

Community involvement towards community objectives

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The World Health Organization "Health for all children by the year 2000"¹ declaration presents an exciting yet timely challenge, but its aims will never be achieved by health workers alone. In order to reach "a state of complete physical, mental and social well being", families must be able to identify and realise their aspirations, to satisfy their needs, and to cope with and adapt to their environments². Only by advocacy, by forming a partnership with families, and by empowering families to exercise greater control over their health and their environment, will health workers begin to see positive change in the community. New outcome measures which address "quality of life" must be developed; these will accord closely with the WHO aims, and will enable communities to set the high standards that must be achieved for our children.

"Health", interpreted in its broadest meaning, should lead to health professionals concentrating on the promotion of a healthy lifestyle and the attainment of "quality of life". There must be a move away from the "medical model" of care to the empowerment of parents who are responsible for the care for their children and the need to work towards better community resources. This paper will consider the determinants of health and the influences on a child's life, and by considering a number of initiatives carried out in Europe, demonstrate ways in which change may be effected in the community. Finally, a strategy to ensure that children will lead wholly fulfilled lives in the future will be proposed.

Determinants of Health

The World Health Organization has declared health to be a basic human right. Health, more than the absence of disease, is the "state of complete physical, mental and social wellbeing". Implicit in this definition is the requirement of all people to enjoy the rewards associated with membership of their community and to work towards its future development. Two strategies need to be developed in order to achieve this. The first is the development of measures which protect and promote the capabilities of individuals to function in society – the traditional aim of health professionals. The second is the development of a society which allows and encourages the successful function of individuals irrespective of their limitations or capabilities.

In a recent review, Alwyn Smith categorised the determinants of health under the headings of Heredity, Freedom from Disease, Environment, Lifestyle, Services and Policies³. Heredity plays an important role in the development of disease – and we may expect major bio-medical advances in determining the genesis of disease processes in the future – although society can little influence this progress. Society can, however, influence the other determinants of health.

In the developed world, reduction of infectious disease owes much to public health measures, the development of successful vaccines and the introduction of anti-microbial agents. That the mortality and morbidity of infectious diseases continues almost unabated in the third world is a sad reflection of global policy and politics.

The environment is crucial to our health. Sadly, clean air, clean water and good food, although basic determinants of good health, are absent from many countries of the world. Adequate housing is still a privilege of the few. As well as natural disasters (earthquake, flood, fire) man-made hazards still threaten our species. There is the threat of nuclear holocaust, and radiation fall-out is no longer a rare event. War is endemic throughout the world.

However, when developing strategies of health promotion, lifestyle is a crucial consideration. The individual's right to choose is sacrosanct. Thus any messages of health promotion must concentrate on "informed choice"; for example, only advice about the consequences of smoking, substance abuse, alcohol abuse and sexual promiscuity can be offered. Society must recognise the individuality of its members; they too, in turn, must accept their responsibility to that society. Lifestyle includes the right and, indeed, the need to effect change in society through democratic process – this to include advocacy on behalf of society's less capable members.

Finally, health must be integrated with the other needs of society – which will include education, economic growth, and urban planning. Consideration must be given to the philosophy of health care; should it be regarded as a commodity to be distributed equally amongst all society's members or should it be an output geared solely to efficiency and the saving of money? Should it be a resource (as the World Health Organization maintains) that should be available to all according to need and,

therefore, discriminated positively in favour of the weak? These considerations ultimately determine the form of health care that is available to society and it is up to individuals, working in the community, to dictate the direction in which health services develop.

Influences on the child

Without doubt the greatest influence on a child's development is his or her immediate family, namely the child's mother and father, especially in early life. The extended family is very important too; unhappily, many children lack the support and security so important to their development from an early stage – particularly in the situations of stress, family disharmony, lone parenting and isolation. Networks – peers and friends – have great influence. Individual cultures must be considered; many ethnic minority groups can become isolated, both culturally and by language difficulty. The education of the child – not just at school but from his parents and family – is vitally important too. Media pressures play an increasing role in development of ideas and standards. The environment, too, plays a key role. Firstly the physical environment; adequate housing, with warmth, privacy and quiet, as well as space for play are essential pre-requisites. Local resources in the community – the need for shops, meeting places, nurseries, schools and health facilities. Children must be protected from violence, from road traffic accidents and there must be emphasis on safety in the home. The psychological environment of the child must be considered too; the child needs love and must be given affection; the child has a right to be happy and contented. These, in turn, depend on the state of mind and the moods of the mother and father.

