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Notes on
 HEALTH ASPECTS OF FAMILY LIFE EDUCATION
 FOCUS ON CHILDREN AND YOUTH

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INTRODUCTION

The nature and quality of family life are of concern to educators and health workers throughout the world. As family structures, functions, and values shift with the times, children and youth are confronted with ever changing conditions and needs while growing up within families and preparing for future family responsibilities. A major goal of education in many countries is that of helping young people become effective family members within the culture of which they are a part. Thus, family life education is increasingly an integral part of school curricula and youth programmes, as well as of parent education, and other educational activities with adults.

These notes focus on one component of family life education, namely the health component, with particular reference to children and youth. They are based on the recognition that throughout life, from conception, through periods of active growth and development, during the reproductive years, and on into aging, health problems and needs exist that must be taken into account when planning for education about family living. The manner in which schools and communities deal with these problems varies widely and is influenced by such factors as socio-cultural characteristics of a country or region, including social norms and mores and the nature of family life; existing health conditions; priorities within a country or region in respect to its own development; educational goals, leadership, and facilities; availability and quality of health and welfare services; and the aspirations of individuals and families amongst whom programmes are being developed.

Family life education is viewed here as an integral part of general education, including health education, though it may be developed conceptually, or in operating programmes, within other contexts. The diversity of approaches to family life education, both in concepts and content, reflects not only such factors as those mentioned above but also the special fields of interest or orientations of its proponents. There is, in truth, no clear-cut and widely accepted point of view as to the nature and scope of family life education. Nevertheless, one can discern within different approaches, though with differing emphases, a concern about health - the health of the individual child or youth, the health of the family as a unit, and the health of the community or larger society of which the family is a part.

In recognition that the field of health is so vast, and family life with all of its manifestations so complex, that all health aspects of family living could not conceivably be encompassed within a single document, items selected for inclusion in the pages that follow have been chosen because they deal with problems and needs which seem particularly critical in many parts of the world. Three interrelated categories of problems and needs form the framework for the document as follows:

Health problems and needs of individuals related to growth and development within the family setting;

Health problems and needs of children and youth as contributing members of families, including those associated with preparation for responsible parenthood;

Health problems and needs of young people pertinent to becoming responsible citizens and productive members of society.

Under each of these broad areas of concern, selected problems and needs are discussed with focus on children and youth, especially in developing countries, together with implications for family life education. An underlying concept which prevails throughout the paper is that the family is the basic unit of society for nurturing the development of children and youth, the citizens of tomorrow. Thus the paper concerns itself with the interaction of the child with his family and through his family with the larger society in which the child must become prepared to live as a responsible adult.

As each locality plans for the incorporation of health concepts and content in specific programmes of family life education, it will be necessary to identify the problems and needs that exist locally. Those which are set forth here are illustrative only. Nevertheless, it is hoped that this approach will provoke further study, testing, expansion and application among educators, health workers and others who attempt to introduce health concepts and experiences into family life education within their own situations.

1. HEALTH PROBLEMS AND NEEDS OF INDIVIDUALS RELATED TO GROWTH AND DEVELOPMENT WITHIN THE FAMILY SETTING

Children and youth have certain basic health needs, regardless of the nature of the family or the community of which that family is a part. As young people grow and develop, they need knowledge about themselves and the desire to apply that knowledge in daily living. An understanding of health factors related to growth and development within the family setting is also important for young people who share in the care of infants and young children and anticipate having families of their own. Parents, teachers, youth leaders and others charged with the education of children and youth likewise should have a background of knowledge in this area.

Individual health problems and needs within the family setting which have been selected for discussion are grouped under the following headings:

- Food and eating
- Alternating periods of activity and inactivity
- Safety
- Prevention of handicapping defects
- Prevention and control of illness and disease
- Development of emotional stability and adaptability
- Drug dependence
- Smoking and health

1.1 Food and eating

The human organism needs food which provides adequate quantities of special nutrients required for body building, production of energy and warmth, and maintenance of health. In many parts of the world, there is neither enough food nor the right kind of food in the diets of people to meet the body's demands. Even where food is plentiful, eating habits, frequently rooted deeply in culture or influenced by fads can result in poor selection of food to the detriment of health. Especially important from the standpoint of education is the sharing out at mealtimes of available foods. For example, the man of the household may receive more than his daily requirement of protein, while young children may fall far below their requirements.

There are periods in the life span when dietary requirements are particularly critical. Mentioned here are pregnancy, lactation, weaning, infancy, and early childhood.

1.1.1 Pregnancy, lactation and weaning

An expectant mother must feed not only herself but the foetus developing within her body; a nursing mother must likewise provide for herself as well as the infant. The effect of the mother's diet upon her own health and that of her offspring is a highly complex matter and cannot be viewed apart from other determining factors, including her age, the number of children she has had, her general health and physique, and the conditions under which she lives and works. To illustrate, babies whose birth weights are under 2500 grams have

relatively high mortality rates and as a group have a high incidence of subsequent physical and behavioural abnormalities. Although the evidence is indirect, it is very suggestive that in developing countries at least, where protein-calorie undernourishment is widespread, there appears to be a relationship between prolonged maternal undernutrition and low birth weights.¹ Studies of mean weights of babies within ethnic groups have shown that "in any given group the well-to-do mothers tend to have bigger babies than the poorer mothers".² Yet to say that the socio-economic factor is the only one operating to make this difference fails to take into account such other possible influences as specific dietary customs and taboos (frequently against protein foods) associated with pregnancy and child care, as well as environmental factors. A WHO Expert Committee report on "Nutrition in Pregnancy and Lactation" states: "The Committee wishes to emphasize that the areas of ignorance relating to nutrition in pregnancy and lactation are extremely large and it is impossible as a rule to state didactically that this or that particular form of dietary change will produce a specific clinical benefit. Nevertheless, it can scarcely be doubted that the diets of pregnant and lactating women in many areas of the world are capable of improvement, as are those of the families of such women."³

Breast milk is believed by paediatricians to be the best food for infants during the early months of life. It meets the nutritional needs of protein, carbohydrates, and fats, and, in addition is free from contamination. Moreover, the infant who is breast fed benefits emotionally by the close contact with its mother. During weaning, however, the infant is transferred from mother's milk to other foods which in many situations are low in proteins and inadequate in calories. The foods may also be contaminated thus increasing the hazards of infections. Rosa has pointed out a connexion between "excess" infant and childhood mortality and an increase in illnesses from poor nutrition and infections among infants who are abruptly weaned because the mother is pregnant again.⁴ Closely spaced pregnancies also affect the mother and the child she is carrying. When intervals between pregnancies are short, the mother cannot adequately build up the nutritional reserve needed to maintain her own health and to breast feed the child soon to be born.

Breast feeding is common practice in most developing countries and its continuance should be encouraged in family life education programmes. Attention should be given, however, to the importance of supplementing the mother's milk with a suitable diet for the infant as the baby outgrows the breast milk supply. Consequently, it is usually recommended that supplementary feeding be introduced by about the fourth month.⁵

1.1.2 Infancy and early childhood

During infancy and early childhood growth proceeds at an active rate and nutritional demands of the body are especially great. Though a well-balanced diet is essential, mention is made here of the special need for protein, vitamins, minerals and enough calories. In many tropical areas, the diet consists to a large extent of carbohydrates taken in the form

¹ Siegel, E. & Morris, N. (1970) The Epidemiology of Human Reproductive Casualties, with Emphasis on the Role of Nutrition. In: Maternal Nutrition and the Course of Pregnancy, Washington, D.C., National Academy of Sciences, p. 10 and p. 20.

² World Health Organization, Expert Committee on Nutrition in Pregnancy and Lactation (1969) Wld Hlth Org. techn. Rep. Ser., 302, p. 14.

³ Ibid, p. 40.

⁴ Rosa, F. W. Organization of Services for Family Planning Care. Working paper (restricted) prepared for Symposium on the Health Aspects of Human Reproduction, Family Planning and Population Dynamics, Teheran, 3-7 October 1970, p. 2.

⁵ World Health Organization, Expert Committee on Nutrition in Pregnancy and Lactation (1965) Wld Hlth Org. techn. Rep. Ser., 302, p. 28-29.

of such staple cereal and root crops as rice, corn, millet, yams, cassava and sweet potatoes. In these areas, diets are likely to be deficient in essential proteins which are especially important for the growing organism. Nutritionists refer to "protein-calorie malnutrition of early childhood" as the most serious form of malnutrition in developing tropical areas. Though its clinical manifestations (including kwashiorkor and nutritional marasmus) are numerous and its causes varied, it is essentially the result of a "diet low in protein but with different levels of intake of calories in the form of largely carbohydrate foods".¹ Severe forms of protein-calorie malnutrition in early childhood result in high mortality; lesser degrees may result in greater susceptibility to infections, physical stunting, and brain damage.

Iron is essential in the formation of haemoglobin of red blood cells. In the early months of life, the infant depends upon iron which has been stored in his liver during the foetal period. This source of iron accentuates the importance of ample intake of iron-rich foods by the mother during pregnancy, especially so, since both human and cow's milk are poor in iron. As the child grows, parasitic infections such as hookworm, may aggravate protein and iron deficiencies in a poorly fed child.

