Role of the Community Health Aide in Public Health Programs

WILBUR HOFF, Dr.P.H.

EVENTS during the past 2 years have strikingly pointed out many problems that exist among large segments of our communities. The National Advisory Commission on Civil Disorders, chaired by Otto Kerner, has discerningly described the effects of deprivation on persons who lack opportunities for a decent education and meaningful jobs and who grow up and live within a social climate of rejection and hostility (*1*). Perhaps of more importance are the findings of the President's National Advisory Commission on Rural Poverty (*2*) that describe the physical and emotional health problems of some 14 million Americans "who live in a state of poverty so acute and so widespread that it is a national disgrace—and its consequences have swept into our cities violently."

Health planners and administrators are under increasing pressures to devise new ways and systems for delivering more effective and more efficient health services to our nation's people. With the passage of Public Law 89–749 by Congress, the concept of comprehensive health planning became national health policy. The law states that ". . . the fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living . . ." (*3*).

Dr. Hoff is health education specialist, Institute for Health Research, Oakland, Calif., and health education consultant, California State Department of Public Health, Berkeley.

As our society begins to recognize that preventive and medical health care is a right not only for those who can afford it but for every citizen, we are faced with providing quality health services at the most economical cost. Obtaining the manpower to carry out this mandate is now of the highest priority. Unless we examine our current systems and practices for carrying out health programs and consider new ways of delivering adequate health services to the people, the impasse we are encountering will worsen. New approaches to the improved use of health manpower are being considered.

Ginzberg (*4*) and Kissick (*5*) discussed several approaches, such as the downward transfer of functions establishing new staffing patterns in health agencies, massive development of subprofessional aides and assistants with new positions and titles, the use of new technologies and mechanisms for recruitment and training, and the development of career systems that enable aides and assistants to move upward in a permanent health career.

Varied Uses of Aides

Many health agencies employ health aides and similar auxiliary workers. Although the concept of community aides in health programs is not new, their use in the United States has increased only within the past few years. The developing countries of the world have used aides

as an integral part of community development programs for nearly two decades.

In the 1950's, two programs in North America piloted the use of health aides. In one, educational aides were introduced into the Navaho Indian Reservation at Window Rock, Ariz., in a project developed by the University of California School of Public Health, Berkeley, for the Division of Indian Health, Public Health Service (*6*). These aides bridged the wide gap that existed between the Indians and the health and medical services that were available to them.

Another program, sponsored in 1958 by the Department of National Health and Welfare of Canada, offered community health for the Indians and Eskimos living north of the 60th parallel (*7*). The health educator in this program recognized 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."

Also in 1958, Florida's Palm Beach County Health Department employed a health aide to help nurses work with migrants in a community health program. The staff recognized the need to employ a person of the same ethnic background to work more effectively with the farmworkers in a migrant health program. In 1961 the Kern County Health Department in California employed a small number of community health aides in a pilot project to extend the services of the health department to the farmworker and his family (*8*). This project was based on the belief that persons with leadership qualities might be effectively recruited from the farmworker community and employed to help their neighbors accept good health practices—and thereby bring about a better understanding and improved use of existing health services.

When the Federal Migrant Health Act passed in 1962 and funds became available for services to migrants, larger numbers of health aides were used for such programs. In the next few years the use of persons from target population groups to dispense services within these groups increased by leaps and bounds. For example, during the first year of operation only two or three local projects included health aides. Four years later, 42 projects listed approximately 160 aides under titles of liaison worker, health aide, homemaker, and sanitation aide.

Heath (*9*) described the use of community health aides in a migrant health program of the Santa Barbara County Health Department in California. The community health aide, she said, "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."

Within the past 5 years, aides and indigenous workers have been used successfully in a variety of health programs. Stimulated by funds from the National Antipoverty Program, the Community Mental Health Program, and other special Federal legislation, health agencies began to experiment with the use of auxiliary personnel in a variety of ways.

In Pittsburgh, the Allegheny County Health Department piloted a successful project by using neighborhood-based workers as new and important members of the public health team (*10*). These nonprofessional workers made door-to-door surveys to encourage residents in one of the worst slum areas in Pittsburgh to get tuberculin tests or chest X-rays. The project was highly successful; 86 percent of all residents participated.

In another poverty area, neighborhood workers were used somewhat differently. In a maternity and infant care project the Denver Department of Health and Hospitals hired residents to interpret to their disadvantaged neighbors the nature and extent of health services that were available to them (*11*). The department found that the culturally and socially disadvantaged patient is not "hard to reach" when health programs are planned around the needs and wishes of the clients. The authors reported that while the workers were in the neighborhoods, the use of clinic services increased by 42 percent. In one neighborhood, more than 60 percent of the patients referred to a maternal and infant care clinic had been referred by the neighborhood worker. The clinics served by these neighborhood representatives treated an

average of 20 percent more unwed mothers than the clinics in comparable neighborhoods not served by representatives.

