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How are the concepts of social capital, primary health care and health promotion relevant to the goals and activities of child and family health nurses?

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Primary health care, health promotion, and social capital are distinct, yet mutually dependent; concepts. That is, one cannot be achieved without the other. This essay will define the concepts of social capital, primary health care, and health promotion, and discuss their application and relevance to the goals and activities of child and family health nurses in Australia.

Social capital is a term used to describe the potential resource that exists between people within the community that can be utilized for the benefit of its' members (Winter 2000). It is the relatively new term for the supportive neighbourly relationships of old, which involved exchanges of goods and services, when people were less able to rely on government funded social welfare and therefore had to rely more on each other (Winter 2000). The concept of social capital has come under greater scrutiny in western societies as economic rationalism has not provided for the needs of society as anticipated (Vimpani 2001). Despite Australia's increasing wealth, we are experiencing lower civic participation levels and trust (Winter 2000), as a result of wide social changes brought about by the need for dual incomes and longer working hours, higher divorce rates and single parenting (Rogers and Moore 2003).

Bourdieu, Coleman and Putnam are the predominant theorists regarding social capital.

Bourdieu (1986) described social capital as individual or collective investment in family, neighbourhood, and/or workplace relationships for eventual economic reward. Therefore, social capital is a means to group resources through group membership (Winter 2000).

Coleman describes social capital as a social structure that promotes access to resources through the group norms of trust and reciprocity, where group members assist each other in return for future assistance (Winter 2000). Putnam views the elements of social capital, trust and reciprocity, in a broader context, to explain the resource that enables collective action, which results in economic and political development in the wider community (Winter 2000).

Social capital holds communities together as it promotes social cohesion within the community by allowing members to engage and work together cooperatively for mutual benefit (Stone and Hughes 2002). Trust is established when altruistic actions are rewarded in the future through reciprocity (Winter 2000). This system of behaviors is reinforced, as the negative outcome of not reciprocating is social exclusion, as the failure to reciprocate is likely to be communicated to others within the social network (Winter 2000). Therefore, the mechanics of this situation increases the predictability of the transaction making it a less risky investment for the individual (Winter 2000). Communities experiencing high levels of trust are more efficient and likely to achieve more than a community experiencing low levels of trust and therefore participation (Stone and Hughes 2002).

Social capital is able to bridge cleavages in the community; however, the very elements that bring some groups together may exclude others. In other words, giving resources to a member inside the group may potentially deprive another outside the group (Winter 2000), for example, a father whose daughter needs a job may know a friend in the local community who can arrange one. Here the father's knowledge about the world of work and his access to a friend (i.e. human capital) interacts with community employment resources and reciprocity (i.e. social capital) to secure a job opportunity (Zubrick, Williams, Silburn & Vimpani 2000, p.31). Therefore, the purpose of social capital needs to be considered as either public regarding or private regarding (Winter 2000).

Bourideau and Putnam view the family as the main source of social capital in the community. Putzel (1997, p.945) proposes that this view is idealistic in its assumption that family life is ‘...a pillar of civic virtue and democracy.’ Feminists would agree with Putzel, as families may not prove to be adequate models for good relationships as their structures are frequently affected by an imbalance of power (Winter 2000). However, as families experience greater participation rates, one may indeed assume that families are the principal social network and therefore the predominant source of social capital (Winter 2000). The question is, do strong families build strong communities?

Child health nursing services directly contribute to social capital within the family by providing ‘...opportunities for parents to join parenting groups... (and) ...to network with other services within the community’ (Department of Health and Human Services 2005). In the clinical practice-setting child and family health nurses witness first hand the bridging of social capital from the family to other social networks in the community. New mothers attend new parent groups to learn about infant care through information passed on by the child health nurse. Arguably, the most enjoyable and beneficial outcome of the group is the new social bonds formed between the mothers, which can last for years. Participation in parent groups provides many other anecdotal benefits for parents and children, and reflects research findings that link social capital with improved care of children, health and wellbeing (Roger and Moore 2003).

