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"FAMILY STRUCTURES AND HEALTH"

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Report

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1. Subject and goals of the workshop

The significance of primary health care by non-professionals is emphasised in the regional strategy of the WHO "Health for all by the year 2000" as well as in various national health promotion and health education programmes. Thus health-related activities of the population and, above all, everyday activities of the family come to the fore. The recognition of the daily health activities of small social networks is not only connected with the problems of financing the further growth of health services but also with the development of a health care system that meets the requirements and is therefore institutionalised in the best possible way while at the same time the individual's responsibility for self-care is encouraged. In this context the work of primary, closely-knit, social nuclear groups as an institutionalised or de facto existing family for the life-long development of the personality in health, crises, disabilities and sickness is undisputed. At the same time in the everyday life of the family, the socio-economic and socio-cultural living conditions are becoming more concrete; it is here that life styles, whose significance for health promotion activities was recognised in 1983 at the 33rd Regional Committee in Madrid, are being formed, practised and modified by conditioning factors of working life. Thus, the family is not a fixed unit but dependent on the overall social system, the nationally and historically specific political, economic, ecological and social conditions which determine family structures in the respective societies and influence the value of this primary group in the life context of its supporting members. In order to be able to include all this in health promotion programmes it is necessary to acquire and exchange knowledge about the family and experience with the family

from different points of view. This interest was the determining factor in the selection of participants from different fields of science and practice.

Consequently, the essential goal of the workshop "Family Structures and Health" was to be: to describe the development of family structures from a social and historical point of view, to summarise the present situation in connection with problems relevant to health and to present possible developments of family structures as well as appropriate health promotion strategies; at the same time special attention was to be given to changes in women's conception of themselves and their rôle.

The four background papers were to be drawn up on the following topics under the aspect of health activities:

1. Socio-historical presentation and analysis of the development of family structures with special attention being paid to the socio-economic living conditions.
2. Early childhood development and parent-child interactions against the background of socio-structural living conditions and cultural traditions and values.
3. Life styles and everyday organisation of families of different social strata and cultural groups from the point of view of coping potentials (coping strategies) of families of different structure.
4. The significance of the family for public activities and the families' image of government and non-government organisations in their health promotion programmes.

The determination of health-related activities as everyday behaviour was important, the quality and quantity of the families' own potentials and strategies being analysed together with their limitation as a result of structural features within the given system, inner-family conditions

and capacities of the subjects. Background papers were drawn up on the goals of the workshop which are intended to provide a historical and present-day survey on the connection between family and health policy, to illuminate the present situation of the family and health-related everyday activities in (family) households. Within this overall framework more specific problems were dealt with in reports and joint reports and ideas for discussions were given. At the same time intended and unintended consequences of health-related programmes were also to be discussed so that these considerations can be included in the development of new health promotion programmes.

## 2. Opening ceremony and welcome

Ministerialdirigent Prof. Dr. Schröder (Federal Ministry of Youth, Family and Health, BMJFG) emphasises in his welcoming speech the high value of family and health policy for the Federal government. He says that in the family the members of the family are prepared for essential tasks of the life in society and that existing and planned family policy measures will continue to improve the conditions and prerequisites for that. He especially emphasised the aspect of mutual care among family members in the fields of maintaining health, regaining health and nursing for the younger as well as for the older generation. He continued by saying that the goal of an integrated family, social and health policy was - employing all political fields - to promote well-being, especially by intensifying private care systems.

Dr. Ilona Kickbusch (WHO-EURO, Regional Officer for Health Education) put the workshop's topic "Family Structures and

Health" into the context of central political questions of the present and the future.

- Crisis of the welfare state form of solidarity
- crisis of the unpaid work of women
- crisis regarding values in the male society
  
- The crisis of the welfare state form of solidarity demands a rethinking process. New forms of solidarity and health care as an answer to problems of social security, so that the patterns to compensate for different risks in life are acceptable and the organisation of health care appropriate to the needs, that means which institutional and social frameworks have to be created so that welfare and care can be paid for and put into practice.
  
- The crisis of work, of paid and unpaid work is closely connected with this. Many things done by the family are not substitutes but prerequisites for the use of welfare state services. Thus, the health functions of the family are - in contrast to the thesis of the decreasing function of the family - continuously increasing. This means that the amount of so-called "shadow work", above all the unpaid work of women in the family, is increasing.
  
- The objectively changed situation and the subjectively changed wishes and needs of women in connection with the two crises mentioned above can be described as the crisis of the patriarchy. The values of the male society are being recognised as worthy of being changed. New values on the basis of which man and woman should live together have to be developed.

These three crises or restructuring processes provide the background for the planning of future health care. It was also made clear that this workshop partly overlapped with programmes and problems of the WHO. The lay care programme

also deals with health services provided by the family with particular attention being paid to the health work done by women. The development of a health promotion programme is based on the two central concepts "life styles" and "health culture" which - as actually lived everyday life - are considerably influenced by the primary socialisation within the family. In the further development of the system of "primary health care" it is recognised that the lay system - and thus also family (households) - are the basis of all health care and sickness care; the extent of the care provided by the lay system was not recognised for a long time. The question in which case lay care is work and in which case it is self-help, in which case self-help is work for others and in which case it is work for oneself serves to counteract the opposite danger of excessive demands on the family.

