

Explaining the principles of health visiting in Brazil

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Abstract

Brazil is a rapidly developing country. Modern health services operate in a situation of extreme social change, which resembles some of the conditions that gave rise to health visiting in 19th century Britain. A visit there revealed much interest in the health visiting principles of the search for health needs, the stimulation of an awareness of health needs, the influence on policies affecting health and the facilitation of health-enhancing activities. Explaining these principles to an audience on the other side of the world highlighted three underlying themes. The principles of health visiting are about health promotion, not assistance; they provide an integrated framework, not a list of competences or skills and they are all underpinned by a particular value and view of health. The explanation was met with great interest. We need to be both more aware, and better able to explain, these underlying themes in this country, as well.

Key words

Principles of health visiting, Brazil,
community public health

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Introduction

Following a visit to São Paulo to advise on a research project about community health needs, the author was invited back to speak about health visiting at an international symposium of policies and practice in collective health nursing. There was much interest in health visiting, and explaining the principles for a Brazilian audience provided an opportunity to reflect on their underlying themes and values. The overall utility of the principles of health visiting is possibly underestimated even in this country, which may be because these underlying themes are less familiar than the four process statements (ie search, stimulate, influence and facilitation as described below).

Following a brief introduction to Brazilian health needs, this paper adapts the conference presentation, aiming to raise awareness of those underlying themes, whilst setting the principles of health visiting in an international context.

Health and social change

Changes in Brazil: a snapshot

São Paulo is the financial capital of Brazil, which is roughly the same size as Europe, with huge diversity in its 192-million population and in policies across the country. As a rapidly developing economy, Brazil is a key player in the World Trade Organization's G20 discussions, and is becoming increasingly significant in international terms (International Labour Organization/ILO, 2010). The country's economic success has brought enormous social change, including a sharp increase in industrialisation and migration from rural to urban areas, with 86% of the Brazilian population now living in towns and cities, up from 75% in 1990 (World Health Organization/WHO, 2010). Similar rises are being seen across the world, with half the world's population living in built-up areas already. This is expected to rise to 80% by 2030 (UN Population Fund, 2007), leading to an increase in urban slums and health threats from adverse living conditions,

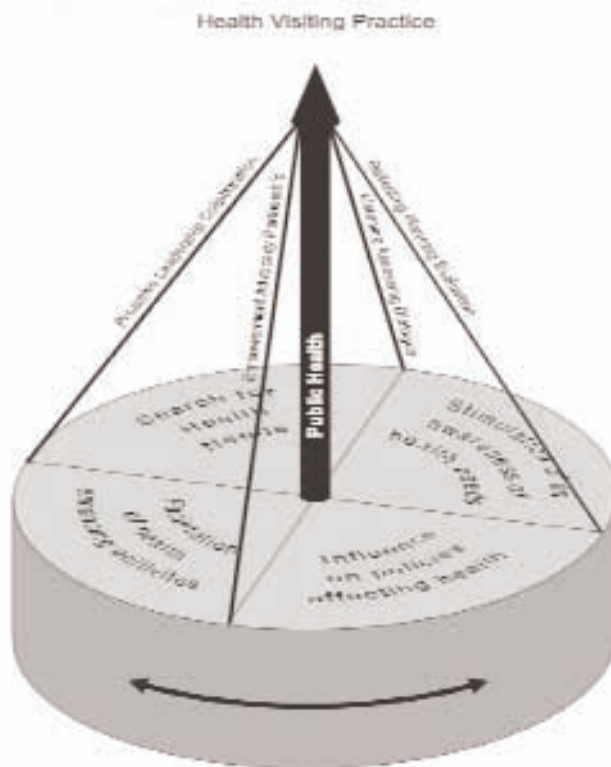
which occur in Brazil as elsewhere. Health inequalities are improving in the country but are still marked, with a Gini coefficient of 55 in 2007 (UN Development Programme, 2009) and 52 in 2008 (ILO, 2010). In this scale, zero corresponds with perfect equality (where everyone has the same income) and 100 corresponds with perfect inequality (where one person has all the income, and everyone else has zero income). For comparison, the UK figure was 36 in 2007.