Child health nurses also promote the use and awareness of The Playgroup Association for parents of toddlers and preschool aged children as participation builds social capital within a community, which has been measured by ascertaining ‘...participation rates in different types of associational life’ (Rogers and Moore 2003). In these groups, good parenting is the group norm. Parents learn parenting skills by watching how other parents interact with their children and manage various behaviours, sharing experiences, exchanging information, and providing sympathy and support. Participation in new parent groups and playgroup are powerful learning experiences for parents that experienced poor parenting themselves, as the group provides role models. Such parents often experience a lack of support from their families and can become isolated as a result from the community. Participation in groups helps break this cycle and reduces the risk

of child abuse (Zubrick et al. 2000). Therefore, new parent groups and playgroups help build social capital within family units with multiple benefits for children and the community (Zubrick et al. 2000). The child health nursing service is a vital facilitator of this process.

‘It is now increasingly recognized that the physical and mental health, coping skills and competence of human populations arise in large part as a function of the overall quality of the social environment during their developmental years’ (Zubrick et al, p.1). The Australian Department of Family and Community Services conducted a national workshop in 2000 to determine indicators of social and family functioning which influence health outcomes; these include the quality and amount of time parents spend with children, household income, human capital (parental employment and level of education), psychological capital (parental mental health, family cohesiveness and perceived emotionally supportive environment) and social capital (Zubrick et al, 2000).

Child health nursing services aim to enhance social and family functioning through the enhancement of social capital (Zubrick et al. 2000). One of the ways in which they achieve this is by providing social support for parents and meeting some of their emotional needs for affirmation (Roger and Moore 2003). This is often achieved by complimenting parenting skills that have attributed to the good health and development of their child. In some instances, the positive feedback a parent receives from a child health nurse may be the only feedback received. It has been shown that ‘...social support directly influences the well-being of children and families’ (Oakley 1992 as cited by Rogers and Moore 2003, p.5). Child health nurses alleviate parental anxiety by providing information to parents regarding normal child development and resulting changes to family life (Roger and Moore 2003). Child health nurses also reduce the risk of poor quality child-rearing and child abuse by ‘...defining and reinforcing normative parenting practices,’ (Rogers and Moore 2003, p.5) and reducing situational stress through referral to local childcare and early intervention services, for example, the Parenting Centre, Mother and Baby Unit and Good Beginnings (Rogers and Moore 2003).

The prevalent problems affecting children today are; ‘...maternal depression (especially postnatal), fetal growth retardation associated with poor nutrition and substance abuse, developmental and learning problems, bullying, aggression and antisocial behaviour, teenage pregnancy, child abuse and neglect, alcohol and drug abuse, eating disorders, suicide, and depression’ (Zubrick et al. 2000, p.9). The current state of child health indicates a socially toxic environment (Vimpani 2001).

The World Health Organization’s (WHO) mission is to promote the health of the global population by lobbying governments to implement measures that will increase the physical, mental and social health of their citizens (Wass 2000). During the 1970’s it became apparent that the increased availability of acute medical technology in richer nations had little real impact on health outcomes (Wass 2000). In poorer nations, the single most important factor that determined health status was poverty (Wass 2000). The growing disparities in health intra-nationally and internationally prompted the WHO to conduct an international conference in order to discuss and formulate a plan that would accomplish an acceptable standard of health for all (Wass 2000). This plan, which became known as the Declaration of Alma-Ata, describes a new approach to health called Primary Health Care, which is defined as ‘...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination’ (WHO 1988, p.16 as cited by Wass 2000, p. 9).

The primary health care philosophy emphasizes that health services require the participation of recipients, in order for interventions to be appropriate and effective, and the enabling of recipients, through education, information and service provision, in order to address the causes of health problems (Wass 2000). The declaration of Alma-Ata lists essential activities for the provision of Primary Health Care in communities, these include:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- provision of maternal and child health care, including family planning;
- immunization against the major infectious diseases;
- prevention and control of locally endemic diseases,
(Wass 2000, pp. 9-10).

Child and family health nursing services embrace the philosophy and activities of Primary Health Care. Nurses typically screen infants and children for common health problems to ensure interventions are promptly implemented in order to enable children to reach their full potential (Family, Child and Youth Health Service (FCYH) 2003). Surveillance requires the child health nurse to work in partnership with parents to facilitate the optimum physical, social, and emotional wellbeing of their children. This is achieved through the provision of information and support, and the recognition of the caregiver's strength and ability (FCYH 2003).

