Why Health Programs Are Not Reaching The Unresponsive in Our Communities

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PEOPLE who do not respond to health services can be found in most communities throughout the world—in villages, migrant farming areas, and urban slums. Their numbers are particularly great, however, among the poor and uneducated.

Public health workers become disappointed and frustrated when these persons fail to respond to health services. Why do people not take advantage of the health programs available to them? Why do mothers, for example, fail to bring their infants and young children to a clinic for preventive immunization shots? Why do certain hard-core segments of a community stay away from venereal disease clinics? Or why do large sections of the public not turn out for a mass tuberculosis X-ray campaign? Health planners have a responsibility to look at questions like these and seek answers. The tasks of providing health services that meet the needs of disadvantaged groups become particularly relevant to public health workers in areas along the United States-Mexican border.

The people who do not respond to the well-intentioned efforts of health and social workers have been called the submerged third, the hard core, the hard to reach, or even the unreachable. They have also been characterized as recalcitrant, reluctant, fatalistic, superstitious, or unmotivated in their health behavior. Sometimes they have been described as the culturally disadvantaged, the marginal man, or the multiproblem family. Numerous efforts have been made to gather data about them.

Socioeconomic studies have related such factors as social class, income, race, and education to sickness and disease. These data show that the hard-to-reach people usually come from lower-income brackets and from families with many problems. The father is often out of work or has unsteady employment, the children come from broken homes and drop out of school at an early age, the adults may be physically disabled, and so on.

Such data describe these population groups demographically, but unless we are careful, this information may lead us away from the answers we seek. D'Onofrio, in reviewing the literature on hard-to-reach groups in vaccination programs, suggests that while these demographic data are useful in pinpointing target groups, they do not explain why people fail to obtain vaccinations (C. D'Onofrio: Reaching Our "Hard to Reach"—the Unvaccinated; unpublished monograph, Bureau of Health Education, California State Department of Public Health). Socioeconomic data are not

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always helpful in pointing out more effective ways to work with these people.

What then should be known and done to reach these people and their families and how can the kinds of health services to which they will most likely respond be supplied? Where do the difficulties lie in providing dynamic health programs to meet their needs? What barriers exist? Or perhaps, what barriers do members of the health team create?

Priority of Basic Needs

It is essential that professional health workers fully understand these segments of our population. The hard-to-reach groups are faced with many problems, and much of their daily activity centers around merely maintaining existence. Much of their effort is spent in meeting the economic needs of day-to-day existence, such as paying the landlord, buying enough food to last the month, getting Johnny a pair of shoes for school, and paying the doctor for emergency medical treatment. These are matters which assume a high priority in the lives of the hard-to-reach clientele.

Until these people are able to satisfy their needs for food, shelter, and safety, they will probably be unable to deal with other needs, such as that for the preventive health care which we value so highly. Until people achieve some degree of control over their basic problems of living, it may be unrealistic to expect them to be interested in obtaining vaccinations, in coming to prenatal clinics, or in bringing well children to child health clinics. Hochbaum (*1*), a social scientist, in describing why certain groups are hard to reach, stated that these kinds of people are difficult to reach "primarily because we . . . appeal to values which are ours, but not theirs, and because we would like them to strive for things which are simply not important, or perhaps . . . [not] . . . understandable, to them."

Attitudes of Health Workers

Another difficulty occurs in the attitudes of public health professionals and the relationships they maintain with the unresponsive. It is a human tendency to classify and place persons in categories. We pin labels on people, particularly when they differ significantly from us in education, cultural background, religion, ethnic group, or social values.

We sterotype people with labels such as "colored," "poor whites," "Okies," "Mexicans," and "Norte Americanos." We say people are fatalistic, that they have a village mentality, and so forth. Putting value judgments on people and classifying them does not help the professional to analyze the situation more clearly or objectively or to understand the problems of these people in their psychosocial environment.

The moment we stereotype, we prejudge. And such prejudgment can create real barriers to the development of a positive climate in which professional help can be supplied and received. If channels of communication can be opened between the health agency and its clientele, between the server and the served, there is a much greater likelihood that the health needs of the hard to reach can be determined and appropriate services planned to meet them. Multiple problems require multiple approaches. Health programs might be more successful if individuals in the target groups were allowed to take part in the planning and the development of the programs.

Flexibility of Programing

Health agencies must be open to the demands and needs of those they serve. The agency that wishes to change the behavior of others must be the first to change itself. Are public health professionals sensitive to special needs and flexible in their programing, or are we a hard-core group that has developed health programs according to the way we think culturally disadvantaged people ought to act? We may be the ones who have difficulty in reaching out. Perhaps it would be more appropriate to designate these groups as the unreached rather than the hard to reach.

