Health Aides in Health Departments

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IN THE PAST decade the use of aides in medical settings has begun. Health aides have been used since 1961 in California health departments, especially where migrant workers are in the county during the peak harvest seasons. Who is the community health aide and how does he fit into health department programs? What kind of person is needed for this type of service? What kind of training and supervision will be essential to equip a person to serve in a subprofessional role? What are the advantages of using the aide on a health department staff? What problems should be expected and planned for?

The concept of using aides in community health programs is not new. In the 1950's community development was promoted in many countries by the U.S. International Cooperation Administration. Extensive agricultural, health, industrial, and educational programs were developed in India and the Philippines.

Griffiths reported on the development of the village worker, who works directly with the people (*1*). The philosophy is self-help. The Minister of Community Development in India viewed the village worker as "the first-aid man in all fields of rural development" (*2*). "Villagers were encouraged to improve their agricultural methods; engage in educational activities; to construct needed physical facilities; to make sanitary improvement; or to engage in work projects which they themselves felt would benefit the community" (*1a*).

Health education aides were introduced into the Navajo Reservation at Window Rock, Ariz., under a program developed by the University of California School of Public Health for the Division of Indian Health, Public Health Service. These aides "completed the bridge across the wide gap between the Indians in their communities and the health and medical services available to them. The aides were thought of as family health educators or hogan level health educators" (*3*).

The Department of National Health and Welfare of Canada has developed a community health worker program for the Indians and Eskimos living north of the 60th parallel. Since 1958 "the health educator recognized as one of the soundest approaches the long-talked-of idea of training native people as assistants to field staff. The natives had cherished the idea for some time of having their own people trained to work in their own communities" (*4*).

Community health aides were first introduced into California in July 1961 in the Kern County Health Department. "This agency has been engaged in extensive health educational programs among Spanish-speaking and other seasonal farm workers and their families. This project has focused on the use of community health education aides who have been selected from the farm labor group, hired and paid to learn basic principles of health and hygiene and to assist in the process of health education among other members of their community" (*5*).

The aide's formal education need not be beyond high school level. Some aides with the

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Santa Barbara County Health Department are not even high school graduates. However, Santa Barbara aides are encouraged to continue their educations, even as preparation for other jobs. The aide is most useful when he can reflect the needs, problems, and feelings of his own people. As he acquires more education, he moves into the middle class and is no longer able to give the same help to persons of the lower socioeconomic levels.

Aides who have been on welfare or had experiences on the receiving end of other social agencies are useful not only in discussing the health department with their people, but in helping the department to learn more about the people's fears, hopes, and hostilities. Since programs with mothers and children form such a large part of health department activities, mothers are valuable aides. We are also beginning to see the need for male aides, for the father's participation in and endorsement of health measures is important, especially in the Mexican population. Seldom will a woman make a decision regarding the health or welfare of her children without consulting her husband. We now have one male aide working in the Santa Barbara health department.

Number of Aides

There is no formula for determining the number of aides to be hired. Factors which need to be considered are the area to be served, supervision available, training needed, and budget.

The Santa Barbara County program started with two community health aides 3 years ago. It is easier for the aide if he is trained with another and has a colleague with whom to work and share anxieties. We attach aides to a program rather than to a specific person. Thus, instead of becoming nurse, sanitarian, health educator, or case aides, they become community health aides, representing all phases of the health department in the community. For example, one aide is now employed in an Office of Economic Opportunity nursery school program which the health department was influential in starting. The community orientation of the aide's training has been invaluable to her in her new role.

The geographic area selected for the use of aides at the beginning of the program was a community of 3,500 persons. As the program was expanded to include another community, we added one and later two more aides. Aides worked half time at first (20 hours per week). After 2 years one aide went on three-quarter time. At the present, all aides work half time. We discovered that aides find it difficult to work more than half time and continue to assume their family obligations. Aides are now working 1 evening per week so that persons who work during the day can receive health department services.

Health department professionals have also directed the training of 10 family planning aides used in health department clinics, homemaker aides used in an OEO project in the county, and home health aides used in Medicare programs. While the community health aide receives 10 to 12 weeks of intensive training, these other aides receive a 4-week basic aide training course. The family planning and homemaker aides are working on an OEO project run jointly by the health department and a private planned parenthood agency. The home health aide is employed by the Visiting Nurse Service, a voluntary agency.

One of the basic elements for a good community aide program is good supervision. Aide supervision requires a great deal of time, and we find that it takes one professional person to supervise adequately four part-time aides in the early development of skills for their new jobs. More experienced aides require less supervision and can learn to function quite independently. I believe we have had no turnover of aides because we allow the aides flexibility in their schedules so that they can meet their personal problems, we are available at all times to work with them on their job needs, and we can deploy them on a variety of assignments allowing for many new and different experiences. Thus, a factor in determining the number of aides to be hired is how much professional time is available for supervision.