Child and family health nurses also promote optimum nutrition of children and pregnant and/or breastfeeding mothers by providing information based on National Health and Medical Research Council (NHMRC) guidelines during consultations, home visits and group work. Nurses endeavour to support parents who make food choices influenced by education, economics, culture, and religion (Ed. Clements 1986). The nurse's awareness and sensitivity regarding these issues affecting nutrition ensures that proposed interventions are acceptable and appropriate to the client. In addition, child and family health nurses promote immunization according to NHMRC guidelines as this enables the community to prevent and control endemic disease.

Child and family health nurses provide care for mothers because their wellbeing directly affects the wellbeing of their children (FCYH 2003). Screening mothers for postnatal depression (PND) is a primary health care activity that nurses perform to detect this

condition as it affects 10-15% of new mothers (FCYH 2003). Symptoms of PND include ‘...depression, feelings of loss, resentment, anger, hopelessness, insomnia, fatigue, or lethargy,’ (FCYH 2003, p.1) and therefore significantly reduces a mother’s ability to care for her child. Nurses assist mothers by providing ongoing support and referring to appropriate services that will meet the mother’s individual needs (FCYH 2003).

The 1986 the WHO developed the Ottawa Charter for Health Promotion in order to increase the relevance of Primary Health Care to industrialized nations (Wass 2000).

The charter describes five key activities for health promotion, these are:

- *building healthy public policy* by considering the potential impacts of public policies on community health,
- *creating environments which support healthy living* by enabling community members to make healthy choices,
- *strengthening community action* by empowering community members to identify problems and solutions,
- *helping people develop their skills* so they are able to make healthier choices and,
- *reorienting the health care system* towards a social model of health (Wass 2000).

The process of changing socio-economic factors that determine health is achieved by the collaboration between government and private sectors of the community and community members (Wass 2000). This process requires ‘...health workers to be effective in advocacy and mediation in order to enable people to gain greater control over their lives,’ (WHO 1986 as cited by Wass 2000, p. 18).

Child health nurses fulfill an advocacy role when gaining support for children and families by networking with other services in the community (WHO 1998), for example, a nurse may assist a depressed mother with poor practical support networks gain access to regular sessional care at a childcare centre by speaking to the centre director regarding the mother’s high level of need for childcare. Child health nurses frequently speak and act on the behalf of children in order to acquire system support

for specific health goals (WHO 1998), for example, a nurse who suspects a child is suffering from abuse will notify The Intake and Assessment Service for Child and Family Services to ensure the child's need for care and protection are met. Advocacy for child and family health is also achieved when nurses group together to lobby governments, mobilize communities and use multimedia to acquire support, commitment or acceptance of a defined health issue (WHO 1998), for example, nurses may support breastfeeding by attending Breastfest Tasmania (a gathering of actively breastfeeding mothers in an attempt to raise the profile of breastfeeding and enter the Guinness Book of Records) with mothers that attend their community centre. Therefore, nurse advocacy assists to create an environment that is conducive to the health of children (WHO 1998).

Inevitably, changing the conditions that determine health may involve conflict between different sectors of the community (WHO 1998). Child and family health nurses, in their role as advocates, may be required to mediate for their clients, for example, a breastfeeding mother planning to return to work may anticipate difficulty with breastfeeding or expressing milk due to workplace culture and/ or management's lack of knowledge regarding the needs of breastfeeding mothers and / or current legislation and health policy. The nurse may act on the mother's behalf to discuss her needs with her employer, and/or provide printed information, which will enable the appropriate preparations to be made and the creation of a supportive environment for her and her child.

Child and family health nurses form partnerships with families in order to develop parental skills through the provision of information and support. This process empowers the parents and increases their access to resources, thereby promoting the health of their children (WHO 1998), for example, home visits by nurses decrease maternal depression, child abuse, and criminal behaviour of family members, and enhance maternal self-esteem and employment opportunity (Stone and Hughes 2002).

Primary health care and health promotion strategies are the means employed by child and family health nurses to enhance the health of children and their families. Child and family health nurses assist parents to provide a nurturing and safe home environment for their children through the sharing of knowledge, support, encouragement, and the provision of networking opportunities and referral to other services as required. This partnership ultimately aims to empower the family by building upon inherent strengths. In conclusion, the primary health care and health promotion activities of child and family health nursing services enhance social capital within the Australian community.

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