One cannot over-emphasize in family life education the importance of good nutrition on a life-long basis. It has been said, "Healthy, wellgrown mothers are derived from healthy, well-grown children."² Women who enter pregnancy in a good state of nutrition and who have good dietary habits in turn contribute to the nutritional well-being of the unborn child. It may be assumed, too, that they are likely later to feed the infant and young child a nutritionally sound diet. Since expecting mothers, infants, young children and adolescents, as well as fathers and others who compose the family unit will usually follow characteristic eating patterns, stress in family life education should be placed on feeding the family and the benefits derived from good nutrition at all age levels.

1.2 Alternating periods of activity and inactivity

The human organism needs alternating periods of activity and inactivity. Physical activity may not only have beneficial physiological effects on the growing child but also may contribute to good emotional and mental health. On the negative side, too little physical activity, or too much of the wrong kind, can be detrimental to health. Sleep and rest are likewise essential for growth and development and for maintenance of health. Too little sleep and rest can cause excessive fatigue and emotional disturbances.

Family living patterns and environmental conditions can affect the ability of a child to attain a suitable balance of activity and inactivity. To illustrate, in many rural areas, children must rise early and walk long distances to school. The physical exertion involved is often compounded by lack of a morning meal before starting out from home. Long and fatiguing distances must also be covered in some areas to fetch water or perform other family chores. Damage may result from these and other common child labour practices when very young children are expected to carry heavy burdens or engage in strenuous household and agricultural work.

Sleep and rest of children are often curtailed when the children keep the same late hours as the adults of the household and engage in over-stimulating activities during these hours.

¹ Jelliffe, D. B. (1968) Infant Nutrition in the Subtropics and Tropics, WHO Monograph Series, 29, 2nd ed., p. 115.

² World Health Organization, Expert Committee on Nutrition in Pregnancy and Lactation (1965) Wld Hlth Org. techn. Rep. Ser., 302, p. 40.

Family life education, starting in primary years, can encourage children to work out their own routines, as far as they are able at their level of maturity and within their home settings, to secure optimum balance of activity and inactivity. Parent education is also needed for many habits are developed long before school years.

1.3 Safety

Safety is presented here as a positive approach to the accident problem, a major cause of disabling conditions and death among children and youth.

Accidents among children are associated with their stage of development and their physical and social surroundings. To illustrate, common causes of home accidents during the first four years of life are suffocation, burns from fires and hot liquids, falls and poisons. Some of these accidents can be attributed to childrens' characteristic behaviour during these early years. Crawling babies can fall off furniture or come into contact with open fires; the toddler, curious and impulsive, can consume poisonous substances commonly found about the home. However, parental supervision and the nature of the environment are other important factors. During school years, as children mature, they will experiment with new motor skills and become involved in ever widening contacts with their physical and social environments with the result that other kinds of accidents are likely to occur. The developmental level of children is only one part of the picture; from the standpoint of the family, modes of living and family values also must be considered.

In programmes of education and control, one must look beyond the hazards themselves, and the nature and degree of injury that may result to consider, also, the "social use of particular environments".¹ To be explicit, a water hole or stream may be in a neighbourhood - the hazard is there and the possibilities of drowning are evident, yet the number and seriousness of water accidents that occur will be influenced by such factors as family supervision and attitudes of children and their social groups towards behaviour in and around water, attitudes that are likely to change as children mature. In family life education, stress on the provision of an environment which minimizes the risk of accidents is important. As important is the development of attitudes and skills on the part of an individual which result in handling one's self safely within the environment. Living safely does not mean avoiding all situations that could lead to accidents. It does mean learning to identify potential causes of accidents and taking steps to correct those conditions amenable to correction as well as the development of attitudes and skills.

1.4 Prevention of handicapping defects

Handicapping defects have an important influence on a child's physical, emotional and social development. Some defects can be prevented; others can be corrected so as to cause minimum interference with the child's current and future activities.

As with accidents, the child's physical and emotional development and social behaviour at different maturity levels, as well as his physical and social environments have a bearing on the nature and seriousness of defects. Accidents are a common cause of some defects, including visual, hearing, and motor defects. Diseases, too, may leave their mark. Trachoma, for example, a damaging eye infection, associated with uncleanliness, close family groups, crowded villages, inadequate water supplies, and failure to use available treatment measures may result in permanent eye damage.²

¹ Watson, W. (1969) Childhood Injuries: A Challenge to Society, Pediatrics, 44, 794-798. In: Supplement on Childhood Injuries: Approaches and Perspectives.

² For further discussion see World Health Organization, Expert Committee on Trachoma (1962) 3rd report, Wld Hlth Org. techn. Rep. Ser., 234, pp. 31-33.

Recent studies are pointing to a variety of factors, many not yet understood, which may result in handicapping conditions of the newborn. Among these are genetic factors, disturbances during the foetal period, and post-natal environmental influences.¹

1.5 Prevention and control of illness and disease

A child's growth and development can be impeded by illnesses and disease which, in extreme cases, may cause death. In many parts of the world, particularly in the tropics, infections are widespread. Tetanus of the newborn, associated with unhygienic practices during delivery, is the cause of more than half of the deaths in the first month of life in some areas.² In the same areas, diarrhoeal and respiratory diseases take heavy toll in illness and death during the first year of life and later. Children who are malnourished, who live in insanitary surroundings, and, in the case of respiratory diseases, are exposed to the elements with insufficient clothing and shelter, are especially susceptible to these infections.

Where malaria, smallpox, and tuberculosis are prevalent, children, no matter what age, are likely victims as well as adults. Venereal diseases occur among older boys and girls in many parts of the world and are becoming an increasing problem as social values change.

Fortunately, many of the disease of childhood can now be prevented. When viewed from the standpoint of education, emphasis should be placed on immunizations starting early in life and improvements in infant care, nutrition, and environmental health, as well as on hygienic living practices which minimize the risks of illnesses and disease.

1.6 Development of emotional stability and adaptability

Emotional health, in the sense of emotional stability and adaptability, refers here to the ability to deal with one's self and one's environment in an effective way. The emotionally healthy person possesses a sense of self-esteem, insight and self-acceptance, and relates effectively to others.

In the first years of life, the infant or child depends upon the family, whether extended or nuclear, for his emotional development and his sense of identity. Laycock has stated "A baby responds to the world as he finds it. If his parents meet his needs for food, dryness and warmth with reasonable consistency and with loving care, if the baby is cuddled and talked to a good deal, and is cherished as a valued human being, he finds his world a warm dependable place, and reacts to it as such. He comes to feel that he is a worthy individual. If, on the other hand, the baby's needs are met in a cold, irregular and indifferent fashion, or if he is treated with harshness, he finds his world undependable and unloving and feels insecure and unworthy. . . . Many studies have shown that a sense of being loved and cherished is vital not only for the sound personality development of children, but also for their physical development as well."³

Pre-school years are likewise crucial ones in the child's emotional development. He needs affection and the realization that there are others upon whom he can depend. In developing areas, where the extended family may share in the care of children, affection is

¹ World Health Organization, Scientific Group on Biological Components of Human Reproduction (1969) Wld Hlth Org. techn. Rep. Ser., 435, pp. 35-36.

² World Health Organization, Expert Committee on Maternal and Child Health (1969) 5th report, The Organization and Administration of Maternal and Child Health Services, Wld Hlth Org. techn. Rep. Ser., 428, p. 8.

³ Laycock, S. R. (1967) Family Living and Sex Education, Toronto, Mil-Mac Publications, pp. 25-26.

usually given freely to the child's benefit. On the other hand, conditions in many nuclear families militate against the fulfilment of this essential role of affection giving. To illustrate, working parents, broken and divided homes, large families which have not found ways of distributing family responsibilities, may result in situations in which children grow up deprived of affection and the physical care upon which they depend.

The neglected child and the abused child, or those caught in the web of deprivation for other reasons, present special problems to the teacher or health worker. They, and children growing up in homes with little or no display of affection, are victims of circumstances that can have adverse effects on emotional development and stability.¹ In contrast, when family members have learned to help each other out, when parents in their own relationships demonstrate affection, a healthy situation can prevail which can have lasting effects. In brief, the ability to give and receive affection in adulthood is influenced greatly by the manner in which affections are bestowed within the family unit as the child grows up and matures.

During later childhood, relationships with peers contribute to the child's emotional development. He needs recognition and approval from his own age-group as from adults and the opportunity to associate with this group to develop desirable relationships. The balance between meeting dependency needs and training for independence within the home and social groups during childhood will differ with values which societies place on these two aspects of emotional growth. There is increasing evidence, however, that the emotional responses of adolescents and adults are influenced profoundly by emotional experiences during infancy and childhood.

Puberty, a period of biological and psychological transition, the length of which varies with the individual and his social and cultural milieu, is characterized typically by emotional problems. The biological changes taking place can cause the young person concern, especially if he has not learned about his own body and what to expect from it.

