaging in CPD. Yet, the CME providers and the resource persons could use these very same aspects of distance and the difficulty of gathering large groups in one place to an advantage by:

- Using the Internet as the main mode of communication for disseminating information about the accredited CPD activities;
- Advising the GPs to use emailing for all their correspondence with the central CPD authority at the Department of Primary Health Care Services;
- Getting CPD organizers who wish to register proposed CPD activities and practitioners intending to participate in specific

CPD events to submit applications online.

- CPD organizers opting for locally-based learning events planned on the practice needs identified by the GPs in the locality, in preference to centrally-conducted major conferences and symposia.

Adult Learning Principles and Reflective Practitioner

The concepts underpinning effective CPD match the broad principles of successful adult education. A key concept described by Schön that is relevant in this context is that of the reflective practitioner. Thus, for the health professional to be a successful adult learner and to use CPD effectively, he or she needs to reflect on the experiences related to the practice, assess the current status, identify future priorities and develop plan for future learning. The workplace is a rich resource and a prime motivator for adults' learning. Additionally, the opportunities provided need to be learner-centered, active rather than passive, relevant to the learner's needs, engaging and reinforcing.

Effective Learning Strategies

When one considers the learning activities that the GP would undertake, some of the strategies that could be gainfully employed are self-directed learning, learning in groups, Journal Clubs, workshops employing practice rehearsal strategies, and the use of local opinion leaders.

Studies on the effectiveness of CPD indicate that broadly-defined, practice-linked CPD events are effective and are likely to lead to changes in practitioner performance. The approaches that may be employed are interactive sessions which use techniques to enhance practitioner participation (role play, discussion groups, hands-on training, problem solving and case-based discussions). It is also important to bear in mind that the widely used didactic presentations are the least effective mode of CPD strategy. There is no evidence that didactic presentations - predominantly lecture format with minimal audience interaction or discussion - change physician performance or improve patient care.

The factor that determines whether a given CPD event is effective or not is the relevance of the content dealt with to the perceived learning needs of the practitioners. The material presented should be relevant to work that is currently being undertaken, and the practitioner should be able to see the applicability of the learning experience to real-life situations.

Categories of CPD

In the categorization of CPD strategies proposed by Davis and his co-workers, three types have been identified:

Type 1 – Predisposing: Involve communicating information such as providing printed material. This approach is reported to be the least effective, with the results of past studies being negative or inconclusive.

Type 2 – Enabling: Aim to help in bringing about change in the practice site. Providing practice protocols, practice guidelines with patient education are examples of strategies included under this category.

Type 3 – Reinforcing: Reinforcing strategies, which involve providing algorithms and conducting workshops based on practice needs are effective to some extent. A positive effect has been reported with reminders or providing feedback, chart review and academic detail visits.

Combining the three is seen to be the most effective approach of CPD, helping in changes in physician performance and health care outcome.

Evaluation of CPD

As with all other educational activities, organizers of CPD activities need to assess the effectiveness of the events they conduct.

The most widely used indicator – participant satisfaction – is of limited value and provides data that would mainly be useful to the course director, planning committee, speakers and administrators responsible for the CPD event. The approach to evaluation should be extended beyond this level, and aspects such as participant competence, practitioner performance and health care outcome should become the focus of assessment.

"Studies on the effectiveness of CPD indicate that broadly-defined, practice-linked CPD events are effective and are likely to lead to changes in practitioner performance".

The Value and Popularity of Family Medicine in the UK

Prof. Salman Rawaf
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"Accumulative evidence indicates a direct association between population health (morbidity/ mortality) with the level of family medicine provision".

I. The Value of Family Medicine

Data from the British National Health Service (NHS) shows clearly the substantial benefits of providing a comprehensive primary care based on family medicine to the whole population. Over 95% of the patient contacts with the NHS take place in primary care. And family physicians only refers patients to secondary care in about 4-5% of consultations.[1,2]

Analysis of NHS daily activities clearly indicates the value and effectiveness of primary care services. With 82% of problems sorted at this level, patient satisfaction is high and at a decidedly low cost to the health system (Table-1).