Stewart (*12*) stated that seven indigenous nonprofessionals were selected from lower socioeconomic groups to recruit patients from neighborhood areas for immunization clinics. The experimental areas assigned to these workers had been the responsibility of public health nurses, who had averaged 200 immunizations per month in the year before the aides were employed. After the aides began working, the immunization rates increased to more than 2,000 per month. When the project was discontinued the rate dropped significantly and within 3 months approached pre-experimental levels.

Reiff and Reissman described the unique characteristics of the indigenous nonprofessional in community action and community mental health programs (*13*). They thought the essential value of the indigenous nonprofessional was "his capability for acting as a bridge between the middle class oriented professional and the client from the lower socioeconomic groups. Implicit in the bridge concept is the notion that people drawn from lower socioeconomic strata may have special skills for establishing communication across class lines. This ability is rooted in their background. It is not based on things they have been taught, but on what they are."

Health workers from poverty areas were recruited and employed in two other projects to extend health services. One work-study project prepared public health subprofessionals for health services that traditionally were provided by professionals. In Massachusetts the Springfield Health Department, in cooperation with Holyoke Community College, recruited high school graduates from poverty areas and trained them as public health assistants in various health programs (*14*).

The other project was carried out by the Environmental Sanitation Program of the National Center for Urban and Industrial Health, Cincinnati (*15*). Persons from the Chicago ghettos were recruited and trained as health educator aides to function as environmental sanitation communicators and educators. They bettered the environmental health conditions of the city by improving the attitude of residents and by strengthening their motivation to achieve and maintain a healthier way of living.

Two local health departments in California experimented with health aides in programs. In 1965, the Alameda County Health Department in Oakland started using 10 part-time demonstration aides in a poverty health program (*16*). The aides' ability to extend health services to the poor became so apparent to the staff that in 2½ years the department employed more than 150 full-time aides to work in a variety of health programs; home care, sanitation, maternal and child health, family planning, dental health, communicable disease control, and alcoholism.

The Contra Costa County Health Department in Martinez piloted a project in a neighborhood multiservice center (*17*). Multipurpose workers, or primary counselors, demonstrated their ability to deliver services for health and wellbeing from three county departments (health, welfare, and probation) to assigned families in a disadvantaged neighborhood. The agency strongly emphasized the importance of training and employing even one multipurpose worker to give broad services to clients within communities.

The California Division of the American Cancer Society and the University of California School of Public Health are experimenting in a project (*18*) with the use of health education aides in local chapters of the cancer society agencies. This 2-year project aims to (*a*) delineate the role of the paid aide from that of the volunteer and the paid professional staff workers in the agency, (*b*) provide operational guides for the use of paid aides in public educational programs for the American Cancer Society, (*c*) develop suitable training guides for use in several voluntary health agency settings, and (*d*) demonstrate the possible areas of career development for indigenous persons in such agencies.

Hoff and Dunbar completed the most recent and comprehensive study on the use of auxiliary health workers in migrant health programs (*19*). The purpose of this study was to determine the nature, use, and effectiveness of aides in migrant health programs. Data on 12 sample projects selected throughout the United States were collected through interviews, activity studies, and performance assessments of 66 nurs-

ing, sanitation, and community health education aides, their supervisors, and 31 other professional staff. Findings included characteristics, recruitment and selection, nature and extent of training and supervision, administrative practices, and evaluation of the aides.

Significantly, the professional staff perceived the overall impact of the aides as a positive one on the health agency and the migrants. The professionals thought that the aides not only lightened the workload of the staff but also helped to create better relationships between the staff and the migrants and to bridge the cultural gap that existed. The main result of this study was a set of guidelines (*20*) for the recruitment, training, employment, supervision, and evaluation of auxiliary workers in health programs. A system model diagramed a series of progressive steps to implement these guidelines.

Future Usefulness of Aides

The health industry is now the second largest industry in the country, and by 1975 it probably will be the largest. Within this vast complex lies a tremendous number of health jobs. The potential exists for developing these jobs, and new ones yet to be created, into challenging health careers for people at all levels of education and experience.

The Governing Council of the American Public Health Association recently adopted a policy statement on health and poverty (*21*). This statement grew out of the members' concerns over our nation's failure to adapt its health system to the needs of large segments of its population. It states that the immediate problem of the poor is employment and recommends "a massive public employment program to complement an accelerated private industry employment program, including necessary training, to help make possible the provision of critically needed health and other community services, especially in poverty areas. The now unemployed can become a significant productive force."