In her introduction Dr. Ute Canaris (Director of the Federal Centre for Health Education, BZgA) justifies the Federal Centre's interest in the workshop entitled "Family Structures and Health" with the experiences made so far with health promotion programmes both in and by the family. The Federal Centre developed two strategies which take the importance of social reference systems of the family into account: precise definition of the target group with respective social living conditions as well as health problems serving as a parameter: involvement of multipliers which function as mediators between the institution and the individuals and social groups such as families. In this way acknowledgement is made of the fact that the family does not exist. Family-related health promotion does not just have to refer to a large number and variety of present-day living conditions and problems of the families, but also has to confront the uncertain future which families face. In addition to that, health promotion in families always has to be sensitive to the field of tension of

autonomy, free decisions of the family and controls from outside like in the area of individual health between one's own responsibility and normative expectations. At the same time it has to be taken into consideration that health promotion programmes are not over-demanding for people. The chances offered by this workshop are to be found in the mutual stimulation to get new ideas and in the exchange of experiences on the part of the participants who are of different nationality and from various professional backgrounds. Above all, with its presentation of health promotion projects for the family, this congress makes a contribution to the setting up of a network: Health Education in the Family, which was started in joint work by the WHO and the BZgA.

### 3. Change in family structures

The analysis of the changed family structures which make new demands on government health policy formed the central topic of the discussion. In the talks given by the main speakers (Agnès Pitrou, Rosemarie v. Schweitzer, Rita Süßmuth) as well as in a lot of contributions made to the discussion, emphasis was put on the changed family reality in European countries and its consequences for health work in the family.

#### 3.1. Household and family systems

The data about the present situation from the individual countries vary, the trend being in the same direction. To cite just a few examples: in Yugoslavia the proportion of urban inhabitants has more than doubled (1953: 21.7%, 1981: 47.7%, Grqurić & Svel) in a period of barely 30 years. The size of households is decreasing, in Yugoslavia it dropped on average from 4.37 in 1948 to 3.61 in 1981. In the Federal Republic of Germany the proportion of three and four-member households decreased slightly, that of households which have five or more members dropped by 50%



(from 1962/63: 14.8% to 7.4% in 1983). On the other hand, the proportion of one-person households in that period increased from 19% to 31.2% in 1983, the proportion of two-person households having remained fairly constant (1962/63: 26.7%, 1983: 29.7%) (Rosmarie von Schweitzer from *Wirtschaft und Statistik* 4/1984, p. 365). In the Federal Republic of Germany the family household is in the minority. The proportion of one-person households in France is 24% (Agnés Pitrou).

This development has partly to do with the sinking birth rates in Western Europe from 2.4 between 1950-55 to 1.6 in 1980, in Eastern Europe from 2.93 to 2.19 in the same period, as well as in Southern Europe from 2.66 to 2.09 (Rosmarie von Schweitzer from *Proceedings of the European Population Conference 1982*, p. 34), the increasing number of divorces and, at the same time, a drop in the number of marriages (1960: divorces: 9%, 1982: 33%) and the increased life expectancy (Western Europe in 1950: 67 years and in 1980: 73 years, and in Eastern Europe and Southern Europe from 61 to 71 and 62 to 72 respectively in the same period (von Schweitzer, see source mentioned above, p. 27)).

Apart from the well-known demographic changes, such as falling birth rate, increased divorce rate, a rise in the number of one-person households, age structure and similar things, the changed connection between household and family systems is also significant. A household system denotes a group living together and managing finances together. A family system is characterised by the degree of relationship (cf. Rosemarie v. Schweitzer). Both systems go together but they can be associated together in different ways and therefore provide differing family resources for health. With the help of this analytic differentiation of family and household systems today's family reality in its actual efficiency can be recorded more precisely.

Above all, new forms of living together (without being related), the change of the typical stages of the family

cycle (marriage behaviour, number of children, divorce, remarriage, life expectancy) and the increasing number of households where not one member is gainfully employed have to be taken into consideration.

The breakdown of private households (excluding foreigners' households, private households in institutions and households with especially high income) according to the social standing of the wage earner shows that from 1962/63 to 1983 the proportion of households of non-gainfully employed persons increased from 29.8% to 41.4%.

The family networks of communication and support function despite independent households; owing to the instability of marriages, for example, they can even get broader and have more branches. It is, for example, not unusual that relationships between grandchildren and grandparents continue to exist despite divorce, despite remarriage (cf. Agnès Pitrou).

If the middle classes favour friends and the lower classes favour the family as a system of help - as Agnès Pitrou explains - owing to existing financial, cultural and inter-human resources a "conservative" effect can easily occur with the support within the family network, that means an existing social imbalance is maintained if no help comes from outside. Although there are plenty of data on the family situation there is a lack of analyses about those new forms of relationships.

Only when we know how these households are connected with each other, what the possibilities of help and the need for help are actually like, can we draw conclusions as to health behaviour and health work in the family.

The "underground networks" (Pitrou) of mutual help have to be analysed just as well as the redistribution of burdens within the family, between husband and wife. It will depend on both factors whether it is possible to find new resources of mutual help or whether the "family boat" is loaded up until it sinks.

### 3.2. Tendencies of disorganisation in the family

Against the background of the analysis of changed "family realities" the far-reaching thesis of health policy should be re-examined whether there are tendencies of disorganisation in the family and how these affect the health of the family. The change of family structure, the increase of one-person households, the rate of divorce and above all the gainful employment of women are all facts which have been described in specialised literature as factors which promote sickness.

In the contributions to the workshop, the impact of instability in today's family on the child was examined without, however, endorsing the hasty conclusion that any "incomplete" family had negative consequences for the health of the child.

On the one hand, there is the external organisational structure of the family, on the other, there is the internal structure. The emotional potential for conflict in the family is being examined by family therapists specialised in depth psychology as well as by systemic therapists. A variety of mental, psychosomatic and somatic disorders are expressions of conflict-burdened family relations.

