

## HEALTH AND THE FAMILY

Paper prepared by the Commonwealth Secretariat

The health agenda for most of the developing and much of the developed world will be dominated for the rest of the century by issues that relate to the WHO target of "health for all by the year 2000". The Alma Ata Conference in September 1978 focused international attention on primary health care and its role in the strategy for attaining the WHO target. Individual countries now face the task of formulating measures for achieving it appropriate to their circumstances and resources. Health funding agencies are also examining its implications for their own policies and programmes.

2. The documentation for the Bellagio Conference on Health and Population in Developing countries in April 1979 examined the merits of three possible approaches to improving national health care systems:

- (a) A vertical approach by which a community's major health problems, once identified, are tackled selectively through appropriate research, eradication and prevention programmes.
- (b) A horizontal approach in which certain basic needs that relate to health, rather than the health hazards themselves, are targets of attack - housing, sanitation, nutrition, education.
- (c) An approach based on the assumption that no substantial gains will be made by any method in the absence of adequate national population control programmes.

3. A balanced combination of the three, rather than exclusive reliance on any single one, is likely to be the choice of most countries.

4. Current national and international discussions on primary health care and community health acknowledge the importance of the active participation of the individual and the family in the methods selected for achieving agreed national health objectives. The special emphasis, however, and the requisite planning for the achievement of such approaches are often missing. Individual and family involvement is at once a condition and a foundation for an effective national health care delivery system. Not many countries have formulated specific plans for achieving it, and few have initiated the health policy changes that would be necessary.

5. Wealth and income, housing and environment, education and social skills, family cohesion and community motivation, these major indicators and conditions of health are unequally divided in all societies. Ultimately, however, in any society it is what the individual does, the adjustments he makes in his mode of life to safeguard his own health and that of his family, that are the most critical determinants of the levels of health attained by his society. Whatever the country and its state of development, the individual and the family hold the key to the

successful expansion of current concepts of primary health care and community health. It is their values, practices and norms that are the critical factors. The need is for personalised systems of health care and personalised approaches to them.

6. Recognising that people, not countries, are central to the development process, the International Labour Organisation emphasised in a recent report that "a basic need-oriented policy implies the participation of the people in making decisions which affect them". Sir John Wilson's comment on blindness is also relevant, as relevant to other health problems as it is to blindness itself: "People do not go blind by the million. They go blind individually, each in his own predicament. In the formulation of strategies and objectives, we must keep in view the individual in his community. He is the reality behind the abstraction of world poverty and disease".

7. Much medical and health work is directed towards attaining arbitrary and often irrelevant objectives and standards rather than towards meeting perceived needs. In the preparation of the doctor and, more recently, of the other members of the health team, more emphasis is often placed on their standards of training than on their roles in national health programmes. In relation to the individual and the family hardly any emphasis at all is placed on either their standards or roles; and this in spite of general agreement that it is the individual's capacity to contribute to his own health needs and those of his family that is the essential underpinning of an effective national health programme.

8. This, however, does not deny the importance of national policies and programmes of health care. The responsibility for change cannot rest entirely on the individual - to avoid alcohol and tobacco, to adopt sensible dieting practices, to take exercise and so on. The social, economic and political dimensions of health need to be considered at the same time. The economic and social pressures which constantly encourage people to adopt unhealthy life-styles are too commonly ignored. National policies, therefore, and all the related factors which influence the will and capacity of the individual to identify and follow sound health practices merit attention. They include:

- (a) the special characteristics and needs of families;
- (b) the community's health resources and how they can be best mobilised;
- (c) national health and health education policies;
- (d) administration and priorities in relation to family health.

