Tribal Community Health Representatives of the Indian Health Service

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FOR the first time a health aide exists in Indian communities who is not an employee of the local, State, or Federal Government or the representative of an outside agency. The community health representative represents the Indian community rather than a single profession. He is an employee of the tribal group who he represents and to whom he is responsible. He is a tribal member who resides within his community, and his training and orientation, though identified with health, are much broader in scope.

The health representative functions as a liaison person who identifies with his tribe and interprets to them and to the outside world their needs for the purpose of bringing existing health resources to bear upon their health difficulties. He also translates the advice of the health professional to Indian people in such a way that it is more clearly understood and a greater impact is realized from the health professional's efforts.

The use of various types of community workers has become commonplace in many Indian communities. These programs have been stimulated by the Office of Economic Opportunity or by the growing interest of many Indians in pursuing their own community development. Experience with OEO-funded health aide programs has been especially encouraging. The success of health aide programs and the expressed interest on the part of many Indian leaders in having more of these auxiliary health workers have resulted in the development of the Community Health Representative Program of the Indian Health Service.

To many health professionals the word "aide" means a person trained as a technician assisting and working under the direction of a health professional. The words "community health representative" carry a broader meaning. As a health worker he is trained in a broad understanding of health skills and practice. He is selected and supervised as an employee of the community. His ability to speak the tribal language as well as the language of the professional health workers helps to make him a more effective representative of his community. The expected result has been to bring into sharper focus the health difficulties and priorities which face the Indians. Demands have been created for more health services, and the delivery of such services has taken place.

The Tribal Program in 1969

Congress has appropriated funds for the Community Health Representative Program and authorized the Indian Health Service to contract with Indian tribes for the services of these health representatives and to provide suitable training for the tribal employees selected.

During fiscal year 1969 the Indian Health

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Service has trained and employed through contracts with Indian communities some 185 community health representatives. This program required negotiating contracts with some 37 Indian contractors who represented from one to several principal Indian tribes in 14 States. In addition, 185 Native village health aides were employed in Alaska for part of fiscal year 1969 and completed phase 1 of a four-phase training program that will extend for more than 3 years.

The function of the Alaska Native community health aide is substantially the same as that of the community health representative; however, the extreme isolation of Alaskan communities requires additional training to prepare the aide to provide a wider range of medical services under professional supervision received via shortwave radio or telephone.

Funds requested for fiscal year 1970 under mandatory increases will provide the additional amount needed to negotiate full-year contracts for the services of the 185 community health representatives and the 185 Alaska Native community health aides that were employed for part of fiscal year 1969. A requested increase in appropriations will permit the training and employment of 100 to 200 new community health representatives for part of fiscal year 1970.

Tribal Responsibilities

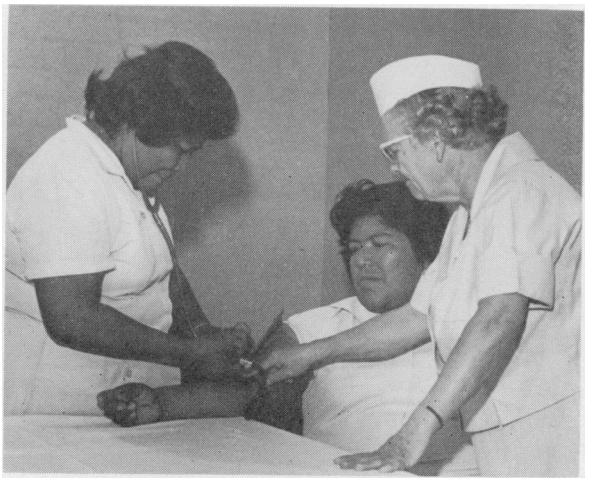
The tribal group which negotiates the contract must develop the proposal defining the types of services which will be provided. The group is also responsible for the recruitment and selection of Indians who are to serve as community health representatives. The tribal group has the additional responsibility, once the health representative has received formal training, to see that he receives adequate administrative supervision and to show that the services for which the Indian Health Service contracted are being provided. Thus, in these respects, the Community Health Representative Program is a new and unique concept for the provision of health services.