There were two different opinions in the discussion regarding the influence of gainful employment of women on family relations. The shift in the family time structure by changes in the time when women are mothers (this tends to be later and shorter) and increased identity, synchronisation of life rhythms of women and men by gainful employment can possibly harmonise the inner-family interaction.

The conflicts that result from the different needs of men who go to work and women who are described as being just a housewife are lessened by the changed organisation of their lives which is a consequence of them both being gainfully employed. On the other hand, this causes a distinction between women who go to work and those who are described as being just a housewife.

This was countered by the statement that the adaption of life rhythms was a euphemism for the fact that the social working rhythm penetrates everything and that thus people lose their inner rhythm. The reduction of conflicts by adaptation has the negative effect of the explosive power of the underestimation of people's own rhythms and their possible consequences for health.

The available data on mental health (cf Alfred Sand) and the physical development of children (Kurt Hartung) do not have to be interpreted against the background of the normative image of an "intact" family. The discussion produced important ideas regarding a normative reference framework for the analysis of the connection between family structures and health.

Differentiated research according to the notion of lifestyles would counteract a limitation to the normative point of view like an attitude that tends to be paternalistic towards the lower class family which is becoming rather conspicuous as a result of the control structure. There is the danger of doing too much therapy work in the lower classes instead of providing material support.

Warnings against the practice of describing family reality against the background of Central European family models were voiced. Comparative studies show significant regional differences even within Europe as far as cultural traditions are concerned. The varying rôle of religion was especially pointed out. Demographic data, too, show considerable regional differences, for example, regarding gainful employment of women. On the other hand, all European countries record a decreasing birth rate. That means for many children that they grow up without brothers and sisters (and sibling solidarity as a stabilising factor).

The historical point of view offers further proof of scepticism regarding the normative model of the normal family (father - mother - child). If one investigates how long these family structures which generally are thought to be normal have existed, the answer is that this "normal family" is very young. From a historical point of view it is not only young but it almost represents an exception in its form as "nuclear family". Because, did this sort of family exist in the times of large migrations of peoples, rural exodus, the prohibition of marriage, during the two world wars? These historical data suggest that the "disorganised", the "unstable" family was the norm. Present-day developments, too, would confirm this. There are new migrations of peoples, there are new forms of living together, consequences of new economic and social crises have to be coped with.

On the model of the "nuclear family" pathogenic structures are drawn which possibly conceal new resources of help within and between generations and increase the dependence on health services. This applies, above all, to Third World countries where the export of the European-orientated couple-related family model destroys workable relationship systems.

On the other hand, the above-mentioned changes of family structure demand new forms of health services which advise and support the family (for example, supporting help can help to prevent a child from experiencing divorce as a loss of confidence).

In the discussion attention was drawn to the fact that second marriages are obviously more satisfying for the partners which can be seen from their greater stability, but that for children there are no models for this situation of remarriage of a parent: to accept the step-father or

step-mother and, at the same time, not to deny the divorced parent. Because the present instability of the family is still accompanied by a subjective orientation towards the intact normal family against the background of which a separation, for example, is experienced as personal failure.

#### 4. Health work in the family

The analysis of family relationships is to provide information on the significance of health work in the family as well as ideas about the prerequisites of a family health policy. The central theme of the preparatory contributions and the discussion was the analysis of the specific health behaviour of the sexes and the particular rôle of the woman as health worker in the family.

##### 4.1. Socialisation theses

The fact that health behaviour differs according to the sex has so far been neglected when developing health education concepts. These result from sex-related socialisation processes such as have already been investigated by socialisation research work without, however, referring this research work to problems of health education (cf. Rita Süßmuth).

Health education in the family can be seen on two different planes. On the one hand, the fact that parents expect their children to behave in a healthy way is in direct contrast to the health practice of many families. Children are therefore expected to understand highly contradictory health-related learning processes.

In their own lives they experience a break between the person-related interest in their well-being as babies and toddlers and the functionalised health understanding which is connected with certain things that are expected of them which begins when the child starts school at the latest; this is experienced as a prerequisite for being accepted and socially integrated.

Children experience the conflict of goals between family, person-related health ideas of consideration for the individual constitution and regard for one's own needs and the social expectations of efficiency (to the limits of one's capacity and partly beyond them) at work and at home.

This conflict or the priority of one of the ideas is passed on consciously or unconsciously (cf. Rita Süßmuth). On the other hand, men and women are brought up to a different regard for and a different way of treating their body.

Norms like female weakness and male strength are learned in early childhood.

The sex-related socialisation in which girls learn to form their physical strength into "fragile attractiveness" and boys into "trained toughness" according to the sex stereotype, while they experience that their mothers are often more robust and can endure more stress than this stereotype prescribes, is also characterised by contradictions (cf. Rita Süßmuth).

A functional health understanding where health is only a means of fulfilling social demands on masculinity and femininity increases this sex-specific health behaviour. The sex-specific health education in the family is additionally intensified by the fact that it is women who alone are responsible for the upbringing of children. The socialisation-specific analysis of health behaviour in the

family provides important suggestions for health education programmes regarding the perception and experience of their own bodies by men and women.

#### 4.2. On the rôle of women

A positive feature of the talks and the discussion was the fact that the rôle of women was specifically analysed. The fact that women play a central rôle in family health education and health work has often been neglected in health policy as well as in research. Because the sole and exclusive responsibility of women for child care is the basis for the future model of health assistance.

