EDITORIAL

A salient visit

I visited Brazil for the first time in 2006, and was struck by three things. First, I was welcomed with so much warmth and enthusiasm that my affection for the country was immediately assured. Second, the sheer size of the country seemed overwhelming, to a native of the comparatively tiny British isles. Third, perhaps reflecting this vastness, the extent of health inequalities was both more immediate and more apparent than any I have encountered before, despite the familiarity of this problem. This led me to reflect on the similarities and differences between our two health systems, on the needs of the populations, and how nurses might provide services themselves, or influence service provision to meet those needs.

I visited a family health unit in São Paulo, and was interested to meet the nurse leading a team of community workers, and to note the similarities with our UK primary health care teams. These usually include doctors and nurses, and sometimes pharmacists and other health professionals, all working from the same base and serving a population registered on the practice list. Until 1974, community nurses and midwives all worked in bases separately from the doctors, and covered a caseload that was geographically defined. People can choose which family doctor's list to register on, so their practices, and associated primary care teams, do not relate to a specific local community. Also, in the UK, we distinguish between the professionals who deal with clinical health care needs (mainly district and practice nurses), and those whose primary responsibility is to promote and improve health (mainly health visitors and school nurses). Close and frequent collaboration between family doctors, nurses and others who provide clinical care to people who need medical treatment helps to promote multi-disciplinarity and best practice. Generally, for this group, the practice list system works very well. However, it is less effective in supporting work for health improvement: the health promotion aspects of community public health. As a result, we are trying to redevelop the geographical links once more, so that health visitors and school nurses are better able to liaise with local residents and communities.

It was this close knowledge of a local area, and potential for community development and health improvement, that I witnessed in action in São Paulo. When we went out into the local area, the nurses and community workers were well recognised and welcomed by the residents, who clearly knew and valued the service offered. The enormity of the difficulties faced by such a small team, and by the population they served, was also immediately apparent. The living conditions in the slum dwellings, which are almost guaranteed to create ill health, cannot be changed by nursing care alone. This does not mean there is nothing to be done; indeed, small actions can make an enormous difference to the life course and health outcomes of residents. However, it does mean being realistic about what can be achieved, about how long it all takes and perhaps also being brave enough to question and influence the larger picture in terms of policies that affect health.

There is increasing evidence about the importance of the very early months and years of life, starting ante-natally [1-2]. So, close support and contact with all new mothers is a very good starting place for improving the health of the whole community. The arrival of a new baby in the family focuses the minds of all concerned: not only the parents, but grandparents, extended family and neighbours. This is a time when the new parents not only need and welcome support, but are particularly likely to take note of health-related information. Of even greater importance, is the increasing evidence about the importance of the relationship between the infant and caregiver, and different approaches to parenting[3]. Poverty and deprivation create enormous threats to health, but some children appear able to defy the odds and thrive despite adversity. Research shows that these are children who have been warmly valued and nurtured through their early years, which provides them with a form of buffer, allowing them to develop some resilience to the difficulties they face later in life[4].

Whilst the huge majority of new parents start out by feeling an overwhelming love for their new-born infants, this relationship can be threatened and challenged in a multitude of different ways: family violence, the anxiety of poverty and adverse living conditions, post-natal depression and a host of other threats. The kind of supportive, listening and valuing provided by a community worker or nurse, can help to model and maintain the positive relationships between mother (or father) and child, which later provides a platform for resiliency[3]. There is evidence that a *strengths-based approach*, is more effective than focusing on risks, deficits and problems[5]. A strengths-based approach means believing[6]:

- that all families have strengths and capabilities and are more likely to respond to interventions that build on these than to ones which identify deficits and weaknesses

- that working in partnership with families empowers them to parent more effectively and builds on strengths as identified by them. The expertise of professional is complementary to expertise of the parent.

• in focusing on family strengths, particularly working with mother/parent to influence child's health and development

• in building skills and capacity rather than dependency, with the professional acting as a resource and facilitator, requiring active participation of client.

Home visiting and relationship-building are key factors in facilitating this strengths-based, empowerment approach. The idea of community workers going out to visit families in their home is public health activity at its most fundamental. Meeting someone in their own, familiar territory is so much more likely to enable them to feel at ease, so they can talk about their everyday worries and difficulties, and work together with the professional to plan ways of countering those problems.

People with similar needs can be brought together through group or community development work, which will help them to develop their own strengths and confidence, so they can advocate for themselves to improve the conditions and situations in which they live. This is the great advantage of having the local health team based in a specific geographical area, within a building that has space in which groups might meet.

Whilst relationships between health professional and client are important, those fostered between family members and across neighbourhoods are more significant for influencing people's long term life chances. This kind of community action and public health work is long term, focusing on promoting and creating health, rather than simply treating or preventing disease. It is increasingly evident that, although the medical approach is extremely important, focusing only on what causes illness, deficit and disease (understanding 'pathogenesis') is simply not enough on its own. Instead, we need to complement this by a focus on what creates health and well being; this is what an author[7] called 'salutogenesis,' an approach that encompasses a more holistic outlook on public health and which seems more suited to the kind of activities engaged in by community health workers and public health nurses.

Ensuring a positive, welcoming philosophy of care is not easy; it can be quicker, and sometimes more acceptable within professional fields, to focus on professionally-defined health needs and medical labels. Ultimately, such an approach builds strengths within the professional community and workforce, rather than within the local population. The professional activities I witnessed in São Paulo looked well able to avoid falling into that self-serving trap; instead, the needs of the local community was uppermost. I look forward to visiting beautiful Brazil again in 2007.

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