Experience suggests that emotional tensions increase during puberty, especially in young people who mature early or late. These tensions may be manifested in illnesses, overfatigue, as well as over-concern about oneself. Little is known about possible consequences on health in traditional societies, many of which have puberty or initiation ceremonies which are entered into by the family and community. One may ask, are the emotional effects on the young person lesser or greater than in societies giving less direct recognition to those changes? Are the physical effects of the sometimes quite strenuous rituals harmful or beneficial?

Recreation for the adolescent who is seeking his or her own identity and growing into manhood and womanhood will increasingly be pursued outside the family in some cultures. Heterosexual relationships may develop at this time. In various cultures today, adolescents engage early in sex experiences, including sexual intercourse. The extent to which such practices are accepted by the family and the culture of which it is a part varies widely. Regardless of the value judgement placed on adolescent sexual ventures, a potential concern from the standpoint of emotional health is the impact of the experience itself as well as the possible consequences.

In many parts of the world, transition from rural to urban living creates special emotional problems for girls. In their own villages they are protected by family and other villagers. The new life in the city results in new contacts, often in situations beyond their ability to cope. They need the guidance and help from teachers, youth leaders and others aware of their difficulties.

¹ For further discussion see Department of Health, Education and Welfare, Perspectives on Human Deprivation: Biological, Psychological and Sociological (1968) Washington, D.C., The National Institute of Child Health and Human Development, 323 pp.

The stresses that adolescents experience are many and complex. This is a crisis point in the lives of those young people who are leaving families that nurtured them and who increasingly are assuming responsibility for their own educational, occupational, and marital planning. Those young people whose family relationships have been warm and understanding are more likely to move through this transitional period with minimum difficulty than those who have been over- or under-protected.

From the standpoint of family life education with young children, discussion of health components associated with the emotional and social development would not be complete without mentioning the importance of learning directly from the children what they want to know about themselves as developing boys and girls, as well as how they feel about heterosexual relations in the home, at play and at school. One of the great dilemmas among parents, educators, health workers and citizens is how to respond to children's natural curiosities and concerns, as well as how to react to their behaviour. To illustrate, in some societies, where sexual expression is accepted as a natural way of life, and viewed in all its aspects by children, where parents and society early accept, and perhaps even accentuate the sex differences, it is possible that a direct and frank approach can be used in health education which would help to prevent some of the physical and emotional health hazards that can arise through ignorance, especially during the ensuing adolescent years. However, in those societies where overt interest in the other sex is frowned upon, where boys and girls are kept separate at school and in play, or where religious or cultural taboos exist, there seems to be no easy answer to education on human development at this age-group. Yet this is, in fact, the period when the emotional impact of such education is likely to be less than during the later, emotionally fraught adolescent years.

The level of physiological, emotional, intellectual and social development of adolescents points to the need for helping them through health education and family life education to make choices and decisions in respect to their own behaviour which may benefit their health and well-being now as well as that of their future families. In some countries where young people have been given opportunities to raise questions pertaining to their emotional development, marriage and family living, and to propose areas of emphasis they feel should be included in the school curriculum, there is evidence that their interests are broad, their concerns mature and their needs profound. Here lies an important task of family life education within the home. Here, too, lies an area for which careful planning is indicated among all those agencies and organizations concerned with adolescent development - the school, youth agencies, health departments and other groups. Developing a positive attitude to human development comes not only through daily living experiences, but also through opportunities to learn about its components, to weigh advantages and disadvantages of alternative courses of action, and to make decisions appropriate to situations a young person faces currently as well as in respect to his goals and plans as he moves towards adulthood. In some instances, it may mean preparing for impending marriage and all the responsibilities marriage entails; in others, it may mean recognizing and accepting responsibilities that are to be assumed by men and women in more casual contacts, in working relationships and as citizens of the larger community, or it may be a combination of all of these.

It has become clear that in examining health implications of adolescent experiences they must be viewed in terms of social norms. There is much yet to be understood about those influences in a young person's life which contribute to, or interfere with healthy development. The whole process of developing one's identity is so deeply rooted in culture that what is right in one culture is not permissible in another. Many of the difficulties arise in cultures that are in transition, where tradition no longer has the influence it has had in the past, yet where the new in social norms has not yet been fully condoned. The possible effects on the young person's physical and emotional development can only be surmised - and it must be viewed in specific ways for each culture.

1.7 Drug dependence

Drugs have become defined broadly by an Expert Committee of the World Health Organization as "Any substance that, when taken into the living organism, may modify one or more of its functions."¹ In various countries, different kinds of drugs are being used by school-age children, to the extent that children have become dependent upon them to the detriment of physical and emotional health.

Drug dependence is a term now employed in preference to "drug addiction" and "drug habituation".² A person may become dependent on a wide variety of drugs, sometimes in combination, with effects varying with the drugs, with the individual, and with the circumstances under which the drug is used. Among drugs which can lead to dependence are morphine type (e.g. opium, morphine, heroin); barbiturate type; alcohol type; cocaine type; cannabis (marihuana) type; amphetamine type; Khat type; hallucinogen type (e.g. LSD).^{3,4} Tobacco is not classified along with these other substances. Though it is associated with "compulsive, repetitive behaviour" it is not dependence-producing from a "psychotoxic" point of view as are the drugs just listed. Because of its importance in relation to health it will be discussed separately.

Since dependence, with all of its concomitant problems, can affect individual, family, and community life, it is important from the standpoint of family life education to attempt to find out within each sub-culture those conditions which lead individuals, or groups of young people, to start taking drugs. Some studies suggest that there is a family influence. Young people see their parents and other adults in the home taking drugs for physical and emotional ills and they often have easy access to the family supply. Cheln et al. in a study of narcotic abuse by selected youths have presented evidence "suggesting that users had experienced, at the time of onset of heroin use, some stress in their personal lives or family environment. There were indications that the users came from families that were less cohesive than those of their non-using peers. . . . Many . . . experienced some radical change in their lives during the critical year - shift in family occupation, move to another neighborhood, and the like . . ."⁵

Rebellion against family and society, inability to tolerate anxiety and frustration during the stressful period of adolescence, as well as seeking new experiences or a thrill, have also been cited as factors leading to drug use and its frequent abuse. A recent report of a WHO Technical Conference on "Mental Health of Adolescents and Young Persons", states "The

¹ World Health Organization, Expert Committee on Drug Dependence (1969) 16th report, Wld Hlth Org. techn. Rep. Ser., 407, p. 6.

² Drug dependence has been defined as "a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug." World Health Organization, Expert Committee on Drug Dependence (1969) 16th report, Wld Hlth Org. techn. Rep. Ser., 407, p. 6.

³ World Health Organization, Expert Committee on Drug Dependence (1970) 18th report, Wld Hlth Org. techn. Rep. Ser., 460, p. 9.

⁴ For a discussion of characteristics of drug dependence see Eddy, N. et al. (1965) Drug Dependence: Its Significance and Characteristics, Bull. Wld Hlth Org., 32, 721-733.

⁵ Cheln, I. et al. (1964) The Road to H., New York and London, Basic Books, Inc., p. 162.

gains sought from drug-taking vary with the individual. Drugs may be used not only to symbolize rebellion or identification with a sub-group, but also to obtain temporary relief from anxiety or to help establish contacts with others (as with alcohol). They may be used to induce general, and especially sexual stimulation (as with amphetamines) or to elicit psychopathological experiences interpreted as leading to profound 'insight' (as with LSD). One must neither disregard the symbolic functions of drugs, nor forget their pharmacological effects on the central nervous system."^{1,2}

In traditional societies where use of drugs is tied in with religious and social events, little has been reported on the extent to which young people engage in such cultural practices, or on the possible effects of the drugs in developing dependence.

The costs of drug dependence in terms of physical and emotional health are great. Among medical complications reported by a WHO Expert Committee on Drug Dependence are coma and marked respiratory depression, as from acute overdose with narcotics or with drugs of the alcohol-barbiturate type. Other complications include "malnutrition due to: (a) drug-induced anorexia (as seen sometimes in amphetamine users); (b) replacement by the drug of normal calorie intake (as in certain forms of alcoholism); and (c) the use of available funds to purchase drugs rather than food".

"Included also are cirrhosis, neurological disorders, . . . and those complications that arise as a result of self-destructive or antisocial behaviour that occurs during the period of drug effect. Examples of the latter include automobile accidents or injuries . . .".

". . . drug-users who fail to observe hygienic principles for hypodermic self-administration are likely to exhibit bacterial infections, both locally, at the sites of injection, and systemically (e.g. septicaemia, endocarditis and lung abscesses). Because of the widespread practice of sharing syringes and needles, viral hepatitis is common and occasionally needle-transmitted malaria is observed."³

Education on drugs within the context of family life education must take into account the individual, family, and community aspects of the problem. Since, in the last analysis, to use or not to use drugs is an individual decision, the facts as they are available, should be made known and individuals encouraged to think through the consequences, on both a short-term and a long-term basis, of dependence upon drugs. In those societies, or sub-cultural groups, where drug dependence is not common among young people, every effort should be made to prevent its becoming a problem.