#### **THE FAMILY : ITS SPECIAL CHARACTERISTICS AND NEEDS**

9. In any society, rich or poor, a well-knit integrated and informed family unit is essential for the attainment not only of health but of other social goals; and it is not surprising that the World Bank, in recommending priorities for structuring a basic needs strategy to maximise health objectives, makes the family the central target for these priorities. They include:

- (a) adult education programmes directed towards parents of young children, emphasising information on improved food production, proper diet, the importance of breast feeding and weaning, health care for infants and young children, and personal hygiene;
- (b) the provision of primary health care and disease control with priority for pregnant or lactating women, children under five, and working men;
- (c) nutrition policies and programmes targeted at improving diets of all family members.

#### **Urban slums**

10. There are special classes of individual and family health problems that are characteristically associated with densely populated areas. These include drug and alcohol addiction, mental breakdown, restlessness, rootlessness, social disruption and family dislocation. It is in this setting that the forces for disruption of family life are most active. What measures can be taken to identify and overcome such problems?

#### **Housing**

11. Each community needs, within its own resources, to set minimum standards of housing based on fundamental health needs. Health conditions in the slums can affect the health of all strata of the community. What is the priority for housing in national health and development programmes? What can be the individual and family contribution to the improvement of housing in a community?

#### **Families with young children and with adolescents**

12. The need for counselling and advice to mothers with young children and during pregnancy is widely accepted and equally widely ignored in both developed and developing countries. The national health plan would need to reflect the importance of appropriate education, training and support for all who are concerned with infants and young children, particularly parents. It should make provision for the exchange of views between responsible groups about the methods to be used and the functions to be performed.

13. The most important aspects of health education for young people are those that foster personal responsibility. The needs of the adolescent on this respect are important and will vary with the sociological, economic, educational and religious make-up of the society. In all societies, however, they should be researched and catered for.

#### **Family planning and population control**

15. It is increasingly recognised, however, that the acceptance of family planning is facilitated only where certain social needs are met. Social policy considerations determine the type of needs which must be catered for and the type of strategies that should be devised to meet the social needs of families in various countries. This challenge calls for new policies of family welfare which provide for the basic needs of the family and at the same time integrate a family planning component into social policy.

16. Despite the clear trend of opinion that there must be such an interaction between family planning programmes and social welfare

measures, there is very little understanding of the requirements for this interaction. Identification of the issues involved and of the options available has to be done in the context of the social needs of the individual country. What is most urgently needed is the formulation of innovative action-oriented programmes to integrate the role of family planning in family health and welfare.

#### **The family and nutrition**

17. National nutritional education programmes should be planned with the family unit in mind. The individual and his family are targets of such programmes and also determinants for their success. It is in this setting that individuals at special risk - infants and young children, the pregnant woman, the elderly, sufferers from chronic or debilitating diseases - are best catered for; that preservation of breast-feeding traditions, prevention of food wastage and spoilage, and inculcation of high standards of food hygiene and beneficial dietary habits are best achieved. It is also in this setting that information is best disseminated on the nutritive value of locally available foods, on appropriate balanced diets for different family groups, and on improvement in food preparation and in infant and child feeding practices.

18. The family is the interface between food and people. Probably more than 90 per cent of all nutrition takes place in the home. Family nutrition is nutrition science applied to the consumer as groups or as individuals. As long ago as 400 BC, Hippocrates stated: "The physician must know, and must be at great pains to know, what man is in relation to food and drink and habits generally, and the relation of each to each individual".

#### **COMMUNITY RESOURCES AND THEIR MOBILISATION**

19. Personal participation in health programmes achieves its greatest effectiveness when it takes place in well-organised communities and is carried out by well-informed, well-trained and adequately motivated community members. The first requirement for achieving this is to find better ways of organising and mobilising community members and of changing their basic orientation from passivity and dependence to increased reliance on their own capacities. The relevant community resources will vary from country to country, but in most they will include health educators, nurses, women's organisations, community health workers, youth and other special groups, the communication media, local benevolent organisations, schools and universities.