Characteristics and Qualifications

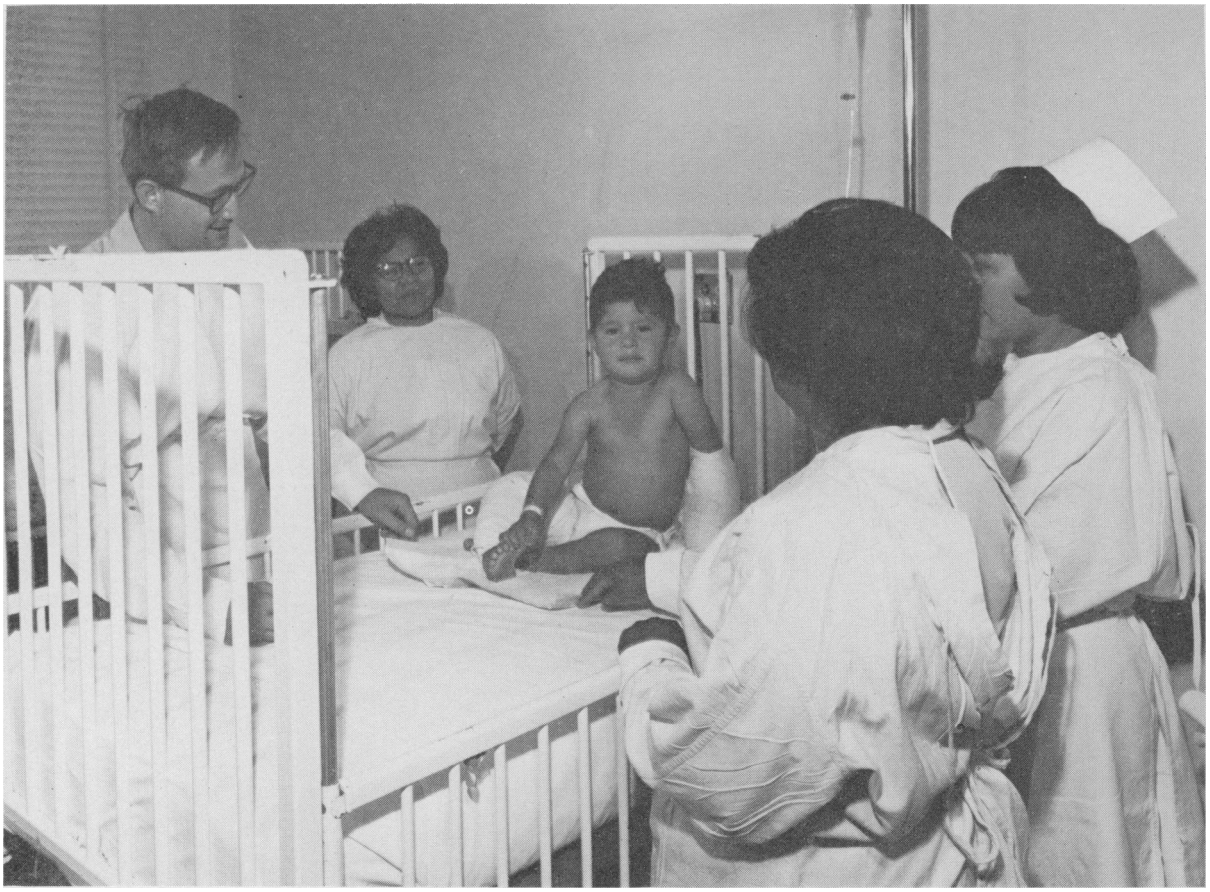
Beyond the essential qualifications of an ability to speak his tribal dialect and to speak and write effectively in English, no specific requirements or restrictions have been established for the age or educational level of the trainee. The important factor is that the tribal groups select persons who they feel will best serve the needs of their tribe.

The community health representative is selected for those traits and characteristics which the tribe feels he must possess to function effectively, within both the Indian and the non-Indian community, although he remains essentially a member of his tribe. Trainees selected for the program have run the spectrum of age and education. The tribes have chosen both men and women in their 20's to 50's, some with less than high school education and some with college training. The average salary is $4,200 a year. The personal characteristics that the tribes emphasize are a sensitivity and ability to recognize the needs of the community; an awareness of prevailing attitudes, beliefs, and practices related to health; and the ability to communicate information both to the Indian and non-Indian community.

The 4 weeks of intensive training at the Indian Health Service Training Center in Tucson, Ariz., followed by periods of varying lengths of training in the field at Indian Health Service units or other health resource locations at the State, county, city, and private levels, are not intended to turn out a health specialist. The training is designed to educate the trainees to



Community health representative learns to take blood pressure under direction of public health nurse at the Pima Reservation near Phoenix, Ariz.