The all-powerful mother, the image of motherliness as a social norm characterises the relationship between man and woman, its sensitiveness and ability to experience or, on the other hand, its emotional dissociation or expressionlessness regarding one's own well-being and physical symptoms (cf. Caterina Arcidiacono).

In general, in the family, fathers show little interest in body and health problems; a survey showed that only 50% of the fathers take care of sick children. If they are involved in child care they react rather nervously or even panic at signs of illness. It seems as if both forms, distance or nervousness, have the same psychodynamic origin: the male denial of helplessness (cf. Caterina Arcidiacono). The special rôle of women regarding body experience can be analysed on two planes. Women have developed a great ability to "nurse". They are experts in dealing with emotions in relationships, in help for others. In this capacity they take on important functions in the family as



well as in health professions. As health workers they are under high pressure both in the family and in the health system.

It is primarily the woman and/or mother who takes on the task of caring for the other family members, encourages them to look after themselves and supports them in this; however, in many cases she cannot manage to realise the same care for herself. In addition to that, women have developed a specific physical behaviour which symbolises their helpless social rôle. Women are made aware of their bodies, of body expression, weakness etc. The woman orientates herself towards the image other people have of her body. Beauty and sexuality determine the symbolic image of her body. The female body is associated with being delicate, beautiful, small, weak, helpless (cf. Christine Woesler de Panafieu).

This female body expression forms the health and sickness behaviour of women, the use of health services and the "flight" into sickness as a consequence of social helplessness. Sickness as the form of behaviour that does not correspond to the norm through which the conflicts of women can be expressed in a "socially accepted" way, which correspond to the female history of socialisation and to the institutional possibilities (of the health system).

More and more women consult medical and social services about their mental and social conflicts. Up to 80% of the use of social welfare centres is made by women (cf. Barbara Riedmüller). The extension of those professional help centres possibly increases the tendency of women, which exists anyway, to express their psychosocial conflicts in a somatic way.

In the discussion some of these theses were questioned, especially those regarding the inner-family rôle behaviour. The sole dominance of mothers in the present time was

questioned. Above all, the new rôle of the fathers was emphasised which characterises the changed forms of relationships between man and woman and between man and child. Is a new attitude towards motherliness and fatherliness developing because of the emotionalisation of the relationship of couples which can be observed today, or are female fields and resources (the birth, the competence for emotions etc.) only "occupied" by men without any basic changes in the relationship between man and woman taking place? Modernisation of the patriarchy? Are new social resources of experience, knowledge and practice being revealed by the emotionalisation of the inner-family structure or are traditional structures of help among relatives or in the community being destroyed by this emotionalisation? The contribution of the new fathers in the family does not look very new in international comparison: for example, in the Federal Republic only 15% of all men help a working mother with one child, in Belgrade it is 40%, in France 21%, in Italy 9%, in Holland 19% (cf. Hilary Rose & Sue Ward).

With the gainful employment of women they are becoming less willing to accept the so-called "natural" division of labour, it is they who look actively for other resources of health self-help.

#### 4.3. Self-help

Health work in the family - this was the name of the central thesis - is always everyday work and bound to the conditions of our everyday organisation. For some years this daily health work in the family has increasingly been recognised from the point of view of self-help in contrast to the professional health system. The empirical findings on self-

help in households, among friends, neighbourhoods and at work show that the willingness to participate in self-help (groups) is widespread. The available data (cf. Dieter Grunow) indicate that 30% of all people are interested in self-help groups. The number of those actively involved, however, is only 3%. It was pointed out that the number of self-help groups in Europe is far lower than in the USA. The definition of self-help in health (here self-help in health means "unpaid for, informal, personal work and mutual help done and provided by laymen within social groups directed at maintenance of health and coping with illnesses" (cf. Grunow, p. 3)) led to some controversial discussions. The report emphasised the facts of health help in the family that can be measured and which is orientated towards limited times of illness and definitions of illness. In the discussion this definition of self-help was regarded as too narrow. If the psychosocial dimension is added to the notion of health, health-related activities in the family are less related to sickness but can be related to the fields of life like work, home, leisure, sexuality. The daily health work in the family thus takes on a preventive character. This aspect of the discussion on self-help could provide important suggestions for family-related health assistance; because in this wide notion of health work the family is not regarded as a system of activities complete in itself but in the family's relation to the environment, to the professional health services, to the available material, temporal and cultural resources.

In the different study groups emphasis was especially put on the fact that the social situation, the stress of gainful employment or of migration cannot be dealt with by the family alone, the same applies to ecological threats.

With the social recognition of self-help in health in the family more self-confidence may develop; through that not only would the health system be required to make services available which relieve the family and which it really needs but associations for the political realisation of health interests would also be supported.

An extended health concept reveals the nonsymmetry of health help in the family, the unequal distribution of resources for self-help in health among the individual social strata (here, above all, the time factor was emphasised) and the cultural significance of self-help activities as an alternative to the professional medical system (cf. Marco Ingrosso).

#### 4.4. The family in relation to the health system

The analysis of the daily health work in the family not only showed that health work is part of everyday experience, but it provided plenty of information on everyday life itself. Ingrosso's attempt to systematise family health strategies according to cultural characteristics provided an important basis for the discussion.

In his typology of cultural attitudes towards mental-physical well-being he distinguishes between six types:

- 1) A traditionalist and defensive attitude is much bound to culture, religion and family and defensive regarding medical services which are only made use of in cases of extreme danger (disability or possible death).
- 2) A modernistic and delegating attitude uses medical experts to check-up well-being and tends to medicate (problems of)

everyday life.