#### **Nurses**

20. To meet the crucial need of providing care for all, most countries, developed and developing, are training more health professionals and expanding their scope. The importance of the role of the nurse in this expansion is being increasingly recognised. Nurses constitute a special community resource essential for developing the basic concepts of primary health care and community medicine. Their broad-based role, in addition to their generally accepted nursing functions, ranges through community education and motivation, aspects of disease prevention and control, to problems of psycho-social adjustment. Their high community status and special skills give them a particularly important responsibility in individual, family and community health.

21. The challenge to be met by nursing action includes a reorientation of their policies, programmes and resources for the new and extended roles they will be increasingly called upon to play; changes in much of their current educational focus; new concepts of community leadership and function; and an appropriate balance of emphasis between the hospital and the community. Nursing groups in many countries have already begun strenuous efforts to educate and reorientate their members to meet these widened objectives. However, there are still many obstacles that require sustained motivation, planning and action by the profession if they are to be overcome. Not the least of these obstacles in many countries has been their traditional and disproportionate emphasis on hospital rather than community service.

#### **Community health workers**

22. Other health workers also have an important role to play both in the delivery of health care and in facilitating the participation of individual community members. Health education is an essential part of the health visitor's work, not only with individuals in home visits but also with groups such as women's organisations, clubs for the elderly, antenatal classes and schools. Whenever a health task is carried out, a teaching opportunity arises to promote the concept that the presenting problem should not only be dealt with but that its recurrence can be prevented if certain basic health rules are followed. Community and village health workers are particularly well placed for this educational role and to encourage individual and group participation in problem solving. Their value lies in their close communal bonds and familiarity with local customs, language and life-style. Because they are part of the community, integration of their work with extension workers of other disciplines such as agriculture and community development is also more readily achieved.

23. Everyone is influenced by the traditional customs of his family, tribe and country. These customs affect almost everything people do, including the food they eat, the houses they live in, their relations with other people, how they live, work and play. Because these traditional practices have such a wide influence, they have an important part to play in health also. This is an area in which health workers can also have a strong and important influence.

#### **Traditional leaders**

24. The role of traditional leaders in the community is also important. Tom Mboya said: "... in fact traditional leaders were regarded as trustees whose influence was circumscribed both in customary law and religion. In the traditional African system an individual needed only to be a mature citizen to participate fully and equally in political affairs". This is equally true for the health field in other traditional societies, in most of which individual participation has an already established place.

#### **School teachers**

25. Teachers in primary schools look after children in many different ways, not only as teachers in the classroom. As a group their potential contribution in the field of health education is enormous. It is surprising how few efforts have been made to capitalise on their formal and informal relationships with young people and to channel through them basic and practical information on the requirements for and value of good personal health habits.

26. Schools can influence the attitudes of children to the health services and in such matters as nutrition, exercise, smoking, drugs and alcohol. They are the logical starting points for community health education programmes. School children and youth groups are even more appropriate targets than adults for such programmes. Health training and education, when begun at these ages, is more likely to initiate a life-long process rather than to remain an isolated episode of professional indoctrination.

#### **Universities and training institutions**

27. A special responsibility lies with universities and other training institutions. In addition to their traditional academic and teaching roles, they have a unique, and commonly neglected, opportunity and capacity for influencing society's attitudes and habits in matters of health. University personnel too frequently take the view that the dissemination of knowledge in a form that is comprehensible to lay members of the society is a responsibility for others. This has done much to retard popular appreciation of, and commonsense action on, some of even the basic concepts of existing health knowledge. The economist is a layman in the eyes of the engineer, the engineer in the eyes of the attorney-at-law; and all of these are laymen in the eyes of the biochemist. The concerns of even such highly-trained groups are often incomprehensible to each other, far less to other members of society. There is a need in all societies for their professional leaders, if they are to deserve the term, to attempt to transmit their expertise in such a manner that it could become a logical and rational basis for thought and action by individual members of the community.

