MARSHALL ISLANDS STUDY

HEALTH EDUCATION PROGRAM

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INTRODUCTION

At this time, there is no health education effort associated with the Marshall Islands Study. Dr. Jan Naidu (Safety and Environmental Protection, Brookhaven National Laboratory) has begun a well-received program to explain the effects of radiation in man. A companion effort mounted by the Medical Program will be directed towards education for the most common pathologic conditions (diabetes, high blood pressure, malnutrition, and dental problems). This will help the Marshallese understand the relationship of exposure to radioactive material in perspective with their overall health.

To be successful, the program must involve Marshallese, as much as possible, from the beginning. In fact, the program should eventually be run entirely by Marshallese, with BNL personnel serving only in an advisory capacity. Competent indigenous health facilitators can be developed more easily than almost any other allied health profession with a minimum dollar investment.

There is considerable interest now in expanding the Marshall Islands Study. This is an ideal time to begin an entirely new thrust. It has been shown in the past that the people do not understand BNL's role and responsibility without ongoing meetings and explanations. This would assure that need is met in a structured, responsible manner.

HEALTH EDUCATION PROGRAM REQUIREMENTS

This program will have two areas of responsibility which need to be closely related for maximum effectiveness:

1. Personnel development and inservice education.
2. Consumer/patient education.

In order to achieve lasting results, the people receiving the educational programs must be actively involved at all levels, from the beginning. In addition, they should have more direct involvement in the ongoing physical examination and screening portion. To accomplish this, more Marshallese need to be brought into the program. Men and women from each island will be recruited to assist MD's during physical examinations. They will serve as assistants/translators, as well as, in the case of females, chaperones. By training people on each island we are:

1. not so dependent on TT manpower;
2. more likely to head off ill will on each island because people who live there will see, first hand, what we are doing, what constraints we have and the mechanics of the program;
3. we develop people who can become indigenous health facilitators in our absence;
4. we cut costs because we do not have to pay for transportation and salaries on sailing days when no work is done.

The initial training can be done by the MD's and RN's now available to the program, plus two interpreters and the island's health aide, while the other BNL staff are setting up. (Initially, these local assistants would not be expected to perform procedures such as blood pressure measurement or dip stick urinalysis. That would be taught on subsequent surveys.)

It is important that the MD's participate in the training program so they will know what to expect from their assistants and they can begin establishing a working relationship immediately. These training programs always provide a forum for discussion of concerns regarding personal and family health problems. The BNL team can begin to ascertain what each island perceives its biggest health problem to be from this kind of exchange.

With the exception of the TT M.O.'s who accompany the survey, the majority of the BNL collaborators are unfamiliar with Marshallese customs and the TT health care delivery system. By assisting with the training and working with the local health aide and the TT medical interpreters, they will become more deeply involved with the community than they have in the past. The result should be a better understanding of one another's strengths and weaknesses.

As soon as the local people are trained and used on one survey, they should be contacted and used again as soon as possible. Those who drop out should be interviewed to determine why. The interview should be conducted by the BNL Marshallese nurse-practitioner to avoid any cultural bias. It is important that she be involved with all phases of the program, since her presence will lend credibility when plans for "Marshallization" of the program are discussed.

Based on information generated through village meetings and individual discussions with the newly-trained assistants, a pilot program will be developed to be given on the following survey visit. It will be relatively short, and simple hand-out materials will be devised that can be upgraded by the people who receive the first programs, demonstrating that they retain some control. The new assistants (facilitators) will be encouraged to assist in setting up and carrying out the program, if it is culturally appropriate.

Because this is an entirely new concept, both to BNL and the Marshallese, it should be implemented slowly, and should respond only to perceived needs, at first. By allowing the staff health educator freedom to do staff development as well as provide consumer/patient education, she is likely to be viewed as a credible professional by both groups. It also assures she will be assimilated into the working team and will find it easier to recruit educational resources from the professional staff.

Her key liaisons on each island will be the president of the women's club, the queen, the health aide, the minister and the school teacher. It is expected the trip leader will establish liaison with the magistrate and the iroij, if appropriate.

As the idea generates more demand for programs, health educator/RN or PA's (US-trained physician's assistants or medex or Fiji-trained medex) should be recruited for each island to work with the indigenous health facilitators. If Marshallese or other Micronesians are available, they should be given first consideration. If not, former Peace Corps volunteers who have gone back for medical training would be good job candidates, since they are familiar with the Marshall Islands and speak Marshallese. This program should work directly with the one currently being conducted by Dr. Naidu, which addresses the effects of radiation in man. It will be desirable to "share" educators.

Based on response to meetings held with women's groups on Rongelap and Utirik, on the May-June, 1979 Survey, the women would like programs on nutrition (aimed at weight reduction) on each island. In addition, on Rongelap, the women want to know how to care for acute and chronic otitis media in their children. On Utirik, a dental health program, with supplies, was requested. All of these requests, along with previous requests for education programs on diabetes and

hypertension, provide ample subject matter areas for starting. The important thing will be to make sure the programs are culturally sound and realistic. (The last TT nutrition consultant who lectured to the people of Utirik did so without mentioning a single food they had access to or cared for. This can be avoided by using Marshallese, whenever possible, in developing and delivering the programs.)

Additionally, at first, it will be better to offer a few programs and make each one a significant occurrence. As the idea is understood and accepted, they can and should be offered on a frequent, regular basis, further necessitating a fulltime staff person on each island. It is anticipated that specific programs could be supported by grant funds from various sources, such as drug companies, private foundations and several sources within HEW. Core support should, of course, come from DOE to assure continuity. The educational program should reach close to 100% of the population of each island within the first two to three years.