Community health representatives help out in pediatric ward of Public Health Service Indian Hospital, Sacaton, Ariz.

sense the health needs and to bridge communication gaps between the Indian and the non-Indian world. In addition, the health representative is expected to identify health problems when they occur and know where, when, why, how, and to whom to go for help either in the medical community or in a related agency.

Training Protocol

Training protocol for the health representatives has been developed in the following four basic study areas.

Socioculture. This training is designed to give the individual trainee sociocultural insights which will enable him to examine and constructively review both the Indian and the non-Indian value systems. Similarities and differences which exist between the two systems are emphasized and included in the training area concerning concepts of health and diseases. The trainee, therefore, realizes how an understanding of both these systems is crucial to the formation of attitudes—especially attitudes relating to health and disease.

Communications skills. The health representative is trained as a two-way communicator. Learning how to do this effectively is the core of all training. The teaching of communication skills is not confined solely to conventional approaches, but also includes innovative approaches to develop the trainee's confidence in situations requiring such basic skills as telephone usage, interviewing techniques, conducting meetings and conferences, public speaking, making reports and referrals, and collecting and interpreting health data. Program planning, role playing, skits, group discussions, panel and group presentations, and group dynamics are used in the training course. In addition, case histories are studied to develop pro-

ficiency in problem solving and competency in techniques necessary to bring about changes in the community and in personal attitudes regarding health matters. Such training gives the trainee confidence in approaching the other members of the health team in a positive and constructive way.

Concepts of health and disease. The approach to imparting technical knowledge and skills in the area of health and disease is carried out in several ways. Didactic teaching in the conventional manner, such as studying body systems, anatomy, physiology, and the germ theory, is kept to a bare minimum. The training begins with the broad concepts of health and disease and how cultural background and value systems strongly influence both the person's and the community's attitudes toward health and disease. Training is related to the trainee's own perception of the well and the ill, and both Indian and non-Indian concepts are explored.

The trainee progresses from a simple understanding of causal relationships and body systems and processes to a working understanding of disease cause-and-effect relationships, including the roles that social, cultural, economic, and environmental conditions play in the prevention and control of disease.

Treatment followup procedures, family relationships, and community involvement are taught in terms acceptable and understandable to the people who will be served by the community health representative. Information on environmental health is not limited to sanitation but deals with the total environment as it relates to health and disease. Topics such as transmission of disease and concepts of prevention and control of disease are covered, as well as home safety, accident and fire prevention, and defensive driving.

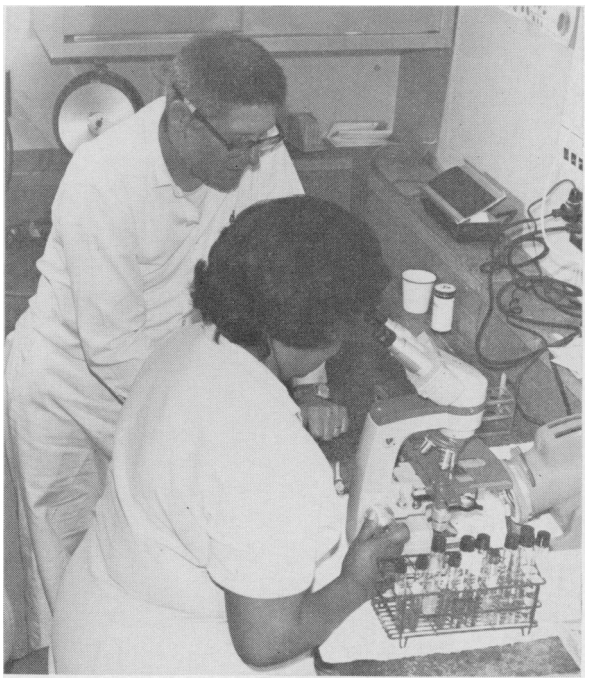
Technical skills. Technical skills such as taking temperatures, pulse, respiration, and blood pressure are taught in small groups to stimulate confidence and to insure that proficiency is developed. Specialized training is provided in home nursing, environmental health, advanced first aid, and other fields of public health as they are requested by the tribes.