- 3) A modernistic and participating attitude distinguishes between medical and social problem situations and, in the latter case, people with this attitude tend to deal with those problems themselves.
- 4) An epidemiological-socialising attitude emphasises the system-orientated primary prevention just as well as the tertiary prevention. This attitude towards health practises critical co-operation with the medical system.
- 5) A pluralistic and pragmatic attitude corresponds to the ideal of a responsible patient who is informed about mental and somatic interrelations and is able to make his choice between those services offered by the health system.
- 6) A systemic attitude tending towards self-administration confines itself in its selective use not only to the health system but also to all possibilities of activating the body's own powers. The aim of improving environmental conditions and of developing a health culture results from this attitude (cf. Marco Ingrosso).

Health work in the family is decisively moulded by cultural attitudes and values. Against the background of a cultural differentiation of health behaviour and health work, criteria for the evaluation of professional help for the family can be established, for example, whether family health strategies meet with obstacles of the institutional system or not or whether health services go on from the daily experiences of families or force professional knowledge on them. All in all, an increased incorporation of everyday knowledge and everyday experience into health policy was demanded.

The care system makes families too aware of what they cannot do. However, every family has powers and resources to help it to develop. Help starts where these blocked resources are revealed as help for self-help. The central view of the sickness problem can be an obstacle to quicker and greater promotion of the hidden wisdom and knowledge of the persons affected and to the encouragement of positive elements in everyday life and life outside the family.

When comparing European and non-European countries considerable cultural differences in the impartation of family and professional health assistance have to be taken into account. In places where family traditions and values like religion, social standing of women and so on are neglected by government health services, professional systems often meet with resistance. A relevant example of that is still the field of medical obstetrics which should include family-related assistance.

In contrast to financial interventions, non-financial assistance like information, advice and similar things should be orientated towards the different cultural and social prerequisites which characterise health behaviour in the family if it is not to fail.

Here, special emphasis was put on the different material and social resources of households and families (cf. Rita Süßmuth and Marco Ingrosso). As a resource the time factor is just as important for health work as are money and rights; mainly old people and women would be disadvantaged by limited resources in these fields. A health policy suitable for families should take these different prerequisites into consideration and should promote alternatives that can provide these.

The family should neither be overtaxed nor underestimated in its efficiency; it is rather a matter of developing intermediate stages between the family and the medical system and to reorganise the organisational structures of the health services accordingly; the Italian experiment of opening up the health services towards participation by the users provided important ideas.

## 5. An extended health concept

An important result of the workshop is that many generally accepted concepts like health have to be redefined and that new forms of health policy for the family have to be found. This has to be based on health as a positive concept and not on sickness. This starting point involves doubt and uncertainties but also leads to a positive concept of health work and health education. The discussion made it possible to face the uncertainty in dealing with new definitions of a health concept and to free oneself from the pressure of practice. A functional understanding of health where health is only a means of fulfilling social requirements was rejected (cf. Rita Süßmuth).

### 5.1. Holistic

Health can only be understood from a "holistic" point of view. Health is personal and related to experience.

"I" am responsible for my health, neither the family nor the state can guarantee me health - this was a central thesis in the discussion. Health is directly linked with concrete working and living conditions and includes physical, mental, intellectual and social aspects.

The organisation of social life must allow itself to be questioned how much life, how much health is possible and where this goal is limited in favour of other fields. This became very clear when looking at the kind of built-up environment. If the senses are not appealed to sufficiently this leads to stress; architecture and building materials, it was demanded, should come up to the needs of perception and should take the human being's senses into account. Health work has to be orientated towards the conditions without giving up the aim of going beyond them. The motto for health as a balance that has to be reached everyday again is "The way is the goal" (cf. Annelie Keil & Jürgen Koch).

The significance of religious, spiritual and political-social orientations for health was also referred to: "He who cannot hope will not recover" (cf. Annelie Keil). The holistic principle definitely existed in the history of medicine but has to be rediscovered today. Modern medicine works according to a "check list" of possible symptoms, it does not have a sensible "picture" of the human being. But health cannot be "prescribed", it has to be worked for. Such health work starts with one's own self, experience, interaction with others.

The discussion revealed that families have a very comprehensive notion of health. This relative notion of health includes a disposition for sickness as well as the dynamics of life, for example, the ageing process. Health is not an idealised norm but a point of view of development; health deficiencies are not interpreted as handicaps but as matters of fact which one has to make the best of according to each situation. Explicit medical diagnoses are



also subordinated to this reference to the subject and its condition. The family notion of health is mainly characterised by an aim behind the activity: to achieve well-being under the given health conditions.

What is the significance of the family in this concept of health work? The family should contribute to the well-being of its members without the woman being the sole instrument for the health of everybody. The mother should support and encourage, she should promote body experience. The family has become the centre of acquiring experience to the same degree as knowledge related to experience "how does life live" is becoming more important as a basis of a holistic health notion in contrast to the "technique" of treatment and assistance.

## 5.2. Body experience

The idea of health promotion based on perception of the body and body experience ensues from a holistic understanding of health. Learning takes place in getting on with one's body; learning is feeling, experiencing, repeating, imitation. The discussion centred on this notion of experience and detaches itself from the usual idea that health education takes place via fear, information or expert knowledge and has to fight against the ignorant family and prejudices within the family milieu (cf Françoise Loux).

If the family is the place where the body is socialised, that is where it receives its social form (cf Françoise Loux and Christine Woesler de Panafieu), then learning with and via the body is the basis for health experience. At a meeting it was possible to experience such a health concept related to body experience on the basis of practical examples (cf Annelie Keil/Jürgen Koch).

