



PAN AMERICAN HEALTH ORGANIZATION  
WORLD HEALTH ORGANIZATION



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### **FAMILY AND HEALTH**

The family is the setting where health behavior and decisions are first established, and where culture, values, and social norms are first molded. The family is the basic unit of social organization that is most accessible to preventive, promotion and therapeutic interventions. Changing demographics have brought about changes in the patterns of family relationships. These changes coupled with widespread poverty and increased and expanded risk behaviors, are exerting significant pressure on the family. The impact of the interaction between changes in family and population structures and disease patterns, however, lack adequate documentation.

The declarations from eight international summits in the past decade have supported and demonstrated the growing need for a new social and health agenda that stressed the role of families. PAHO is proposing an approach that places the family as the focus of health care interventions, the aim being to increase the role and involvement of the family and communities in improving the quality of life and health outcomes of the population in the Americas. This approach seeks to attend to the Region's unfinished agenda in health, as well as to the need of maintaining the gains reached in health. The family health focus proposed rests on a life-cycle approach that fosters comprehensive and synergic health actions at each stage of the cycle, and emphasizes ongoing monitoring and evaluation to determine impact.

During its discussion the 132nd Session of the Executive Committee praised PAHO's initiative in bringing forward the topic of family health in a regional forum, and in presenting an approach that responds to the health needs of individuals and their families using the life-cycle approach as its guiding principle. The Committee urged Member States to identify effective means to insert this approach in their primary health care strategy, and support the evaluation of existing country experiences. Member States were also asked by the Committee to provide with national experiences of the family health approach and for PAHO to systematically collect and analyze these experiences, to identify key lessons learned and best practices. The Committee further asked PAHO to develop practical approaches of how this approach might be implemented at country level, with special vigilance to monitoring and evaluation components to measure health outcomes.

The Directing Council is invited to analyze this document and to consider special policy options in relation to this topic.

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## **Introduction**

### ***Importance of the Family as a Social Institution: Why the Focus on Family?***

1. The role of the family in health and illness has gained recognition since the World Health Organization published the 1976 statistical indices of family health, which state that “The family is the basic unit of social organization, and also the most accessible for preventive and therapeutic interventions. The health of the family goes beyond the physical and mental conditions of its members, it provides a social environment for the natural development and fulfillment of all who live within it.”
2. The family is the key social institution that joins individuals related by birth or by choice into a household or a domestic unit. The family is the setting where health behavior and health decisions are first established. In the Americas, cultural factors in families impact significantly on access to, and on health- seeking behavior; for example, women may assign a lower level of priority to their health needs giving preference to other family needs such as food and education. This priority setting may adversely affect the health of the family; however, it is in the context of the family that this behavior is best modified.
3. Health institutions and professionals have adopted the individual as the focus for health services delivery. Consequently the needs of the family as a whole are not addressed properly.
4. The active participation of families and the community in promoting and protecting their own health has been shown to improve effectiveness: Empowering families and communities will increase awareness and demand for quality health services. In effect this may be achieved using a model based on a primary health care approach.
5. Families in crisis in the Region have increased. Societies can no longer assume that all families will protect and nurture their members by themselves. Cultural norms, socioeconomic conditions, and education are significant determinants of family health. Child abuse, neglect, sexual exploitation, spousal and other domestic violence, and neglect of the elderly are common occurrences within the family that are of public health significance. Elder abandonment and elder maltreatment have become a silent epidemic throughout the Hemisphere. Data from Canada and the United States of America indicate that only one out of every four cases of elder abuse in the family is reported. Addressing these problems will require social support, social policies, and the development of a support network, using an intersectorial approach along with treatment of the family.

6. Increasing poverty and social inequity have resulted in decreasing access to services by larger proportion of the population. These changes call for a reevaluation of the traditional approaches guiding the models of care and its content. New approaches should enlist social institutions that can support culturally sensitive participatory health interventions.

***Family and Health Links to Culture, Education, and Development throughout the Life Cycle***

7. Technological development and its diffusion have contributed to the improvement of living standards globally. The family has experienced gains in enhanced educational opportunities for children and greater security, along with increased leisure time. Negative effects are also known, including the stresses of change in the living and working environment, displacement, and dislocation.