Each agency has a professional, social, and moral responsibility to open its health programs to the citizens who live in the ghettos and slums and to create a place in the health system for them. We must do this immediately. We can provide meaningful health careers for the poor and the disadvantaged by first developing entry-level jobs for aides and then creating further opportunities for upward mobility. By recruiting and training aides and auxiliaries and making them full-fledged members of the health team, they not only can help in delivering more effective health services to poverty groups but can add new dimensions to the planning and organization of the health delivery system.

Summary

During the past decade the use of auxiliary personnel in public health programs has increased rapidly. Community health aides have been employed to perform a wide range of duties in health programs such as health education, communicable disease control, maternal and child health, dental health, family planning, and environmental health. Evidence from a variety of health programs and projects has demonstrated the value of using community aides. Increasing communications, bridging the cultural gap, and improving the delivery of health services to poverty, ethnic, and other neighborhood groups are values that have been demonstrated.

As the nation demands comprehensive health care for all its citizens, the need for more and new types of health personnel will increase. The creation of entry-level jobs for persons with low levels of education and experience and the development of meaningful health career opportunities for the poor are ways to meet these demands. To insure effective functioning of the new health manpower systems, adequate education and training programs for both health aides and professional workers are needed.

REFERENCES

(*1*) U.S. National Advisory Committee on Civil Disorders (Otto Kerner, chairman): Report. U.S. Government Printing Office, Washington, D.C., 1968.

(*2*) President's National Advisory Commission on Rural Poverty. The people left behind. U.S. Government Printing Office, Washington, D.C., September 1967.

(*3*) U.S. Senate: Comprehensive health planning and public health service amendments of 1966. Public Law 89–749. 89th Cong., U.S. Government Printing Office, Washington, D.C., Nov. 3, 1966.

(*4*) Ginzberg, E.: New dimensions of public health:

Their impact on the evaluation section of health personnel. II. A manpower strategy for public health. Amer J Public Health 57: 588–592, April 1967.
(*5*) Kissick, W. L.: Effective utilization. The critical factor in health manpower. Amer J Public Health 58: 23–29, January 1969.
(*6*) Roberts, B. J., Mico, P. R., and Clark, E. W.: An experimental study of two approaches to communication. Amer J Public Health 53: 1361–1381, September 1963.
(*7*) Martens, E. G., and Ryoner, S. N.: Health education for 200,000 Canadians. *In* Health educators at work. Vol. 15, edited by E. S. Tyler and L. S. Morgan. University of North Carolina School of Public Health, Chapel Hill, June 1964.
(*8*) Potts, D., and Miller, C. W.: The community health aide. Nurs Outlook 12: 33–35, December 1964.
(*9*) Heath, A. M.: Health aides in health departments. Public Health Rep 82: 608–614, July 1967.
(*10*) Domke, H. R., and Coffey, G.: Project planning and development by official health agencies. III. The neighborhood-based public health worker: Additional manpower for community health services. Amer J Public Health 56: 603–608, April 1966.
(*11*) Kent, J. A., and Smith, C. H.: Involving the urban poor in health services through accommodation: The employment of neighborhood representatives. Amer J Public Health 57: 997–1003, June 1967.
(*12*) Stewart, J. C.: Employment of indigenous personnel as a strategy for increasing immunization rates in hard core areas. Doctoral dissertation. University of Oklahoma, Oklahoma City, 1967.
(*13*) Reiff, R., and Reissman, F.: The indigenous nonprofessional: A strategy of change in community action and community mental health programs. Community Ment Health J Monograph Series, No. 1, Lexington, Mass., 1965.
(*14*) Bellin, L. E., et al.: Preparing public health subprofessionals recruited from the poverty groups: Lessons from an OEO work-study program. Amer J Public Health 57: 242–252, February 1967.
(*15*) U.S. Public Health Service: Health educator aides: A method for improving the urban environment tested in Chicago, Illinois. National Center for Urban and Industrial Health, Cincinnati, Ohio, February 1968.
(*16*) California State Department of Public Health: Alameda County Health Department is sold on health aides. Calif Health 25: 8–12, April–May 1968.
(*17*) Blum, H. L., et al.: The multipurpose worker and the neighborhood multiservice center. Initial experiences and implications of the Rodeo Community Service Center. Amer J Public Health 58: 458–468, March 1968.
(*18*) Callan, L. B.: Health education aide trainee project. Public Health Rep 84: 459–464, May 1969.
(*19*) Hoff, W., and Dunbar, R.: The use of auxiliary health personnel in migrant health programs. Migrant Health Program, U.S. Public Health Service, July 1968.
(*20*) Hoff, W.: Guidelines for the use of health aides in migrant health projects: Migrant health program. U.S. Public Health Service, Washington, D.C., January 1969. Mimeographed.
(*21*) American Public Health Association: Health and poverty: A policy statement. Amer J Public Health 59: 158–159, January 1969.

Tearsheet Requests

Dr. Wilbur Hoff, Farm Workers Health Service, California State Department of Public Health, Berkeley, Calif. 94704