Finally, children with special needs are important members of society and must expect to enjoy the same rights as all other children. Resources should be available for these children who should be fully integrated at all levels in the community.

Against this background, it can be seen that the influence of health workers, unless their role is carefully defined, is likely to be of little import. However, by working in partnership with the family, empowering them to address these influences, change may be effected.

Effecting change

The key to effecting change is the recognition that all parents, irrespective of background or educational level, are capable of making responsible decisions, making choices, and determining their futures. This depends on their being given appropriate information, and allowed the responsibility of choice.

Tab. 1. Effecting change.

• Empowerment of parents	
Communication	
Recognition of their	Expectations, needs, resources
	Priorities, aspirations
Identification of barriers	Language, culture, social
Teaching, training	Individuals, Groups
	Data interpretation
	Advocacy skills
• Identifying needs of	
Parents and their children	
The community	
• Information	
Data collection	local, regional, national
Data dissemination	
• Interventions by health professionals (partnership)	
• Advocacy	
By community members themselves	
By Health professionals for community	
Locally, regionally, nationally	
Self-help groups/Politicians/Media	

The health professional is, in the primary health care setting, ideally placed to work alongside them. Each will learn from the other. Baseline knowledge of parents' expectations, their needs and their available resources will determine the level of information required and the changes that can be made. Similarly, interventions will depend in turn on the resources available to the health care workers. Between them, parent and health care worker will develop a level of priorities, again based on their aspirations. Barriers will need to be removed; many will feel isolated from and suspicious about the role of health professionals. This can be achieved by setting up appropriate health care systems – ideally based on community health centres, staffed by personnel known locally. The emphasis will be on team work – doctors, nurses, health visitors, social workers working together with a common aim. Where appropriate, there will be translators, health workers from different ethnic minority groups who are well versed in local cultures and knowledgeable about social practices. Efforts made by the primary health care team will be well received by the local community. Teaching and training are pre-requisites of those in the primary health care team. First, professional training for the workers themselves is essential and will include, as well as basic medical knowledge, the theory and practice of health promotion, audit, counselling and teaching skills. Individual teaching and teaching in groups will be very important tools. Health care workers must learn to work with other members of the community – school teachers, religious leaders, town planners, architects, community paediatricians and hospital personnel. They will be well versed in

advocacy both in exhorting community members to advocate for themselves and also practising advocacy on behalf of the community.

The need for data collection and audit

By adopting an integrated approach, it will be possible to identify the true needs of the parents and their children. Apart from their medical needs, they will be able to identify the resources and facilities that are required for the community itself. Much of this depends on careful data collection and interpretation. Much more medical information should be available: as well as infant mortality rate, uptake of immunisations and notifiable diseases, more should be known about morbidity. Information about common diseases – for example upper respiratory tract infections, asthma, accidents in the home – should be available as they are closely related to the environment in which families live. Furthermore, detailed local sociological data must be collected. The make-up of families in the area – ethnic mix, numbers of lone parent families and the population mobility – should be known. Baseline information about housing conditions – including data on homelessness, overcrowding, sanitation, cooking facilities – parents' education, their employment and the resources available to them. Community resources – nursery placements, primary schools, areas for play, shopping facilities, health facilities – all are very important. School truancy rates, teenage pregnancies, teenage smoking and drinking habits as well as sexual mores should be documented.

Who should collect and collate this data? The information would be collected from several sources. Primary health care teams with their direct interface with community members will be able to produce information about parents' aspirations and concerns, as well as much information about the families. They could also collect morbidity statistics as computerisation is commonplace in medical practice today. The information will need to be centrally compiled and consensus as to what information is relevant met. The community paediatrician, working in harmony with the primary health care team, is ideally placed to coordinate this work. Together with data from hospitals, information from local councils, from local schools, and by using national databases, a picture of family life will emerge. The data protection act – which allows individuals access to all information held about them on computer – will ensure responsible data selection and collection. Centrally compiled, the potential of such information is enormous as, made available to community leaders and, indeed, members of the community, change may be effected. With consensus as to the data collected, meaningful comparisons between local areas, other

cities, and even at an international level can be made. Properly disseminated, this information can be used to both as a tool for education in the community, and for obtaining better resources. Using this information, parents themselves can be empowered to effect change both for themselves and their communities.