Working on the basis that "awareness of the body" has to be learnt again in our civilisation, then health education also means that it develops a "model" of the body and of the relationship with the body.

Socio-historical examinations provide important clues. Throughout history the physical appearance of the sexes has adjusted itself, the male body functioning as the ideal even if make-up, clothing and other rituals still signalise the biological differences socially. The process of adjustment also takes place in the physical image, the inner representation. Women are transforming their more redundant physical image to a more functional, more active physical image which can be called masculine, whereas men are beginning to integrate aspects such as emotionality into their self-image and their physical image (cf. Christine Woesler de Panafieu). In more modern academic studies it is reported that in the last few years the body has become a central topic of discussion. A different attitude towards the body is being established, for example, regarding nudity in the family. Physical images are changing accordingly. The focus is no longer on "morbidity" but on "enjoyment", morbid moments being pushed into the professional medical system. Such a physical image would explain why sickness and death are being put out of visible everyday life and why they are being professionalised. Physical images and physical patterns are characterised according to both the social strata and the social class. This aspect also has to be taken into account when dealing with concepts of health education.

## 6. Innovative projects

The presentation of projects of family-related health promotion during this workshop by participants from differing national and cultural backgrounds showed the variety of concepts. These are based on regionally different structures, culturally specific problems and approaches in health education and promotion and finally on the way they are incorporated from an organisational point of view. In order to support the development of health-promoting lifestyles within and with families, our interest is concentrated on innovative projects aimed at health education and promotion in Europe.

In the collaboration agreement between WHO/EURO and the BZgA this aim is being pursued in the project network "Health Education in the Family", which is setting up international documentation and an exchange of experiences on actions, programmes and materials on health education in the family. This project is institutionalised by means of an office in the Federal Republic of Germany at the BZgA in Cologne, where material is analysed and coordinated, i.e. projects are coordinated, communication channels are set up such as, for example, the newsletter. 5 selected projects from every country go into the network so that an intermediary transnational system is developed. The start for the network in Europe was made with the Federal Republic of Germany, Italy and Yugoslavia in 1983, for this year France, Spain and Portugal are being incorporated and in 1985 the network will be extended to Great Britain and the Scandinavian countries. The projects are to be characterised by their emphasis on the field of primary prevention and their work should promote the integration of cognition and emotion, the ability to communicate and physical awareness as well as the various different environments, all of which are characterised by individual social, ecological and cultural features. The way in which the family is moulded by environment and

vice versa must be taken into consideration here. In this way the projects are characterised by a close link with the WHO's comprehensive concept of health. The projects introduced attach differing amounts of importance to the dimensions of health education, rôle of the woman and family planning.

The three research projects at the Institute for the Protection of Mother and Child in Zagreb, Yugoslavia, were centrally related to health education. Questions were raised as to the effects of (temporarily) incomplete families and health education on the children's state of health. This examination which is relevant for all migration problems produced the result that, despite the temporary absence of the father, the family remains stable and receptive for health education. The findings of a study into the reasons for the high rate of hospitalisation of children in some regions of Yugoslavia were that this is due to a lack of or insufficient health education. All studies lead to the conclusion that health education is an important step to be taken at school and that efforts going in this direction must be made among professionals as well.

The Director of the Central Organisation for Health Education from Morocco reported about preventive health policy and actions on the basis of specific demographic preconditions. Apart from the central institution, decentralised regional projects are being carried out in the provinces. These have both stationary and mobile centres (exhibition vehicles and tents) so that they can realise the plan of being places for the family to consult which are near at hand.

Health education media include the state of development, i.e. presentation appealing to the senses and audiovisual programmes.

As a result of demographic conditions family planning has an important rôle to play in health education. Family planning in the sense of protection for mother and child must also encompass the aim of preserving the life of children apart from contraception.

A task which has already been started is the development of the health educator's ability to communicate. The organization of health education on a state basis and the inclusion of all institutions of health education measures (including also military, free institutions like the Red Crescent) fosters the uniformity of health-relevant statements - an important prerequisite for the credibility of health promotion.

One element of health education is family planning as shown by the example from Morocco.

The following two projects show the access to health-relevant problems in families via family planning.

There is a report from Spain about a health promotion project in Catalonia. The Servei de Planificació Familiar is a local institution with 6 employees which works preventively in the fields of education and assistance. In accordance with the family planning approach most visitors are women with whom work is done in groups which leads to a mutual learning process on the part of both professionals and laymen. The basis of the thinking behind the consultation is to respect women's values, to establish links with the range of experience so far and to suggest solutions to problems by providing insights into difficulties, thus to make the individual capable of dealing with a conflict.

Increased work in urban districts as well as attempts to make women's groups more dynamic are in the process of being started as new projects of the Family Planning Bureau.

A report from the Federal Republic of Germany on the model project undertaken by Pro Familia involving home calls on Turkish women in Berlin was introduced. This project, carried out by an established family planning institution, was guided by the question as to how the advice offered should be modified to be suitable for migrant women and especially Turkish women. The plan involving the use of key persons to have women's groups meet together in private flats, who are then visited by advisors, means leaving the Advice Bureaus and also that the advisors assume the status of guests. This approach came closer to the Turkish women's way of life and their working situation than the visiting of an advice bureau would, and, at the same time, the choice of subjects from the "advising context" was modified. Family planning is not given priority - the main problems of this group (mostly working women between the ages of 25 and 40) are home and job. Despite the success of this project involving house calls it has not become a regular thing because of the work input (cost and time) involved.

