The micro-ecological approach to home care

Can it contribute to the promotion of health?

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In her article, Niehof attempts to reformulate some of the conceptual linkages between health status and health behaviour of individuals on the one hand, and the domestic production of health care on the other. The attempt is motivated by the idea that traditional disciplinary models do not really contribute to finding comprehensive solutions to major health problems. Indeed, disciplinary models generally deal with only one part of reality, and they often disregard the processes that lead to (ill) health. Health is complicated and therefore I am a strong advocate of interdisciplinary approaches towards health and health care.

I have no background in sociology or medical anthropology. I am a social psychologist working in the field of health education and health promotion. Health promotion is defined as "the process of enabling people to increase control over, and to improve their health" (WHO, 1986). One of the key principles of health promotion is that it actively involves the people in the settings of every day life (cf. Ashton & Seymour 1988; Koelen & van den Ban 2004). Nutbeam (1998) defines 'settings' as the places or social contexts in which people engage in daily activities, in which environmental, organisational and personal factors interact to affect health and wellbeing. Settings generally are considered to be places like school, workplace, hospital or neighbourhood. Reading Niehof's article, I realised that the household is an essential setting for health promotion as well. Indeed, as Niehof states, households represent to a large extent the 'arena of everyday life'. Households take care of resource management and the primary needs of its members, which is essential for preserving health. Before I comment upon (the building blocks of) the framework, I want to state that, in my opinion, Niehof has made a valuable contribution to the understanding of health and health improvement with the MEAH model.

Strengths and weaknesses of MEAH

In building up the model, Niehof first outlines the contours of the micro ecological approach by combining theoretical concepts about households and about care. The household is seen as a system. Resources and assets are inputs the household organisa-

tion are the systems throughput and care and well being are the outputs. The author further describes and critically assesses two alternative frameworks, the framework of the household production of health (HHPH) and the critical ecological model for medical anthropology (CEMMA). Each of these frameworks, however, have a different focus. The first one is made for examining the role or function of household in health improvement. The second model is an approach to health and factors influencing health. Niehof includes essential aspects of both frameworks to include in her new model.

Niehof's choices are well argumented, but in my opinion, some choices need further consideration. I will address five topics: the use of CEMMA as a model for health, the household as a level of analysis, the use of the HHPH model, the role of integrity in care, and the concept of coping.

The CEMMA framework or is there a better alternative?

If we study the role of households in the production of health it is necessary to conceptualise health. Since the constitution of the WHO in 1948, 'health' has been defined in terms of physical, mental and social wellbeing. Nonetheless, for several decades the biological perspective has persisted. The influential work "A new perspective on the health of Canadians" by Lalonde (1974) set an agenda for a broader perspective. Lalonde argued that health and illness not only depend on medical conditions but also on the environment and conditions of living. He pointed out four distinct elements: human biology, environment, lifestyle or behavioural factors, and the health care organisation. Based on this work, attempts to clarify the forces that affect health gathered momentum and several frameworks were developed.

The framework that I find useful for understanding the multifaceted character of health is based on the model which is used by Ruwaard et al (1994) for the Public Health Status and Forecasts of the Dutch population. In this model, a distinction is made between endogenous and exogenous determinants of health. The endogenous determinants affect health from the inside and thus include the biological factors. The exogenous determinants refer to the external influences and relate to the physical environment, lifestyle factors and social environment. The social environment typically also includes the household. The endogenous and exogenous determinants are influenced by the third determinant, the health services in relation to care, cure and prevention.

The framework is based on the notion that health results from the *interaction* between an individual's personal needs and possibilities and the influences of environmental factors (see Figure 1). The advantage of this model is that it comprises the attractive features of Young's CEMMA, but also provides a solution for Niehof's objection towards the central position of the individual's mental and physical needs in Young's model. Niehof takes the position that ... "at the end of the day, providing such needs is not done individually, but in the context of the household. The emphasis should not be on the needs themselves but on the manner in which they are met" (p. 252).

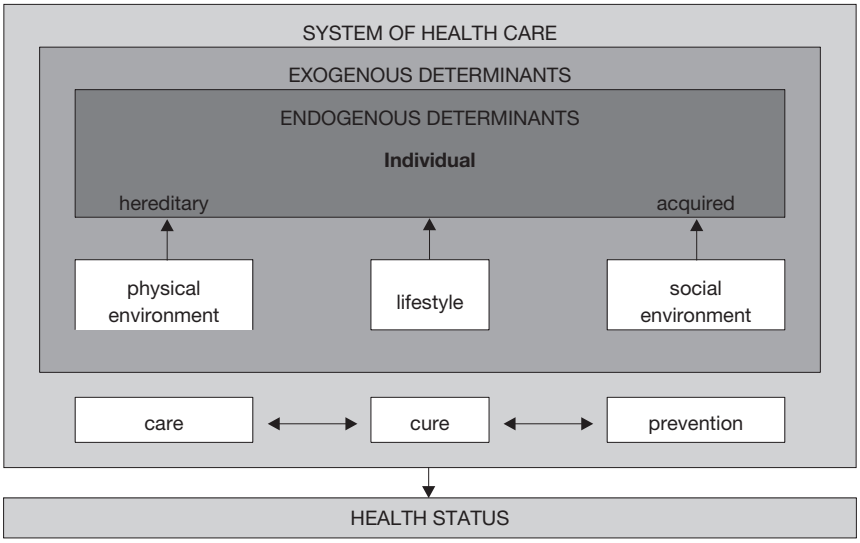

Figure 1 Overview of determinants influencing health (based on Ruwaard et al. 1994)

If I understand it well, Niehof thereby postulates that it is the *interaction between needs and provision of needs* which is decisive (if there are no needs, there is nothing to be met). I agree with this position and therefore think that the framework presented here would fit better in the MEAH approach than CEMMA.