8. The Copenhagen World Summit for Social Development recommends that full educational opportunities be developed, paralleled by adult education and lifelong learning, which focuses acquisition of skills on ways of learning rather than on a subject content. From a cultural perspective, it is important to recognize the role of the family in the development of such a learning habit. Education is known to facilitate access to basic health and social services. Better-educated women are more likely to marry later, bear fewer and raise healthier children, make better decisions for themselves and their children, and make greater economic contributions to the household and family unit. One of the strongest statistical correlations in countries of the Americas is between a mother's education and infant mortality. The children of women with more years of schooling are much more likely to survive infancy.

***International Summit Mandates and Goals that Favor the Family***

9. The International Conference on Population and Development (Cairo, 1994), the United Nations Millennium Development Goals, the Special Session of the United Nations General Assembly on Children (2002), the World Summit for Children (1990), the Education for All Declaration (Jomtien, 1990) and the World Education Forum (Dakar, 2000), the United Nations International Plan of Action on Ageing (2002), have all addressed family issues extensively.

10. The Summits' declarations state that the family is the basic unit of society, entitled to receive comprehensive protection and support, and should be strengthened. The family has the primary responsibility for nurturing and protecting children; their introduction to the culture, values, and norms of their society begins in the family.

11. The declarations seek to develop policies and laws which support and contribute to the family and its stability, promote equality, and identify objectives and actions of direct relevance to the family. These objectives and actions are related to improving women's access to employment and educational opportunities; supporting shared responsibility with men and active involvement in responsible parenthood; emphasizing the importance of investing in child and adolescent health and development as a cost-effective way of securing future prosperity for nations; highlighting older persons' contributions to children and grandchildren; and calling for immediate action to break the vicious circle of poverty and ill-health affecting families worldwide.

12. The Mexico 2000 Declaration urges the promotion of health across the life cycle and the establishment of healthy public policies to strengthen the family. It also stresses the importance of the role of the family in promoting health and identifies the need to reorient health services with a family focus. These recommendations were adopted in Resolution CD43.R11 of the 43rd Directing Council of PAHO in 2001.

13. The declarations from the summits demonstrate the growing need and recognition for a new social and health agenda for families. The goals identified are a global challenge and can only be achieved by finding new ways to expand coverage to underserved groups.

## **Situation of the Family in the Americas**

### ***Definitions, Structure, and Dynamics***

14. In the last decades, the structure and definition of understanding the family has been broadened. New trends in family formation, structure, and function are shifting toward: (1) single-parent family and female-headed households; (2) higher average age for women's first marriage and child birth, delaying the formation of first families; (3) increased entrance of women into the labor force in unprecedented numbers and changes in gender roles within the family, shifting the balance of economic responsibilities in families; (4) decreasing family and household size; (5) increased burden on working-age family members by young and older dependents. Additionally, the household has emerged as a strong socio-economic unit, frequently taking the place of the family exclusively formed through parent-child and extended family relationships.

15. The effects of social forces exerting pressure on the family are notable. It is recognized that the family has a major responsibility for the socialization of its members, their education, and the set-up of social norms and gender roles. Also, the family's responsibility in the reproduction of power relations between men and women is considerable. Although some of the socialization functions such as education and labor have been transferred to schools, the family is still performing key socialization

functions, such as developing stable interrelationships and solidarity with other persons, as well as developing mechanisms for coping with conflict within the family and managing pressures created in the work, social, and political spheres.

16. The health paradigm based on the family as the primary unit of analysis, diagnosis, and practice should be grounded on the etiology of health and illness, and definitions of family as a functioning structural unit of society. This creates a definition of family as a dynamic process that is greater than its parts. However, the family health paradigm is also concerned with explaining the development of the physical, mental, and emotional well-being of its members. Consequently, this document addresses both the health of the family and its individual members.

### ***Demographic Aspects, Trends, and Projections***

17. In the Americas, patterns of family and household composition and marriage are changing. There is a marked trend toward households headed by women since the 1970s.

18. The changing demographic structure, as well as the social, economic, and political environment in the Region places families and communities under great stress. The average family size is shrinking due to dispersal of family members. This affects the rhythm of the family cycle, family-centered socialization of children, and care of young children as well as aging adults. Given the above changes, dependent and aging family members are less likely to receive adequate care.

19. Other factors that fuel this include rapid urbanization, decreasing prevalence of the nuclear family, greater access and participation of women in the labor market, low levels of education, and high prevalence of absolute poverty. The result of this trend is the acquisition of new lifestyles related to urbanization, a gradual decline of infectious diseases with increasing burden of chronic illnesses (including violence, accidents, addiction, and mental illness) which are important causes of death and disability.