28. Universities, particularly in the developing world, need to re-examine their objectives in this regard. They need to recognise the importance of maintaining a continuing awareness of the health priorities of their countries, of ensuring the effectiveness of their teaching and research programmes in the context of these priorities, of being adaptable and flexible in their capacity to respond to them, and of being imaginative and innovative in the leads they give. This can be achieved only by bringing the programmes of the medical school into the closest possible relationship with the health targets and needs of the community. Medical schools need to be identified as integral parts of the total system of community health care and not simply as institutions for teaching, research and scholarship. There are not many medical schools that have defined their objectives in these terms, and there are few governments that have made appropriate provision to enable medical schools to function in these roles.

#### **Youth groups**

29. In a number of countries specific efforts are made to recruit and train students and young people at various educational levels to do much of the routine work involved in health care and preventive activities. As future parents as well as family and community leaders, they have pivotal roles to play in national health and health-related programmes, such as sanitation projects and agricultural extension schemes. They can also play a role of introducing new ideas and practices to their families. They constitute at once a resource on which the community can draw and a group in which it can profitably invest.

## **The woman**

30. Heads of Commonwealth Governments recognised at their Meeting in London in June 1977 that "unless women are active participants, both in contributing to the process of development and as beneficiaries, the goals of social and economic growth would not be fully realised". This recognition was endorsed by the Lusaka Meeting of Heads of Government in 1979, and in no field is it more pertinent than in health. The overall responsibility for achieving active participation by women lies, of course, with national governments; and the pace at which it will be achieved will vary from country to country, depending on national policies and social mores. There is no area of development in any country, however, that will not be strengthened or accelerated by the fullest possible integration of women in national planning and action.

31. Experience has shown that most women's organisations can be effective in the health field. They can stimulate interest and collaboration in immunisation programmes, clinic attendance for medical disorders, maternal and child care programmes, nutrition, family planning and a wide range of community health activities.

32. It is the woman who normally makes decisions on when or whether a child should be vaccinated, on when he should attend a doctor or health clinic, on weaning, and on what meals should be prepared for the family. She is sometimes responsible also for growing food crops and for marketing cash crops. She already plays a central role on the health stage.

33. A more definite focus on her role is required in national health plans and policies. How can appropriate educational programmes be designed to assist her to play it more effectively? How far is she being equipped to perform her health-related activities as expertly as possible, in association with those community workers on whom she would normally call for additional help - the traditional healer, birth attendant, village worker, nurse, medical assistant or physician? It is here that the weakest link in the chain of health care is commonly found.

## **Health and the media**

34. Sean MacBride has recently observed that fundamental changes in the world often occur without being much noticed. He quotes as an example the shift of the balance of power in recent years from governments to public opinion. The techniques by which the mass media bring news, information and views instantly to the entire world population have been greatly expanded. People in the most remote and impoverished social areas, who might not be even able to read or write, usually have access to a transistor radio, which has become one of the most powerful instruments of public information. Public opinion, as a consequence, is now in a better position than it has ever been before both to be informed about and to influence important developments in the world today.

35. The roles played by journalists and others who control the media, written and audio-visual, are greater than ever before and they will continue to increase. In the health field, they have been almost completely ignored. The extension of primary health care services, the strengthening of community health systems and the growth of community participation will all be determined in the final analysis by the strength of public opinion and the reliability and effectiveness with which it has been informed. No real progress will be made until health ministries and their training agencies, universities, and medical and

other professional organisations come to grips with the reality of the power that the media wield in guiding public opinion in the health field as in others, and the need for planned strategies in relation to it. Its potential for influencing national health care systems can no longer be disregarded.

36. Most health ministries, medical schools and other national health training agencies have accepted the importance of a broad-based system of primary health care and of community participation in its implementation. This cannot be achieved without a complete revision of the philosophical basis for national health planning. In most societies it has come to be recognised that it is what the individual does and the modifications he makes in his own personal life-style which are the critical determinants of his own level of health and that of his society. The individual and the family hold the key to the successful expansion of current concepts of primary health care and community health.

37. The need for personalised systems of health care and for personalised approaches to them has been already emphasised. The individual and the family unit, rather than the doctor and the hospital, need to occupy the centre of the health stage.