With commitment, modest local interventions by health professionals and other workers can be effective and cheaply implemented. As well as benefiting the local community, they can ably demonstrate how parents can be empowered by working in partnership with health workers. In 1985, in the author's own deprived inner city family practice seven cases of nutritional rickets amongst Rastafarian infants⁴ were identified. This resulted from their adherence to a strictly vegan diet. Moreover, being somewhat suspicious of medical services, the mothers had not brought their children to the well baby clinics. Furthermore, these children were found to be anaemic and none had been immunised. By adopting a sensitive approach to the problem, by working with community leaders, it was possible to correct the nutritional rickets by the introduction of vitamin drops without the need to change the children's culturally determined diets; the fact that the rickets was cured reinforced to the mothers that doctors and health visitors were able to offer a useful service and, as a result, the anaemia was corrected and the children regularly attend for child surveillance. This demonstrated that the baby clinic was poorly run; uptake of immunisations was low (75%) and the record systems had failed to identify non-attenders. By listening to the mothers, it was possible to change the running of the clinic – it was made open access for both well and ill children and, as a result, clinic attendance doubled and the immunisation rate currently exceeds 95%⁵. Routine screening for iron deficiency (25% prevalence in the under twos) has been introduced and, following a programme of health education, the prevalence has been reduced to 8%. More recently, by working with needy mothers struggling with their diets, a strategy for helping their planning, shopping and cooking skills has been developed. The nutrition of these children has improved significantly⁷. More importantly, the mothers' feeling of wellbeing has also increased. They now feel important and useful members of the community, and are beginning to change their lives.

There are many other examples of successful interventions – several studies working with families and schools have shown impressive results in Piraeus, Greece⁸. The World Health "Health Cities" Intervention^{9,10} is also proving, on a much larger scale, very successful.

Once members of a community are aware of the problems and have an idea as to how they may be addressed, plans for change may be made. As already mentioned, local data is a powerful tool for

implementing change and attracting resources to the area. The community must advocate on behalf of itself and, in particular, on behalf of the most needy members – the socially deprived, the poor, and children with special needs. Health workers, too, have a duty to advocate on behalf of all community members to improve medical services, health promotion, and the environs in which they live. This advocacy may be local, may be regional and may also be at national level. Local and national media can be powerful influences.

The Future

What of the future? The World Health Organization has set the lead by declaring the “Health for all children by 2000” charter. This must attract support from all European countries and must be a unifying force. Paediatricians must unite locally, must meet nationally and set up international links with fellow paediatricians. The European Society for Social Paediatrics, ESSOP, is one such organization which brings together like-minded health workers in the field of Social Paediatrics from all over Europe. ESSOP offers training courses, a forum for the exchange of ideas, and is committed to empowering members of the community. ESSOP has been instrumental in bringing together health care workers, community leaders and both local and national members of government in the service of children. Three recent ESSOP symposia in Athens, Greece^{11, 12}, and Lisbon, Portugal¹³ have achieved these very aims.

Many have raised the question of political representation for the needs of children. The world is still very much orientated towards adults; in European government, no one politician has responsibility for the needs of children; the appointment of a minister or commissioner for children is an attractive proposition; he or she would be able to represent the needs of children to all responsible government departments. Public debate, with the specific needs of children as a central theme, could have enormous benefits. It is tempting to surmise the consequences of allowing children a vote. The changes would not benefit just children but families and communities as well.

Tab.2. The future.

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- Charter for children WHO, European community
National, Local
 - Political representation for children
Commissioner, government minister,
Advocates? A vote for children?
 - “Quality of life” as an outcome measure
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Quality of life

Many of the outcomes mentioned for health are crude. Several workers – principally in the Nordic countries^{14, 15} – are working towards a true measure of quality of life. This will encapsulate the spirit of the World Health definition of health – allowing a child to achieve his or her potential for playing a useful role in society and becoming fulfilled. Not just physical health, but happiness, contentment, friendships and fulfilment. “Quality of life”, once quantified, should prove a powerful tool for advocacy, for securing more appropriate resources for the community, and for setting standards. Only then will families will be truly integrated in their communities, ensuring that children will have a real future.

Summary

The World Health Organisation “Health for all children by the year 2000” declaration presents an exciting yet timely challenge. If these aims are to be achieved, the role of the health worker must be broadened. There must be a recognition that families will determine the true health of their children – physical, mental and social. Families must be able to identify and realise their aspirations, to satisfy their needs and to cope with and adapt to their environments. Only by advocacy, by forming a partnership with families, and by empowering families to exercise greater control over their health and their environment, will health workers begin to see positive change in the community. There is a need to collect and collate data from the community in order that the true needs of families are met. New outcome measures which address “quality of life” must be developed; these will accord closely with the WHO aims, and will enable communities to set the high standards that must be achieved for our children. “Health”, interpreted in its broadest meaning, should lead to health professionals concentrating on the promotion of a healthy lifestyle and the attainment of “quality of life”. There must be a move away from the “medical model” of care to the empowerment of parents who are responsible for the care for their children and the need to work towards better community resources.