From a preventive point of view, a sound and rational approach to the use of drugs in general, starting early in school years, is indicated. What will be taught will vary with the patterns of drug use and abuse within each local situation, as well as with the developmental levels of the children involved. In "low risk" areas, the possible dangers of overdramatizing drug use must be considered without at the same time denying children and adults the information they need to avoid practices which could lead to dependence. Much yet has to be learned about the best methods of approach in "high risk" areas where problems are immediate and acute. From a long-term point of view, there is growing recognition that an

¹ May, A. R., Kahn, J. H. & Cronholm, B. (1971) *Mental Health of Adolescents and Young Persons*, Wld Hlth Org. Publ. Hlth Pap., 41, p. 30.

² For a helpful discussion of hypotheses to explain the causation of drug dependence, see World Health Organization, Expert Committee on Drug Dependence (1970) 18th report, Wld Hlth Org. techn. Rep. Ser., 460, pp. 12-13.

³ World Health Organization, Expert Committee on Drug Dependence (1970) 18th report, Wld Hlth Org. techn. Rep. Ser., 460, pp. 17-19.

important aspect of education is the involvement of young people themselves in community-wide efforts toward improving conditions in family and community life which may precipitate drug dependence.

1.8 Smoking and health

In many cultures, cigarette smoking is a common practice which can have harmful effects on health. Studies over the past 20 years have shown that cigarette smoking "plays a major part in deaths from many diseases, the most important of which are ischaemic heart disease, lung cancer, chronic bronchitis, and emphysema. Apart from these, it causes much disability from chest and heart diseases and both mortality and disability from several other conditions."¹ Some of these health effects of smoking become manifest only after many years of the habit, a fact which makes it difficult to associate them with the habit and thus to make an impact in educational programmes with youth.

Of more immediate concern in family life education is the adverse affect on birth weights of babies born to mothers who smoke during pregnancy. Though data are still incomplete, there is suspicion that among such low birth weight babies, post-natal physical and mental development may become impaired.²

Smoking can start at an early age, especially in those environments where adults and older children smoke. The influence of the family has been especially noted in studies of characteristics which distinguish smokers from non-smokers. In this respect, Fletcher & Horn wrote: "First, conformity to a family smoking pattern appears to be important; smoking is commoner in children whose parents smoke and in children who have older siblings who smoke. Second is a pattern of low achievement . . . Third is a pattern of peer group influences. . . . Finally, there is some indication that smoking for some children is a symbol of independence and rebellion against the norms set either by the family or by their peer group."³

On the basis of present knowledge, there is no easy answer to preventing young people through education from starting the smoking habit or stopping the habit once it has started, particularly in view of the many influences surrounding the practice. As with other personal health measures, in the final analysis the decision is an individual one and should be viewed within the context of an individual's present needs and values and his long term goals. With focus on family life education, is it possible that there could be a deterring effect on some young people were they to learn that an older brother or sister who smokes can influence young children in the family to start smoking? Will girls who have learned about the possible relationships between smoking and pregnancy and who aspire to have children of their own hesitate to start the smoking habit during school years? It is hoped that educational programmes of the future may benefit as more is known about influences at play among young people who have never smoked or who have stopped smoking.

¹ World Health Organization, Health Consequences of Smoking. Report by the Director-General prepared for the Twenty-fourth World Health Assembly and dated 31 March 1971, p. 4.

² World Health Organization, Expert Committee on The Prevention of Perinatal Mortality and Morbidity (1970) Wld Hlth Org. techn. Rep. Ser., 457, p. 17 and p. 27.

³ Fletcher, C. M. & Horn, D. (1970) Smoking and Health, Wld Hlth Org. Chronicle, 21, 358.

2. HEALTH PROBLEMS AND NEEDS OF CHILDREN AND YOUTH AS CONTRIBUTING MEMBERS OF FAMILIES, INCLUDING THOSE ASSOCIATED WITH PREPARATION FOR RESPONSIBLE PARENTHOOD

Most young people want families of their own. For this they need preparation. A vital part of this preparation is growing up in a family which meets a developing child's health needs as discussed in the previous section on "Health problems and needs of individuals related to growth and development within the family setting" and which perform effectively its basic functions, including those functions to be discussed in this section of the paper. Just as these elements of health development and health care are fundamental to the well-being of the growing child and youth, so, too, should they become essential content of his formal and informal education in preparation for future family responsibilities. Experiences in the home, however valuable they are in laying foundations, may not be fully adequate as preparation for such responsibilities. Even when adequate, they need reinforcement and extension through educational institutions, including the schools.

The health problems and needs associated with fulfilling of family responsibilities, including parenthood, are viewed here within the framework of selected functions characteristically performed by families of many types, whether they are extended, nuclear, one-parent or communal families. These functions are:

- Reproduction
- Physical maintenance and protection
- Education and socialization
- Home management
- Child care - responsibilities of parenthood

The degree to which, or the manner by which, boys and girls will become involved with these functions as they grow and develop within a family setting and move toward families of their own will vary with age, sex, and the expectations and demands of family and society. Consequently, this discussion of factors in family living which affect the health of its members is viewed broadly. The problems and needs as set forth in relation to family functions are illustrative only of those which teachers, youth leaders, health workers, and others may wish to take into account as they plan programmes of family life education.

2.1 Reproduction

The health of the child, as well as of the mother and other members of the family, is inextricably tied in with events surrounding pregnancy and child birth.

Kessler & Kessler have stated that "During the past few years an increasing number of studies have focussed on the interrelationships between the number of pregnancies, family size, inter-pregnancy spacing and parental age, and factors relating to pregnancy outcome, maternal health, child health, and even family health. An overall picture, by now quite familiar, emerges from these studies, linking large family size, high parity, excessive maternal youth and short inter-pregnancy intervals with varying degrees of morbidity and mortality for mother, child, and family. Conversely, pregnancies between the ages of 20 and 30, spacing of two or more years, and family size from one to three or four, appear to favour maternal efficiency, better child development and well-being."¹ These factors are now discussed within the context of early marriages and teenage pregnancies.

¹ Kessler, A. & Kessler, S. (1971) Health Aspects of Family Planning. In: Diczfalusy, E. & Borell, U. eds, Control of Human Fertility, Nobel Symposium 15, Stockholm, Almqvist & Wiksell, p. 338.

In many parts of the world, young women under the age of 20, whether or not married, are giving birth to children. The extent of such pregnancies is not known and data on marriages and births when available are not comparable. Kessler & Kessler, in summarizing health risks associated with age and pregnancies, have stated: "Generally the risk of the mother dying increases below the age of 20 and above the ages of 30-35. In many countries complications of pregnancy and delivery show the same pattern of risk, with the highest rates below 20 and over 35 years of age. Effects on foetal death, neonatal mortality, and prematurity show a similar age distribution pattern under 20 and over 34 years of age."¹

Teenagers are in a high risk group in part because of biological factors operating independent of cultural factors. The young girl is not fully developed physically, with the result that she may have serious difficulties during pregnancy and delivery. Moreover, in many instances she is too immature emotionally to cope with a pregnancy. Added to biological and emotional factors are socio-economic and cultural factors that can increase health hazards of pregnancy at this age level. In developing areas, impoverished conditions accompanied by poor nutrition, insanitary surroundings, prevalence of infectious diseases and often overwork and lack of personal hygiene, can create serious problems. Rituals surrounding pregnancy and child birth in traditional societies may also add to the risks.

Pregnancy outside of marriage is another problem that may arise in some cultures. The World Health Organization, Scientific Group on Health Aspects of Family Planning has stated: "In most societies, a pregnancy that occurs outside marriage has a high chance of being unwanted. Virtually every available measure of maternal and infant mortality and morbidity shows that the unmarried mother and her child face significantly higher health risks than the married mother and her child, even when allowance is made for socio-economic factors. In New York City, from 1955 to 1959, maternal mortality and morbidity rates for out-of-wedlock births were as much as nine times higher than the rates for legitimate births. Infant death rates twice as high for the children of unmarried mothers as for those of married mothers have been reported. The few studies carried out so far on the health, including the behaviour, of unwanted children are difficult to interpret and are inconclusive."² Studies in the Netherlands show 15 per cent. higher stillbirth rates for children of unmarried mothers than for those of married mothers, while for primiparae, the excess was 35 per cent. Moreover, mortality in the first week was 70 per cent. higher and post-natal mortality 80 per cent. higher for children out of wedlock than for those whose mothers were married.³ It is difficult to interpret these data in terms of teenage pregnancies since ages of mothers giving birth are not stated in the studies. However, it is perhaps not too much to assume that teenagers accounted for an appreciable number of the births out-of-wedlock.