38. There can be no more effective channels for promoting this change, for informing, influencing and motivating individuals and families about health and their roles in it, than the communication media. The time is long overdue for their role in this respect to be acknowledged, for a clear understanding of their potential contribution and for a planned strategy for achieving it.

39. An appropriate first step in this direction might be the establishment of regional fora for fostering consultation between the media on the one hand and national health education agencies and professional groups on the other. Details of the measures eventually agreed upon would naturally vary from region to region and from country to country; but common patterns of need and of approach are likely to emerge and it is with these patterns that the discussions at this Meeting might be most profitably concerned.

40. Initial consultations might include representatives of university medical schools, other governmental health institutions, national health professional associations, press, radio, television and other public information media.

41. Topics for discussion at these initial consultations might include:

- (a) the designing of community health education programmes with special reference to the role of the media in their implementation;
- (b) the requirements for establishing and sustaining collaboration between the media and national health education and service institutions;
- (c) strengthening the dialogue between and within professional health groups on relevant health issues;

- (d) the nature and content of media health messages; designing messages and approaches for specific social groups; the criteria for choosing alternative media; the influence of the media on the public's image of health;
- (e) the roles and responsibilities of university medical schools and other national and regional health training institutions;
- (f) the requisite personnel for achieving these objectives and their training requirements;
- (g) identification of funding agencies that might be expected to collaborate in the promotion of these developments.

## NATIONAL HEALTH AND EDUCATION POLICIES

### Health policies

42. A number of needs will have to be met if the objectives of the Alma Ata Conference are to be achieved. The most critical is for a strong and sustained political commitment to promote active and full participation of community members in national health programmes. The requirements for it include:

- (a) a clearly defined national policy for the promotion of community participation in health matters and for coordinating the sectoral activities and interests that bear on it;
- (b) support for it at the highest level of national decision-making; and
- (c) a specific plan for its implementation.

43. Most national health planners agree on the importance of defining and integrating the roles of the community member, the family unit and the community health team. Few national health plans, however, adequately reflect this emphasis. Methods for reaching it should be clearly and precisely charted. In particular, it is not enough to formulate plans and policies at national levels. The resources and requirements for mobilising and motivating individual and family participation must be identified and a strategy developed for achieving it.

44. In developing this strategy account would need to be taken of the modifications that would be entailed for national health organisation and administration, for the methodology of health care delivery, and for the wide range of resources to be employed and the variety of skills to be coordinated. It would entail planning at the highest level of national decision-making. The requisite multi-sectoral collaboration, the delegation of responsibility, the harmonisation of the related interests, the determination of priorities, the choice of training and educational methods, the provision of the necessary facilities and resources - none of these could be achieved in the absence of an appropriate level of political commitment. And this needs a more powerful and broader base than can usually be provided by health ministries alone.

45. Questions that relate to these issues would include the following. What is the place of the individual and of the family in the national health plan and what precise roles in it are envisaged for them? How far is their participation encouraged through the propagation of relevant information? What arrangements have been made for inter-sectoral planning and collaboration - in finance, health education, agriculture, etc? How can the necessary follow-up action on agreed health policies be achieved? What would be the appropriate administrative and legislative framework for promoting it?

#### Health education policies

46. The prime objective of the promotion of community health participation is to create and maintain a sense of individual and family responsibility, self-reliance and self-confidence in health matters; and community education is the key. It is perhaps here that there has been least progress and it is here that advances are most necessary. The old emphasis has tended to disguise the true nature of ill-health and to obscure individual and family responsibility and capability for countering it. There is need for a shift of the health focus from the hospital and the doctor to the individual and the family. The solution is people's participation in an individual and family-oriented system of health care based on an effective system of community education.

