THE EVOLUTION OF A VILLAGE-BASED HEALTH EDUCATION PROJECT

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The Maniilaq Health Education Program, like many health education programs in the circumpolar region, serves a discrete, isolated rural population, focusing on the preventative health needs of Northwest Alaska. This area, which covers 36,000 square miles includes Kotzebue and the ten other villages of the Northwest Arctic Borough: Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Noatak, Noorvik, Selawik and Shungnak, as well as Point Hope, which is located in the North Slope Borough.

About 80% of the 7,000 inhabitants are Inupiat (Eskimo). There are no connecting roadways between villages. Only air travel is possible year-round. Communications are often facilitated by the use of the "Tundra Telegraph" on our local Public Service Radio and CB's.

Located mostly above the Arctic Circle, the area experiences severe and prolonged winters. It is rich in natural resources, which sustains the population with subsistence hunting, fishing, and berry gathering.

Due to a loss of identity, a result of the introduction of western culture, and a change in lifestyle, the region is plagued by substance abuse and its side effects, an unnaturally high suicide rate and teen pregnancy. Village Councils, Elder's Councils, the School Board, the Regional Student Council, as well as local citizens, called upon this and other programs to help address these problems.

The Village Health Educator Project is one of our responses. It is a community-based, grass roots approach to dealing with health infonnation gathering and dissemination in the villages. Health strategies that are successful in the lower forty-eight states and other industrialized areas are not viable in this setting. Thus, we have developed a program tailored to our needs and circumstances.

DEMONSTRATED NEED

Our program is a comprehensive rural health education program, preventative in nature. Targeted health concerns, include but are not limited to adolescent pregnancy, fetal alcohol syndrome, self-esteem and decision making, substance abuse, suicide, cancer prevention and detection, diabetes education, parenting and child development, and weight reduction.

Although adolescent pregnancy does not carry the social stigma in this culture as in some others, physical, economic, educational, and social problems associated with teen pregnancy for both the mother and child are no less significant here, in a region with an already high infant mortality rate.

Substance abuse, particularly alcohol, has had an undetermined, though significant, impact on the region. It strongly influences the incidence of injuries and suicides. It causes an extremely high rate of police encounters, domestic violence, Fetal Alcohol Syndrome and Fetal Alcohol Effect, child abuse and neglect and various other negative life actions. There are singularly few families that are not touched by its presence. Statistics indicate that approximately one-half of Native Alaskan families are seriously affected by substance abuse.

The suicide rate is eight times the national rate overall and twenty-five times the national rate for males between the ages of 15 and 24 years. Nearly every family in the region has been touched by this tragedy in one way or another.

Recommendations concerning health and social issues were made at the 1989 Regional Elders Conference. These recommendations encompassed alcohol and drug use, tobacco use, and teen pregnancy.

The Northwest Arctic Borough School District Regional Student Council specified home problems which, when listed, actually reflected health and social problems found in the region as priority issues to address.

Statistics gathered by Maniilaq Association indicate a pressing need for adoption of preventative measures and education. The high rate of teen pregnancies, suicides and accidents and injuries demanded that different and more localized interventions were necessary, as previously used traditional approaches had too many limitations. Thus a community development model was chosen.

Although the above mentioned health concerns are priorities which we are continually addressing, we are also responsible for the planning, development, implementation and coordination of all preventative health education efforts on a variety of health concerns in our region.

BACKGROUND

Because we are potentially involved with the whole preventative health arena of our population, we put our efforts into areas identified by consumers which concern our population as well as interventions targeted by the medical staff of our service area. Many in the region have minimal access to primary health care. Each of the eleven villages in our service region has a clinic staffed by Community Health Practitioners who see and treat patients in their communities or refer them to Kotzebue for consultation with a physiciaa or hospitalization. The Community

Health Practitioners provide acute primary medical care and, unfortunately, do not have time for health education interventions beyond counselling individual patients.