Another important consideration in developing an aide program is the amount of training time necessary. It takes at least 200 hours of basic training to prepare a community health aide. Training is an expensive, necessary, and time-demanding task. Health department offi-

cials cannot think about adding aides to the staff without being willing to undertake a complete aide training program. We have found it easier to increase the work hours of an aide than to put on a training program for one or two persons as we are limited in budget for hiring more aides and in staff time needed for training them.

Community health aides, now numbering four, are paid by the hour. At the beginning of the project aides received $1.55 per hour and now receive $2.05 per hour. Hourly workers in Santa Barbara County, aides do not get retirement, sick leave, or vacation benefits; they are entitled to mileage and travel expenses, and are permitted to drive a county car.

It should be recognized that not all aides are good at all things, and allowance should be made for special skills and limitations. For example, some aides can speak before a group while others cannot. Some can help in mental illness cases; others find it too threatening. Aides who do not speak Spanish cannot be used with persons who do not speak English.

Role of the Aide

In the Santa Barbara County Health Department the community health aide has many roles. The aide is a person with a professionalism based on his grasp of the culture and feelings of a group rather than on specific academic preparation. Training, of course, is essential, but it is his unique capacity to communicate with a specific group of persons that makes the aide a member of the health department team. The aide is not a handmaid to the professional and does not perform menial tasks that the professional wishes to avoid.

One role which the aide performs is that of interpreter when language is a barrier to effective communication. This is a skill a person does not possess merely because he can speak a foreign language. Aides must have a fine grasp of the medical concepts which the professionals wish to have interpreted, but have to simplify and explain at a different level the ideas which are being presented. In addition, he has to gain the trust of the patient, who may be suspicious of the professional, and develop a rapport with the patient. We have found that when an aide interprets for the professional in an interview, the aide and the patient discuss the professional and establish a climate of trust before information can be transmitted. It is in this special area that the aide makes a unique contribution.

In some counties health departments use volunteers in clinics as we use aides, but in our clinics we use both aides and volunteers. The aide serves as a kind of hostess for the clinic—welcoming the patients, speaking to them while they are waiting, presenting such education material as films in the waiting rooms, calling patients into the physician's room, interpreting as needed for the physician, and entering data on records. The volunteers, in baby clinics for example, perform such services as weighing and measuring babies, giving PKU tests, assisting in dressing and undressing babies, and putting clean papers on tables.

The aides, because they are staff, are regarded by patients as confidants. Many people have reported that they came to the clinic only because they knew the aide would be there to help interpret, and because the aide knew things about the family. Also, because the aide is on the staff, confidential information, which ordinarily could not be told to a volunteer, is told to him by the professional staff member. Thus, aides can be used in venereal disease clinics and on cases involving severe marital problems.

The aide performs one of his most important functions in the patient's home. Community health aides make visits alone or with a professional, generally a nurse or social worker. If the aide acts alone it is at the direction of the professional. Aides follow up broken appointments for child health conferences and tuberculosis clinics. Often the reason for the broken appointment is lack of transportation or babysitters or because of illness in the home. But sometimes the real reason is resentment of the agency, fear of the treatment or the disease, or failure to comprehend the need for care. Health department nurses have been amazed at the amount of information, previously unknown by the health department, that the aides are able to ascertain about the family and its problems.

There are a number of cases which aides in the Santa Barbara health department can handle on their own. These involve new arrivals from Mexico who need help with such matters as how to use the laundromat or shop at the

supermarket. Aides have been helpful in working with young girls who have withdrawn to a point where they cannot attend school, by acting as a friend, taking the girl out for a soda or a ride. Aides have secured food, clothing, and household necessities for destitute families.

The results of the aide program have demonstrated the need for a homemaker service where some of the social aspects of family problems can be handled by other aides, leaving the community health aides free to deal with health problems. The community health aide may serve as an interpreter to private physicians or to help families in their relations with the courts, welfare department, mental health clinic, or mental retardation clinic.

The Santa Barbara County Health Department has always put education at the core of the community aide program. Many services are available to people; the problem is getting persons of the lower socioeconomic levels to use these services.

One approach has been to determine what people know and do not know about health and disease. The aides administer questionnaires and, based on the findings, appropriate health education materials are prepared. Pretests of these materials are carried out with aides administering them to families selected on a sampling basis. Pretests are always given before materials are printed in order to determine their readability level. The health educator supervises this aspect of the program. To reach the Mexican-American more effectively, tests to determine beliefs about health and disease are given by the aides. The aides make followup visits to determine why people fail to attend clinics. Door-to-door educational visits are made as part of extensive casefinding in tuberculosis control. Aides are taught to operate all audiovisual equipment, clip news articles, prepare bulletin boards, assist with proofing and translating written materials, and assemble mimeographed data.