Table-1:
What the British NHS does?: contacts per day (thousands)?[3]

Type of Contact	Contacts/Day (thousands)
Primary Care	1350 (82%)
Consult GP or Practice Nurse	836 (51%)
Community Contacts	389 (24%)
NHS Dental Treatments	73 (4%)
Sight Tests	28 (2%)
NHS Direct Calls	18 (1%)
Walk-in Centres	6 (0%)
Secondary Care	303 (18%)
Outpatient Attendances	124 (7%)
In Bed as Emergency Admission	94 (6%)
A&E Attendances	49 (3%)
In Bed as Elective Admission	36 (2%)

Source: RCGP, UK 2006

Accumulative evidence indicates a direct association between population health (morbidity/mortality) with the level of family medicine provision. In England, for example, the standardized mortality ratio (SMR) of 15 to 64 year olds was found to be lower (better) in areas with a greater supply family physicians, with each additional GP per 10,000 population (a 15 to 20% increase) associated with a 6% decrease in mortality.[4] Nation-wide in the UK, a 15 to 20% increase in GP supply per 10,000 was found to be significantly associated with a decrease in hospital admission rates of approximately 14% for acute illnesses and 11 per 100,000 for chronic diseases.[4]

II. Popularity of Family Medicine

UK General Practice currently is a popular career choice for junior doctors after their foundation years as other hospital based specialities.[5] The GP registrar training is well developed. Trainers have to be experienced GP's and attend a half-day release course over 1 year. There are a number of standards a practice has to achieve to become a training practice.[6] Registrars pay is fully funded and he practice also receives a grant of around £8,000.

The average NHS GP pay is now greater than that of a NHS consultant This pay differential has developed on the back of then new GP contract (it should be noted that this applies to GP partners, there has become a divide in General Practice with most new posts being salaried). GP's pay is more than in other European countries.[7]

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The *'Expert'* Patient

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The practice of medicine faces unprecedented changes related to the delivery of services, the imperative for increased safety of care, health care financing revisions, as well as greater demand for a more personalized, compassionate, and accessible health care delivery system.

The move from a paternalistic system (doctor-centered) that emphasized the autonomy and expertise of the professional to a more flexible and empowering patient-centered model of practice is central to understanding the current transformation of health care.

This new paradigm incorporates many elements, including notion of citizenship, choice and co-production which emphasizes the quality of the relationship between professionals and active and empowered patients. What we are witnessing are radical shifts in the distribution of power. Patients are no longer cast in a passive role, the grateful, uncomplaining recipients of the benign and benevolent "gift" of the state-funded heath care. The role of the patient is not purely passive, to try to get well and comply with the medical regime, prescribed and accepted without question or debate.

In this formulation, the consultation between patient and doctor (GPs as gatekeepers to other services) is an integral in the delivery of health care system.

A further challenge for professional is the changing pattern of morbidity. The predominant diseases pattern (non-communicable illnesses), is one of complex and continuing illnesses rather than acute disease. In Britain alone, 17.5 million people live with a long term condition. Chronic problems require continuity and emphasis the importance of active relationship and working with the expertise and knowledge of patients.

In the UK, the Experts Patient Programme has become mainstream policy in the NHS. This educational programme for patients, delivered positive impact of peer-support and education in supporting self management and promote the concept of self care. The evidence shows that the more informed patients may reduce, rather than increased patient demand. This concept has not been completely acknowledged by all professionals.

In addition, cost-containment pressure means that governmental and health care service leaders are trying to renegotiate professional and patient roles. These moves threaten professional status and values. Learning opportunities for professionals with Expert Patients can help professionals discover and appreciate how patients can contribute to improve health outcomes while professional's effectiveness is also increased.

For this to work, the patient has to be conceived differently by professionals. The "resourceful patient" has to be perceived to be as competent and responsible partner.

In this scheme, the priority is to ensure resources are made available to help patients develop their capacities for self-care and independence, rather than investing in professionals as the only competent partners in this relationship.

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"The patient has to be conceived differently by professionals. The "resourceful patient" has to be perceived to be as competent and a responsible partner".

"The wisest mind has something yet to learn."

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Your contribution is valuable to us:

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Note to contributors:

While submitting articles related to studies conducted in Oman, the authors should attach the approval of ethical committee/research committee of the institution or the Regional Directorate. Similarly contributions by all authors in each of the following areas should be mentioned: design and conduct of the study; collection, management, analysis, and interpretation of the data; and preparation, review, or approval of the manuscript. Each author must have a specific role in the manuscript.

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