Some of our present patterns of health services may have to be altered to care for the special needs of certain groups. A recent 3-year experimental project (*2*) operated by the Family Counseling Service of the Episcopal Community Services in Philadelphia showed that there was a lack of community welfare resources in terms of services and personnel and

that the present structure and rigidity of some of the agencies and their services indicated that they were "hard to reach." The Philadelphia project was designed to provide help to multiproblem families who did not seek help on their own initiative or, who after asking for help, did not continue using the service.

We cannot assume that all people follow the same behavior patterns. Public health services have usually been based on the middle-class values with which most public health workers grow up and feel comfortable. To help effectively these unreached elements in the community calls for a re-examination of the kinds of services and facilities a health department normally provides, of when and where it provides them, and of the persons who staff them.

The traditional hours of a child health clinic, from 9 to 11 a.m. or from 2 to 4 p.m., may not meet the needs of a mother who works all day. An immunization clinic on the downtown premises of the health department is difficult for a rural family to attend when traveling to it involves several bus transfers.

Our policies for preventive and medical care may confuse and bewilder people having less sophistication and means than ourselves. How does one explain to a migrant family that a baby, if well, can receive immunization at a well-baby clinic every Tuesday, but that if the baby becomes sick, he must be taken to the county hospital 6 miles away, and that older children and adults must come for immunization to a different clinic on a different day at still different hours?

Services for education, welfare, and employment needs follow still different patterns. In 1962, Corsa and Jessup (*3*) pointed out that in California 14 separate kinds of health services were being provided to 500,000 children under 18 years of age. They stated that "Medical care for . . . [these] children . . . is a confusing, fragmented jumble involving many agencies. Nowhere is it comprehensive and rarely is there reasonable consistency or coordination among the fragmentation." It is no wonder that people become bewildered at the complexities of our public health, medical, and other public services and are unresponsive to our appeals.

The public health team must become more aware of the varying needs of its hard-to-reach clients. A 3-year study to determine the health attitudes and practices of low-income families was conducted by Howard University in Washington, D.C. (*4*). The report pointed out that "The responses of both Negro and white families strongly suggest that in a low-income area variations exist among families of the same race not only in regard to income, but also in the range of health knowledge, health habits, health attitudes and utilization of health services. Multifaceted programs have to be developed in order to appeal to the range of interests among the people of these areas."

Special Approaches Required

Special interests and needs among lower socioeconomic groups require special health programs. First of all, increased contacts between health agencies and their clientele would help to establish the necessary rapport and understanding for planning more effective health services. Small informal meetings with groups such as mothers, migrants, and the elderly would provide an opportunity for them to talk out anxieties, fears, hostilities, and other feelings which tend to block their accepting and using services offered by health professionals.

Increased attention should also be given to using localities that these groups frequent for carrying out educational programs. Health education should be carried into barber shops, pool halls, beauty parlors, small churches, and other places where the unreached gather. Most health agency activity is carried out within the confines of middle-class society organizational structure such as the health department building, the clinic office, and schools. Health agencies that wish to reach effectively these population groups must use more imagination in carrying their message and services into the community where these people work, live, and play.

Health agencies may also need to give greater attention to special training for their staffs. Inservice training designed to develop within physicians, nurses, sanitarians, health educators, and social workers a greater understanding of the nature and differences of the cultural backgrounds of lower socioeconomic groups would do a lot to improve working relation-

ships with them. Health professionals must learn how to communicate with people of different cultural backgrounds. There may also be language problems which present barriers to effective communication.

Sensitivity training would equip professional staffs to deal more effectively with the different value and belief systems of these persons. Health workers must search for new methods and techniques to reach people in ways that are meaningful to them.

Another method of working effectively with low-income groups may be to use auxiliary workers who are members of these groups. Recruiting such persons and using them under supervision of the professional health staff may be one answer to bridging the cultural gap between the health agency and their target clientele. Health aides from the same environment as the families served can assist the nurse, sanitarian, health educator, and social worker. Because these aides talk the same language and know the group leaders, they can motivate their fellows to adopt better health habits.

This approach has been used effectively to reach farm workers in California. In Kern County (*5*), the health department recruited and trained community health aides. The aides were housewives, laborers, and students who lived in the communities where migrant workers are employed. Employed at a minimal wage and trained by the health department, the community health aides went back to their communities to talk with, and to stimulate, their friends and neighbors. By working with the professional health department staff, the aides provided a meaningful link between the agency and the community, and they were able to promote sanitation, child care, immunization, and other health programs which had never before been successful.