Training the Aide

How do we bring a person who is untrained in public health, and who is shy and has feelings of inadequacy about his abilities to function in the working world, into a useful staff position in the health department? This is no small task and, accordingly, great care must be taken in the planning and execution of the training program. At least 200 hours (20 hours per week for 10 weeks) must go into the training before the aide can function relatively independently on the job.

We have found two general topics which can be successfully introduced early—the concept of disease and the various programs of the health department and other community agencies. Neither topic includes threatening information. The aides seem to learn most rapidly when they study the nature of bacteria, make observations in the laboratory, learn about various communicable diseases and their control, and observe immunization clinics. Along with the formal presentation, the aide can gradually be taught to assist in the clinic.

The aide needs to learn how he, as a member of the staff, must conduct himself along certain lines, including dress, punctuality, ethics, confidentiality, and role in the office team. He must gradually learn the structure and function of the entire health department, including the names and titles of the staff members. He should observe each clinic and be well informed on each program.

In general, lecture-discussions, films, and clinic observations are the chief methods used in teaching aides. Since many of the words are new to the aides, we encourage the use of word boxes with cards for each new word showing correct spelling and definition for frequent review.

The entire health department staff should be brought into the training program to familiarize the aide with each discipline and program and facilitate his eventual acceptance by the staff. The staff member in charge of training has to plan the schedule, arrange for speakers and films, introduce speakers, and help evaluate the aides as well as those helping with the training.

The heart of the aide training program is the human relations sequence. Here we present information on perception and communications using the rumor experiment. In the rumor experiment, four or five persons are sent out of the room. A picture with some religious, racial, or other potentially threatening material in it

is shown, and the first person looks at it with the audience. He then faces the audience and tells what he remembers of the picture to the second person (the picture remains visible to the audience). Each of the four or five persons in turn relates this memory of the picture to the next person. At the end the group discusses what was changed and why.

We also use the film, "Eye of the Beholder," followed by instruction on principles of interviewing given by the social worker. Role playing is introduced as a method to study more effectively the feelings of each participant. The aides observe a home visit of a senior aide, noticing techniques used to gain the confidence of the family.

A discussion of the aides' feelings and attitudes about working with families on various health problems is supplemented with a showing of the film, "Working for Better Public Health Through Recognition of Feelings." Broken appointments and their causes are discussed, and a film of the same name is shown. An understanding of patient resistance and the aides' reactions to it is stressed.

Many changes begin as the aides proceed through this sequence, which lasts at least 2 to 3 weeks. Gradually the aides go out on home visits, first with a senior aide, later alone. Much time is allotted for feedback of experiences in terms of kinds of problems encountered and effective ways to approach patients.

Other topics in the course are community resources, mental health and illness, child growth and development, working with groups, and survey methods.

Supervising the Aide

One device which is useful in giving the aide a sense of security is his weekly schedule. Each aide is assigned a variety of tasks each week, such as clinic work, recording, home visits, and special surveys. Individual requirements of aides are considered, and each is given an opportunity to participate in every activity and work under each nurse. This rotation eliminates competition and jealousy between aides. It also provides an opportunity for each aide to have some successes—in areas in which he is strong—and to improve his skills in areas in which he has limitations.

A weekly staff meeting is not only a clearinghouse for schedules and activities to be performed that week, but serves as continuous in-service education for all aides. Experiences are shared and doubts and fears can be forthrightly handled.

Individual conferences are held frequently with aides to discuss their own marital, health, and financial problems. These problems need to be relieved so that the aide can become more objective in working with others, and often solutions cannot wait for a scheduled staff meeting. Thus, the supervisor must be readily available.

Aides are carefully supervised in their case responsibilities. Aides are sent on patient visits at the request of the nurse or social worker, although certain cases are regularly carried by the aide. (These are often multiproblem families, known by several agencies, that need continuous supportive, understanding followup.) The aides record their visits for professional evaluation and, in addition, confer with professionals regarding the patient's problems and the aide's problems in dealing with the patient. Many times they must return again and again to the same family. Through these aide visits, much professional staff time is saved, for the aides can arrange for food or medical care, or both. A social worker formerly made agency contacts for case referrals, but we are now training aides to contact the agencies or other community resources.