47. Perhaps the most rational starting point is an acknowledgement that the individual, family and community are in fact already involved and already participating. It is the attitudes, habits and actions of the individual that promote or endanger his health. It is the individual who has to agree to be vaccinated or to accept and carry out specific disease and accident prevention measures. He has to recognise departures from normal health and present himself for medical care. The requirements for making him more effective in this role are commonly ignored. High on the list of such requirements would be training for him and his family members, particularly in those subjects in which their informed participation and collaboration are likely to have beneficial effects: immunisation; maternal and child health; diagnosis and standardised treatment of minor disorders and highly prevalent diseases; prevention and control of common disorders; vector control; food hygiene; and basic nutrition.

48. A critical reappraisal by most countries of their health education programmes is often as urgently needed as additional funds. How adequate are such programmes and how can their relevance to defined health problems be achieved and maintained? What role and responsibility is allocated to the health educator? What resources has he? Can the roles of special community groups, youth, women, religious groups, workers, school-teachers and university personnel be improved? What are the lessons to be learnt and the courses to be followed by the average individual and his family? Are these lessons clear, simple and practical? What measures are there for ensuring that an appropriate relationship is maintained between the training of health professionals and the health needs of individuals and families? These are some of the issues that need to be examined.

49. There is need also to face the fact that few national health education programmes have been successful; and a useful beginning perhaps would be to attempt to analyse the reasons for this. Did countries set unfeasible objectives? Were they important? Did they run counter to vested interests? What was the level of commitment of health educators? Educators themselves need to be convinced and

committed if they are going to be effective. How is this achieved? A further possible cause of failure of past approaches might be the fact that they were often limited to the health sector alone. The school teacher, the agricultural extension worker, the general educationalist, the community nurse all have important roles to play. It might be very helpful if the discussions at the meeting led to tangible recommendations on how to involve others than "health educators".

50. The responsibility and opportunities for promoting better public understanding of health, therefore, cannot be left entirely to health professionals. It is essential also to improve the health component in general education, in schools and in youth and adult education programmes. This can be achieved only by a better liaison between national health, education and related ministries and also between the professional groups that serve them. This liaison is often lacking even between members of the health team. Although the functions of its members are agreed to be interdependent and complementary, and in spite of general acceptance of the need to train the team as a whole, the fact is that they are usually trained and commonly practise in isolation.

#### **ADMINISTRATION AND PRIORITIES IN RELATION TO FAMILY HEALTH**

51. The provision of health care facilities at the social and geographical periphery of the community, as well as at its centre, and the fostering of self-reliance and involvement of the individual and the family may be approached in different ways by individual countries. There are certain issues, however, other than those already referred to, which relate closely to these objectives and which are likely to have high priority in all countries.

#### **Quality of country health services**

52. What are the best and most cost-effective ways of improving family health in any given country? What ought to be the mix, timing and emphasis between primary health care, other health approaches and other sector activities designed to improve health? How can the community's health services be best adapted to local resources and skills? What measures are taken, or are needed, to ensure an adequate balance between personal, community and environmental health services? How can the best advantage be taken of existing international health services? How can governments improve their benefits from the World Health Organisation's specific function and responsibility "to assist member countries, upon request, in strengthening health services"? What guidance can be offered to, and assistance obtained from, international funding agencies for the promotion of primary and community health care programmes?

#### **Health administration and organisation**

53. What methods are adopted to ensure that administrative arrangements are consistent with national health policies and programmes? What arrangements are there for ensuring co-ordination of the sectoral interests and resources that bear on health services and health manpower development - those of ministries of health, education, agriculture, planning and finance; those of universities; and those of other national and international health agencies? Are the human resources available for appropriate health programme planning, management and evaluation? If not, what are the training needs?

## Politics and health

54. What are the factors that determine the relationship between politics and health in any given community? On what basis do national leaders and administrators set priorities and allocate resources for health and health-related enterprises? How far are community and family perceptions of health taken into consideration in establishing national health priorities and programmes? What steps might be taken, and by whom, to influence national decision-making on health matters? What specific qualitative and quantitative data are lacking for health policy formulation? Has health been relatively neglected as a component of national development strategy? If so, how is this to be corrected?