Responsibilities of the Health Professional

The unresponsive people in our communities are more than statistics; they are people with dignity and life goals like anybody else. They consist of people like Carlos Gonzales, who never learned to read or write, but who tries to support his wife and five children by harvesting field crops 10 hours a day under the hot summer sun; or like Harriet Smith, who, deserted by her alcoholic husband, tries to keep her three children in school by washing and ironing clothes part time; or like retired Henry and Mabel Jones who live in a small two-room apartment on a meager welfare check and fear the insecurity and uncertainty of medical care in their old age; or like Johnny Walker who dropped out of school at the age of 16 to help support his family when his father became disabled because of a farm accident.

If physicians, nurses, social workers, sanitarians, educators, and others on the public health team sincerely desire to help these people function more fully as healthy human beings in society, they have a responsibility to look at themselves and answer some crucial questions. Are they doing all they can to achieve the confidence and understanding of those whom they desire to reach? Have they created in the health agency the organizational structure, the staffing patterns, and the program activities which truly meet the needs of the culturally and socially disadvantaged? Are they doing all they can to overcome the psychological, social, and cultural barriers that tend to separate these groups from the rest of the community?

Those persons whom we fail to reach have many problems. They have been denied or are unable to attain minimal levels of education, food, housing, health, and recreation. They come from all walks of life—from rural and urban areas. They may be stable or mobile, young or old, white or colored, single or married. The public health team must find out who they are, where they are, and plan health programs that fit into their way of living.

Summary

Certain lower socioeconomic groups of people fail to respond to organized health services. These groups, which health workers often label "hard to reach," may more appropriately be designated as unreached.

Some reasons why health agencies fail to reach these people are lack of understanding of the basic health and welfare needs of the target clientele, negative attitudes on the part of health professionals, poor or insufficient communication with some segments of the community, and the rigidity of health programing in terms of the services and facilities the agency offers.

Several ways are suggested to increase contacts with these groups—conducting health education in localities familiar to them, giving health department staffs sensitivity training in the value and belief systems of such groups, and recruitment of auxiliary workers who are members of these groups.

REFERENCES

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Federal Standards for 1968 Vehicles

Federal standards for the control of air pollution from 1968 American-made and imported gasoline-powered passenger cars and light trucks have been established by Secretary of Health, Education, and Welfare John W. Gardner. The standards, issued under provisions of the 1965 Clean Air Act Amendments, will limit emissions of hydrocarbons and carbon monoxide produced by the vehicles.

The standards require reductions in tailpipe emissions from new motor vehicles in three engine-size categories. Engines of 50 to 100 cubic inches cylinder displacement are limited to an average of 410 ppm of hydrocarbons and 2.3 percent carbon monoxide over a vehicle life of 100,000 miles. Engines of 100 to 140 cubic inches are limited to 350 ppm of hydrocarbons and 2 percent carbon monoxide; those over 140 cubic inches cylinder displacement are limited to 275 ppm of hydrocarbons and 1.5 percent carbon monoxide. Emissions from most motor vehicles with small engines now range from 700 to 1,600 ppm of hydrocarbon and 2 to 5 percent carbon monoxide; those with large engines emit 600 to 975 ppm of hydrocarbons and 3 to 3.6 percent carbon monoxide.

The standards also require 100 percent control of hydrocarbon blow-by emissions from the crankcase of all new vehicles with engines of 50 or more cubic inches cylinder displacement.

Representative motor vehicles must undergo a series of road and laboratory tests to determine if they will meet the prescribed limitations on emissions in ordinary use. Manufacturers must make test results available to the Department; they may also be required to furnish representative vehicles for testing in Federal facilities.

Regulations pertaining to enforcement of these standards make it unlawful to offer 1968 model motor vehicles for sale unless they comply with the standards. In addition, motor vehicles equipped to conform with the standards may not discharge any noxious or toxic pollutants that they would not discharge without the control equipment.

Vehicle manufacturers may request the Secretary to certify new vehicles and engines as being in compliance with the Federal standards. If the tested equipment is found to conform to the established standards, the Secretary is authorized to issue a certificate of conformity to the manufacturer for a period of not less than 1 year. This certification will apply to all vehicles and engines which are essentially identical to the tested equipment.

Manufacturers may request a hearing when notified that a certificate of compliance has been denied or issued on a conditional basis. The presiding officer of the hearing, designated by the Secretary, will submit his findings and recommendations to the Secretary, who will make the final decision.