To help increase the level of knowledge of preventative health care and healthy life skills and choices in the villages, the Maniilaq Health Education Program decided to pilot a Village Health Educator Project. Since our goal is to provide the people of the Northwest Arctic Borough with the tools that will enable them to make knowledgeable decisions concerning their lifestyle and health, we must first determine the needs of each individual village. Each village is unique and has its own set of concerns and priorities. In one village, the substance abuse problem may concern inhalant use among pre-adolescents, in another alcohol abuse may be the main issue. Sanitation and hygiene may be a priority in a third community whereas it is of no concern in a fourth village. For these reasons we believe that a system of making unilateral decisions in Kotzebue about the health areas that each clinic and community should address is ineffectual and not meeting the needs of the region.

Utilizing the experiences of the Program Manager and the basic tenets of Community Development and Health Promotion, we wanted to place the health status of each community into its own hands, encouraging ownership of individual as well as community health decisions.

Another factor involved in the transition from centralized to local planning was the transportation problem unique to serving eleven villages in the Arctic. Because of the vagaries of the weather it was often difficult to fulfil commitments to individual communities. Not only is it not possible to fly in extreme cold, but the region experiences fog and high winds often making air travel unreliable. Thus, having health educators in each village is more efficient and cost-effective.

IMPLEMENTATION

The Village Health Educator project was designed to involve the rural communities in identifying, maintaining, and/or improving their health status through education and commitment. This project enables each village to have a health educator who is trained to advise, inform, and facilitate health promotion activities. Through their village health educator, each community is able to identify and address its own specific health needs and then formulate a plan of action that will generate solutions to meeting those identified needs.

Criteria for the selection of the Village Health Educators are few. They must be from the village in which they will work and have plans to stay in that village. They must be concerned with the people of their village and be accepted and respected in the village. They must also demonstrate honesty, reliability, maturity, an eagerness to learn, openness to new ideas, an ability to lead and organize and show good judgement.

Their duties and responsibilities are, first and foremost, to conduct a needs assessment of their village, identifying not only health needs but cultural, social and economic factors which influence health. They conduct a community survey with the help of their neighbours, the village Council, Community Health Practitioners, Public Safety Officers and school staff. The elders help address the community concerns by offering their wisdom in finding solutions to the community problems together with younger generations resulting in a community commitment to bettering their health status. The Village Health Educators act as resource persons for their students and liaisons between the youth and their parents or elders when necessary. Since they are members of the community, the Village Health Educators enable villagers to talk to friends and paraprofessionals they know rather than outsiders. By working on the community level, the communities themselves discover the reasons for substance abuse, family violence, suicide, and accidental deaths. They can then explore solutions and institute interventions such as support groups, class activities and counselling to help meet the community needs. The villagers acquire an ownership in helping each other and the program thus insuring its continuation.

After community priorities are established other responsibilities of the Village Health Educator include facilitating discussions in the community, giving classes on health topics, preparing monthly reports and attending training sessions.

Selection of Village Health Educators for the pilot project began in September, 1989 and training began in October. The orientation sessions was held for three days and included instruction on community dynamics, basics of health education, program planning and documentation. Specific health issues and topics included maternal-child health, nutrition, substance abuse, self-esteem and decision making, dental hygiene, cancer prevention and detection, and environmental health issues. Training was provided by Maniilaq Association staff.

To demonstrate and reinforce the teaching method the Village Health Educators are to use in their sites, a non-formal and small group discussion format was used. Since many health topics are controversial, personal and sensitive, the relaxed atmosphere helps many people discover and discuss topics that they may not normally discuss in public. Therefore, the facilitator should strive for the most comfortable setting possible.

Subsequent training is held on a quarterly basis. In these sessions, we cover health specific topics such as Fetal Alcohol Syndrome and Fetal Alcohol Effect, AIDS, and community affairs. We also discuss what each Village Health educator is doing, what has

worked for them and what hasn't. In addition we take time to develop activity centres and work plans for the following quarter.