Although within-country differences are still rife, infant mortality rates have improved dramatically in Brazil over the last two decades, from 46 per 1000 live births in 1990 to 18 in 2008 (WHO, 2010). In 2006, 40% of their infants were exclusively breastfed for the first six months. Apart from the rise in living standards, much of the health improvement has been linked to two particular health innovations developed during the last two decades (Macinko et al, 2006). First, hospital and primary care services were brought together in a single 'unified health system', with a new 'Family Health Program' designed to bring medical and nursing services to every community, starting with the most deprived areas. Second, these new primary care services incorporated an existing initiative to introduce a network of lay workers, called 'community health agents' (CHAs) to reach into the homes and families of the local population, for purposes of health education and promotion (Kluthkovsky and Takayangui, 2006).

Parallels with British health visiting

These 21st century changes in Brazil are reminiscent of the rapid industrialisation and migration from rural to urban areas in 19th century England, which gave rise to the development of the health visiting profession (Dingwall, 1977). In response to urban squalor and a high infant mortality, in 1862 the Manchester and Salford Ladies Sanitary Reform Association agreed to begin employing local women to visit homes and families, offering help and advice about how

Figure 1. Principles in practice (Cowley, 2007)



best to feed the family, care for the sick and improve the chances of their children growing up healthily. The profession of health visiting, as we know it today, developed from this belief in the importance of home and family for children's health, and in delivering services through home visiting. Health visitors still focus mainly on family health and home visiting, practices that are supported, now, by a large body of research evidence. Early child development is acknowledged as a key social determinant of health and health inequalities (Irwin et al, 2007; Center on the Developing Child/CDC, 2007), and home visiting has been shown to be a particularly effective strategy for health improvement (Olds, 2006; Macleod and Nelson, 2000; Karoly et al, 2005; Elkan et al, 2000).

These days, instead of health visitors, a closer British parallel to the Brazilian CHA programme might be the community mothers movement (Johnson et al, 1993; Parents 1st, 2010), since both involve lay workers offering support, health education and networking within their own neighbourhood, aiming to improve access to primary care and enhance health across disadvantaged populations. Community mothers often link with local health visiting services, and CHAs link directly to primary care nurses based in the Family Health Centres, which are responsible for meeting health needs in a local

catchment area. Research about how best to determine those health needs led to contact between King's College London and the University of São Paulo, then in due course an invitation to explain more about health visiting at a conference there. Bringing the principles of health visiting to an audience of public health and primary care nurses operating in a different system, but also with many similarities to those in the UK, meant starting with an explanation of how and when they were developed.

The principles of health visiting

In response to what were described as 'rapidly changing health and social conditions [leading] to new legislation and new patterns of working and new consumer expectations' (Council for the Education and Training of Health Visitors/CETHV, 1977:7) in 1974, health visiting tutors decided to hold an investigation into the principles and process of the work. They wanted to clarify the underlying principles of health visiting to inform education, so students could gain the depth of understanding needed to encourage flexibility and adaptation to new circumstances. The results of the investigation provided a framework to organise the knowledge and skills required for health visiting practice. This framework became a touchstone for

continuing development, but also needed regular revision. Updated versions of the principles document were published in 1992 (Twinn and Cowley) and 2006 (Cowley and Frost), to demonstrate their continued relevance, application to contemporary health needs and current research.

There was agreement across the profession that health visiting is implemented by using four enduring processes, which are collectively known as the 'principles of health visiting':

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on policies affecting health
- The facilitation of health-enhancing activities.

There are three things to note about these principles. They are about health promotion, not assistance. They provide an integrated framework, not a list of competences or skills, and they are all underpinned by a particular value and view of health. These will be considered in more detail, in turn.

Health promotion

The principles are not concerned with doing things directly to or for someone who is unable to perform essential activities of daily living. Providing help and assistance is a common focus of nursing practice, so this is the first big change for nurses when they enter the additional training needed to become a health visitor. Families being visited in the community are not ill just because they have a new baby, or are living in a very deprived area, and it would undermine them if the health visitor were to offer expertise from a highly professional perspective (Davis et al, 2002). Instead, which is much harder than just giving advice and information, the challenge is to enable families to find ways of improving their health for themselves, drawing on their own strengths, knowledge and the expertise developed by living in their own particular circumstances.

To take one example: the relationship between expectant mothers smoking, living in poverty and the health of their babies is very strong, across the world. Yet, there is also seminal research, which explains that young mothers who live in poverty smoke because it helps them to cope with stress and violent relationships, and the caring responsibilities they face (Graham, 1984). When money is short, smoking a cigarette stops them feeling hungry. Simply advising them to stop smoking, or even offering a support group or education to help them stop smoking, just makes them feel bad. Then their stress rises and they smoke even

more. First, we must deal with their stress, support to cope with their relationships and respect for the way they are coping with difficult circumstances; this helps to lay a foundation from which they can change, so it facilitates health-enhancing activities. Then, when we have built a strong relationship, we might ask them what they think will help their baby to be healthy, to stimulate an awareness of health needs. Before long they identify smoking as a problem. That is the time to offer them nicotine patches and support groups; they are more likely both to succeed in stopping smoking, and to feel good about themselves.

