NURSES AND MIDWIVES IN RELATION TO FAMILY HEALTH

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It has become an accepted principle that community health services are of vital importance in improving the health status of nations. The family, as the basic social unit in a community, is an institution which is familiar everywhere in the world. In some countries, interesting experiments such as Kibbutzim have been demonstrated effectively, but these are not yet widespread. For most people, the family is the primary social group to which they belong and through which they are linked to the wider community. Families have a pervasive, though often masked, influence on people, and for this reason it is relevant to regard them as a key focus for health services.

2. Nursing and midwifery, including both professional and auxiliary staff, often make up the largest occupational grouping in a country's health service. Its members have practical skills which are wide-ranging and adaptable. Further, where other categories of basic health workers are employed, professional nurses often have major contributions to make towards the planning, administration and supervision of their work and in their training.

3. In many countries then, the extent and nature of the nursing input has a crucial impact on the quality of family health. Conversely, the imperative requirement to provide good quality family health care represents a major challenge to nurses and midwives.

4. Attention has been drawn to the ambiguity which surrounds the term "healthy family functioning" and a suggestion made that it be defined:

"... in terms of a family unit (whatever its concept in any given society), effectively coping with cultural-environmental, psycho-social and socio-economic stresses throughout the diverse phases of the family life cycle ...". (David, 1978)

5. This definition has relevance for health care staff in general and nursing and midwifery staff in particular. Causes of stress spring from characteristic features of family or community life (as illustrated in paragraphs 9-17 below). On the other hand, the same family and community environment may also contain beneficial aspects which help families to function effectively. More specifically, various concrete problems which can be prevented or managed (as outlined in paragraphs 18-26 below) may themselves be viewed as potential or actual causes of family stress. Both the predisposing conditions of life and the immediate problems need to be considered by those offering family health care.

6. Thus, a holistic approach to family health care is necessary, the overall aim of the service being to facilitate the process of coping with stress whether this is physical, psychological, social or some combination of these. With this principle firmly in mind, the needs for various practical interventions by nurses, midwives and other health personnel fall into place. Family-oriented health care is not limited to one cadre of personnel working in the community but is needed in every health worker's approach.

7. This policy has major implications for nursing and midwifery with regard to both service and education. It requires that, whether they work in the community, in hospital or in any other setting, nurses and midwives consider the individuals for whom they are caring in a family context, with all the complexity this entails. Provision of such care would necessitate a change in the nursing services of many countries (as discussed in paragraphs 27-37). It is based on a comprehensive understanding of the various interrelated aspects of family health as well as on an analytical approach and team work. Incorporating these into existing nursing and midwifery training programmes would entail changes in course content and in teaching and learning methods (as indicated in paragraphs 38-42). Specific recommendations with regard to the training of nurses and midwives are made in the final section of this paper (see paragraphs 43-46).

8. Undertaking such changes is more than justified. By enabling families to prevent or manage stress situations, a country's health service makes a major contribution towards improving the health status of its people.

FEATURES OF FAMILY AND COMMUNITY LIFE

9. In most societies, family and community life are closely interwoven. In fact, the term "social structure" in anthropology is often used to mean the family and kinship structure (Goode, 1964). Whilst it would be inappropriate in this context to try to present an exhaustive check-list for analysing family systems, it is suggested that the following points are particularly pertinent to decision-making of varying complexity regarding family health care.

10. Most individuals are born into families and cared for in them during times of dependence such as childhood, periods of illness (acute or chronic) and old age. Many health problems which arise at these times of vulnerability can be prevented or dealt with fairly simply at an early stage if family members have easy access to nursing staff and are aware of how they can help and/or if nursing staff are in contact with families and aware of their circumstances. When appropriate measures are not applied early enough, problems often become much more severe and complicated.

11. Through the family, a person initially learns how to think and behave as well as who he/she is in that circle of people and in the wider social environment. The way that children are cared for in the family has a major influence on their psycho-social development. A World Health Organisation Technical Report (1977) has highlighted the urgent need for attention to the mental health needs of children, stressing the close interrelationship between mental and physical health and social well-being as well as the long-term effects of mental disorders. Effective family health care can help to prevent or alleviate individual problem situations.

12. The traditional functions carried out by women in most societies are also of great relevance to family health. They include caring for children, obtaining, storing and cooking food for the family, other housekeeping responsibilities, and often family budgeting. With regard to these duties, education and support from the health personnel can be very beneficial to the health of the whole family. In addition to their immediate value, there is the prospect of the development of long-

term habits and attitudes conducive to good health.

