Staffing Health Education Programs for American Indians

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THAT EDUCATION has an important role in any health program is axiomatic. More often than not a consensus on what to teach can be reached without a great amount of discussion. Deciding how, when, and by whom the educational program is to be developed is invariably difficult. Since the question revolves around the personnel who can get the job done, a description of the setting will be helpful in understanding the educational task in the Indian health program of the Public Health Service.

American Indians today receive a variety of services, including health, from the Federal Government. These services originated in treaties, laws, agreements, and other formal and informal understandings between the Indians and the U.S. Government. As a result of these arrangements, no other group of citizens today stands in precisely the same relationship to the Federal Government as do the Indians. The unique relationship has led to protection of Indian lands and resources and to provision of public services such as health, education, welfare, law and order, and construction and maintenance of roads. These services, normally made available to the populace through State and local units of government, are, for the most part, considered to be the responsibility of the Federal Government where Indians are concerned.

"The past half century has been one of revolutionary improvement in preventive and curative medicine generally. To the Indian health program, the years between 1900 and 1955 brought appropriations earmarked specifically for health. They brought expansion and modernization of hospitals, and larger numbers of qualified personnel. They also brought the development of special disease control programs, the introduction of public health nursing, and many other advances. Several major surveys, including the Public Health Service survey of 1913 and the Meriam Survey of 1928, focused public attention upon unmet needs and proposed means of satisfying those needs.

"Health education emerged as a distinct activity of the Indian health program in about 1910, in systematic efforts to teach Indians at agencies and schools about the treatment and prevention of tuberculosis, trachoma, and other infectious diseases. Among the devices used in the early years to promote healthful living habits were pamphlets, illustrated lectures, and motion pictures. In 1924, the Indian Bureau obtained the help of the American Red Cross and American Child Health Association in designing health courses for Indian schools.

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Another step forward in the organization of health education for Indians was the appointment in 1934 of a supervisor of health education, to work under the joint auspices of the health and education units of the Indian Bureau. In general, low standards of living on the reservations retarded progress in health education. Various Indian customs and medical practices introduced complications, as in the case of the tuberculous mother accustomed to chewing food for her baby. Special problems arose when the white man's health teaching conflicted with that of Indian medical practitioners" (*1*).

This background can be reviewed in terms of three broad groups of people involved in the health education of the Indians. The three groups are the Indian people themselves, the staff of the official agency directly responsible for health services to the Indian people, and representatives of all other agencies that concern themselves with the health of the Indians. Educational objectives are based on the distinctive character of each group and circumstances of the moment.

The Indians are people in transition. About one-half of them retain strong ties to the traditions of their several cultures; they are not a homogenous group ethnically. Some do not understand the concepts of modern medicine, and they have their own beliefs concerning the causes and cures for illnesses. An innate problem, not always recognized, is the degree of understanding or misunderstanding that non-Indian health personnel have of the Indian.

Best use of the potentials of the other agencies interested in the health of the Indian in providing needed services presents still another incompletely solved educational puzzle. Perhaps the major difficulties with the central agency staff are to secure enough specialists in health education to work directly with the Indians and to develop the educational facets inherent in activities of other members of the Division of Indian Health.

In planning for the transfer of responsibility for the health of the Indian people from the Bureau of Indian Affairs to the Public Health Service (achieved in July 1955) it became apparent that a health education staff was not readily available. This fact led to a more careful analysis of the jobs to be done, where the work should take place, and what type of administrative organization was needed. As a result of the analysis, activities were decentralized, with staff functioning at headquarters in Washington, at seven area offices, and on the various Indian reservations (*2*).

The decision was made that positions in the area offices, as well as at headquarters, should be filled by fully qualified public health educators, that is, persons with an M.P.H. degree and at least 5 years of experience. Securing these staff members was a normal task of recruitment; the real problem was finding the personnel needed to live and work on the reservations.

The 45 positions on the reservations called for two new types of health education staff—the community worker (health) and the community health education aide. The aides were to be similar to village aides found in many health programs throughout the world.

The keys to the growth, both in function and numbers, of the community worker (health), now titled education specialist (health), have been (*a*) careful selection, (*b*) adequate and continuing inservice training, and (*c*) proper supervision. Basic qualifications, established through the Civil Service Commission in 1955, are still in effect. They require applicants to have a baccalaureate degree and at least 1 year of successful experience in working with Indian people in a community setting. The degree must be in a field allied to health education such as education, sociology, anthropology, psychology, nursing, sanitation, or one of the sciences. This requirement not only provided a good foundation for the necessary on-the-job training but made it possible for the person to seek graduate-level training in health education later if he desired. It also gave him status in working with the professional health staff members, such as physicians, nurses, sanitarians, medical social workers, and pharmacists. Successful experience in working with Indians in a reservation setting was a qualification of great significance because judgment of a candidate's qualifications could enter the selection process.

Satisfaction of these two requirements automatically brought a third consideration into play—applicants of Indian descent who met the two qualifications would be given preference.