An integrated framework

The second thing to note about the principles is that they are not separate skills or activities to be learnt. Instead, they provide an integrated and interlinked framework for implementing the knowledge base of health visiting, in the interests of public health (see Figure 1) (Cowley, 2007). One principle or another may predominate as activities and interventions are carried out, but any aspect of health visiting practice is informed by all the principles, with public health as the central pivot and focus (Twinn and Cowley, 1992; Cowley and Frost, 2006). Public health is a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention (WHO, 1998).

The principles of health visiting reflect the public health need for what has been called the 'nutcracker effect,' using both top-down, strategic policies for whole populations (like the provision of a universal health visiting service, for example), and bottom-up, grass roots activities to engage individuals, families and communities in their own health (Baum, 2007). Practitioners who are in daily contact with the most vulnerable and excluded populations often know best how to describe and explain their real health needs. Health visitors' work needs to reflect both a bottom up and top down focus. First, they need to explain and support people in making best use of services and policies designed to help them. Then, because they can also see how, when and why those policies go wrong, they need to explain where the barriers lie, and help policy makers to see what further changes are needed to policy. This influence on policies affecting health is often described in terms of feeding back health intelligence to managers and commissioners (Cowley and Frost, 2006).

The value of health

The third point to note is that the word 'health' features in each of the principles. This focuses attention on both the way the term is understood, and the value afforded to health, rather than (for example) health care, or concerns about illness. Health visitors placed a value on health for its own sake, and a broad understanding of this underpins the principles and practice of health visiting (CETHV, 1977; Cowley and Frost, 2006).

Understanding of the term 'health' has developed considerably since the initial principles investigation was published in 1977, but it is still a phenomenon that is hard to research, because it is fraught with ambiguity, and defies objective definition and quantification (Robinson, 1985). In accepting that everyone has a fundamental right to the best possible state of health, health visitors take on a responsibility to do something about the present inequalities in health and health care. Instead of trying to define the value of health in philosophical terms, therefore, when the principles were revisited in 1992, the working group decided to emphasise its practical application through health promotion, identifying seven key, underpinning beliefs that informed their practice (see Box 1) (Twinn and Cowley, 1992). These beliefs still pertained for the 2006 (Cowley and Frost) edition.

These underpinning beliefs are implemented by a focus on health as a social rather than an individual construct, so understanding the whole family and community perspective is essential. In practice, health visitors appear to treat health as a process (not a state of being to be obtained) and to consider health in its overall socio-cultural context (Cowley, 1995a). It is long term work, sometimes

taking more than one generation, with beneficial outcomes from home visiting showing up many years later (CDC, 2007; Karoly et al, 2005).

It is not necessarily the problem that individuals or families face, as such, which determines whether they need support or not; the deciding factor may be the situation in which they are living (Cowley and Billings, 1999). Some people face enormous risks without harm, and others come to grief with a lesser level of risk. The extent to which individuals need support and the nature of that support varies according to their own personal resources, and those in the situation they are living in. Personal resources include financial resources, but are by no means only concerned with these. Resources for health include emotional strengths, or physical or practical resources, or the ability to understand and reason about what would help; strong faith or a supportive family or stamina all help. Health visiting practice involves supporting the development of these resources, using what has become known as 'strengths-based practice' (Cowley and Frost, 2006). However, families might be destructive as well as helpful; some faith groups are damaging and demanding, and a partner might be abusive and violent instead of supportive. So, to determine whether they are helpful or not, we need to know the extent to which resources are immediately accessible to the individual, and under their personal control. This means that health visitors need to identify their clients' strengths and resources, and how these may change and develop over time, offering more or less support at different periods in the process. The search for health needs is, therefore, as much about strengths as about difficulties.