13. From culture to culture, family systems operate in many different ways. Between societies there is tremendous diversity in the rights, duties and status attached to various family roles. It is particularly essential for those providing family health care to be aware of the decision-making power (or lack of it) associated with particular roles. In many traditional cultures, important choices affecting family health can be made only by the males in the family, often the elders. Issues resolved in this way may include the selection of a "traditional" or "western" health care resource in times of illness of any family member and acceptance or otherwise of health projects concerned with family planning, immunisation or environmental health problems. Although many such programmes have major consequences for women with regard both to their own health and their traditional work, they are often not allowed to make decisions about the utilisation of these services. It is a prerequisite for appropriate action by nursing staff that they be aware of local cultural practices in this regard. There is need for concern about women's rights to self-determination in these areas as well as the implications for health of the actual decisions made.

14. Another feature of the diversity which exists in family structure is the variation in household form. Perhaps the most striking is the difference between the extended family and the nuclear family, the latter becoming more usual in those parts of society that got through the drastic social change associated with modernisation and large-scale urbanisation. This is a rapidly growing problem. It has been estimated that the proportion of the world's population living in urban areas will increase from 24 per cent in 1970 to 40 per cent in the year 2000 and that:

"... in developing countries, about one third of the city dwellers live in slums and shanty towns and 50 per cent of these are children". (David, 1978)

15. The nuclear family system often gives younger adults more freedom from the control of older relatives but deprives them of the psychological support and mutual exchange of practical help which are taken for granted in the extended family. Also, confusion often arises about changing family roles concerning, for example, decision-making for the woman's household responsibilities when she has a regular job outside the home. This psychological conflict is more acute when the changes are not clear-cut, as occurs when people are living in nuclear families through choice or circumstances but still feel strong bonds and obligations to the extended family. (For example, there may be obligations to provide extended family members with fairly substantial financial help and to allow them to stay for prolonged periods in a small city home appropriate for a small nuclear family).

16. There are advantages and disadvantages for individuals of both extended families and nuclear families as well as all the variations of these which exist. The significant factor for nurses and other family health workers is to identify points of stress and to be aware of the potential effect of these on the family's health and its approach to coping with health problems.

17. As indicated above, the formal and informal organisation of community life in a society is related to the kind of family structure which predominates there. In turn, aspects of life in the community

and features of the physical environment (rural or urban) influence the quality of family living and thus the health of the family. Whilst it is beyond the scope of this paper to discuss these in detail, they require careful consideration by nurses and other health planners interested in running an appropriate health service. Depending on circumstances, these external influences include: cultural norms; religious principles; opportunities for work, mobility, education and health care; and availability of home-produced or reasonably-priced good quality food, clean water, appropriate sewage and refuse disposal, suitable housing and an organised system of social welfare. The roots of family health problems can frequently be traced back to inadequacy in one or more of the interrelated factors of this nature.

THE NATURE OF FAMILY HEALTH NEEDS

18. The concrete health problems which arise in the family setting have a personal impact and meaning for members of the family unit and the nursing approach in family health care is oriented towards this. Nevertheless, a community perspective is also useful for an assessment of those major areas of need which occur in many families, particularly in developing countries.

19. Much basic data of this nature can be obtained from normal statistical sources such as demographic or epidemiological records. This information can be used to help determine the priority problems for those concerned with family health. For example, the age distribution of the population may be considered with differential mortality rates (such as the infant mortality rate) and any available figures for morbidity. In most developing countries there is a priority need to focus on children, particularly with regard to respiratory diseases, diarrhoeal and other gastro-intestinal diseases, malnutrition and communicable diseases. Accidents in the home are also a significant problem. The majority of these childhood conditions are preventable through immunisations or by measures implemented as a result of health education. Where these are inadequate there may be a need for diagnosis, treatment, personal care and/or referral of a sick patient. However these needs may be presented, they are the responsibility of staff concerned with family health.

20. It is emphasised that these health needs are due to interrelated factors (as discussed in paragraphs 9-17). A frequently observed example of this in developing countries is malnutrition. Where this is not a result of sheer lack of food, it may partly be a consequence of cultural or religious practices which prevent the inclusion of certain foods in the family diet. This problem may then be compounded where there is a low level of general education contributing to the lack of knowledge about nutrition and where the existing health service does not monitor adequately the growth and development of children so that those at risk are not identified until a late stage. For the nursing approach to be appropriate and realistic, these causative factors must be analysed and feasible measures to improve the situation must be pursued.