Gabrielson et al. have found attempted suicide a problem associated with teenage pregnancies. In a study of 105 pregnant females admitted to the Yale-New Haven Hospital for delivery during 1959-1960, 14 were known to have subsequently attempted or threatened suicide. They state, "Within the total study population, the risk of attempting suicide was somewhat higher among single girls, Catholics, and those not from poverty areas. Suicide attempts were also associated with pregnancy complications and venereal diseases. It is suggested that this excess of suicide attempts may be due to the stress of the pregnancy, or that both the pregnancy and the suicide attempts or threat may be forms of disturbed adolescent

¹ Kessler, A. & Kessler, S. (1971) Health Aspects of Family Planning. In: Diczfalusy, E. & Borell, U. eds, Control of Human Fertility, Nobel Symposium 15, Stockholm, Almqvist & Wiksell, p. 340.

² World Health Organization, Scientific Group on Health Aspects of Family Planning (1970) Wld Hlth Org. techn. Rep. Ser., 442, p. 10.

³ United States Department of Health, Education, and Welfare (1968) Infant Loss in the Netherlands. National Center for Health Statistics, Series 3, No. 11, Washington, D.C., Public Health Service, p. 25.

behaviour."¹ Similar data are not available from developing countries but health workers have reported instances where the problem was serious enough to withhold from pregnant teenage girls certain products which they were purchasing from pharmacies for self-destruction.

Continuing and adequate prenatal care are important for the health of the expectant mother and her child. In too many instances, prenatal care is not sought, or given, until near the time of delivery, unless complications occur earlier. Absence of maternal and child health services or services not readily available may be one reason for lack of care. Ignorance of the importance of prenatal care may be another, while in communities that condemn births out of wedlock, hesitancy to seek care may be still another factor. Too often when a pregnant, unmarried person does seek medical advice alone, or with a parent, her initial contact is unsatisfactory from her point of view and she may not return. Vincent, viewing physician-patient relationships from the standpoint of a Western, middle-class situation, stresses the importance of good communication between the physician and pregnant girl and the need of dealing with the girl herself as the primary patient. He states that arrangements should be made with the girl for follow-up prenatal care and that, when indicated, separate counselling of parents may be desirable so that they in turn can provide constructive help in the situation.²

Abortions to interrupt unwanted pregnancies among this young age-group occur. When done by unqualified persons or when self-induced they are a major health risk. As an increasing number of countries legalize abortions, a study of the impact of the experience on the emotional health of young people would be helpful, as well as of the longer term effects on attitudes toward contraception for family spacing and other health benefits.

Spacing pregnancies is becoming more and more recognized as important from the standpoint of health. Studies have indicated that a progressive rise in foetal, neonatal and infant mortality rates occur when the time between the termination of one pregnancy and the beginning of the next is less than 24 months.³ Though data on the relationship between family spacing and health are incomplete, and at times inconclusive, they do suggest the need for helping young people to see the possible consequences on their own health and that of their future families if too many children come too often over a long period of time. In societies that are ready for help, and with individuals who want to space their families, it also suggests the value of providing contraceptive information when requested.

Early marriages are often followed by a continuum of pregnancies with resulting large families. The World Health Organization has stated: "All over the world, there is a statistical relation between the number of pregnancies and maternal and infant death-rates. High infant and child mortality rates reflect the dangers of excessive pregnancies for the health of mothers and children and the inability of large families in developing areas to support all their offspring. Large families often cannot adequately feed and nurture all their children, and those who survive are often stunted in their growth and development. On the other hand, high infant mortality is one reason for consecutive pregnancies that debilitate the mother and result in high maternal morbidity. It is well known that maternal mortality rises with each successive pregnancy. Repeated pregnancies are not only a drain on maternal nutrition and haemoglobin level, but may also cause serious pelvic disease."

¹ Gabrielson, I. W. et al. (1970) Suicide attempts in a population pregnant as teen-agers, Amer. J. publ. Hlth, 60, 2300.

² Vincent, C. E. (1968) Unmarried Mothers and Pregnant Brides. In: Vincent, C. E. ed., Human Sexuality in Medical Education and Practice, Springfield, Ill, Charles C. Thomas, pp. 464-468.

³ World Health Organization, Scientific Group on Health Aspects of Family Planning (1970) Wld Hlth Org. techn. Rep. Ser., 442, p. 13.

"The result is too often an anaemic, malnourished mother whose already inadequate reserves are further depleted by almost continuous pregnancy and nursing, and an infant of low birth weight who dies if the breast milk fails or is curtailed by another pregnancy, or whose growth and development are stunted if he survives."¹

Family life education can play a part in efforts to deal with problems associated with teenage pregnancies. In those areas where early marriages with resultant pregnancies are the norm, an initial step could be that of making known the hazards and possible outcomes as already discussed. Young people, too, should know the importance of prenatal care - and further, receive help in finding the care they need. If health services for mothers and children are not accessible, then family life education on a community scale might help to create public demand for such services and instigate community planning procedures to secure the services.

Some countries today are facing realistically the fact that an increasing number of teenagers are becoming pregnant out of wedlock and are seeking to determine underlying causes, possible preventive steps, and ways of providing services for the girls and boys involved. Counselling services in schools, public health centres, clinics, physicians' offices as well as through youth agencies, social service agencies and religious groups are increasingly providing immediate help to the young people. Strengthening family life education in the home, at school and through the various community agencies with relevant health aspects can be a step in the right direction. However, such education must be adapted to the culture and provide opportunity for young people to consider those health factors related to responsibilities associated with pregnancy and parenthood.

Education systems are finding various means of keeping the pregnant girl in school and in many instances are arranging special classes to prepare her for the events leading up to her delivery and the decisions she must make regarding the child. Regardless of the form which family life education takes, it is becoming increasingly evident that it must be directed to boys (who must jointly share the responsibility) as well as girls.

2.2 Physical maintenance and protection

The focus here is on health aspects of the physical environment within and about the home.

The first to be mentioned is the provision of safe and healthful housing. Basic among family housing needs is protection from the elements - excessive heat, extreme cold, rains, flooding, sandstorms and winds. Infants and young children are especially sensitive to the elements and must be protected from their traumatic effects, though not over-protected to the extent that they are kept inside dark, poorly ventilated homes, with little freedom to move about in the out-of-doors.

Crowding is another common housing problem. Infectious diseases can more readily spread when large families live in very limited quarters, a situation which exists not only in many developing areas where large families are common but also in poor areas of other countries. Where there is little room to carry out the necessities of daily living, to say nothing of the amenities, one can expect an increase in emotional and social problems, though measurement of their effects cannot readily be made. Crowding is a part of a vicious cycle associated with poverty, high mortality and morbidity rates, and the desire of families to have enough surviving children to meet economic demands of the future and assure the perpetuation of the family. Young people anticipating families of their own should become aware of the causes of overcrowding and the effects on individual, family and community well-being. Such understanding is basic to a study of population dynamics.

¹ World Health Organization, Expert Committee on Maternal and Child Health (1969) The Organization and Administration of Maternal and Child Health Services, Wld Hlth Org. techn. Rep. Ser., 428, pp. 9-10.

Health is closely associated with sanitary conditions of the home environment. Lack of sanitary facilities and poor maintenance and use of those facilities on hand are major factors in the spread of infectious diseases.

Water, one of man's basic needs, easily becomes polluted as it moves on the surface and underground. People drinking polluted water from unprotected wells, springs, streams or other sources, may develop enteric diseases such as diarrhoeas, dysenteries and typhoid fever. In vast areas of the world, the family's health and development are seriously affected by the absence of safe and ample water supplies. As a part of family life education, consideration should be given to ways in which families are currently securing and using the available water as well as to its quantity and quality in terms of family needs. Steps taken within the schools themselves to provide and dispense water that is ample in amount and safe to drink could be a practical demonstration in rural areas where responsibilities must be assumed within each household.

Disposal of body wastes and of refuse can cause other major health problems. When improperly disposed of they may be sources of water pollution and breeding places for flies, mosquitos and other disease transmitting insects. Indiscriminate defecation or urination on land or in water can result in the spread of diseases from infected persons to those in contact with contaminated soil or water. Common among these diseases are schistosomiasis, ascariasis and hookworm disease. Schools should be first to set an example within a community by providing clean, well-equipped and maintained toilets, which children are taught to use and maintain in a hygienic way. Schools should likewise demonstrate proper covering and disposal of refuse accumulated on the premises. Where schools have taken such leadership their influence on homes has been considerable.

Food hygiene is a critical problem all over the world, but particularly so in those areas where there is little basic knowledge of good food-handling practices and where facilities are inadequate for processing, distributing, preparing and storing of foods. The food a family purchases from shops, markets or street vendors may already be contaminated because of faulty practices and lack of controls. Within the home, food can likewise become contaminated through poor handling in preparation and storage. As in other areas of sanitation, the school has a responsibility to set an example in food handling practices, as through school canteens and hygienic storage of food brought from home until ready to eat. The more the children themselves become involved in planning and carrying out improved hygienic practices at school, the greater the likelihood that they will carry over some of these practices to their home life, now or in the future.

Though problems of sanitation are great in rural areas, they often become even more critical in congested urban areas to which many rural people are now migrating and carrying with them their traditional insanitary practices. This world-wide problem is dealt with further in another section of the paper under the heading of "Urbanization".