Résumé

L'engagement de la communauté pour des objectifs communautaires

La résolution de l'OMS «Santé pour tous les enfants en l'an 2000» est un défi d'actualité passionnant. Si l'on veut espérer atteindre ces objectifs, le rôle des assistants sociaux doit être amplifié. Il faut réussir à promouvoir l'idée que les familles doivent être

capables d'estimer l'état de santé réel de leurs enfants tant sur le plan physique que psychique que social. Les familles doivent pouvoir identifier et prendre conscience de leurs aspirations, combler leurs besoins, faire face aux difficultés et s'adapter à leur environnement. Ce n'est que par le biais de groupes de pression, en s'associant aux familles, et en renforçant le contrôle de ces dernières sur leur santé et leur environnement que les assistants sociaux commenceront à voir une évolution positive au sein de la communauté. Des données de population seront recueillies et comparées afin d'atteindre les buts fixés. De nouveaux instruments de mesures évaluant la «qualité de vie» devront être développés; ils seront en étroite conformité avec les objectifs de l'OMS et permettront de fixer les critères de haut niveau à atteindre pour nos enfants. La «santé» entendue dans sa signification la plus large doit amener les professionnels de la santé à se concentrer sur la promotion d'un mode de vie sain et l'obtention de la «qualité de vie». Il est nécessaire de s'éloigner du «modèle médical» des soins afin d'aller vers un plus grand pouvoir des parents, responsables des soins à leurs enfants, et afin de développer les ressources disponibles au sein de la population.

Zusammenfassung

Miteinbezug der Gesellschaft zum Erreichen deren Ziele

Die Weltgesundheitsorganisation (WHO) stellt sich mit ihrem Leitbild „Gesundheit für alle Kinder bis zum Jahr 2000“ einer sowohl zeitlosen als auch interessanten Herausforderung. Falls man deren Ziele wirklich erreichen will, muss der Aufgabenkatalog der Gesundheits- und Sozialarbeiter erweitert werden. Dies im Bewusstsein, dass es die Familien sind, die die tatsächliche Gesundheit ihrer Kinder, d. h. deren physische, geistige und soziale Gesundheit, beeinflussen und bestimmen. Die Familien müssen aber zuerst dazu fähig sein, ihre eigenen Wünsche und Vorstellungen zu identifizieren, um diese anschließend in die Realität umsetzen zu können. Nur dann können ihre Bedürfnisse erfüllt werden. Zudem müssen sie fähig sein, mit ihren Bedürfnissen unter Anpassung an ihr Umfeld umzugehen (coping). Die Gesundheitsarbeiter können erst eine positive Veränderung in der Familiengemeinschaft feststellen, wenn die Familien durch Beratung, Partnerschaft und Stärkung des eigenen Selbstbewusstseins eine grössere Kontrolle über ihre eigene Gesundheit und Umgebung ausüben können. Hierzu müssen aber unbedingt vorher Daten und Fakten über die Struktur und das Leben der Familiengemeinschaft sowie der Gesellschaft gesammelt werden. Damit werden deren wahre Bedürfnisse ermittelt. Neue, auf die „Lebensqualität“ bezogene Massnahmen, die auch eng mit den oben erwähnten WHO-Zielen

übereinstimmen, sollten geplant werden. Erst dies wird es der Familiengemeinschaft ermöglichen, die gesteckten Ziele und den hohen Standard, welche für ihre Kinder notwendig sind, zu erreichen. „Gesundheit“ im weitesten Sinne des Wortes, sollte dazu führen, dass sich die, die sich professionell mit der „Gesundheit“ befassen, auf die Promotion eines „gesunden Lebensstils“ und auf das Hinarbeiten zum Erreichen der „Lebensqualität“ konzentrieren können. Die bisherige medizinische Art, sich der Sorge und der Pflege anzunehmen, sollte einerseits durch die Stärkung der elterlichen Sorgfalts- und Pflegepflicht ersetzt werden, da ja die Eltern für ihre Kinder verantwortlich sind. Andererseits sollte sich aber auch die Notwendigkeit ergeben, die bestehenden familiären Möglichkeiten besser zu nutzen.

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