21. With regard to childbirth, statistics such as the birth rate, the maternal mortality rate and the infant mortality rate give an overall picture of the community's need for service. In developing countries, ante-natal care is particularly important in view of the usual high birth rates and mortality rates and the low socio-economic status of most of the people. This care includes the making of a decision with

the mother concerning where and by whom it is appropriate for the baby to be delivered. The need for a safe delivery is also a family health requisite, whether this is carried out at home or in an institution. Subsequently, good post-natal care both prevents long-term complications and contributes to the continuity of the holistic approach.

22. A high population growth rate may lead a country's government to adopt a policy of population control. However, for the more immediate concerns of family health, the need for family spacing and family limitation is focused on the mother's health and indirectly that of the whole family. Among the many findings of a recent comparative study on family patterns were the following:

"... the risk of under-one-year mortality was found to be high for births occurring within short intervals (less than 1-2 years) after previous births";

"the medical examination attested .... that infection increased with family size in most areas";

and there was "... a positive relationship between prolapse and parity". (Omran et al., 1976)

There was also fairly positive evidence from some of the countries studied that:

"... induced abortion, although illegal at the time, was widely used". (Omran et al., 1976)

As this study illustrates, besides the physical benefits of adequate and appropriate family planning services, the relative psychological health and social well-being of a planned family are also important considerations for those concerned with family health.

23. Apart from the occasional need to provide nursing care at home during a short illness incident, some families also have a chronically sick or disabled member to care for. Needs for physical help with care in any of these circumstances are usually fairly clear-cut. If they are widespread they can constitute a heavy demand on the nursing service. Also, this kind of problem almost always has socio-economic consequences for the family. However, the associated physical burden and psycho-social stress may be experienced very differently by an extended family and a nuclear family. Similar considerations apply when the elderly are cared for at home. As discussed above, the extent of the family's ability to cope with these socio-health problems is as much a part of its total health need as is the presenting problem.

24. The kinds of socio-health problems associated with rapid social change in a society also frequently have major implications for family functioning. For example, there is often an increase in venereal diseases and in alcoholism, as well as in mental disorders. Although such problems are multi-causal, there is usually a vicious spiral in operation between the breakdown of support from a cohesive family and the psycho-social phenomena.

25. Another example of the fairly direct link between factors in the social and physical environment and family health is highlighted in literature from South East Asia. Where women have a low social status, their level of general health is likely to be lower than that of men. It has been noted that in South East Asia there is:

"... an accumulating body of data to support the hypothesis that women are an unhealthy and badly nourished group compared to men". (Nelson, 1979)

Given the importance for the whole family's health of the mother's traditional role, this kind of deprivation has far-reaching consequences. Nursing staff concerned with family health cannot detach themselves from involvement in issues of this nature.

26. As the points discussed in this section demonstrate, the specific needs to which nurses respond in relation to the family are usually of a concrete, practical nature. Underlying these, however, is the complex question of the total functioning of the family in its social and physical environment and the way in which the nursing promotes this.

APPROACH TO FAMILY HEALTH NURSING

27. Given the wide-ranging nature of family health needs, it is evident that nursing and midwifery personnel may contribute to family health in a variety of ways and in many different locations, such as the home, a village compound, a community hall, a school, a mobile clinic, a health centre or an institution such as a maternity unit or a hospital. Wherever it is carried out, nursing care may be regarded as contributing to family health if all or part of if is intentionally concerned with helping families to cope or function.

28. This entails a shift of emphasis in the more usual approaches to nursing care. In the hospital setting there is often a tendency to concentrate on procedures related to the dependency needs of patients or on the technical tasks to be done. Whilst both of these have an important place in nursing care and may incidentally benefit the family, they are only portions of a holistic approach.

29. In community health, there is often a tendency to concentrate on specific programmes with limited objectives. These too may have positive results but they are short-term measures. Care which deliberately contributes to family health may be provided in the home, the health centre or any other community setting. In any of these places, it is part of a holistic approach to the family.

30. To implement this in the commmunity, a flexible team approach is required. The composition of teams will inevitably vary from country to country, depending on the numbers and categories of health care personnel available. It is likely to include both professional and auxiliary* nurses and midwives. Where numbers of the former are severely limited, as in many developing countries, it is recommended that they do not normally carry out functions which the auxiliary staff are competent to perform. Other health personnel such as doctors, social

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* The term "auxiliary nurse" is used in the sense defined by both the World Health Organisation and the International Council of Nurses. "An auxiliary worker is a technical worker in a particular field with less than full professional qualifications" (WHO Technical Report No. 212, 1961, p.4. See also WHO Technical Report No. 633, 1979, pp 15-16, for further discussion of this definition). "The term 'auxiliary nurse' as used here refers to a person who has completed a required programme of study of a less comprehensive nature than that undergone by the nurse, and who contributes under supervision to the total nursing care of the patient" (I.C.N., 1969, p.1).

workers or environmental health officers may be included in the teams on a full or part-time basis according to their availability in a country.