Box 1. Beliefs about health (Twinn and Cowley, 1992)

- Rights and responsibilities – everyone has a fundamental right to the best possible state of health
- Health in context – health cannot be separated from the socio-economic and cultural context in which it is experienced
- Choice and blame – health must be regarded in broad, holistic terms, encompassing individuals and families within their personal situation
- Positive health – health is a positive concept, encompassing social and personal resources, as well as physical capacities
- Health improvement – a positive sense of health enables people to make full use of their physical, mental and emotional capacities, so they can reach their full potential for achievement
- Empowerment – achieving health means that people have the power to shape their own lives and those of their families
- Community partnership and participation – healthcare services should be readily accessible and acceptable, and involve full community participation

Traditionally, health visitors maintained a relationship with all families with pre-school children, starting in the antenatal period and continuing over the next five years, regardless of the presence or not of 'problems'. This kind of longitudinal, universal process is unusual among health professionals, who commonly aim to identify a specific diagnosis as soon as possible, since this provides a basis from which a care pathway can be predicted, and from which an end point for discharge can be reached. Instead, maintaining universal coverage across a health visiting caseload offers a route in to the whole community, to promote strengths and identify concerns as early as possible.

Communities and family life are less predictable than a medical diagnosis (Cowley, 1995b), but formal organisations like the health service require predictability as a basis for their planning. The unpredictability of community and family life requires the ability to manage uncertainty and ambiguity in practice (PRIME Research and Development, 2001), working toward goal-setting in conjunction with the family, at the appropriate time for them. This is an advanced level of ability, which also needs careful explanation to colleagues who are more used to dealing with medical diagnostics and prescription, to raise their awareness of health needs in complex community and family settings. Without that awareness, some medical and nursing colleagues, health services commissioners or managers mistakenly regard health visiting work as 'simple,' except when there is an obvious acute or severe need, such as child protection or a significant mental health problem, which seems to parallel a medical diagnosis. In practice, once there is the clarity of a definite label, the complexity of the work is reduced, and it can seem less stressful (Appleton, 1994).

Taking a longitudinal, process approach helps health visitors to offer support in ways that are the most empowering for individuals and groups at different stages (Macleod and Nelson, 2000; Cowley, 2000). There is a delicate balance between the need to allow, enable and encourage people to own their health in the sense of exercising full autonomy and choices in the way they live their lives (Rijke, 1993), and the individualistic approach to health education that stresses personal responsibility and blame. Parents are often, understandably, very sensitive to any suggestion that they are being judged, an attitude that has been singled out as inhibiting engagement with services. Clients have reported that they did not feel subjugated by

health visitors if the interventions were based on acceptance and a professional caring approach (Machen, 1996), although the opposite is true in that individuals can be further disempowered by their interactions with health visitors if practitioners do not accept individuals' views or are shocked by their situation (Roche et al, 2005).

Relationship skills appear critical in determining the degree to which health visitors are acceptable to clients (Normandale, 2001). These communication and partnership skills can be learnt (Davis et al, 2002), but need to be at a very high level, especially when engaging clients who are deeply vulnerable and socially excluded (McIntosh and Shute, 2006). Such people may include young mothers, those whose childhood was insecure, who use drugs and other illicit substances, or parents experiencing domestic violence. These vulnerable populations may distrust authority in any form, perhaps initially rejecting the health visitor or any offers of support or information as irrelevant. This makes families seem hard to reach whereas, more realistically, they are experiencing services as hard to access or use in a way that seems helpful. Basic attitudes and personal attributes of empathy, warmth, personal integrity, humility and enthusiasm help to enhance the accessibility of services. Being open to the great variety of perceptions and expectations about health, family life and norms and of acknowledging that the way people perceive health and well-being affects the way they live their lives helps to increase acceptability. If services are accessible and acceptable to vulnerable people, then they are more likely to use them. This was the basis of the idea of 'opening the door to public health,' which was the sub-title of the 2006 review of the principles of health visiting.

Conclusion

Explanations of the principles and practice of health visiting practice are often associated with a service review, or of being called to account for actions, as if they are a source of disapproval rather than interest. In contrast, the experience of explaining health visiting to an interested audience on the other side of world was refreshing. Brazilian services are developing rapidly to try and keep pace with the equally rapid social change, as they strive to deal with conditions which, in many respects, are similar to those that gave rise to development of health visiting in this country nearly 150 years ago. At the same time, they have sophisticated, modern health services. Simply identifying the 'process

statements' about how health visitors search, stimulate, influence and facilitate was insufficient for clarity, yet once these were explained with the underlying values and examples of practice there was enormous interest. Perhaps we need to be both more aware, and better able to explain, those underlying themes to colleagues in this country, as well.

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KEY POINTS

- Abc

Parents 1st. *Parents 1st, community mothers, fathers and carers*. See: www.parents1st.org.uk (accessed 6 Oct 2010).

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