Although the core training program provides uniform basic knowledge in public health, individual classes are tailored to the needs and requests of specific tribal groups. To prepare for such classes, the community health representative training staff visit the home communities of the trainees and meet with the tribal leaders and health officials in that community. Classes are limited to 10 to 12 trainees with an individual training officer for each class.

Discussion

Although it is too early to make an indepth evaluation of the impact of these workers in the communities where they are now employed, preliminary reports are optimistic. The unique position of this worker as a tribal employee rather than an employee of a government agency has enhanced the effectiveness of the health representative in carrying out his or her responsibilities. Early reports indicate that the presence of these representatives in the community, visiting individual homes and conducting group meetings, has generated an increased demand for health services.

In many locations where well child, chest, influenza, poliomyelitis, diabetes, and various physical screening clinics were held, attendance



Community health representative looks through a microscope in the Sacaton (Ariz.) Indian hospital laboratory

Home visit on the Pima Reservation near Phoenix, Ariz.

rose considerably at each successive clinic after community health representatives began to work. On one northwestern reservation, an unprecedented 85 percent of the village population turned out for examinations and immunizations at a general clinic. On a southwestern reservation, the community health representatives succeeded in getting 350 Indians to a conference on the problems of alcoholism.

They have effectively helped Indians reach sources of health services that were heretofore unknown to them. As a liaison between the tribe and health agencies they have stimulated the health agencies to take a greater interest in the Indian citizens of the communities for which they have responsibility.

The health representatives are channeling information to the Indian Health Service staff about how Indians perceive health and illness and what they think is good or bad about the health programs provided. This information should enable health programers to devise approaches that will be more readily accepted by the Indian people and thus be more effective in improving and maintaining their health status. Members of the Indian community have been helped to better understand why it is important to seek treatment or to participate in preventive health activities and thus improve their own health. In many instances community health representatives have brought patients in for treatment who had needed but had resisted care, either for themselves or for their children, for days, weeks, or months.

Community health representatives also show evidence of being viable change agents in the communities where they work because they stimulate both Indian and professional health staff to be concerned with the total community and to develop the human resources that exist

within it. This concern has resulted in health being viewed as only one input in community development and not an end all, be all unto itself. As a result, resource agencies across the board are being stimulated to cooperate and work together more effectively than they have in the past.

Because the health representative is a tribal employee and not a member of any one of these several agencies, he has been singularly effective in catalyzing this type of cooperative effort on behalf of the total development of the community in which he works. Thus far experience shows that this program will more than achieve its goal and that it has already become a vital and effective component of the total system delivering health services to Indian people.

Summary

The community health representative is the first health aide in an Indian community who is not an employee of the local, State, or Federal Government or the representative of an outside agency. He is an employee of the tribal group who he represents and to whom he is responsible.

For fiscal year 1969, Congress appropriated funds for the Community Health Representative Program and authorized the Indian Health Service to contract with Indian tribes for services of these health representatives. The service was also authorized to provide suitable training for the 185 tribal members selected.

Community health representatives receive 4 weeks of intensive training at the Indian Health Service Training Center in Tucson, Ariz., followed by field training of varying lengths. The intention of the training is not to turn out a health specialist, but to educate the trainee to sense the health needs and bridge communication gaps between the Indian and the non-Indian world. Emphasis is placed on identification of health difficulties and use of resources available to serve them.

Although it is too early to make an indepth evaluation of the impact of these workers, preliminary reports are optimistic. Their presence in the community, visiting individual homes and conducting group meetings, has generated an increased demand for health services and brought many patients into health facilities who had previously accepted services infrequently.

On the basis of experience thus far, there is substantial evidence that the program will more than achieve its goal.

Tearsheet Requests

Mrs. Jean M. Nowak, Indian Health Service, Room 822, Willste Bldg., 7915 Eastern Ave., Silver Spring, Md. 20910

Reflectorized Materials for Children's Clothing

The American Academy of Pediatrics strongly recommends that retroreflective materials, such as reflectorized tags attached to a child's coat zipper, be worn by children at night. This, the Academy emphasizes, will help to reduce significantly the more than 1,000 childhood deaths each year attributed to poor visibility during evening hours.

The Academy's Committee on Accident Prevention encourages the development of various commercial reflectorized materials to make pedestrians readily visible to drivers at night. Retroreflectorized materials can be affixed to clothing or incorporated in the design of a garment.

The Academy further recommends that more information concerning traffic safety be given to children.