31. Using criteria such as those already discussed (in paragraphs 9-26), the team jointly plans its general approach and determines its priorities. Whilst optimal use is made of the occupational skills and personal qualities of all team members, they do not ritually carry out pre-defined tasks. Rather, they are ready to extend their roles if necessary in order to respond to family needs. Easy referral is possible between team members when appropriate for families or individuals in them. Inherent in this approach is mutual respect and support of team members for each other. Where it is operated effectively, this cooperative mood of working gives greater job satisfaction to all team members than do work schedules based on occupational routines. It also gives better results in terms of cost-benefit.

32. Appropriate care from such a family health team is integrated, incorporating self-help with curative, preventive and promotional aspects of care. It is relevant for particular family circumstances and thus based on an analytical problem-solving approach. For nursing staff, this entails working in collaboration with other health care staff and family members to:

(a) assess health and illness states in individuals and families;

(b) identify and analyse health care needs at each of these levels and the extent of the family's own resources for meeting them;

(c) plan appropriate nursing action which is integrated with care provided from other sources;

(d) implement the comprehensive nursing care using appropriate practical skills;

(e) evaluate the service provided.

33. This list of steps is parallel to that identified by nursing leaders as the logical approach to patient-centred care and known as "the nursing process" (see, for example, Kratz, 1979). It also reflects the approach to community health nursing advocated by an international Committee of Experts (WHO 1974).

34. Application of this concept of family health nursing in developing countries requires practitioners who have both nursing and midwifery skills. Further, it almost always necessitates some extension of the nurse-midwife role. The core of their work will inevitably include a high proportion of maternal and child health care (including family planning) and of health education in these and other areas. Henderson (1978) has suggested that the true role of nurses is to be "rehabilitators par excellence" and this is a relevant description in relation to many family health care functions. As the same eminent nurse-author has recognised, with regard to functions normally regarded as being in the province of other health professionals, such as doctors, nutritionists, physiotherapists or social workers, it will often be necessary for the nurse's role to extend into these areas (Henderson, 1978). As long as nurses are trained to do this competently, there is no inherent reason why they should not do so. Whatever the specific functions agreed

upon for the nurse's role, they incorporate an appropriate response by a health care worker available to the family with regard to the various stresses which arise.

35. The issue of authority to act based on competence is interestingly outlined by Clark (1978) who concluded logically:

"To the question 'In what circumstances should a nurse diagnose and prescribe?', the answer must be 'In those circumstances where she is competent and not in those circumstances where she is not competent'."

She sees the law as an institution which "... recognises and formalises the authority which competence bestows" (Clark, 1978). Nevertheless, whilst a wide-ranging, flexible approach by nursing staff to family health care has been stressed in this paper, it is considered essential for them to know clearly which functions they may (or may not) perform in particular circumstances.

36. Whilst utilising many specific skills, the nurse-midwife's overall role in family health care is necessarily very generalised. The importance of diverse features of family and community life and the multi-causality and interrelationships between aspects of family health needs were discussed in paragraphs 9-26 above. In order to analyse accurately the causes of stress on families, nurses must be aware of this intricate complexity. As responsible family health practitioners, they also have an obligation to make known in appropriate forums their informed opinions regarding the broader community influences on family health.

37. With regard to the organisation of the family health care provided by nurses and midwives, the health team approach has already been emphasised. In addition, nursing and midwifery personnel should also be part of a distinct occupational structure which links them with their colleagues in other parts of the health service. This contributes towards a sense of professional identity, enables systematic support and guidance to be provided to field staff by more senior nurses and provides a career ladder for nursing staff. As well as facilitating communication for administrative purposes, this arrangement provides a channel for the insights of the community health service staff working closely with families to be shared with colleagues in other parts of the nursing service, and vice versa. All of these factors are important for the morale of nurses, an important consideration in circumstances which are often exacting.

TRAINING OF NURSES AND MIDWIVES FOR FAMILY HEALTH

38. Achievement of the approach to family health care outlined in this paper also has important implications for the education and training of nursing and midwifery staff. As indicated throughout, provision of family-oriented health care is not limited to those working in community health services but is also required in other settings such as hospitals. This necessitates a much more generalised approach to training than is usual in traditional nursing or midwifery courses.