Problems in an Aide Program

Problems can be expected when aides are used in a health department program. One of the most difficult steps is to get the professional staff to accept the aide in their programs and to use the aide effectively. Our sanitarians are extremely shortstaffed, but they have not as yet accepted aides in the sanitation program. The men seem to feel that the use of aides would lower the professional status of the sanitarian. The nurses used aides exclusively for interpreting at first and were afraid to allow aides to visit families alone. As the aides have demonstrated their skills, trust has grown and aides are now used extensively in the nursing program.

Initially, the people in the community were

wary about the aides, unsure if they could be trusted. In fact, some tested the aides by deliberately telling pieces of information to see if they would be carried further. As people have found that the aides regard the information told to them as confidential, they have turned to the aides with more and more intimate problems.

The community health aides are often confused with welfare department workers and encounter resistance from people who think the aides are checking on their use of welfare funds. The aides always carry an identification card and, where possible, drive a county car. Gradually, the aides have become known and appreciated by the people.

A number of problems need to be anticipated because of the aides' own situations. Aides are of a low socioeconomic level and often have serious financial problems. They are not accustomed to waiting 30 days for a paycheck and often the supervisor has to help out over the first few months. For women aides, home obligations take priority and the aide may need to take time off frequently for illness or problems in the home. Aides often do not assume the professional responsibility of calling into the office when they cannot meet appointments; they often do not carry through on assignments and must be reminded of them several times. Aides frequently fail to plan ahead for time off and vacations, but instead give very short notice. Some aides have trouble with transportation—either no car or a disabled one needing many repairs—although we now require a car for employment. All of these problems, if recognized, can be talked through in the training and given attention in the scheduling. Occasionally rivalry will develop. This can be anticipated and prevented by giving each aide an equal number and variety of clinic and home assignments, showing no favoritism.

Benefits From an Aide Program

Probably the most important result of this aide program has been an increased understanding of the problems of the Mexican-Americans. The aides have taught the professional staff and, consequently, the professionals are able to exercise more insight in their contacts with patients. The patients are most trustful of health department services and, as a result, the attendance at clinics has increased tremendously. Broken appointments occur less frequently. Two years ago only 10 percent of the patients kept their appointments at the chest clinic; now 90 percent keep these appointments.

Unquestionably, the aides have saved staff time, especially nursing time. More rapid interpretation of the patients by the aides for the physicians and nurses in clinics have made it possible for them to see more patients per day. With the aide to check on broken appointments, home visits by nurses are fewer.

Aides also deliver appointment slips and, at that time, tell the patient about the clinic, why it is important to keep appointments, and where to call if appointments cannot be kept. Patients are encouraged to take their own sputum bottles to the laboratory when they can, but unless the aide takes the bottle for those without transportation, it is never delivered to the laboratory. Followup X-rays and frequent sputum tests are, therefore, accomplished because the aide keeps after the patient.

The aides have also been able to ascertain information on a family by securing their trust and confidence at an interview. And lastly, the number of cases of tuberculosis found among the Mexican-American population has increased because of the intensive education program in Spanish carried on by the aides.

Recently health department aides have been assigned to a new migrant medical care clinic which they staff and to which they refer patients and do appropriate followup. In the clinic they take temperature and blood pressure measurements, greet patients, interpret for the physicians and nurses, and show health films in the waiting rooms.

Staff members of the Santa Barbara County Health Department are convinced that aides should be employed in general health department programs, not merely in the migrant project.

Within the jurisdiction of every health department are persons of low socioeconomic status from a variety of ethnic backgrounds. Aides can be drawn from the various groups to be reached and trained for a role on the health department team. The health department of San Jose City, Calif., for example, has included health aide positions in its civil service classi-

fications. Aides in that program are recruited from the lower socioeconomic area and must be bilingual. They work on assignment with nurses and sanitarians, and have been used successfully in public health nursing home visits and in helping the patient through the red tape at the county hospital.

In addition, aides are now being used in many Medicare programs as home health aides—either in health departments or with private nursing agencies.

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Study of Fatal Automobile Accidents

From on-scene investigations of 139 fatal automobile accidents during 4 years, researchers found that of 177 persons killed, 48 (27 percent) died by being thrown from the car; that was the leading single cause of death. Two-thirds of the 48 persons were thrown through doors that opened during the crash; others were propelled through windshields, door windows, or from open convertibles.

These conclusions were reached in a research project by Dr. D. R. Huelke and Dr. P. W. Gikas, University of Michigan School of Medicine. The project was supported by the Injury Control Program of the Public Health Service.

The investigators estimate from their examinations that 80 percent of the ejection deaths would have been prevented if the ejectees had worn seat belts.

Dr. Richard E. Marland, chief of the program, said that the study emphasizes the need to keep all doors of a car locked, as well as to have all seat belts fastened, while traveling in an automobile.