Much could be said about safety factors associated with physical maintenance and protection. Though data are not generally available on hazardous conditions in or about homes of developing areas, those conditions which exist within a specific locality can be investigated by boys and girls and become subjects for class discussion as well as points of action toward improvements by the children themselves within their own home. For example, in a syllabus being used in a developing country, attention is called to such hazards as charcoal fires in a closed room and handling of matches, fire sticks, charcoal or petrol; insect bites, snake bites, and other animal bites; fruit peelings on the floor; poisonous substances; and objects that can cause cuts or wounds. These are hazards children can help prevent or correct through their own behaviour within the family setting.

2.3 Education and socialization

Education and socialization, basic functions of the family, have a direct bearing on family health. When planning for health education, including family life education, attention needs to be given to the family as a milieu for education within the locality, and to the manner in which it prepares its young people for participation in the larger society of which they are a part. Moreover, family attitudes toward change and the degree to which they are caught in change will influence what can be accomplished through the intervention of educational programmes and procedures.

In traditionally oriented families there tends to be a perpetuation of health practices, deeply rooted in culture, practices which often adversely affect the health of family members. At the other end of the spectrum, families caught in the throes of rapid change, with visions of a better life for their children and exposure to other values and ways of living, may be responsive to innovations, whether or not soundly based, which they believe can improve family health. In developing areas, one is increasingly finding families which are in transition, holding to the past yet aware of the new as modern methods of communication and advances in education reach them.

Aspects of family life which reflect broadly the influence of internal education and socialization processes on health are discussed briefly here, under the headings of patterns of family living, status conferring, recreation, and the defining of masculine and feminine roles.

2.3.1 Patterns of family living

Patterns of living within a single family are frequently observed which can create health problems. Though hereditary factors, as well as cultural norms may enter in, there seems to be a continuity of practices within a family not fully explained nor yet well understood. Mention has already been made of family patterns in respect to smoking. Obesity is another family pattern which is often observed. Obese parents often have obese children. Though genetic predispositions, family and cultural food and activity patterns, and psychological or social problems may be factors, family and cultural attitudes toward obesity must also be taken into account. In some families and societies, obesity is considered a sign of affluence and status.

2.3.2 Status conferring

Families seek status for themselves within the larger society of which they are a part. They likewise act in ways that will give status to their children. In traditional societies, these status-seeking, status-conferring practices are dictated to a large extent by custom or social pressure. Rituals at puberty, early arranged marriages, delayed marriages until status goals have been reached, preferences shown for one sex over the other, and many other actions associated with status can affect the nature and quality of family living. The tendency exists to imitate people perceived to be of a higher status level. Thus, one finds families, who for example use limited funds for clothing instead of food, or who purchase imported luxury foods instead of locally grown and less expensive products of nutritive value.

In some societies, status is gained through high fertility; the more children a family has the higher the social status. Men who have contributed to the size of the clan may be accorded special positions of authority within the clan. Women with several children have high status while barren women are scorned and ridiculed. The health and health education implications of high fertility have already been touched upon elsewhere in this paper.

Fortunately, many status-conferring steps can lead to improved health practices, for as families move upward economically and socially, they are likely to want better health care, better education and a better social life for the next generation.

2.3.3 Recreation

Through recreation, members of a family, including children and youth, can gain many physical and emotional health benefits. Interactions among family members who enjoy common recreational activities can contribute to mental and social well-being. A well integrated family will recognize the needs of children and youth for recreational activities outside the home, as well as within, and will provide time and encouragement for such activities. They will evince confidence in the ability of youth to make wise choices and decisions in this respect.

Health problems can arise in connexion with recreation. When young children are taken along by families in their recreational pursuits they may become involved in activities deleterious to health. Lack of sleep, over-eating, and over-stimulation are all too common phenomena among children so exposed. In families where there is a constant flow of visitors and family life becomes too diffuse, children may again be the ones to suffer.

2.3.4 Defining of masculine and feminine roles

Most cultures have certain concepts of what is desirable and undesirable masculine and feminine behaviour at different age levels. Every human being is endowed with masculine and feminine qualities which need to be developed in ways that will give satisfaction to the individual and contribute to desirable human relationships according to the culture of which he is a part.

The sexual development of its children and youth has been a preoccupation of all societies over the generations. The processes of education and socialization according to culturally acceptable gender roles, begin at birth and continue through childhood and adolescence. By late adolescence, maleness and femaleness, according to expectations within the cultural milieu in which the child and his family live, have become well defined. As he gets older, the young adult is faced with added adjustments which are required for functioning effectively as man or woman in the adult world. Concurrently with these processes, and most certainly affecting their emphasis and direction, there are occurring anatomical, physiological and psychological changes. It is suggested here that when imbalances exist between developmental needs and social expectations and demands a variety of health problems may arise.

Two aspects of child-rearing practices in the early years are noted here along with possible influences on health, namely, preferential treatment because of sex and differential treatment according to culturally acceptable sex roles.

Sex preferences displayed toward children occur in many cultures as well as in individual families. Theoretical considerations of why this is so are not explored here, but rather the possible effects of such preferences on offspring. The writer has found few references in the published literature on effects on health of preferential treatment because of sex. Nevertheless, examples have been given by workers who have met such situations in their field experience. To illustrate, it is reported that in cultures where the male child has higher value than the female, parents will take male children to hospitals for care more often than female children. When funds for schooling are limited, it is the boy rather than the girl who is given preference. Though much has been written about the child who has been damaged through parental abuse or neglect, such damaging treatment has not, to the writer's knowledge, been equated with the treatment of the non-preferred child because of sex.

The possible effects on health of differential treatment according to culturally acceptable sex roles are more readily observed, if not supported by definitive studies. To illustrate, in many cultures girls at an early age are burdened with excessive household duties, including care of younger siblings. In lieu of schooling they work in the fields, carry heavy loads, including children hardly smaller than themselves - in other words, they do the traditional duties of the female member of the family. Though this is a natural defining of the female

roles in such societies, one may question whether the value of being a contributing member of the family unit outweighs the possible damage to the child's physical and emotional growth. Boys are expected, in most societies, to develop early those traits associated with masculinity.

In some traditional as well as in modern cultures, conditioning for sex experiences starts during early and late childhood through actions of adults who accentuate the differences between the sexes by the way they clothe or handle children. In certain societies, early cohabitation is expected if not condoned. Heterosexual relationships take on numerous forms depending upon social norms. In recent years, and in many parts of the world, a complex shift is occurring in accepted standards and expectations in such matters as boy-girl relationships during adolescence, sex roles within the family unit, and male and female involvement in the economic and social world outside the family. General health aspects associated with sexual expression, as previously discussed, are inseparable from the psychological, emotional, and social aspects, and should be taken into account in family life education programmes.

2.1 Home management

The manner in which families manage their affairs, including use of time, distribution of family responsibilities, sharing of resources, and planning of family size can influence the health and well-being of all family members. Each of these items is discussed briefly with reference to families in developing areas, living in both rural and urban settings.

The management of time among those families living off the land is for the most part perceived according to the seasons. There is the time for preparing the land, planting and harvesting the crops, and then to benefit from those crops which provide food for the family or are a source of income. When the use of that time is disrupted through illness, such as malaria, of the head of the household who manages the crops, then others in the family can be adversely affected, too. In these self-contained families, usually living in poverty, time may seem to be of little consequence on a day-to-day basis, yet time required to fetch water, to reach the land being cultivated, to care for the multitude of children, and to perform the numerous household tasks can be so consuming that little energy is left to carry out the basic necessities of healthful living, to say nothing of thinking or planning ahead. For many families, this is the only way of life that they have known. Yet within these same cultures, young people with visions of self-fulfilment are beginning to question those never-ending routines that seem to lead only into further poverty and ill health. In family life education, opportunities exist to help boys and girls, within the limitations imposed by the realities of their situation, to consider how better they could use their own time, both within and outside the family, now and in the future.

The management of time in urban areas must be first of all on a daily basis. For those families whose roots are in a rural setting the need for such day-by-day planning is difficult to comprehend and to adjust to. This situation, confounded further by the necessities of living in a strange environment, results often in leaving undone the essential tasks for healthful living. Here, again, education for improved family living can help young people think through how time can be used best for protecting and maintaining the health of family members.

Family living is enhanced when responsibilities, including health responsibilities, are distributed and the needs of all members of the family are taken into consideration. Under survival or subsistence conditions in rural areas, necessity dictates the institutionalization of such practices, with male and female tasks, and even the duties of the children, well defined. Within the extended family, there is usually someone prepared to take on such functions as child rearing, food preparation, or education and socialization when parents themselves are unable to assume full responsibility, either on a temporary or permanent basis.

It is within urban communities that the sharing of duties can present particularly difficult problems from the point of view of health, when both the father and the mother work. The extended family is not likely to be near to carry on the daily duties; children too frequently are left to fend for themselves. Health problems become magnified, as pointed out in a later section of this document. Once again, young people within these families who may, in fact, be expected to perform themselves numerous child care and other family duties, can be helped through realistic programmes of family life education to learn how to deal with the actual health conditions existing within these urban homes.