20. In the Americas there is no ongoing analysis that links mortality and morbidity with socio-economic data that allows us to accurately characterize the family and analyze family behavior. In developing a family approach to health, consideration will have to be given to the critical relation between social variables and the major health areas. In the Region only a few countries collect this type of data. Monitoring, evaluation, and strengthening of information systems will be a crucial part of the effort to design, plan, and implement family-centered interventions.

### ***Poverty, Marginalization of the Family, and Families in Crisis***

21. Poverty is an underlying factor in the health of women, children, adolescents, and the elderly. Globally under-5 mortality currently averages 6 deaths per 1,000 live births in the high-income countries but is as high as 175 per 1,000 in low-income countries. In the Americas 22,000 women die each year from complications during pregnancy and child birth. Maternal and child health is worse among the poor. In some countries children in the poorest third of the population are six times more likely to die before the age of 5 years than those among the richest 10%. Older people who survive to age 60 and belong to the lower quintiles of income level tend to have more years living with chronic disease and functional limitations than those in the upper quintiles.

22. Inequities in socio-economic conditions have implications on the physical quality of the workforce, educational achievements, composition and size of the household, nutritional levels of the population, and availability of services and basic consumer goods, quality of housing, and levels of crime and violence. These factors influence family structure and economy and consequently the health of the family.

### ***Resiliency and Family Connectedness***

23. The family has shown remarkable vitality and resilience. Rather than indicating an erosion or decline of the worth of the family, new forms of family life are developing to meet the challenges of the modern world. Adverse health outcomes associated with these family changes impact on children, whose self-esteem and basic life skills are influenced by and are established at an early stage in life. Data from the United States show that 22% of girls and 12% of boys have attempted suicide at some stage in their adolescent lives. The data from the Caribbean region (2000) is similar: suicide attempts are associated with friends or family ever attempting or completing suicide and other risk factors, such as drug and alcohol use, physical or sexual abuse, health concerns, availability of a weapon, and a history of being in a special education class. For both males and females, discussing problems with friends or family, emotional health, and connectedness to family were protective against suicide attempts. The probability of attempting suicide increased dramatically as the risk factors to which an adolescent was exposed increased; however, increasing protective factors was more effective at reducing the probability of a suicide attempt than was reducing risk factors.

24. In addition, older persons are disproportionately likely to commit suicide. In the United States, older people made up 13 % of the population, but they accounted for 20% of all suicide deaths in 1997. In addition to a higher prevalence of depression, older persons are more socially isolated and more frequently successful in the use of lethal methods of suicide. Fear of overburdening the family with long-term care is often one of the motivating factors behind suicide in the elderly. It is in this changing context that we

need to reexamine the role of the family in promoting health and preventing illness. We need to contribute to family resiliency by increasing the protective factors associated with the family in our health interventions.

### ***Impact of Family Links to the Community and Role of Family in Health***

25. Families are often a reflection of the community and provide the first level of education for its members about healthy behaviors that should be followed, unhealthy behaviors to be avoided or changed, and their roles and responsibilities to themselves and to society. Sometimes elements in the family setting are not conducive to promoting or protecting the health of some of its members. It is therefore important that the community have family support systems in place in cases where the health of family members is threatened by violence, abuse, neglect, or abandonment.

26. Many different stakeholders in the community, such as religious and social groups, contribute to the social support networks needed to strengthen the role of the family in promoting and protecting health. Increased awareness, information, advocacy, and access to health services, especially early detection and preventive care are of critical importance. The family as the focus for health promotion will require the development of practical approaches that employ social variables in the analysis of health and human development strategies, and the recognition of the power of social variables in influencing healthy behavior.

### ***Role of Grandparents in the Health and Well-being of Grandchildren***

27. In the Region of the Americas, grandmothers caring for grandchildren enable mothers to incorporate themselves into the formal or informal labor market, thus increasing the health and well-being of children and the family. In Guatemala “Grandparents for Health” and in Uruguay “Grandparents by Choice” link older people with children and adolescents. In the United States, grandparents who are the primary caregivers for grandchildren have new legislation to protect their rights, and they receive support from a number of NGOs in their parental role.

### ***Experiences in Family Health in the Americas and Cost-Effectiveness***

28. The Statistical Indices of Family Health report (WHO, 1976) observed that in spite of its central position in society, the family has not been studied frequently from a public health point of view. The family is one of the social systems that characterize all human societies. The complex interrelationship, however, between family and health is poorly documented; available data still tells very little about the family setting.



### ***Specific Country Experiences with the Family Health Program***

29. In analyzing the family program in the Americas, the Brazil and Cuba models have many similarities, are physician oriented, focus on the family in their communities, are State funded, and offer services that are delivered in an integrated manner.