Many of the health issues the Village Health Educators will address in their villages are issues of which they are already knowledgeable. The Kotzebue office provides them with the skills to teach and advise their neighbours. In the areas where they need more information, the entire Maniilaq Association staff and health education program are resources to provide that knowledge. We also use outside technical assistance from various agencies such as American Lung Association, Planned Parenthood, the Alaska Native Health Board and the American Cancer Association. The training continually stresses that the Village Health Educators are educators and facilitators to behaviour change, not clinicians. They are encouraged to receive CPR and First Aid training when it is available in their villages.

Our next training session will be held in one of the villages instead of in Kotzebue so that all Health Education staff can learn about villages other than their own. In a joint venture between the Manillaq Health Education Program and the American Lung Association, smoking cessation training will be offered.

Other services provided to the Village Health Educators are access to our Resource Center and a quick response by the Health Education program staff to questions submitted to us. We will do library searches upon request. We promote access to the hospital clinical staff, mental health professionals, alcohol and drug outreach personnel and other Maniilaq programs to use as resources.

Between quarterly training sessions, we conduct site visits and weekly teleconferences with the Village Health Educators to insure that they receive timely and accurate information for their communities. This also helps the main office in the gathering of data and information for fundingsources as well as supporting the Village Health Educator in the work that they are currently doing.

The Village Health Educators work ten to twenty hours a week, September through May with the option to work in the summer.

DISCUSSION

The Village Health Educator Project is in its infancy, and four out of the eleven villages in the Northwest Arctic Borough are in the Pilot Project. The feedback we are receiving from the villages and other Maniilaq programs is favourable. The Village Health Educators are filling a void, especially in the school health field. They are acting as resource people to teachers, giving classes on AIDS, drugs and alcohol, suicide, adolescent sexuality, self-esteem and decision making and many other topics. They talk to the teachers and recommend videos and other resource materials that can be obtained through our resource. center and they organize Health Fairs for the villagers. They are working with the Elders in identifying community strengths and weaknesses. Most importantly, they are there to answer their friends and neighbours questions immediately and confidentially.

Weaknesses of the project lie in the administrative challenge of selecting highly motivated personnel and training those individuals, and in the communities themselves. We are working with the individual's in identifying and using their strengths as well as trying to improve their areas of weakness. Frustration from attempting projects too grandiose or from lack of attendance has demoralized all of the Village Health Educators at one point or another. But they keep trying and are beginning to see more community participation and interest.

We have also lost personnel in two villages due to social and family problems. Such situations are unfortunate but a part of village and individual reality.

Training personnel who have diverse educational backgrounds and needs is a challenge. We address this problem by working with the individual Village Health Educator during site visits. At times we bring them into Kotzebue for a few days of one-on-one training where training is focused on the individuals needs. This may be difficult because of the wide scope of community priorities. Since we are attempting to tailor the program to the needs of the individual communities, there is a wide variety of topics to be addressed. Findinga middle ground for the large training sessions is often difficult. We ask the Village Health Educators in what areas they feel they need instruction and base our training sessions on the topics most often mentioned. We cover other areas during site visits and by mail.

The communities themselves have a profound effect on the success of this project. Some of the villages in the region have identified areas of concern and are ready to confront the issues and work toward solutions. Others are uninterested or denying that they have problems or are waiting for somebody else to find solutions for them. This phenomenon is found worldwide and as yet, there is very little the community organizer can do except help them through this stage of development.

Funding for the project, which is currently being met by a grant from The Henry J. Kaiser Family Foundation, Menlo Park, California is an ongoing concern for the Health Education Program. This project has priority over our other projects. Thus we are actively seeking additional funding for its continuation.

We want this project to be successful as funding will follow recognition of a successful program. We also hope that the Village Health Educator Project will be adopted throughout Alaska and other rural areas that are in need of a comprehensive health education program.

In closing, the Village Health Educator Project in Northwest Alaska, though it is still a pilot program, is showing itself to be viable and effective. Given another three years in which to mature in interested villages, we believe it will help to improve the health awareness and status of the communities of the Northwest Arctic Borough, Alaska.