Although family planning should really be a decision about the future taken by partners, the effects are still different for women and men. The consequences of motherhood as a social idea for all women and the health-related consequences are dealt with as a theme of a self-organised project at the feminist Virginia Wolf Culture Centre in Rome, Italy. The planning and holding of seminars on motherliness and motherly competence is the development of an approach to health education which is very much related to the women's well-being. Starting point for the approach is not concrete problems but those problems which arise for women from social changes. Reflections on these problems would constitute a contribution towards health promotion in the family.

Despite the variety of organisational incorporation and specific cultural and national requirements, the projects which were introduced do, in fact, have common features: the transnational dimension of the ideas of family planning as an aid to decide about the number of children and when to have them, which prevents family planning from becoming population policy; health education as the ability to bring up the children that are wanted and to make it possible for them to lead a healthy life; the way of thinking and ideology of a movement, the women's movement, which has an influence on the projects' development and execution.

## 7. The family in health policy

The described structural change of the family has consequences for government health promotion. How can health policy react to the changed conditions and what measures should be taken?

The question whether the state's interest in the family was shared by the family was the focal point of the discussion on health policy measures and alternatives. This question is of interest both historically and in the light of present socio-political developments.

### 7.1. "Birth policy"

A historical analysis of the initial stages of government health policy shows that the interest in the family was primarily directed towards birth and the "bringing up" of children. The example of the development of birth policy in France since the 18th century can illustrate the roots of the origin of health policy as population policy.

By recognising that its power depends on many and healthy subjects, the absolutist state becomes a pioneer of modern thinking: to promote the health of the individual by political influence on family privacy with the help of doctors. Centuries-old traditions of birth and the upbringing of children were substituted by "new-fangled scientific" methods (cf. Marie-France Morel). The discussion showed that the development in other countries was similar although it did not happen at the same time. The development of state health policy as "birth policy" goes hand in hand with the fact that births are becoming increasingly "medical affairs", the use of medical birth methods and, connected with this, the decreasing importance of midwives who are forced into minor rôles. Through the fact that now midwives are state educated and controlled and thus take on a rôle subordinate to the medical profession, obstetrics is becoming a field occupied by men. This example of a professionalisation of obstetrics demonstrates at the same time the ambivalence of health policy interventions in the family, as resistance against the modern birth techniques and hygienic demands can be recorded up into the 20th century, the causes of which lie in the suppression of traditional birth methods.

The discussion dealt with the question which socio-historical conditions influenced this development of the spreading of new medical methods and technologies and which social groups played a leading rôle in this process. This question can also be asked regarding the present reverse development of the use of new birth methods and the return



to the "home birth". This tendency, however, varies from country to country in Europe.

At the same time, however, the carrying out of this birth policy is interwoven with a re-orientation of the family; it centres on the child and in the 19th century forms the family and child centred mother ideal. A new quality of sex-specific division of labour corresponds with this state health policy. But as another side of the efforts to achieve a high birth rate, the emotional needs of the modern family thus produced do not fit in with wishes of the makers of population policy. State actions had little influence on the reduction of the birth rate of the family from the 18th century onwards, first in the bourgeoisie, then among the nobility and lower classes. The state interest in birth also includes birth control. Population policy motives have moulded abortion legislation in a decisive way. In all European countries the contradiction between interests of family policy, population policy and the interests of the family or women is now being discussed again. The discussion made clear that under health policy aspects the women's autonomy, too, had to be taken into consideration.

The liberalisation of the laws on abortion can be justified by the fact that well-being from the point of view of health also depends on the individual being able to take decisions about his/her own body. On top of that, the available methods of family planning are not safe or detrimental to health so that the problem of unwanted pregnancies cannot be eliminated. The possibilities regarding health in the sense of well-being that society grants to women can be seen in the laws on abortion.

## 7.2. Health and family as an object of politics

The central thesis of the discussion was that state health promotion has to follow on from the experience and practice gained in dealing with health in the family. A warning was given that health policy intervention could be directed against the interest of the family and the individual members of the family. Assistance should not turn into control (cf. Rita Süßmuth).

On the political level this means trying to find a balance between assistance and control and, for the families themselves, finding a happy medium between autonomy and opening to counter the danger of keeping themselves too much to themselves as well as the danger of dependence on others and of being told what to do by others within the framework of health strategies.

State health programmes are often bound to fail if they do not take cultural traditions, attitudes and interests into consideration. Such problems that occur when putting health promotion programmes into practice was discussed by participants from various countries. Participants from Eastern European countries, for example, reported that state measures tended to be ineffective (cf. joint report Piroshko Komlosi). Numerous regulations that support the family and many institutions have not been "accepted" by the family. As a result of the workshop it can be said: attitudes and ways of behaviour of families change, new family models, changed structures of relations within the family develop. In contrast to that the public image of the family and state activity is still orientated towards the so-called nuclear family, the complete family with the woman as housewife and mother. Health policy for the family was basically "birth policy". It was usually women who were explicitly or implicitly approached in matters of health education; state interest was directed

at their health work for others not for themselves. Based on this thesis, the necessary redefinition of family policy measures was demanded which would do justice to the changed structures and the interests within the family. An analysis of family policy (cf. Barbara Riedmüller) shows three different stages of the changing family policy models: the idealisation of the family, the political and scientific diagnosis of the family's reduced function and, finally, a renewed emphasis on its efficiency. Cultural, political and social models are reflected in these stages which were mainly reflected in a tendency towards individualisation, towards the development of individual social rights of individual family members; above all, women's social security is worthy of mention here.