30. Project HOPE in Ecuador is an example of an integrated project that views the family as a setting where health is produced. It has developed a health education/promotion component that helps to meet the economic and education needs of the family, increasing women's income and empowering them through education in business management and finance. The health of women, their families, and the community has improved.

31. These models are examples of the family health interventions in the Americas. All use a team concept; however, some models utilize nurse practitioners, nurses, and paramedics with referral to polyclinics or referral centers for specialist diagnostic techniques. Others have focused on using fully qualified physicians to handle every level and aspect of health care. Most models place the health system resources directly in the community by placing the teams in close proximity to the families whose health they manage. Many countries in the Region, including Brazil, Canada, Chile, Cuba, Ecuador, Mexico, Peru, United States, and some countries of the Caribbean, have to varying extents introduced family health interventions.

32. However, the evaluation of these experiences is not completely documented and their applicability in varied settings has not been tested on a wide scale. PAHO has been working with the countries in this area and proposes to build on these experiences, using health promotion and prevention strategies. These country experiences have produced positive results; however, their applicability in different settings has not been evaluated.

33. The country experiences analyzed provide some information on functioning models that contain the following components: empowerment of the families to solve their own problems, an integrated approach with promotion of an intersectoral approach, state funding usually, a focus on the family from a holistic point of view with educational and economic needs considered, involvement of the community, access to services facilitated, and strengthened monitoring, evaluation, and surveillance as an integral part of the system.

### ***Challenges/Obstacles to the Implementation of Family Health Models***

34. Reorienting health services to respond to the needs of families presents many challenges. Moving from an individual-centered service to a family-centered service requires a new model of care that places the family as the object of health intervention

and views the family as an environment for health interventions. This requires organizational changes at the system level and management changes at the service level. For those countries that have already implemented a family-oriented care model, efforts are needed to improve the services' resolution, quality and efficiency aspects.

35. Implementing a family approach also required overcoming the need for changes in family health providers' competencies and attitudes, political commitment, and resource allocation at national level.

36. At the policy level, national governments need to decide on the model of care to be embarked upon and approval of the legal framework to support the family approach. In the Region, Chile's family-oriented care model has been developed in the context of health sector reform to more effectively respond to the challenges of primary health care. The model seeks equilibrium between increased access to services, increased user satisfaction, improved response, and operational cost containment. Using a multidisciplinary team approach, Chile has increased promotion and prevention interventions, enhancing the role of beneficiaries and the community as active participants in their health situation. Additionally, Brazil used a multidisciplinary team approach but also created financial incentives that facilitated the access to services for the underserved groups in the population. These incentives facilitated physicians moving to underserved areas in the country. Countries have worked with schools of medical sciences to alter curriculum for physicians, nurses, and technicians, and have created in-service training to improve the competencies of the staff.

37. An important challenge for some countries, like Chile and Brazil, has been the restructuring to a family approach with parallel changes toward an insurance-driven health care system with choices based on one's ability to choose and pay for services.

### **Guiding Principles for Action in Family and Health**

38. The foundations of health are laid in the preconception, early childhood, and adolescent periods. At the same time, many individuals are not reaching their full potential due to poor health and inadequate care for their physical, intellectual, and social development. Therefore, a life-cycle approach is needed to adequately respond to the needs of individuals and their family in the setting of their community.

39. Preliminary data available from the Region shows that using a family approach as the focus of health activities can lead to improved health outcomes. Interventions will seek to strengthen PAHO's health promotion and protection approach, which addresses inequities and poverty, serving marginalized groups, while facilitating respect for and the protection of the rights of families.

40. A public health, intersectoral, interdisciplinary approach will be the basis for the planning of comprehensive family interventions.

### **Priority Areas for Action for PAHO**

***PAHO family health interventions will focus on the family using a life-cycle approach. The family will be viewed in a holistic manner and will seek to provide family health interventions in an integrated manner***

41. Families are essential to and are active partners in promoting healthy growth and development during all stages of life. Families play an important role in strengthening protective factors and minimizing risk factors for every individual within the family. The involvement of the family will be promoted at all levels through improving individual and community empowerment, promoting healthy environments, development of healthy public policies, reorientation of health delivery activities, and the development of new approaches based on family-centered interventions.