The household as a level of analysis

Based on the notion that the provision for mental and physical needs on a daily basis requires allocation and management of household resources, Niehof argues that the household, and not the individual, is the unit of analysis. I can agree with that position to a large extent, but not fully. Driven by arguments provided in the article, my major concern involves the illustrated collapse of households who are unable to cope with the impact of dreadful life events and non-reversible diseases like AIDS. Niehof is not clear about this problem, and in fact argues herself that "...traditional household surveys are inadequate tools for detecting these vanished households, which results in a positively biased picture of the ability of households to cope" (p. 256). The unanswered question, therefore, is how to deal with this problem if the household is the unit of analysis?

Criticism on the HHPH model

Niehof criticises the HHPH framework in that it limits the institutional environment of households, relevant for health production, to the formal health services. The author

strongly advocates the position to include the informal health care services (e.g. the services of indigenous healers) in the institutional environment. The necessity of this is clearly illustrated and supported by the analysis of the case of Sam and Liza. It is easy to imagine other examples. Even if formal health services are available and affordable, people may seek informal help, either as a stand-alone service or in combination with the formal health services.

Another criticism of Niehof on the HHPH is that no distinction is made between intended health behaviour and behaviour having no health purposes but leading to certain health outcomes. This is an omission we often find in domain specific health (care) models, where the focus is on the production of health, thereby overlooking all other aspects of life with a health impact. It is a pity though that this extension does not return in Niehof's summary of the MEAH.

The integrity of care

The four interconnected phases of care as described by Tronto and its five requirements of good care: attentiveness, responsibility, competence, responsiveness and integrity are rather interesting. The case of Sam and Liza accurately shows that indeed these phases and requirements play a role in the household production of health. In my opinion, the fifth requirement of good care, integrity, is the most essential one. Integrity means that, in order to be successful the four phases should be linked. As Niehof states "integrity is lacking when, for example, care needs are identified but no one is taking responsibility or when those taking responsibility subsequently delegate the problem to caregivers without bothering to check whether these are adequately equipped for their task' (p. 248). But even if the requirements of attentiveness, responsibility and competence are adequate, if the responsiveness of the care receiver is inadequate, the impact of the provided care is poor. Therefore I would consider integrity not just a fifth requirement but as a precondition for adequate care.

The concept of coping

A problematic concept in Niehof's article is that of coping. Generally, when a situation is perceived to be stressful, people try to master (or to reduce or tolerate) the situation. In the areas of psychology and health education coping is defined as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands, that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman 1984: 141). Niehof uses 'coping' in different ways: On page 255 she writes "... the surviving children try to cope by growing food crops for their own consumption and selling their labour to neighbours". Here she uses coping in the sense of 'survival'. Also we find "... households unable to cope because they sold all their assets have no social capital left (...) collapse and disappear" (p. 256), and ... dissolve and become invisible" (p. 260). Again here, coping is considered to be a strategy for

survival. However, in her conclusion about using the concept of coping, Niehof mentions that "when people cope they do so at the expense of their assets...which further increases their vulnerability". So, in fact, if people cope they 'lose', if the do not cope, they lose too. For this reason, it is likely interesting to further unravel the concept of coping and to link it to the variety of strategies (see for example Stroebe 2000) people use to cope.

Conclusion

As I wrote in the introduction, the micro-ecological approach to home care offers a valuable contribution to conceptualising the promotion of health. Households are the primary community to which individuals belong and within which they develop lifestyles and interact with the social and physical environment. Households are settings of everyday life. In health promotion 'settings' are usually referred to as 'organised institutions', like school or workplace. As Nutbeam (1998) mentions, settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organisational structure. In my opinion these characteristics apply to households as well. Households are essential entities for the production of health and the provision of health care. The MEAH framework provides a tool for identifying care needs of individuals and households and for assessing the constraints in meeting them. Consequently it also contributes to finding comprehensive solutions.

Note

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References

Ashton, J. & H. Seymour
1988 *The new public health*. Milton Keynes: Open University Press.
Koelen, M.A. & A.W. van den Ban
2004 *Health education and health promotion*. Wageningen: Wageningen Academic Publishers.
Lalonde, M.
1974 *A new perspective on the health of Canadians*. Ottawa: Government of Canada.
Lazarus, R.S. & S. Folkman
1984 *Stress, appraisal, and coping*. New York: Springer.
Nutbeam, D.
1998 *Health promotion glossary*. WHO/HPR/HEP/98.1. Geneva: World Health Organisation.

Ruwaard, D. et al. (eds.)
1994 *Public health status and forecast: The health status of the Dutch population over the period 1950 – 2010*. RIVM. Den Haag: SDU-Uitgeverij.
Stroebe, W.
2000 *Social psychology and health*. Buckingham: Open University Press, 2nd edition.
World Health Organisation
1986 *Ottawa Charter of Health Promotion.* Copenhagen: WHO.