In all industrial nations health policy is becoming less and less part of family policy. It is primarily part of social insurance policy. Since the development of health insurance, health as a risk has been insured, organised goods, health services, being allocated to it like on a market. These health services, however, are services in case of sickness with the goal of re-establishing fitness for work.. This network of services has been more and more extended, more and more "risks" were thus institutionalised as insurance objects and directed to the professional system of treatment; in this way pregnancy, birth, early recognition diagnosis with infants and other early recognition measures have been included in health insurance. Thus women got the benefit of health or sickness services - even if they were not gainfully employed - but, and this must be emphasised, it was in their function as mothers, as childbearers. Women who are not gainfully employed are not recognised by the health insurance system as individuals,

as people with their own needs and health concepts. Women became a residual quantity of health policy as a consequence of the functional link of "health" to gainful employment: as a social fact that constitutes an individual insurance claim, as a goal for the employment of services of the health system and as a form of dealing with sickness. This dilemma is also expressed in the political competence of the Ministry of Family Affairs, a ministry which administers "family" and "health" in the Federal Republic without being responsible for health in the sense of social insurance.

In the Federal Republic and in other European countries, too, a renewed orientation towards family values, self-help and solidarity can be noticed.

An interesting and partly highly controversial discussion was developed on this point. Because on the one hand, it was denied that the course of history can be altered, that women give up their claims to emancipation, that functional losses and disturbances in the family can be done away with by redefinition. Reference was made to the real demographic and social processes of the change in family and household systems which had been pointed out at the beginning of the discussions. On the other hand, the danger, too, was noticed that old family solidarities are destroyed and no new forms of solidarity emerge. How can the justified interest of individual family members be referred to without speeding up a one-sided negative process of individualisation as isolation, and, in many cases, increasing loneliness. The history of social insurance shows the ambivalence of social rights concerning individuals. Although the family as a "social network" has always been a prerequisite for the social services system with all its negative consequences for the social security of women, the solidarity of this social security has disappeared. Today it cannot be

presupposed at all that the family is a place of social security. The facts of poverty mainly among old women in all European countries are evidence against this. What, however, are the ways out of a policy of individualisation where the individual family member gets more rights without solidarity being destroyed? A "forced solidarity" where the "personnel" of earlier forms of living together is welded together and where a substantial solidarity no longer exists received negative criticism. Is there still such a thing as assistance based on solidarity which is judged positively by family members? This question was answered in the affirmative mainly with regard to the support between generations, whereby the cultural differences between the various countries have to be taken into account. Systems of assistance that are not organised with a view to the individual but that start from neighbourhoods and from community structures and that support the interest of the individual were regarded as a primary alternative. Such new forms of solidarity are mainly known from self-help projects. Such systems can overcome a family policy which regards the family as a "system" into which health can be "instilled".

#### 8. Recommendations of the working groups

Health policy and health pedagogics must not ignore the trends of this century, such as for example, the falling birth rate, gainful employment of women and the development of various different forms of private life.

With regard to health work in the family, it must be aware of the limits imposed on it by the current political, economic and ecological systems.

The starting point for health promotion has to be the wishes and requirements and general capacities of the families.

Research must be done into the cultural, social and regional differences in health concepts in the family, such as for example, in the Mediterranean region, so as to develop new criteria for health programmes.

Health programmes directed at individual members of families such as mothers and children, have to be examined with regard to their effects on the health of other members of the family. This is particularly true with regard to the overstrained women.

Women bear the main burden of paid and unpaid health work in institutions and in the family. But their own health is neglected by health policy. It therefore has to be the task of health policy to demand a new distribution of the work load in the family.

An important prerequisite for health promotion is the recognition of the fact that families have a positive potential for coping with difficulties.

Up to now, health programmes have been started at the initiative of welfare institutions. But an approach should be used starting from family health work as a basis with health services being built up on that basis. These programmes should be developed together with the families.

The orientation towards everyday health work has to be reflected in a change in professional assistance. This involves:

- recognition of the everyday knowledge and everyday competence of the families
- an acceptance of the independence of self-help groups
- social workers and health workers must have the competence and experience to communicate with the family
- health education should become a component of the training and further education of professionals.

Health promotion programmes should fulfil the following criteria:

- "supportive health education", i.e. to make resources, rights and rooms available
- setting-up of flexible support close to the local area and corresponding to the respective situation.

The fact that the activities of institutionalised health care are directed towards illness, leads to services being rendered only in the case of illness.

Health promotion must not also make this separation between illness and health, it must not make taboo subjects out of illness and disability.

#### 9. Final comments on perspectives of this seminar in the fields of research

The seminar concentrated above all on today's development in family structures and the ensuing change of the relationship between men and women as expressed in sex-specific health behaviour. From this perspective it follows that the understanding of health in the family has changed; on the one hand, it can no longer be simply presupposed that family health work is women's work, but on the other hand, new resources of family self-help are being developed. State health promotion would have to react to both processes by compensating for deficits through professional help and by taking the changing interests and needs into consideration. But what should such health assistance look like? What contents, what forms of organisation correspond to

these new needs. This question has remained largely unanswered. It is directed towards a field of research whose object is the networking of family health work with professional health services. The rôle of so-called intermediary stages like advisory bodies, self-help groups and so on would have to be examined here just as well as the learning processes the professional assistance systems have to go through in dealing with changed interests and needs of families. Health promotion would then no longer be orientated to an "imaginary" intact family or, on the other hand, to its deficits, but to the interfaces of those places where assistance is offered and used and where requests for assistance are articulated in and around the health system. The reports of innovative projects of the individual countries contain important starting points for such a process of gaining experience.