Sharing of resources, as well as duties, is a necessity for healthful family living. In rural areas, the extended family, the clan, or the tribe are usually so organized that such sharing is done as a matter of course. To illustrate, Lubart reports that among those Mackenzie Delta Eskimos of Canada, where hunting still provides the sole means of subsistence, sharing extends beyond the family, including the hunting range and game "to ensure that in time of famine the stronger, more effective hunter would not monopolize the food supply, leaving the weaker to starve Similarly, families of the same hunting band also have reciprocal obligations. Orphaned infants and children - or a new child in a family that already has many children - will frequently be adopted by a widow whose children have grown. And everyone has the right to use any of the resources of the hunting band, whether food or tools. The concept of 'personal property' seems not to exist".¹

Quite different is the situation in urban areas where there are likely to be not only fewer resources to share, but fewer people associated with a family to do the sharing. Here financial resources, usually limited, must be used to buy clothing, pay the rent, feed the family, and provide for whatever recreation is possible. The competition for these funds can present critical problems in family relationships. Family budgeting becomes a necessity, and toward this, family life education can make an important contribution.

In both rural and urban communities, each young person anticipating a family of his or her own, should be helped to think through his own ability to share with a future partner the financial and other responsibilities involved in managing a household and maintaining a family in good health, as well as the capacity of the intended partner to do the same.

Planning of family size and the spacing of children are important if each couple is to have the number of children desired in terms of timing, health, socio-economic position and life goals. Family planning and child spacing are increasingly recognized as desirable in many rural and urban areas, but particularly so in urban areas for reasons given here and in other parts of the paper. Though the need for planning family size may not be as evident in rural areas where a large family with many children may be viewed as an asset, and in fact aspired to, there is growing evidence from surveys made in different parts of the world that more and more rural families, as well as urban, do wish to maintain families which they can support within their limited resources, and at a level which allows for adequate health care, education, and more comfortable living. Education in family living and in population dynamics can increase the understanding of young people as to the need, both within the family and on a national and global scale, for planning family size and child spacing.

2.5 Child care - responsibilities of parenthood

In the preceding pages, the rationale for, and elements of, good child care have been touched upon from numerous angles. In this section, child care as a family function is approached from the standpoint of responsible parenthood.

¹ Lubart, J. M. (1969) Field Study of the Problems of Adaptation of Mackenzie Delta Eskimos to Social and Economic Change, Psychiatry, 32, 449-450.

Four concepts pertaining directly or indirectly to parental responsibilities are presented here as suggestive of concepts needing development and application in family life education programmes. Together they provide a synthesis of health problems, needs and responsibilities previously stated and around which one can broadly view this area of concern. Moreover, they reflect the principles set forth in the "Declaration of the Rights of the Child" as proclaimed by the General Assembly of the United Nations on 20 November 1959.¹

2.5.1 Good health and mutually satisfying interpersonal relationships in the growing and developing years are important preparation for future parenthood

A vital part of preparing for parenthood is growing up in a family which meets a developing child's health needs and which provides, both within and outside the home, for the young person's optimum emotional and social development in accordance with the culture. The ability in adulthood to share family responsibilities harmoniously, and to give and receive affection, is influenced greatly by emotional and social experiences during infancy, childhood and adolescence.

2.5.2 The child has the need to be brought into a world where he is wanted

Principle 6 of the United Nations Declaration states in part "The child, for the full and harmonious development of his personality, needs love and understanding. He shall, wherever possible, grow up in the care under the responsibility of his parents, and, in any case, in an atmosphere of affection and of moral and material security; a child of tender years shall not, save in exceptional circumstances, be separated from his mother."² Such needs can be met satisfactorily only under those circumstances where the child is wanted.

A basic principle underlying current family planning and family spacing programmes is that every family should have the right of free choice regarding size. The factors determining whether or not a child is wanted are many, and differ widely between families where children are an asset and those where they are a liability. There is a growing recognition that children have their rights, too, as expressed in Principle 2 of the United Nations Declaration as follows: "The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration."³ Opportunities should be given young people anticipating sexual relationships in or out of marriage to consider these mutually interrelated rights in the light of their own goals.

2.5.3 The development of responsible parenthood demands the provision of good prenatal and post-natal care and continuing attention to the physical, psychological, emotional and social development of children and youth as they mature into adulthood

Again we turn to the "Declaration of the Rights of the Child" to find in Principle 4: "The child shall enjoy the benefits of social security. He shall be entitled to grow and develop in health; to this end, special care and protection shall be provided both to him and to his mother, including adequate prenatal and post-natal care. The child shall have the right to adequate nutrition, housing, recreation and medical services."⁴ Though these

¹ United Nations Division of Human Rights, 1968 International Year for Human Rights, Human Rights, New York, United Nations, 1967, pp. 89-91.

² United Nations Division of Human Rights, 1968, International Year for Human Rights, Human Rights, New York, United Nations, 1967, p. 90.

³ Ibid, p. 89.

⁴ United Nations Division of Human Rights, 1968 International Year for Human Rights, Human Rights, New York, United Nations, 1967, p. 89.

rights as stated go beyond the responsibility of parents to include the community and its provisions for child care services, they are rooted within the home, the first line and principal line of care for most children.

An essential task of health education, including family life education, is to provide young people with the knowledge which is basic to good child care, and to help them to develop the willingness and ability to put such knowledge into practice.

2.5.4 Responsible parents, when they cannot fully cope with health problems, seek help from reliable outside resources

This concept implies the importance of including in health education an understanding of available or needed health resources within a community and how to obtain and use the resources when required. In many instances it may mean involving young people in community-wide efforts to build a health service which more adequately meets the local needs. It may even mean involving them further as volunteers in essential health services.

3. HEALTH PROBLEMS AND NEEDS OF YOUNG PEOPLE PERTINENT TO BECOMING RESPONSIBLE CITIZENS AND PRODUCTIVE MEMBERS OF SOCIETY

A broad objective of education in many countries is to prepare a young person for his position in the local, regional, national, and world community. Health education, including family life education should contribute at every possible point to such preparation. A boy or girl growing up in this ever contracting world should not only be aware of the health conditions and services in his own neighbourhood, village, and country, but also gain appreciation of world-wide needs and comprehension of world-wide efforts to improve the health of people everywhere. In addition, through appropriate planning between school or youth programmes and health authorities, opportunities can be found for the young people themselves to participate in community health endeavours. Such participation can not only provide a useful service to the community but also become a valuable educational experience for the young people themselves.

In this final section of the document, two topics are discussed which have a bearing upon the interrelationship of the family and the community. The first, urbanization, is especially important from the standpoint of child development and family life for today almost 40 per cent. of the world's population lives in urban places, many of them people who have recently moved from rural areas. Upon the second, availability and use of health services, much depends for the implementation of programmes to meet needs as discussed throughout the paper.

3.1 Urbanization

Urbanization, as discussed here, focuses on selected health problems and needs associated with living in rapidly growing cities, especially those in developing areas where the tempo of growth is fastest.

A report of a 1970 WHO meeting on "Health Effects of Urbanization" states "The tremendous influx of population to the cities has severely strained facilities of every kind - provision of medical care, social services, employment, water supply, sewage disposal, housing. Mass migration, particularly in the developing countries, has led to serious over-crowding and to the development of uncontrolled peri-urban slums. New problems have arisen and old ones have been seriously aggravated: one has only to mention such things as air pollution, juvenile delinquency or traffic accidents. The movement of population from countryside to the city may lead to the reduction of some age-old disease threats (such as malaria, zoonotic and parasitic diseases), but the crowding of the city may greatly increase the possibilities of spread of other communicable diseases and mental illness.

"On the other hand, it is clear that health technology, like all other technologies, tends to be centred in cities; medical care, environmental protective services, and standards of living tend to be of higher quality in cities than in rural areas. And, for whatever reason, people feel very often that opportunities for a full life are most likely to be found in the metropolis. Whereas for most of the history of the world cities were relatively unhealthy places, today this is no longer the case. But with the problems of crowding, pollution, blight and unrest, how long may this be so?"¹

Within many cities great pockets of poverty are common. Both within and surrounding large numbers of cities, yet a part of them, can be found "villages" of migrants from rural areas who have brought their rural habits of living with them. Rosa, in adding to the picture, states: "The developing countries face many of the same problems with urbanization that were faced in Western countries during the last century. Here we have families with rural habits trying to adjust to an urban setting. High birth-rates and large families that were convenient to manage in rural areas are difficult to handle in the cities. Rural sanitation habits are unsatisfactory in the urban setting. Communicable disease hazards increase. Nutrition availabilities may deteriorate, insofar as the family was able to supply itself with its own needs in the rural setting. Child labour in industries is a problem in some areas. Space is lacking for children to exercise and play in. New accident hazards appear."² It is within these cities that children are growing and developing, that families are performing their various functions, often under the greatest of handicaps. It is within these cities, too, that many of the health problems discussed elsewhere in this paper are intensified. A few of these problems that have special implications for family life education in the urban setting are expanded here.