39. It is recommended that policy decisions be made concerning the actual roles which nurses and midwives will carry out in specific countries and that the training objectives be directly based on these. Such roles may vary somewhat from area to area, but given the basic needs common to most developing countries (discussed in paragraphs 9-26)

certain principles will be constant in preparing staff for a holistic, family-oriented approach.

40. Key features of appropriate programmes of study are: the integration of the nursing and midwifery approaches; an orientation towards a problem-solving approach to family needs and towards functional competency in a wide range of basic skills; and joint team training with members of other health care occupations. All of these principles are of vital importance and planning for nurse education should start with them.

41. Additionally, nursing staff need to develop their understanding of the underlying influences on family health and the interrelationships between various factors. Obviously, the educational programmes of nurse-midwives leading to registration will consider these issues in greater depth than will be feasible for auxiliary staff.

42. Implementing these proposals in a country would entail some or all of the following steps:

(a) Close liaison between senior nursing/midwifery staff having service and educational responsibilities. Linked with this would be a system of nursing/midwifery management whereby staff are given the expert support they need to perform their exacting roles. Nurse managers might themselves require an appropriate training to prepare them for these functions.

(b) Curriculum planning for all grades of nursing/midwifery staff, based on a methodical analysis of the tasks they would be required to perform as well as on the broad philosophy of the family-oriented health service. Teaching staff might need further training themselves in this kind of curriculum development.

(c) Provision of post-basic courses for registered staff to reorientate them to the new approach. These might be organised on a full-time or part-time basis and might be of various lengths, depending on the circumstances of the country concerned.

(d) Revision of the training programmes for the student nurse/midwives so that these are relevant with regard to the future roles of staff.

(e) A similar systematic review of the training programmes for auxiliary nursing/midwifery personnel.

CONCLUSIONS AND RECOMMENDATIONS

43. Given the powerful influence of families upon people, it is logical to direct health care provision towards this social unit. Families are susceptible to various stress situations of a physical, psychological or social nature. These are often rooted in the fabric of a particular society and some illustrations have been put forward in this paper. A health service which has a major orientation towards enabling and

helping families to cope with these situations is effective in both humanitarian and cost-benefit terms. The broad-ranging scope of this undertaking necessitates a comprehensive approach.

44. Nursing/midwifery staff are often the occupational group at the centre of this kind of health care provision, though, in order for them to carry it out effectively, there may be a need for them to change their traditional orientation. In particular, they need to work as members of health teams using an integrated, problem-solving approach combined with competency in functional skills. This expertise is based on an understanding of the fundamental importance of the family system in general and of its characteristics and special health needs in their own society in particular. Nursing staff in all parts of the health service may make family-focused contributions to health care and therefore need an appropriate education and training for it.

45. This kind of contribution by nursing and midwifery staff is of major benefit to the development of a nation. Changing its emphasis to the holistic approach needed to provide the care is of major benefit to the development of a nursing service.

46. For governments who wish to operate the kind of family-oriented health service described in this paper, the following lines of action are suggested.

For national action

(a) A realistic analysis of the specific roles required in nursing/midwifery personnel in order to meet appropriately the particular family health needs of their own country.

(b) Clear policy statements concerning these roles and the training programmes required to prepare personnel of all levels for them.

(c) The setting-up of an appropriate occupational management structure for nurse-midwives (as discussed in paragraphs 27-37) and where necessary the appointment of adequately educated senior staff.

(d) The implementation of realistic programmes to provide holistic, problem-solving, family-oriented training for all grades of personnel (as discussed in paragraphs 38-42).

(e) The secondment of nurse/midwifery staff to appropriate overseas courses when they are not adequately trained to carry out the action suggested in (c) and (d) above.

(f) The requesting of consultants from outside agencies where necessary to help with the analysis and planning outlined in the preceding items.

For regional action

(g) The organisation and running of regional workshops and/or seminars on topics related to family health. These could usefully be open to all members of health teams, including nurse/midwives.

(h) Consideration of the future organisation of longer post-basic courses oriented towards: family health care, management of services providing family health care, and the planning and running of basic courses with a family health focus.

For action by the Commonwealth Secretariat and other agencies

(i) The identification of overseas courses appropriate for nurse/midwives and others having key responsibilities in either management or education.

(j) A sympathetic response to requests for the provision of fellowships for such personnel to undertake the appropriate courses.

(k) A sympathetic response to requests for the secondment of consultants to countries to help with the analysis, planning and formulation of specific recommendations required for items (a)-(f) above.

(l) A sympathetic response to requests for the provision of professional and financial assistance for the carrying-out of workshops, seminars or courses on a regional basis.

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