### ***Maternal, Newborn, Child, and Adolescent Care***

42. The maternal and newborn health focus will be on early enrollment to prenatal control with guaranteed access to higher levels of care, according to the risk/needs of the mother, postpartum care, family planning counseling, responsible fatherhood, and prevention of cervical and breast cancer. Newborn care and child health and development will focus on breast-feeding, complementary feeding, and growth and development counseling and immunization.

43. Parenting skills will be strengthened focusing on interfamily dynamics; public policies, mainly in the areas of education and health; and images that are identified and the types of relationships that are modeled by media and social communication systems.

44. PAHO proposes to strengthen the empowerment of families with children/adolescents (33% of families in Latin America and Caribbean countries have a child or adolescent) through the development of healthy public policies. PAHO will also promote evidence-based interventions to strengthen families, as well as adapt health services at the primary level using a family approach for adolescence.

### ***Safe Physical and Social Environment***

45. Many issues that potentially threaten the safety of the community's physical and social environments lie outside the control of the family. These physical and social threats are amenable to improvement through anticipatory planning for their prevention or control. Collective solutions can be found within families and through intersectoral support from multiple community institutions that will respond to the felt priorities of its residents.

### ***Family Caregiving of the Elderly with Disabilities and its Effect on Family Health***

46. Research on family care giving has consistently validated its significant role in preventing or delaying institutionalization, but has also shown the problems and needs experienced by informal caregivers. Half or more of family caregivers juggle work, family, and care giving responsibilities, resulting in work disruptions and lost productivity. The family continues to be the preferred setting for the delivery of care to older persons with disabilities; policy initiatives need to be developed to support the role of family members in the provision of care for the elderly.

### ***Mental Health/Psychosocial Development, Violence and Suicide Reduction as a Continuum Across the Life Cycle***

47. The focus will be on early interventions to prevent school failure. The results of research relating to the mental health of mothers/children will be used to foster early child development, develop tools to evaluate child care institutions, and promote improvements in the quality of care of institutionalized children, reducing violent behaviors and delinquency. The results will also be used to strengthen the coordination between the various agencies, such as health, education, and justice departments and institutions involved in the care of children with mental and psychosocial disorders.

48. The focus for intra-familial violence reduction will be on helping families before the risk of violence or neglect escalates, i.e. prevention intervention that focuses on the family as a whole, and in providing proactive and mutual support along with crisis and recovery interventions supported by education and policy development, along with strengthening the focus on alcohol and substance abuse.

### **Proposed Strategies**

49. PAHO proposes using a combination of health promotion strategies, including the generation and dissemination of scientific knowledge and experiences, development of local models for health and education focused on the family, including community empowerment and participation in family health, as well as providing support to

caregivers of persons with disabilities. PAHO will also advocate for and support healthy public policies and legislation development that will guarantee that essential support and services are provided to the community.

50. PAHO also proposes strengthening strategic alliances/partnerships with other agencies and stakeholders, e.g., religious institutions, NGOs, and the private sector. PAHO will build on and integrate evidence-based interventions in the reorientation of health services in close collaboration with the countries of the Region.

51. Under these proposals, PAHO will:

- (a) Develop in conjunction with countries a framework for the implementation of a family approach to care throughout the life cycle to ensure optimal growth and development and improve the quality of life for families. This framework will emphasize synergic actions between each stage of the life cycle, and will be adapted to individual country needs, taking into consideration the different stages of development and disease evolution;
- (b) Support the development and promotion of policies and legislation in support of families, as well as the creation of enabling physical and social surroundings to achieve healthy and productive family life;
- (c) Strengthen the role of family and community in education and health;
- (d) Strengthen community participation and empowerment of families so they may become key actors for better health for themselves and their communities;
- (e) Contribute to human resources development and re-orientation of the existing human resource base in the areas of family health;
- (f) Promote and support operational research on reorientation of services with a family focus, and develop evidence-based information on the cost-effectiveness of family health interventions; and
- (g) In collaboration with Member States, develop indicators for the evaluation and monitoring of the family approach to care.

**Action by the Directing Council**

52. The Directing Council is invited to discuss the issues presented in this document and to consider the importance of the Member States in setting national priorities to strengthen the role and capacity of families in promoting and protecting their health, and the health system capacity to respond to the needs of the families.

53. The Council is further invited to provide suggestions and comments regarding the following considerations: (a) develop public policies that empower the families and support legislation to protect the health of families; (b) support the design, implementation, and evaluation of family health models, programs, and services; (c) develop advocacy/social communication interventions focused on the family; (d) provide PAHO information of existing experiences with the family health approach in a country; (e) improve information and surveillance systems to develop indicators for the evaluation and monitoring of a family approach.

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