understood by the other partner as implying that he or she is polluted.⁹ As well as prejudicing potential users, this negative symbolism affects governments and health care planners and providers. Prejudice against condoms is only part of the problem: condoms must be used correctly, and many men lack instruction or skill in their use.¹⁰ Some may use them only when they perceive that the risk of infection is high.

Epidemiological trends in the United States (AIDS is set to become one of the five leading causes of death in women between 15 and 44, disproportionately affecting the poorest) illustrate the need for preventive measures being freely available from the health care providers most likely to be consulted by those at risk.¹¹ As well as providing free condoms, these providers need skills in introducing the topic into consultations, countering the negative associations of condom use, and teaching how to discuss using condoms with a sexual partner.

Financial constraints on health authorities in Britain are forcing many family planning clinics to close, restricting access to free condoms. Although health authorities may use some of their earmarked AIDS funds to provide free condoms for distribution by general practitioners, other calls on these funds—genitourinary medical services, services for drug misusers, the care of people with HIV infection, and other local preventive measures—make this unlikely, particularly when other drugs and supplies prescribed by general practitioners are separately funded.

No matter how much information on AIDS is disseminated by a responsible media, resources are wasted if people are not helped to act on the information they have acquired. They may know about safer sex, and even believe that it is worth while and sensible, yet fail to adopt it.¹² Finding that condoms are not available from their general practitioner (who seems reticent to discuss sexual behaviour^{13,14}) may hinder patients' ability to make use of what they have learnt about HIV.

Difficulties about discussing the need for safe sex with a partner may be compounded.

Rightly or wrongly, the outcome of a general practice consultation is heavily influenced by what can be prescribed. If general practitioners could prescribe condoms on FP10s, and this was well known, it might substantially change their consultations, not only with women requiring contraception but also with sexually active men. With condoms costing something like £12 for a hundred, this could prove expensive for the NHS, especially as some of the cost would be incurred by those using condoms for contraception who were not at increased risk of acquiring HIV. These costs will, however, seem small when compared with the costs of an HIV epidemic.

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Health education and ethnic minorities

Needs may differ, the techniques don't

Health education officers in inner cities are often asked by doctors, nurses, and other health professionals for help with the "problem" of providing health education for ethnic minorities. This is an unfortunate attitude as health promotion is based on the same broad principles whatever the community—what changes are the needs and how they may be met. Indeed, some communities may have a high uptake of some health promotional activities—for example, in one Turkish speaking community, uptake of BCG and diphtheria, pertussis, tetanus, and polio immunisations was at least one quarter higher than the average for the population (R Atun, S Jenkins, unpublished observations). Nevertheless, health professionals are probably less likely to take up all opportunities for health promotion with patients of a different culture from themselves, especially if preferred languages are different.

Defining needs is the first step in health promotion, with those defined by the community not necessarily coinciding with those defined by the health professionals.¹² Imposing trained outsiders' views on a community may be resented and rejected, and community members must participate in deciding which topics should be tackled. The dangers of racism and stereotyping in deciding what to campaign about should be acknowledged.

Once the target for health promotion has been determined—for example, the low uptake of cervical smear tests in "at risk Asian women" in Leicester (p 833)³—the methods of carrying out the campaign must be decided. Here, much research, not only with ethnic minorities but also with the whole population, needs to be carried out. Personal intervention may be more effective than printed material and is likely to be even more so if carried out by a trained member of the relevant ethnic minority.^{4,5} Videos and personal intervention by trained members of the target community may give the best results with groups that are hard to reach.

For doctors and nurses who include health promotion in their consultations special communication skills (for example, eliciting present behaviour and beliefs and jointly planning change) are useful in promoting healthier behaviour. Where the ethnic group of patient and health professional differs skills in cross cultural consultation should be acquired.^{5,7} These include being aware of differing expectations and how to negotiate them, acknowledging that stereotyping affects the consultation, understanding how accent and language interfere with the consultation, and being able to assist patients whose language differs from the health professional's to express themselves, either directly or through an interpreter. Training in health education and health promotion

consulting and in cross cultural consulting should be available to all health professionals and differs from that in any other communication skills only in emphasis. How many of us have listened to or watched any of our own health education consultations with anyone, let alone with someone from a different culture?