Feeding the family often becomes a very difficult task in the city. As just suggested, foods that were obtainable in rural areas and to which families have been accustomed, may not be available in the city. Foods at hand are frequently unacceptable or too costly to purchase.

Food preparation at home can be difficult to arrange through lack of facilities or time to prepare the food. Fuel may be expensive and cooking arrangements inconvenient. Basic sanitary facilities for protecting food from human, insect, or rat contamination may be lacking. In some urban areas, families purchase prepared food from street vendors, markets, or small shops rather than prepare the food at home, thus adding to the risk of food infections. Children of all ages are often left to tend to themselves, eating whatever food is around, whenever and wherever they can find it.

Many young mothers work and consequently curtail breast feeding. Early weaning and artificial feeding can lead to serious diarrhoeal problems as well as to malnutrition. Milk and other foods given to the infant may be contaminated; foods may be deficient in proteins and calories.

Health hazards associated with housing have already been mentioned in the earlier sections of this paper. They can be particularly acute in congested urban areas. There is the problem of providing sanitary water supplies and sewage disposal facilities fast enough and adequate enough to meet the needs of rapidly growing cities. There is the problem also of people not using available and often unfamiliar facilities in a safe and healthful way. When families have come from rural areas where social life has revolved around the common well or standpipe, where fields or bush were used for excreta disposal, it is not simple for them to adapt to the ways of the city. Instances have been cited where inside toilets,

¹ World Health Organization, Meeting on Health Effects of Urbanization, 2-7 November 1970, pp. 3-4. Unpublished Report.

² Rosa, F. (1970) Maternal and Child Health and Family Planning Programmes in Urban Areas, Participant Journal, 4, No. 12, p. 23.

perhaps shared by several families, are not used because they are both aesthetically distasteful and culturally unacceptable. In crowded urban areas that lack potable water supplies and central sewerage systems, health hazards associated with substitute arrangements for obtaining water, for bathing, and for disposal of wastes are particularly great. The magnitude of the problem of environmental sanitation in urban areas has been set forth in technical publications.^{1,2}

The accumulation of refuse in cities and towns can be a serious health menace as well as an aesthetic disgrace. Refuse provides a harbourage for rats that are potential spreaders of disease and dangerous to young children. Rats are widely distributed throughout the world. Infants are attacked. It is known that rats running over people in a crowded room will be attracted by the smell of dried milk around an infant's mouth; the infant may become startled, in turn startling the rat which bites ugly gashes on the infant's face.

In some parts of the world the Aedes aegypti mosquito has become a city dweller. In the Western hemisphere, particularly the south-eastern United States of America, the Caribbean area, and Central America, this mosquito, a carrier of dengue fever (and more rarely now the potentially fatal yellow fever and haemorrhagic fevers in other parts of the world) breeds principally in water caught in artificial containers which accumulate readily about a dwelling or in vacant lots. Used tires, tin cans, plastic bottles, toys, abandoned cars, discarded appliances, vases and other containers for rooting or growing plants in water, are among the many objects in which the female Aedes aegypti will lay her eggs.

Eradication of Aedes aegypti has become a goal in those parts of the Western Hemisphere where the mosquito breeds. Its close association with households and its dependence, in these areas, upon the litter created by human beings, makes the co-operation of families, neighbourhoods, and the larger community, including schools, imperative for its control. The use of insecticides, intensive clean-up campaigns and similar externally applied measures have not been enough to get rid of the mosquito. Here is an area of concern in which continuing family life education could conceivably play an important role.³

The Culex pipiens fatigans mosquito is an urban vector of filariasis in Africa, Asia and South America which, unlike the Aedes aegypti (a clean water breeder) breeds essentially in sewage, such as in cesspits, soakage pits and ill-maintained drains. As urban populations increase beyond the ability to handle sewage and drainage problems, the problems of controlling the mosquito likewise multiply.

Tuberculosis rates are high in many urban communities as is the incidence of intestinal diseases. Persons from these high incidence areas are special risks in food industries, where, without proper food handling, they may contaminate the food. As servants, as those caring for children, or performing other tasks in close contact with people, they may likewise be responsible for the further spread of these infectious diseases.

Social and economic problems associated with urban living have impact on individual and family health. Migrants to the cities are largely young persons seeking employment in industry and service fields. Removed from the protection and restraints of family or tribe, often without steady work, they may react to situations in ways that can lead to crime, violence, drug addiction, alcoholism, and prostitution.⁴

¹ World Health Organization, Expert Committee on the Public Health Aspects of Housing (1961) First Report, Wld Hlth Org. techn. Rep. Ser., 225.

² World Health Organization, Expert Committee on Environmental Health Aspects of Metropolitan Planning and Development (1965) Wld Hlth Org. techn. Rep. Ser., 297.

³ United States Department of Health, Education and Welfare (1966) The Aedes aegypti Eradication Program., Atlanta, Ga., Communicable Disease Center, 17 pp.

⁴ Urbanization and Public Health (1967) Wld Hlth Org. Chronicle, 21, 428-429.

Urbanization dramatizes the difficulties that can arise with large families. If the family is a nuclear family, as may be the case in an urban setting, the pressures associated with limited living space, with limited food to feed the family, with limited funds, and often with no extended family ties to share the burdens, can lead to hopelessness and serious family crises. The importance of limiting the size of the family, as well as spacing the children, has significant health implications.

On the positive side of urban living, health facilities are more likely to be in greater number than in rural areas. Thus, it may be a question of knowing about their availability and location. It may also be a matter of providing services at a time when, and a place where, they can be used most conveniently by people for whom they are intended.

3.2 Availability and use of health services

If children and youth are to grow up healthfully in a family and are to be ready to assume future family responsibilities, there are needs for health services, including the educational components, at various phases of their development and learning.

Health services are needed during the prenatal period, at delivery, and through the post-natal period to assure the health of the mother and child. They are needed in infancy, early childhood and adolescence to assure essential preventive and corrective measures. Education coupled with health and related services are needed throughout the formation and continuity of family life if family tasks are to be performed in a healthful manner and if family illnesses and diseases are to be prevented or ameliorated. And they are needed in the community at large if the environment is to be a safe and healthful place in which to grow up and to raise a family. Yet despite these obvious needs for education and health services, adequate and available to all, large portions of the world's population are without them. Even when health services are available and known, they may not be used properly when needed.

There are many attitudes and practices of people, and related factors, which need to be better understood by health personnel if they are to serve the people effectively. These include attitudes of people toward use of clinics or hospitals; recognition of the importance of immunizations; sufficient desire when ill to seek health or medical care; dependence on folk medicine; and fear and frustration when health services are poorly dispensed. Here lie areas for study by providers of health services working in close collaboration with existing and potential users to ascertain in a more systematic manner the physical, psychological, cultural, educational and economic factors which should be taken into account in planning for services. Here, too, lies an important area for the education of children, youth and adults toward the support of efforts to secure essential services and toward their wise use.

Numerous countries are now actively engaged in co-ordinating and upgrading the services they already have, as well as extending coverage and improving quality in an orderly way as resources become available. In working towards the establishment and strengthening of health services, such components as maternal and child health, nutrition, nursing, health education, mental health, drug dependence, as well as programmes on environmental health and against specific diseases are playing an important role. Family health is a recently added component within the programme of work of some countries with particular focus on health aspects of family planning toward improved family health. The activities essential to family health include the contribution of all of the previously mentioned services and those concerned with education and training of professional and auxiliary health workers. They also involve co-operative planning with other agencies and organizations.

4. SUMMARY

The health aspects of family life education are viewed in this document as a part of general education, including health education. Selected health problems and needs are discussed, with particular reference to children and youth, especially in developing countries, together with implications for family life education. The paper concerns itself with the interaction of the child with his family and through his family with the larger society in which the child must become prepared to live as a responsible citizen. Recognition is given throughout to the need of identifying problems and needs that exist locally and to developing educational and health programmes which are appropriate to the culture.

Health problems and needs of individuals related to growth and development within the family setting are first examined. The rationale behind the concepts and content of this section is that as young people grow and develop, they need knowledge about themselves and the desire to apply that knowledge in daily living. Moreover, an understanding of health factors related to growth and development within the family setting is important for young people who share in the care of infants and young children and anticipate having families of their own.

Reference is made also to health problems and needs of children and youth as contributing members of families, including those associated with preparation for responsible parenthood. Health factors related to fulfilling of family responsibilities, including parenthood, are discussed within the framework of selected functions characteristically performed by families, namely, reproduction; physical maintenance and protection; education and socialization; home management; and child care.

The document concludes with a section on health problems and needs of young people pertinent to becoming responsible citizens and productive members of society. Two topics are discussed which have a bearing upon the interrelationship of the family and the community, namely, urbanization and the availability and use of health services. In presenting problems associated with each of these areas of concern, recognition is given to possibilities for young people themselves to participate in community health endeavours, not only as a useful service to the community but also as valuable educational experiences for the young people themselves.