(This policy was to prove very beneficial to the program. Subsequent experience has shown that each Indian education specialist gained the immediate acceptance of the Indian group with whom he or she worked.)

The first step in channeling the knowledges and skills of the new worker into his new assignment is thorough orientation to health, health education, the Division of Indian Health, the Public Health Service, and to the locale where he is assigned. In 1955 when the area public health educators were as new as the other area staff members, and getting a new program underway was extremely time consuming, it was decided that the incoming community workers should receive their health education inservice experience in groups in central locations. Albuquerque, N. Mex., and Window Rock, Ariz., were selected. Contracts to provide this service for the Division were made with the health education departments of the University of California (Berkeley) and the University of North Carolina Schools of Public Health. The schools placed experienced health educators in these two locations to plan, conduct, and help to put the health education program into effect.

Since 1960 each area public health educator has assumed responsibility for all on-the-job training for new and old staff. This function is actively pursued in each area with a number of specific sessions each year on current, pertinent problems. The number of sessions and the problems discussed vary, of course, according to the needs of each area. The initial inservice training period, with few exceptions, is for 4 weeks. It has the following objectives:

1. To give the community worker (health) an understanding of his job so he will be ready to begin field activities in the Indian health program.

2. To familiarize the community worker with the Division of Indian Health, Public Health Service, so that he will have pride and satisfaction in his position within this organization.

3. To provide the worker with information about other activities in the division so he will be comfortable with other professional workers and effective in his own role.

4. To learn the principles and practices of health education and how to apply them to the solution of a specific health problem.

5. To develop sound health education programs based on studies which have pointed out community health problems.

6. To learn that each health education program has to be planned in terms of the needs and resources of the community involved.

7. To demonstrate the team approach in the solution of a community problem.

8. To learn and develop good interpersonal relationships.

The objectives are achieved through lectures, various group participation methods, and field demonstrations. Qualified specialists—physicians, nurses, sanitarians, dentists, and social scientists—give the lectures and conduct the demonstrations.

Proper supervision lends stability and enables the community health worker to function effectively. He must assume responsibility for his actions as soon as possible because distances between the reservations and the area offices preclude day-to-day supervision. For the most part, the supervisory area health educators confer with community workers during monthly visits and quarterly staff meetings or communicate in writing or by telephone. Of course, special field visits are made when circumstances demand.

Probably the community worker's greatest single contribution has been his ability to persuade Indian residents of the reservation to participate in activities which give them an understanding of communicable diseases and their responsibility and role in the control of these diseases. The effectiveness of the health education staff is illustrated in the dramatic reduction in mortality and morbidity figures for tuberculosis among Indians since 1955.

Selection, inservice training, and supervision are no less important to the community health education aide, who represents the third type of health education staff of the Division of Indian Health. The need for these positions was expressed in the budget justification for 1958. "In order to move more closely into the social and cultural patterns of certain of the Indian people we plan to establish positions for community health education aides on the Navajo Reservation."

To do this job, a candidate should be able to speak, read, and write the English language at

the sixth-grade level and be able to translate and interpret health concepts from English into Navajo. He must have achieved a position of esteem in his village and must have worked successfully with the adults in his village to obtain their support of governmental or tribal programs. The inservice training of the aides was patterned after that of the community workers with, however, much greater emphasis on control of communicable diseases and mother and infant care. Supervision by the now experienced community workers was more intense and contacts were daily in contrast to the relations between the area public health educators and the community workers.

Initially it was proposed that the aides work on reservations where Indian languages cause communication barriers. At present, however, only the Navajo Reservation in Arizona and New Mexico has such aides, a total of six.

The health education aide's outstanding contribution has been to serve as interpreter-translator between the professional health staff and the Indian residents of the Navajo Reservation. The effectiveness of the aides is reflected in the impressions of physicians and nurses that patients now arrive at the hospitals in earlier stages of their illnesses and can be treated more effectively and for shorter periods. Community workers live in the community where the reservation headquarters is located, but the aides live in the villages where they work.

Developing staff to meet new program needs is essential in an ever-changing society. This staffing pattern in the Division of Indian Health, unique in health education efforts in the United States, was devised because of a shortage of public health educators. Qualifications of candidates and type of on-the-job training and supervision were tailored to meet the conditions under which health education must be conducted on Indian reservations.

In this way, with few failures, a new type of health education worker was developed. He is capable of performing many health education functions at the community level, and his academic background permits him to qualify for graduate work for an advanced degree in health education if he so desires. There are now 39 education specialists (health) in the Division of Indian Health. Of the 39, 10 have attained an M.P.H. degree in health education. Three others who received their M.P.H. degrees while in the Division are now employed in other programs as health educators.

Aides have been used in nursing and sanitation for many years in this country and abroad. Village health aides with some educational duties have also been used abroad and to a limited extent in this country. To my knowledge, health education aides have been used in the Indian health program on a longer sustained basis than in any other program in this country.

Because the health education staff team in Indian health, composed of the public health educator, the education specialist (health), and the community health education aide has done so well, I think other public health programs could profitably give serious consideration to adapting the concept to their own situations.

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