The Health Education Authority has a list of useful resources for those wishing to provide health promotion to different ethnic groups.⁸ Providing material in different languages may be costly: we estimate that printed materials for any campaign cost £750 for each language (including English), meaning that the costs of a campaign may have to be multiplied by 10 or more to reach all the communities targeted in an inner city. Advice about preparing material in different languages is available,⁹ and several commercial companies provide translation and typesetting in London. (A list is held by City and Hackney Health Promotion Unit and may therefore be held by other interested organisations.) Many inner city local authorities also run interpretation departments. Despite these facilities, however, of 97 district health authorities providing a health education leaflet with their invitation for a cervical smear test, only five provided special material for women from ethnic minorities.¹⁰

Health authorities should consider employing specialist health education officers for ethnic minorities. More health

education officers should be drawn from ethnic minorities, and all health education officers, regardless of ethnic background, should receive relevant training. More research is needed into what are appropriate methods of health promotion.

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Treating obesity

The first law of thermodynamics still holds

For more than a decade obesity has been acknowledged in developed countries as "one of the most important public health problems of our time," mainly because obese people are more liable to heart disease, hypertension, stroke, non-insulin dependent diabetes, and some cancers sensitive to sex hormones.¹ Mortality from these causes increases if Quetelet's index (weight/height²; kg/m²) exceeds 30. Recently it has been shown that, although mortality hardly increases in moderate obesity (Quetelet's index 25-30), the risk of disability, mainly from musculoskeletal and cardiovascular diseases, is significantly increased.² Experimental obesity in normal young men causes a decreased sensitivity to insulin, which returns to normal with return to normal weight.³ Intra-abdominal fat cells are particularly apt to release high concentrations of free fatty acids into the portal circulation, which is probably why people with abdominal obesity (indicated by a high waist to hip circumference ratio) are particularly liable to the metabolic complications of obesity.⁴ Despite growing concern about the clinical importance of obesity and better understanding of the mechanism by which it causes ill health the prevalence of obesity is rapidly increasing in Britain. A survey in 1980 showed that between the ages of 16 and 64 years 6% of men and 8% of women were obese (Quetelet's index >30), but a survey using similar methodology in 1987 showed that the prevalence had increased to 8% and 12% for men and women respectively.⁵

Treating obesity is, in theory, very simple. The energy stored in 1 kg of adipose tissue is 29 MJ. If energy intake is less than energy expenditure by this amount each week then any number of kilograms of excess weight can be lost in as many weeks. Experiments in a metabolic ward confirm that this theory works in practice.⁶ Losing 0.5-1 kg of weight a week is a suitable target for any slimmer.

The difficulty is to attain, and maintain, the energy deficit

for many weeks or months and, after losing weight, to avoid regaining it. As slimming is big business the public is offered many solutions to this problem, which are seldom as effective as their proponents imply. The principles of behaviour modification are certainly helpful and should be known by any competent dietitian or slimming group leader.⁷ Incorporating additional dietary fibre into a low energy diet makes a small contribution towards decreasing hunger and increasing weight loss,⁸ and a large trial showed that treatment with dexfenfluramine was associated with a loss of 9.82 kg after 12 months, compared with 7.15 kg in the placebo group; all this weight loss occurred in the first six months.⁹ Moderate exercise benefits fitness and increases insulin sensitivity but does not increase the metabolic rate unless more food is given to compensate for the energy used during exercise.^{10 11} Indeed, the mystery among trained athletes is why they do not lose more weight in view of their energy intake and output.¹² So far no drug designed to increase energy expenditure has been shown to be useful in treating obesity.

Large weight losses require large energy deficits, which are usually achieved either by very low energy diets or by preventing normal food intake surgically. The rapid weight loss caused by semistarvation indicates a loss of lean tissue, which presents dangers to many types of patient,¹³ and similar criticisms may be made of surgical procedures that drastically reduce food intake.¹⁴ The Food and Drug Administration licensed an intragastric balloon to reduce food intake in 1985, but subsequent experience has been disappointing.^{15 16} Vertical banded gastroplasty is now the preferred surgical treatment for obesity, and the physical and psychological results are usually good.¹⁷ Weight loss is maximal about one year after the operation, and thereafter some weight may be regained. Wiring the jaw is cheaper and safer than gastroplasty and causes similar weight loss, but fitting a waist cord to